**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR Parts 410 and 419**

**[CMS–1471–FC]**

**RIN 0938–AL19**

# Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2004 Payment Rates

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

**ACTION:** Final rule with comment period.

**SUMMARY:** This final rule with comment period revises the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements and changes arising from our continuing experience with this system. In addition, it describes changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system. These changes are applicable to services furnished on or after January 1, 2004. Finally, this rule responds to public comments received on the August 12, 2003 proposed rule for revisions to the hospital outpatient prospective payment system and payment rates (68 FR 47966).

**DATES:** *Effective date:* This final rule is effective January 1, 2004.

*Comment date:* We will consider comments on the ambulatory payment classification assignments of Healthcare Common Procedure Coding System codes identified in Addendum B with new interim (NI) condition codes, if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 6, 2004.

**ADDRESSES:** In commenting, please refer to file code CMS–1471–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission or e-mail.

Mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1471–FC, P.O. Box 8018, Baltimore, MD 21244–8018.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to one of the following addresses: Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

**FOR FURTHER INFORMATION CONTACT:** Dana Burley, (410) 786–0378—outpatient prospective payment issues; Suzanne Asplen, (410) 786–4558 or Jana Petze, (410) 786–9374—partial hospitalization and community mental health centers issues.

**SUPPLEMENTARY INFORMATION:**

*Inspection of Public Comments:* Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call (410) 786–7195.

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*Alphabetical List of Acronyms Appearing in This Final Rule With Comment Period*

ACEP American College of Emergency Physicians
AHA American Hospital Association
AHIMA American Health Information Management Association
AMA American Medical Association
APC Ambulatory payment classification
ASC Ambulatory surgical center
AWP Average wholesale price
BBA Balanced Budget Act of 1997
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999
CAH Critical access hospital
CCR Cost center specific cost-to-charge ratio
CMHC Community mental health center
CMS Centers for Medicare & Medicaid Services (Formerly known as the Health Care Financing Administration)
CPT [Physicians'] Current Procedural Terminology, Fourth Edition, 2002, copyrighted by the American Medical Association
CY Calendar year
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DRG Diagnosis-related group
DSH Disproportionate Share Hospital
EACH Essential Access Community Hospital
E/M Evaluation and management
ESRD End-stage renal disease
FACA Federal Advisory Committee Act
FDA Food and Drug Administration
FI Fiscal intermediary
FSS Federal Supply Schedule
FY Federal fiscal year
HCPCS Healthcare Common Procedure Coding System
HCRIS Hospital Cost Report Information System
HHA Home health agency
HIPAA Health Insurance Portability and Accountability Act of 1996
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
IME Indirect Medical Education
IPPS (Hospital) inpatient prospective payment system
IVIG Intravenous Immune Globulin
LTC Long Term Care
MedPAC Medicare Payment Advisory Commission
MDH Medicare Dependent Hospital
MSA Metropolitan statistical area
NECMA New England County Metropolitan Area
OCE Outpatient code editor
OMB Office of Management and Budget
OPD (Hospital) outpatient department
OPPS (Hospital) outpatient prospective payment system
PHP Partial hospitalization program
PM Program memorandum
PPS Prospective payment system
PPV Pneumococcal pneumonia (virus)
PRA Paperwork Reduction Act
RFA Regulatory Flexibility Act
RRC Rural Referral Center
SBA Small Business Administration
SCH Sole Community Hospital
SDP Single drug pricer
SI Status Indicator
TEFRA Tax Equity and Fiscal Responsibility Act
TOPS Transitional outpatient payments
USPDI United States Pharmacopoeia Drug Information

## I. Background

### *A. Authority for the Outpatient Prospective Payment System*

When the Medicare statute was originally enacted, Medicare payment for hospital outpatient services was based on hospital-specific costs. In an effort to ensure that Medicare and its beneficiaries pay appropriately for services and to encourage more efficient delivery of care, the Congress mandated replacement of the cost-based payment methodology with a prospective payment system (PPS). The Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), enacted on August 5, 1997, added section 1833(t) to the Social Security Act (the Act) authorizing implementation of a PPS for hospital outpatient services. The Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113), enacted on November 29, 1999, made major changes that affected the hospital outpatient PPS (OPPS). The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554), enacted on December 21, 2000, made further changes in the OPPS. The OPPS was first implemented for services furnished on or after August 1, 2000.

### *B. Summary of Rulemaking for the Outpatient Prospective Payment System*

- On September 8, 1998, we published a proposed rule (63 FR 47552) to establish in regulations a PPS for hospital outpatient services, to eliminate the formula-driven overpayment for certain hospital outpatient services, and to extend reductions in payment for costs of hospital outpatient services.
- On April 7, 2000, we published a final rule with comment period (65 FR

18434) that addressed the provisions of the PPS for hospital outpatient services scheduled to be effective for services furnished on or after July 1, 2000. Under this system, Medicare payment for hospital outpatient services included in the PPS is made at a predetermined, specific rate. These outpatient services are classified according to a list of ambulatory payment classifications (APCs). The April 7, 2000 final rule with comment period also established requirements for provider departments and provider-based entities and prohibited Medicare payment for nonphysician services furnished to a hospital outpatient by a provider or supplier other than a hospital unless the services are furnished under arrangement. In addition, this rule extended reductions in payment for costs of hospital outpatient services as required by the BBA and amended by the BBRA. Medicare regulations governing the hospital OPPS are set forth at 42 CFR part 419. Subsequently, we announced a delay in implementation of the OPPS from July 1, 2000 to August 1, 2000.

- On August 3, 2000, we published an interim final rule with comment period (65 FR 47670) that modified criteria that we use to determine which medical devices are eligible for transitional pass-through payments. The rule also corrected and clarified certain provider-based provisions included in the April 7, 2000 rule.
- On November 13, 2000, we published an interim final rule with comment period (65 FR 67798) to provide the annual update to the amounts and factors for OPPS payment rates effective for services furnished on or after January 1, 2001. We implemented the 2001 OPPS on January 1, 2001. We also responded to public comments on those portions of the April 7, 2000 final rule that implemented related provisions of the BBRA and public comments on the August 3, 2000 rule.
- On November 2, 2001, we published a final rule (66 FR 55857) that announced the Medicare OPPS conversion factor for calendar year (CY) 2002. It also described the Secretary s estimate of the total amount of the transitional pass-through payments for CY 2002 and the implementation of a uniform reduction in each of the pass-through payments for that year.
- On November 2, 2001, we also published an interim final rule with comment period (66 FR 55850) that set forth the criteria the Secretary will use to establish new categories of medical devices eligible for transitional pass-through payments under Medicare's OPPS.
- On November 30, 2001, we published a final rule (66 FR 59856) that revised the Medicare OPPS to implement applicable statutory requirements, including relevant provisions of BIPA, and changes resulting from continuing experience with this system. In addition, it described the CY 2002 payment rates for Medicare hospital outpatient services paid under the PPS. This final rule also announced a uniform reduction of 68.9 percent to be applied to each of the transitional pass-through payments for certain categories of medical devices and drugs and biologicals.
- On December 31, 2001, we published a final rule (66 FR 67494) that delayed, until no later than April 1, 2002, the effective date of CY 2002 payment rates and the uniform reduction of transitional pass-through payments that were announced in the November 30, 2001 final rule. In addition, this final rule indefinitely delayed certain related regulatory provisions.
- On March 1, 2002, we published a final rule (67 FR 9556) that corrected technical errors that affected the amounts and factors used to determine the payment rates for services paid under the Medicare OPPS and corrected the uniform reduction to be applied to transitional pass-through payments for CY 2002 as published in the November 30, 2001 final rule. These corrections and the regulatory provisions that had been delayed became effective on April 1, 2002.
- On November 1, 2002, we published a final rule (67 FR 66718) that revised the Medicare OPPS to update the payment weights and conversion factor for services payable under the 2003 OPPS on the basis of data from claims for services furnished from April 1, 2001 through March 31, 2002. The rule also removed from pass-through status most drugs and devices that had been paid under pass-through provisions in 2002 as required by the applicable provisions of law governing the duration of pass-through payment.
- On August 12, 2003, we published a proposed rule (68 FR 47966) that proposed the Medicare OPPS conversion factor for CY 2004. In addition, it described proposed changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system.

*C. Summary of Changes in the August 12, 2003 Proposed Rule*

On August 12, 2003, we published a proposed rule (68 FR 47966) that proposed changes to the Medicare hospital OPPS and CY 2004 payment rates including proposed changes used to determine these payment rates. The following is a summary of the major changes that we proposed and the issues we addressed in the August 12, 2003 proposed rule.

1. Changes Required by Statute

We proposed the following changes to implement statutory requirements:

- Add APCs, delete APCs, and modify the composition of some existing APCs.
- Recalibrate the relative payment weights of the APCs.
- Update the conversion factor and the wage index.
- Revise the APC payment amounts to reflect the APC reclassifications, the recalibration of payment weights, and the other required updates and adjustments.
- Cease transitional pass-through payments for drugs and biologicals and devices that will have been paid under the transitional pass-through methodology for at least 2 years by January 1, 2004.
- Cease transitional outpatient payments (TOPS payments) for all hospitals paid under OPPS except for cancer hospitals and children s hospitals.

2. Additional Changes to OPPS

We proposed the following additional changes to the OPPS:

- Adjust payment to moderate the effects of decreased median costs for non-pass-through drugs, biologicals, and radiopharmaceuticals.
- Implement a new method for paying for drug administration.
- Create new evaluation and management service codes for outpatient clinic and emergency department encounters.
- Change status indicators for Healthcare Common Procedure Coding System (HCPCS) codes.
- List midyear and proposed HCPCS codes that are paid under OPPS.
- Allocate a portion of the outlier percentage target amount to community mental health centers (CMHCs) and create a separate threshold for outlier payments for partial hospitalization services.
- Create methodology and payment rates for separately payable drugs and radiopharmaceuticals for 2004.
- Make several changes in our current payment policy with regard to payment

for Q0081, Q0083, Q0084, and Q0085 to facilitate accurate payments for drugs and drug administration.

- Change the status indicator and payment amount for P9010 by assigning it to APC 0957 (Platelet concentrate) with a payment rate of $37.30.
- Establish new payment bands for new technology APCs.

*D. Public Comments and Responses to the August 12, 2003 Proposed Rule*

We received approximately 876 timely items of correspondence containing multiple comments on the August 12, 2003 proposed rule. Summaries of the public comments and our responses to those comments are set forth below under the appropriate section heading of this final rule with comment period.

We received comments from various sources including but not limited to health care facilities, physicians, drug and device manufacturers, and beneficiaries. Hospital associations and the Medicare Payment Advisory Commission (MedPAC) generally supported our proposed approach to revising the relative weights for APCs. Pharmaceutical and medical device manufacturers and some individual hospitals that furnish particular devices or drugs were concerned with the proposed reductions in payment for medical devices and drugs. We received many thoughtful comments from a wide range of commenters with regard to methodological issues in OPPS. In addition, several comments provided external data to support their assertions. The following are the major issues addressed by the commenters:

- The proposal to use $150 as the packaging threshold for separate payment of drugs.
- The proposal to pay for orphan drugs within the OPPS, basing payment on claims data.
- The proposal to pay for generic drugs at 43 percent of average wholesale prices (AWP) beginning with the time of the generic drug's Food and Drug Administration (FDA) approval.
- The proposed payments for blood and blood products under OPPS.
- The proposal to establish a separate outlier pool for community mental health centers(CMHCs).The proposal to apply an adjustment to increase payment to small rural hospitals' clinic and emergency room (ER) visit rates to ameliorate the effect of the sunsetting of the transitional corridor payments.
- The proposal to reinstitute drug and device coding requirements.
- Propose APC assignments and status indicators for numerous services.

In addition to comments regarding the policy proposals in the August 12, 2003 proposed rule, we received comments about the publication date of the proposed rule and the comment period.

*Comment:* Some commenters objected to the use of the date on which the August 12, 2003 proposed rule was made public by web posting and by public display at the Office of the Federal Register as the beginning of the comment period. They indicated that we should start the comment period only on the publication of the proposed rule in the **Federal Register** because that is where subscribers look for it. They objected to what they view as a 55-day comment period if it were to start on the date of **Federal Register** publication (August 12, 2003). Some commenters objected to the publication of the proposed rule so late in the year. They indicated that our publication on August 9 resulted in the comment period ending so close to the publication deadline for the final rule that they believed that their comments could not be fully analyzed and used and would not be as effective as if the proposed rule were published in June or early July. They urged us to publish the proposed rule in late spring. Some commenters objected to the scheduling of the APC Panel meeting so soon after the issuance of the proposed rule because they felt that it gave them inadequate time to prepare their presentations for the Panel.

*Response:* The comment period on a proposed rule begins on the day that the proposed rule is available for public comment. We believe that putting the document on display at the Office of the Federal Register and also making it available on the CMS Web site meets the test of being publicly available and that, therefore, is the start of the comment period. The publication of the proposed rule on the internet makes it available to many more people than routinely access the **Federal Register** or can visit the Office of the Federal Register where the display copy is located. The public had 60 days to comment on the proposed rule. This is the standard amount of time generally allowed for comment on notices of proposed rulemaking. Therefore, we do not believe the public was at a disadvantage or limited in the amount of time available to make public comments.

Our review of the public comments is extensive, with the comments being read and considered carefully, often by many staff. We agree that it is preferable, when possible, to issue the proposed rule as early as possible. However, the important issue is whether we have sufficient time to carefully and thoughtfully consider all comments in development of the final rule, rather than the amount of time between the end of the comment period and the publication of the final rule.

**II. Changes to the Ambulatory Payment Classification (APC) Groups and Relative Weights**

Under the OPPS, we pay for hospital outpatient services on a rate-per-service basis that varies according to the APC group to which the service is assigned. Each APC weight represents the median hospital cost of the services included in that APC relative to the median hospital cost of the services included in APC 0601, Mid-Level Clinic Visits. The APC weights are scaled to APC 0601 because a mid-level clinic visit is one of the most frequently performed services in the outpatient setting.

Section 1833(t)(9)(A) of the Act requires the Secretary to review the components of the OPPS not less often than annually and to revise the groups, relative payment weights, and other adjustments to take into account changes in medical practice, changes in technology, and the addition of new services, new cost data, and other relevant information and factors. Section 1833(t)(9)(A) of the Act requires the Secretary, beginning in 2001, to consult with an outside panel of experts to review the APC groups and the relative payment weights.

Finally, section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (referred to as the ''2 times rule'').

We use the median cost of the item or service in implementing this provision. The statute authorizes the Secretary to make exceptions to the 2 times rule ''in unusual cases, such as low volume items and services.''

For purposes of the proposed rule and this final rule we analyzed the APC groups within this statutory framework.

*A. Recommendations of the Advisory Panel on APC Groups*

1. Establishment of the Advisory Panel on APC Groups

Section 1833(t)(9)(A) of the Social Security Act (the Act) requires that we consult with an outside panel of experts, the Panel, to review the clinical integrity of the APC groups and their

weights. The Act specifies that the Panel will act in an advisory capacity. This expert panel, which is to be composed of representatives of providers subject to the OPPS (currently employed full-time, in their respective areas of expertise), reviews and advises us about the clinical integrity of the APC groups and their weights. The Panel is not restricted to using our data and may use data collected or developed by organizations outside the Department in conducting its review.

On November 21, 2000, the Secretary signed the charter establishing an ''Advisory Panel on APC Groups.'' The Panel is technical in nature and is governed by the provisions of the Federal Advisory Committee Act (FACA) as amended (Pub. L. 92–463).

On November 1, 2002, the Secretary renewed the charter. The new charter indicates that the Panel continues to be technical in nature, is governed by the provisions of the FACA, may convene ''up to three meetings per year,'' and is chaired by a Federal official.

To establish the Panel, we solicited members in a notice published in the **Federal Register** on December 5, 2000 (65 FR 75943). We received applications from more than 115 individuals nominating either a colleague or themselves. After carefully reviewing the applications, we chose 15 highly qualified individuals to serve on the Panel.

Because of the loss of 6 Panel members in March 2003 due to the expiration of terms of office, retirement, and a career change, a **Federal Register** notice was published on February 28, 2003 (68 FR 9671), requesting nominations of Panel members. From the 40 nominations we received, 6 new members have been chosen and have been identified on the CMS web site.

We received one comment regarding our selection of Panel members.

*Comment:* One commenter stated that Community Mental Health Centers (CMHCs) have not been represented on the APC Panel even though the names of qualified nominees have been submitted. The commenter went on to say that the **Federal Register** (February 28, 2003, at 68 FR 9671 through 9672) specifically states, ''Qualified nominees will meet those requirements necessary to be a Panel member. Panel members must be representatives of Medicare providers (including Community Mental Health Centers) subject to the OPPS * * * [therefore,] I feel that it is imperative to have a freestanding CMHC representative on the Panel.''

*Response:* The **Federal Register** notice on the APC Panel to which the commenter referred, states in section II, Criteria for Nominees, the following: ''The Panel shall consist of up to 15 members selected by the Secretary, or designee, from among representatives of Medicare providers (including Community Mental Health Centers) subject to the OPPS.'' The language does not mandate that a CMHC representative will be on the Panel. In the regulation, we simply identified representatives from CMHCs—or any other organizations—as possible nominees.

This year, when we requested nominations for the APC Panel, the list of nominees was long, prestigious, and included representatives from all aspects of the health care industry: Doctors, nurses, hospital administrators, coders, etc. Therefore, our choices were difficult; however, since there are definite Federal guidelines governing our selections, and specific Panel and Agency needs to address, given the clinical range of services paid under the OPPS, we were able to identify the most qualified individuals. Since the needs of the Agency and the Panel change due to members leaving, we invite all concerned Medicare providers to continue to nominate qualified individuals when the need arises.

The Panel's biannual meetings are forums to discuss APCs and representatives from the CMCHs—and other organizations—are invited to attend Panel meetings and to make presentations to the Panel on relevant agenda items.

*Comment:* The commenter also stated that the APC Panel sets the payment rates for the outpatient services.

*Response:* While the Panel is an advisory committee mandated by law to review the APC groups, and their associated weights, and to advise the Secretary of Health and Human Services and the Administrator of the Centers for Medicare & Medicaid Services concerning the clinical integrity of the APC groups and their weights, the APC Panel does not set payment rates for outpatient services. The advice provided by the Panel is considered by us in our development of the annual rulemaking to update the hospital OPPS. The APC Panel's activities most often address whether or not the HCPCS codes within the APCs are comparable clinically and with respect to resource use, assigning new codes to new or existing APCs, reassigning codes to different APCs, and the configuring of existing APCs into new APCs.

2. August 2003 Meeting

The APC Panel met on August 22, 2003 to discuss issues presented in the proposed rule of August 12. We announced the meeting in the **Federal Register** on July 25 and invited the public to make presentations to the Panel on issues discussed in the proposed rule. In this section, we summarize the issues discussed by the Panel, their recommendations on those issues, and our decisions with respect to their recommendations.

*a. Blood and Blood Products*

The Panel heard testimony by suppliers of blood and blood products and their representatives who expressed significant concerns about the proposed payment rates, particularly in light of new safety and testing requirements. These presenters to the Panel recommended that we exclude blood and blood products from the OPPS and pay for them at reasonable cost. After listening to the testimony, reviewing the median costs and proposed payments rate from our hospital claims data, and deliberating the issue, the Panel recommended that we continue to pay for blood and blood products within the OPPS. However, the Panel further recommended that we freeze the payment rates for blood and blood products at 2003 levels for 2004 and 2005 while we undertake further analysis of the cost data. The Panel also recommended that hospitals be educated on the proper billing for blood and blood products.

As discussed elsewhere in this final rule, we will accept the Panel's recommendation with respect to 2004. We will freeze the payment rates for blood and blood products at the 2003 payment levels. However, we are not making a decision with respect to 2005 at this time. Any proposals regarding our 2005 payment rates or policies for these items will be discussed in our proposed rule for the CY 2005 update. The Panel also recommended that the APCs for blood and blood products be on the agenda for the winter 2004 meeting in time for consideration of the 2005 payment rates. We agree to place this item on the agenda for the next APC Panel meeting.

*b. Nuclear Medicine, Brachytherapy, and Radiosurgery Services*

(1) Nuclear Medicine APCs and Radiopharmaceuticals

The Panel heard testimony on and considered the proposed restructuring of the nuclear medicine APCs discussed in the August 12, 2003 proposed rule. The Panel recommended that we move forward with the categorization system in the proposed OPPS 2004 rule absent strong, reasoned opposition from provider groups. If strong opposition was revealed in the public comments,

the Panel recommended that we maintain the classification system that is in place for 2003. The Panel also recommended that we change the HCPCS code descriptors for radiopharmaceuticals to be on a ''per-dose'' basis—not on a ''per-unit'' basis.

We have accepted the Panel's recommendation that we move forward with the proposed restructuring, after considering public comments on this issue. As discussed in section II.A.3 of this final rule, we will implement the restructuring with certain changes to the proposed reclassification based on our review of the public comments. For reasons discussed in section VI.B.3 of this final rule, we are not accepting the Panel's recommendation to change the HCPCS code descriptors at this time.

The Panel further recommended that APCs for radiopharmaceuticals be on the agenda for the January 2004 meeting. In preparation for that meeting, the Panel recommended that our staff analyze the claims for the nuclear medicine APCs and do the following: Itemize the costs, determine what proportion of the median cost can be attributed to radiopharmaceuticals, and present the data at the Panel's January 2004 meeting. The Panel recommended that the issue of packaging the costs of radiopharmaceuticals under the 2003 threshold of $150 be placed on the agenda for the Panel's winter 2004 meeting.

We will consider this topic for placement on the agenda for the Panel's 2004 meeting. As discussed in section VI.B.3 of this rule, however, we are revising our threshold for packaging radiopharmaceuticals from $150 to $50.

(2) Brachytherapy Services

The Panel recommended that we review whether the codes for needles and catheters were included in the payment rate proposed for APC 0313. The Panel also recommended that we consider outside data presented by commenters in establishing payment rates for APCs 312 and 651 to arrive at an appropriate payment rate. See our discussion, below, regarding APCs 312, 313, and 651 and our considerations concerning the claims used to set the relative weights for these APCs.

The Panel further recommended that we discontinue use of G codes for prostate brachytherapy and use appropriate Current Procedural Terminology (CPT) codes paid in clinical APCs when making payment for these services. The Panel recommended we pay separately for brachytherapy sources for the treatment of prostate cancer in the same manner by which we are paying separately for the brachytherapy sources for the treatment of other types of cancer. We have accepted the Panel's recommendation. As discussed in section II.B.4 of this final rule, we will discontinue use of the special G codes for prostate brachytherapy and allow separate payment for the sources used in these treatments.

(3) Radiation Therapy and Radiosurgery APC Issues

The APC Panel heard testimony concerning radiation treatment delivery codes CPT 77412 through 77416, which we proposed to assign to APC 0301 and CPT 77417, assigned to APC 0260. The presenter stated that many hospital billing departments had not updated their charge masters since the inception of OPPS to reflect the costs of newer technology, specifically with respect to the use of x-ray guidance during external beam radiation treatment delivery. The APC Panel recommended that we review whether the use of x-ray guidance (as opposed to CT or ultrasound guidance) for radiation therapy is being properly reported and included in the payment rates for the radiation treatment delivery codes. We agree that we should review these issues further and will do so in preparation for the 2005 update. However, we did not receive sufficient or convincing information upon which to base a change for 2004. Therefore, we encourage interested parties to submit any additional information on the use of these codes and cost of providing these services in the outpatient hospital setting in response to this final rule with comment period.

The APC Panel also heard testimony concerning the proposed payment rate for CPT 77418, assigned to APC 0412 (IMRT treatment delivery). The presenter stated that the proposed amount was too low. However, the APC Panel supported the proposal in the absence of compelling evidence that the rate derived from the claims data is wrong. We concur with the APC Panel's recommendation and will retain CPT 77418 in APC 0412. We used approximately 113,000 claims to set the weight for this procedure, which we believe is a sufficiently robust set of data.

During this section of the APC Panel's August 22 meeting, the Panel members also heard testimony concerning HCPCS codes G0251 and G0173 used to report stereotactic radiosurgery. The APC Panel supported the proposed payment rates for these codes until more data become available. The APC Panel also asked to review this issue further at its winter 2004 meeting. We discuss stereotactic radiosurgery in further detail below. We have decided to make certain changes to the payment for these procedures. However, the APC assignment for these codes for 2004 is interim final. We solicit comments on the 2004 assignments, and we will also include this on the APC Panel's agenda for its winter 2004 meeting.

The final topic in this section of the APC Panel's August 22 meeting pertained to HCPCS codes G0242 and G0243 (multi source photon stereotactic planning). The APC Panel was requested to recommend that we combine the coding for these procedures under one code, with the payment for the new code derived by adding the payment for G0242 and G0243 together. The information presented to the APC Panel stated that the services represented by the two G codes represent one continuous procedure, that it is a surgical procedure, and the cost center mapping should be to a surgical cost center. The APC Panel will review this request at its winter 2004 meeting. The APC Panel is interested in receiving comments on this topic from professional societies representing neurosurgeons, radiation oncologists and others concerning this proposal.

*c. Payment and Coding for Drug Administration and for Certain Drugs, Biologicals, and Radiopharmaceuticals*

The APC Panel heard testimony and discussed the proposals described in the August 12, 2003 proposed rule on payment for drug administration and the packaging of the costs of drugs, biologicals, and radiopharmaceuticals. The APC Panel recommended that:

- We continue to use the current ''Q'' codes for drug administration and not institute new ''G'' codes to represent the administration of either packaged or separately paid drugs.
- We allow billing of Q0081 on a per-visit basis, rather than on a per-day basis as proposed.
- We delete Q0085 and allow hospitals to use both Q0083 and Q0084 when billing for chemotherapy administered by both infusion and other techniques in a given visit.
- That we consider adopting the final option among the three new methods of paying for drug administration that we proposed, as options to the current policy, in the August 12, 2003 proposed rule.
- That we look further at hospital pharmacies' costs for preparing drugs and radiopharmaceuticals and this issue be examined more closely by the Panel during its winter 2004 meeting.

The APC Panel also expressed serious concern about the dollar threshold for

the packaging of drugs and the adequacy of payment for separately paid drugs. However, in the absence of alternative proposals by us, the APC Panel did not make further recommendations on that issue. The APC Panel requested that we present alternative options during the winter 2004 meeting, including a new APC structure for drugs and radiopharmaceuticals. As for specific drug issues, after hearing testimony concerning the codes for Baclofin refill kits, the APC Panel recommended that we delete code C9010 and retain the other codes for this product used in the treatment of Parkinson's disease and spasticity.

We have carefully considered each of the APC Panel's recommendations along with comments on the subject of drug administration and payment for drugs, biologicals, and radiopharmaceuticals. For the reasons discussed more fully elsewhere in this final rule, we have decided to accept the APC Panel's recommendations that we continue using Q0081 through Q0084 in 2004; that we continue to define these codes on a per-visit, rather than per-day basis; that we delete code Q0085; and that we delete code C9010. We have decided to continue paying for the drug administration ''Q'' codes according to our current rules and discuss that decision further in section VI.B.4 of this final rule. We will consider the Panel's recommendation that we investigate other approaches for paying for drugs and radiopharmaceuticals. However, for 2004, we have determined that we will pay separately under their own APCs for drugs, biologicals and radiopharmaceuticals for which the median per day costs are in excess of $50.

(4) Device-Related Procedures

The APC Panel heard testimony from the device manufacturing community and others concerning payment for procedures that involve the implantation of devices. The presenters discussed concerns that affected such procedures in general, such as the absence of a proposal to limit payment reductions for such procedures between 2003 and 2004 and issues related to the hospital claims for these procedures. Presentations to the APC Panel also discussed inadequacies in the claims data or our methodology for using the claims data to set relative weights for specific device-related APCs (APCs 0046, 0107, 0108, 0222, 0225, 0385, and 0386. Presenters urged that the APC Panel advise us to use the best external data possible, including proprietary data that would be held confidential. Presentations to the APC Panel also addressed the multiple surgical reduction with respect to device-related APCs.

The APC Panel recommended:

- That we use credible external data that can be made publicly available for establishing the median costs for APCs 0107 and 0386.
- That we change the status indicator for CPT 61885 so that it is not subject to the multiple procedure discounting.
- That we assign the new CPT codes for central venous access devices into appropriate APCs, either clinical APCs or new technology APCs.
- That the APC assignments of the new central venous access devices be reviewed by the APC Panel at its next meeting.
- That we provide the APC Panel with median cost data for all APCs in spreadsheet format for its consideration in advance of and during its next meeting.
- That we review the presenter's suggestions with respect to APC 0046 and make recommendations for any changes to this APC to the APC Panel at its next meeting.
- That we change the status indicator for CPT 93571 and 93572 from ''N'' (packaged status) to an appropriate indicator that allows separate payment under the APC.

We considered the final set of recommendations from the APC Panel's August 2003 meeting and have accepted several of them. Specifically, we decided to use external data in setting the median cost for 2004 for APC 0107. We have not used external data for APC 0386. Each of these decisions is discussed in greater detail elsewhere in this final rule. We accepted the Panel's recommendation to change the status indicator for CPT 61885. In order to do so, we moved this code into its own APC, 0039, Implant neurostim, one array. We have assigned the new CPT codes for central venous access devices to New Technology APCs as displayed in Addendum B. The range of new CPT codes is 36555 through 36597, and the new APC assignments include APCs 0032, 0115, 0109, 0187, and 1541.

The assignment of these codes is subject to public comment and will be placed on the APC Panel's agenda for its next meeting. During that meeting, we will also provide the APC Panel with spreadsheet data on the median costs of all APCs. With respect to APC 0046, we are sympathetic to the presenter's concerns. However, we were not provided with data that we considered sufficient to assess whether a new coding structure with increased payment rates is warranted for the treatment of bone fractures with external fixation devices. However, we would support the specialty societies' efforts to request changes to the existing CPT coding structure. For reasons discussed elsewhere, we have not accepted the Panel's recommendation with respect to CPT codes 93571 and 93572.

*Comment:* An association voiced concern that the Panel meeting on August 22, 2003 came too soon after the publication of the August 12, 2003 proposed rule for its members to prepare adequately for presentation to the Panel.

*Response:* The agency must schedule the Panel meetings sufficiently in advance of the meeting in order to provide ample notice to the public of the meeting and to allow sufficient time for the Panel members to arrange their schedules. We attempted to balance those needs with the goal of conducting the first mid-year meeting of the Panel during the comment period so that issues discussed in the August 12, 2003 proposed rule could be topics for the Panel's consideration and interested parties' testimony before the Panel. The July 25, 2003 **Federal Register** notice (68 FR 44089) announced the second 2003 meeting of the APC Panel, which we believe provided sufficient advance notice of the meeting.

While it is true that the proposed rule was placed on display on August 6, published on August 12, and the meeting was held on August 22, 2003, many interested parties attended the meeting and presented thoughtful comments on most issues discussed in the proposed rule. Nevertheless, we will take this comment into consideration for future planning of APC Panel meetings.

*Comment:* Several commenters expressed concern about the length of the meeting and time allotted on the agenda to particular issues. One commenter stated that scheduling only [1] day for Panel deliberations was inadequate. A commenter was concerned that device-related issues were relegated to the last hour, that presenters were given only 2 minutes, and that there was little time for Panel discussion and consideration of the issues presented.

*Response:* We appreciate the commenter's interest in ensuring that adequate time be allowed for the public to present issues for the Panel's consideration and for the Panel to have sufficient time for their discussion and deliberation.

Although the device issues were scheduled for the last hour of the meeting, the Panel members received the written presentations beforehand, and had an opportunity to review them

before the meeting. Placing a limit on presentations is a prerogative of the Panel Chair and must at times be done in order to allow all interested parties to make presentations on agenda items. However, we will take all of the concerns into consideration when scheduling future meetings.

3. Recommendations of the Advisory Panel and Our Responses

*January 2003 Meeting*

In this section, we consider the Panel's recommendations affecting specific APCs. The Panel based its recommendations on claims data for the period April 1, 2002 through September 30, 2002. This data set comprises a portion of the data that will be used to set 2004 payment rates. APC titles in this discussion are those that existed when the APC Panel met in January 2003. In a few cases, APC titles have been changed for this final rule, and, therefore, some APCs do not have the same title in Addendum A as they have in this section.

The Panel's agenda included APCs that our staff believed violated the 2 times rule as well as APCs for which comments were submitted. As discussed below, the Panel sometimes declined to recommend a change in an APC even though the APC appeared to violate the 2 times rule. In section II.B of the August 12, 2003 proposed rule, we discuss our proposals regarding the 2 times rule based on the April 1 through December 31, 2002 data that we used to determine the final 2004 APC relative weights. Section II.B (68 FR 47977) of the August 12, 2003 proposed rule also details the criteria we used when deciding to propose exceptions to the 2 times rule.

Unless otherwise specified in each of the following discussions of the APC Panel's recommendations, our proposed actions are finalized in this final rule.

*a. Debridement and Destruction*

APC 0012: Level I Debridement & Destruction

APC 0013: Level II Debridement & Destruction

We expressed concern to the Panel that APCs 0012 and 0013 appear to violate the 2 times rule. In order to remedy these violations, we asked the Panel to consider the following changes:

(1) Move the following codes from APC 0013 to APC 0012:

| HCPCS | Description |
|---|---|
| 11001 | Debride infected skin add-on. |
| 11302 | Shave skin lesion. |
| 15786 | Abrasion, lesion, single. |
| 15793 | Chemical peel, nonfacial. |
| 15851 | Removal of sutures. |
| 16000 | Initial treatment of burn(s). |
| 16025 | Treatment of burn(s). |

(2) Move code 11057 (Trim skin lesions, over 4) from APC 0012 to APC 0013.

The Panel agreed with our staff and recommended that we make these changes. We proposed to accept the Panel's recommendation.

However, we received comments from a group of hospitals concerning the proposed change for CPT code 15851, removal of sutures under anesthesia (other than local), same surgeon. In their comments, the hospitals noted that the descriptor for CPT codes 15851 and 15850 (removal of sutures under anesthesia (other than local), other surgeon, were virtually identical with the exception of which surgeon performs the suture removal. The commenters did not believe that the identity of the surgeon could result in a significant difference in resource costs to the hospital. Our clinical staff agree and believe that the difference in hospital median costs derived from our claims data may be due to a misunderstanding about the coding. For 2004, we have decided that we will place both CPT codes for suture remove under anesthesia in APC 0016.

*b. Excision/Biopsy*

APC 0019: Level I Excision/Biopsy

APC 0020: Level II Excision/Biopsy

APC 0021: Level III Excision/Biopsy

We expressed concern to the Panel that APCs 0019 and 0020 appear to violate the 2 times rule. In order to remedy these violations, we asked the Panel to consider the following changes:

(1) Move the following HCPCS codes from APC 0019 to a new APC:

| HCPCS | Description |
|---|---|
| 11755 | Biopsy, nail unit. |
| 11976 | Removal of contraceptive cap. |
| 24200 | Removal of arm foreign body. |
| 28190 | Removal of foot foreign body. |
| 56605 | Biopsy of vulva/perineum. |
| 56606 | Biopsy of vulva/perineum. |
| 69100 | Biopsy of external ear. |
| 11404 | Removal of skin lesion. |
| 11423 | Removal of skin lesion. |
| 11604 | Removal of skin lesion. |
| 11623 | Removal of skin lesion. |

The APC Panel recommended that we make these changes, and we proposed to do so in our August 12, 2003 proposed rule.

(2) Move the following HCPCS codes from APC 0020 to APC 0021:

The Panel recommended that we not change the structure of APCs 0019, 0020, and 0021 at this time in the interest of preserving clinical homogeneity. In August, we proposed to accept the Panel's recommendation that we make no changes to the structure of these APCs for 2004. However, following our review of the median costs developed for the final rule, using a more complete set of claims for services from April through December 2002, we determined that CPT codes 11404 and 11623 should be moved to APC 0021. We plan to place these APCs on the Panel's agenda for the 2005 update.

*c. Thoracentesis/Lavage Procedures and Endoscopies*

APC 0071: Level I Endoscopy Upper Airway

APC 0072: Level II Endoscopy Upper Airway

APC 0073: Level III Endoscopy Upper Airway

We expressed concern to the Panel that APCs 0071 and 0072 appear to violate the 2 times rule. In order to remedy these violations, we asked the Panel to consider the changes below.

Move the following HCPCS codes as described below:

TABLE 1.—HCPCS CODES FINAL TO BE REDISTRIBUTED FROM APCS 0071 AND 0072 TO APCS 0071, 0072, AND 0073

| HCPCS | Description | 2003 APC | 2004 APC |
|---|---|---|---|
| 31505 | Diagnostic laryngoscopy. | 0072 | 0071 |
| 31575 | Diagnostic laryngoscopy. | 0071 | 0072 |
| 31720 | Clearance of airways. | 0072 | 0073 |

The Panel recommended that we make the above changes. We proposed to accept the Panel's recommendation, with the exception of CPT code 31720. After reviewing an additional quarter of claims data that were not available at the time the Panel convened, placement of CPT code 31720 into APC 0072 better reflects its resource consumption. Therefore, we proposed to keep CPT code 31720 in APC 0072.

*d. Cardiac and Ambulatory Blood Pressure Monitoring*

APC 0097: Cardiac and Ambulatory Blood Pressure Monitoring

We expressed concern to the Panel that APC 0097 appears to violate the 2 times rule. We asked the Panel to recommend options for resolving this violation and suggested splitting APC 0097 into two APCs. The Panel recommended that the structure of APC 0097 should not be changed at this time based on clinical homogeneity considerations. We proposed to accept the Panel's recommendation that we make no changes to APC 0097 for 2004. We received no comments disagreeing with this proposal, and we will adopt it for 2004. We also plan to place this APC on the Panel's agenda for the 2005 update.

*e. Electrocardiograms*

APC 0099: Electrocardiograms

APC 0340: Minor Ancillary Procedures

We expressed concern to the Panel that APC 0099 appears to violate the 2 times rule. We asked the Panel to recommend options for resolving this violation, and suggested moving CPT code 93701 (Bioimpedance, thoracic) from APC 0099 to APC 0340. The Panel believed, however, that the structure of APC 0099 should not be changed at this time based on clinical homogeneity considerations. We proposed to accept the Panel's recommendation that we make no changes to APC 0099 for 2004. We plan to place this APC on the Panel's agenda for the 2005 update.

*f. Cardiac Stress Tests*

APC 0100: Cardiac Stress Tests

A presenter to the Panel, who represented a device manufacturer, requested that we move CPT code 93025 (Microvolt t-wave assessment) out of APC 0100. The presenter believes that the actual cost for this procedure is significantly higher than for other procedures in the same APC. Since this technology is often billed in conjunction with other procedures (for example, stress tests, CPT code 93017), few single-APC claims were available to evaluate the presenter's contention.

The Panel believed the data presented are insufficient to merit moving the code and recommended that CPT code 93025 remain in APC 0100 until more data are available for review. We proposed to accept the Panel's recommendation that CPT code 93025 remain in APC 0100 until more claims data become available for review. We will adopt this proposal for 2004.

*g. Revision/Removal of Pacemakers or Automatic Implantable Cardioverter Defibrillators*

APC 0105: Revision/Removal of Pacemakers, AICD, or Vascular

We asked the Panel to review the codes within APC 0105 for an apparent violation of the 2 times rule, stating that we believe the apparent violation is a result of incorrectly coded claims. The Panel agreed and recommended no changes to APC 0105 at this time. We proposed to accept the Panel's recommendation that we make no changes to APC 0105 until more accurate claims data become available and support the need for a change. We will adopt this proposal for 2004.

*h. Sigmoidoscopy*

APC 0146: Level I Sigmoidoscopy

APC 0147: Level II Sigmoidoscopy

We expressed concern to the Panel that relatively simple procedures such as anoscopy and rigid sigmoidoscopy have higher median costs than more complex procedures such as flexible sigmoidoscopy. Panel members suggested the high costs may be due to the need to perform an otherwise minor office procedure in a hospital setting (for example, due to the clinical condition of the patient). Panel members also suggested that claims may be incorrectly coded because coding instructions do not clearly state how to code when the procedure performed is not as extensive as the procedure planned (for example, when a colonoscopy is planned but only a sigmoidoscopy is performed). In these cases, coding instructions are unclear as to whether the planned procedure should be reported with a modifier for reduced services or with the code for the actual procedure performed.

The Panel recommended that we make no changes to APCs 0146 and 0147 at this time. We proposed to accept the Panel's recommendation that we make no changes to APCs 0146 and 0147. We will adopt this proposal for 2004. However, we plan to place this APC on the Panel's agenda for the 2005 update.

i. Anal/Rectal Procedures

APC 0148: Level I Anal/Rectal Procedure

APC 0149: Level III Anal/Rectal Procedure

APC 0155: Level II Anal/Rectal Procedure

We expressed concern to the Panel that APCs 0148 and 0149 appear to violate the 2 times rule. We asked the Panel to recommend options for resolving these violations, and suggested rearranging some of the CPT codes within APCs 0148, 0149, and 0155. The Panel recommended that we move CPT code 46040 (Incision of rectal abscess) from APC 0155 to APC 0149. We proposed to accept the Panel's recommendation, and we will adopt it for 2004.

*j. Insertion of Penile Prosthesis*

APC 0179: Urinary Incontinence Procedures

APC 0182: Insertion of Penile Prosthesis

A presenter to the Panel representing manufacturers and providers requested that APC 0182 be split into two APCs, based on whether the procedure used inflatable or non-inflatable penile prostheses. The presenter stated that the complexity of the procedure, the cost of the devices, and related resources were all significantly higher with inflatable prostheses.

The Panel recommended that we eliminate APCs 0179 and 0182 and create two new APCs, 0385 and 0386, that contain the following CPT codes:

APC 0385

| HCPCS | Description |
|---|---|
| 52282 | Cystoscopy, implant stent. |
| 53440 | Correct bladder function. |
| 53444 | Insert tandem cuff. |
| 54400 | Insert semi-rigid prosthesis. |
| 54416 | Remv/repl penis contain prosthesis. |

APC 0386

| HCPCS | Description |
|---|---|
| 53445 | Insert uro/ves nck sphincter. |
| 53447 | Remove/replace ur sphincter. |
| 54401 | Insert self-contained prosthesis. |
| 54405 | Insert multi-comp penis prosthesis. |
| 54410 | Remove/replace penis prosthesis. |

We proposed to accept the Panel's recommendation to eliminate APCs 0179 and 0182 and create two new APCs, 0385 and 0386, containing the above CPT code configurations.

*k. Surgical Hysteroscopy*

APC 0190: Surgical Hysteroscopy

A presenter to the Panel, who represented a device manufacturer, requested that we move CPT code 58563 (Hysteroscopy, ablation) from APC 0190 to a higher paying APC. The presenter noted that endometrial cryoablation is included in a new technology APC, while a thermal ablation system is included with older, less costly

techniques. The presenter expressed concern that cryoablation may be reimbursed at a higher rate than the thermal ablation system, giving its manufacturers an unfair competitive advantage.

Panel members agreed that new, more expensive technologies that prove to be more effective merit review for a higher payment rate. Without substantial evidence of greater effectiveness, however, the Panel was reluctant to create APCs that provide an incentive to use a more expensive device. In its discussion of whether or not to recommend moving CPT code 58563 to a higher paying APC, the Panel recommended that we take into account different methods of endometrial ablation associated with hysteroscopy, adequately reflect the resources used for the various procedures, avoid creating a competitive advantage or disadvantage, and collect data needed to track costs on the type of technologies used for this procedure.

After consulting with experts in the field, we proposed to split APC 0190 (Surgical Hysteroscopy) into two APCs that are more clinically homogeneous. We proposed to change the description for APC 0190 from ''Surgical Hysteroscopy'' to ''Level I Hysteroscopy'' and keep the following HCPCS codes in APC 0190:

| HCPCS | Description |
|---|---|
| 58558 | Hysteroscopy, biopsy. |
| 58559 | Hysteroscopy, lysis. |
| 58562 | Hysteroscopy, remove fb. |
| 58579 | Hysteroscope procedure. |

We also proposed to move the following HCPCS codes from APC 0190 to newly created APC 0387 titled ''Level II Hysteroscopy'':

| HCPCS | Description |
|---|---|
| 58560 | Hysteroscopy, resect septum. |
| 58561 | Hysteroscopy, remove myoma. |
| 58563 | Hysteroscopy, ablation. |

In addition, we proposed to move the following HCPCS codes as described below:

TABLE 2.—HCPCS CODES TO BE REDISTRIBUTED TO APCS 0130, 0195, AND 0190

| HCPCS | Description | 2003 APC | 2004 APC |
|---|---|---|---|
| 58578 | Laparoscopic procedure, uterus. | 0190 | 0130 |
| 58353 | Endometrial ablate, thermal. | 0193 | 0195 |
| 58555 | Hysteroscopy, diagnostic, sep. procedure. | 0194 | 0190 |

We believe these final changes take into account the different technologies used to perform these procedures while maintaining the clinical comparability of these APCs as well as improving their homogeneity in terms of resource consumption.

1. Female Reproductive Procedures

APC 0195: Level VII Female Reproductive Proc

APC 0202: Level VIII Female Reproductive Proc

A commenter requested that we place CPT code 57288 (Repair bladder defect) in its own APC because it requires the use of a device. Our staff suggested that CPT codes 57288 and 57287 remain in APC 0202, while the remaining codes in APC 0202 be moved to APC 0195:

| HCPCS | Description |
|---|---|
| 57109 | Vaginectomy partial w/ nodes. |
| 58920 | Partial removal of ovary(s). |
| 58925 | Removal of ovarian cyst(s). |

The Panel agreed with our staff, and we proposed to accept the Panel's recommendation to move CPT codes 57109, 58920, and 58925 from APC 0202 to APC 0195. We will adopt the Panel's recommendation for 2004.

*m. Nerve Injections*

APC 0203: Level IV Nerve Injections

APC 0204: Level I Nerve Injections

APC 0206: Level II Nerve Injections

APC 0207: Level III Nerve Injections

Several commenters suggested changes in the configuration of APCs 0203, 0204, 0206, and 0207 because of concerns that the current classifications result in payment rates that are too low relative to the resource costs associated with certain procedures in these APCs. Several of these APCs include procedures associated with drugs or devices for which pass-through payments are scheduled to expire in 2003.

We requested the Panel's input regarding whether or not these APCs should be restructured. The Panel stated that the current configuration of APCs 0203, 0204, 0206, and 0207 is more clinically cohesive than the previous year's configuration and that more data should be collected before making any changes. We proposed to accept the Panel's recommendation that we make no changes to the structure of these APCs until more data become available for review. We will adopt the Panel's recommendation for 2004.

*n. Laminotomies and Laminectomies; Implantation of Pain Management Device*

APC 0208: Laminotomies and Laminectomies

APC 0223: Implantation of Pain Management Device

A presenter to the Panel, who represented a device manufacturer, requested that we move CPT code 62351 (Implant spinal canal catheter) from APC 0208 to APC 0223 to better capture the device cost that may be involved with the procedure. The Panel believed the data were insufficient to merit moving the code and recommended that CPT code 62351 remain in APC 0208 until more data are available for review. We proposed to accept the Panel's recommendation that CPT code 62351 remain in APC 0208 until more claims data become available for review. We will adopt the Panel's recommendation for 2004.

*o. Extended EEG Studies and Sleep Studies; Electroencephalogram*

APC 0209: Extended EEG Studies and Sleep Studies, Level II

APC 0213: Extended EEG Studies and Sleep Studies, Level I

APC 0214: Electroencephalogram

We expressed concern to the Panel that APC 0213 appears to minimally violate the 2 times rule. In order to remedy this violation, we asked the Panel to consider a commenter's suggestion that we move CPT code 95955 (EEG during surgery) from APC 0214 to APC 0213. The Panel agreed with the commenter's suggestion. We proposed to accept the Panel's recommendation to move CPT code 95955 from APC 0214 to APC 0213.

*p. Nerve and Muscle Tests*

APC 0215: Level I Nerve and Muscle Tests

APC 0216: Level III Nerve and Muscle Tests APC 0218:

Level II Nerve and Muscle Tests

We expressed concern to the Panel that APC 0218 appears to violate the 2 times rule. In order to remedy this violation, one commenter requested that we move CPT codes 95921 (Autonomic nerve function test) and 95922 (Autonomic nerve function test) from APC 0218 to APC 0216, while another

commenter requested that we move CPT code 95904 (Sensory nerve conduction test) from APC 0215 to APC 0218. Alternatively, our staff suggested to the Panel that the following CPT codes be moved from APC 0218 to APC 0215.

| HCPCS | Description |
|---|---|
| 95858 | Tensilon test & myogram. |
| 95870 | Muscle test, nonparaspinal. |
| 95900 | Motor nerve conduction test. |
| 95903 | Motor nerve conduction test. |

After considering all of the above proposals, the Panel recommended that we move CPT codes 95858, 95870, 95900, and 95903 from APC 0218 to APC 0215. We proposed to accept the Panel's recommendation.

*q. Implantation of Drug Infusion Device*

APC 0227: Implantation of Drug Infusion Device

APC 0227 contains only two CPT codes: Implantation of programmable spine infusion pumps, 62362, and Implantation of non-programmable spine infusion pumps, 62361. A commenter requested that we split APC 0227 into two APCs to recognize the cost difference between CPT code 62361 and CPT code 62362. However, since our cost data do not show a significant cost difference between the two devices and APC 0227 does not violate the 2 times rule, the Panel recommended that CPT codes 62361 and 62362 remain in APC 0227. We proposed to accept the Panel's recommendation, which we will adopt for 2004.

*r. Ophthalmologic APCs*

APC 0230: Level I Eye Tests & Treatments

APC 0235: Level I Posterior Segment Eye Procedures

APC 0236: Level II Posterior Segment Eye Procedures

APC 0698: Level II Eye Tests & Treatments

We advised the Panel that APCs 0230 and 0235 violate the 2 times rule but that the current configuration of these APCs reflects the Panel's previous recommendations. A presenter to the Panel, who represented a device manufacturer, expressed concern that the pass-through device category ''New Technology: Intraocular Lens'' was discontinued and these devices are now packaged. The presenter asked the Panel to recommend that future new intraocular lens devices be considered for a new pass-through category.

To remedy the violations to the 2 times rule, we asked the Panel to consider moving CPT code 67820 (Revise eyelashes) from APC 0230 to APC 0698 and CPT code 67110 (Repair detached retina) from APC 0235 to APC 0236. The Panel recommended that we make these changes. We proposed to accept the Panel's recommendation and monitor the data for APC 0235 for possible review next year. We will adopt this recommendation for 2004. The Panel also acknowledged that making recommendations concerning pass-through categories is beyond their purview.

*s. Skin Tests and Miscellaneous Red Blood Cell Tests; Transfusion Laboratory Procedures*

APC 0341: Skin Tests and Miscellaneous Red Blood Cell Tests

APC 0345: Level I Transfusion Laboratory Procedures We advised the Panel that APCs 0341 and 0345 minimally violate the 2 times rule and suggested moving several CPT codes within these APCs into a new APC because a commenter expressed concern over the combination of skin tests and miscellaneous red blood cell tests in APC 0341, asserting that services within this APC cannot be considered comparable with respect to resource usage.

In order to remedy these violations to the 2 times rule, we suggested moving CPT code 86901 (Blood typing, Rh (D)) from APC 0345 to a new APC along with the following CPT codes from APC 0341:

| HCPCS | Description |
|---|---|
| 86880 | Coombs test, direct. |
| 86885 | Coombs test, indirect, qualitative. |
| 86886 | Coombs test, indirect, titer. |
| 86900 | Blood typing, ABO. |

The Panel recommended that we make the above changes. We proposed to accept the Panel's recommendation to move HCPCS codes 86880, 86885, 86886, and 86900 from APC 0341 to new APC 0409 and to move CPT code 86901 (Blood typing, Rh (D)) from APC 0345 to new APC 0409. We will adopt the Panel's recommendation for 2004.

*t. Otorhinolaryngologic Function Tests*

APC 0363: Level I Otorhinolaryngologic Function Tests

APC 0660: Level II Otorhinolaryngologic Function Tests

We expressed concern to the Panel that APC 0660 appears to violate the 2 times rule and suggested moving CPT codes 92543 (Caloric vestibular test) and 92588 (Evoked auditory test) from APC 0660 to APC 0363. The Panel recommended that we make these CPT code changes. We proposed to accept the Panel's recommendation to move CPT codes 92543 and 92588 from APC 0660 to APC 0363, and we will adopt the proposal for 2004.

*u. Tube Changes and Repositioning*

APC 0121: Level I Tube changes and Repositioning

APC 0122: Level II Tube changes and Repositioning

We expressed concern to the Panel that APC 0121 appears to violate the 2 times rule. In order to remedy this violation, we suggested moving the following CPT codes from APC 0121 to APC 0122:

| HCPCS | Description |
|---|---|
| 47530 | Revise/reinsert bile tube. |
| 50688 | Change of ureter tube. |
| 51710 | Change of bladder tube. |
| 62225 | Replace/irrigate catheter. |

The Panel recommended that we make these CPT code changes. We proposed to accept the Panel's recommendation to move CPT codes 47530, 50688, 51710, and 62225 from APC 0121 to APC 0122. We will adopt the proposal for 2004.

*v. Myelography*

APC 0274: Myelography

We advised the Panel that APC 0274 minimally violates the 2 times rule and suggested moving CPT codes 72285 (X-ray c/t spine disk) and 72295 (X-ray c/t spine disk) from APC 0274 to a new APC. A presenter, from an organization representing radiologists, agreed with our proposal. The Panel recommended that we make these CPT code changes. We proposed to accept the Panel's recommendation to move CPT codes 72285 and 72295 from APC 0274 to new APC 0388. We will adopt the recommendation for 2004.

*w. Therapeutic Radiologic Procedures*

APC 0296: Level I Therapeutic Radiologic Procedures

APC 0297: Level II Therapeutic Radiologic Procedures

We advised the Panel that APCs 0296 and 0297 appear to minimally violate the 2 times rule as a result of changes recommended by the Panel and adopted by us last year. The Panel recommended that no changes be made to APCs 0296 and 0297 in the interest of preserving the clinical homogeneity of these APCs. We proposed to accept the Panel's recommendation that we make no CPT code changes to APCs 0296 and 0297, and we are adopting the proposal for 2004.

*x. Vascular Procedures; Cannula/Access Device Procedures*

APC 0103: Miscellaneous Vascular Procedures

APC 0115: Cannula/Access Device Procedures

A commenter requested that we move CPT code 36860 (External cannula declotting) from APC 0103 to APC 0115, asserting that this procedure is more similar to other procedures in APC 0115 and does not fit well in its current miscellaneous APC. The Panel found that the claims data were insufficient to support moving CPT code 36860 from APC 0103 to the higher paying APC 0115 and recommended that CPT code 36860 remain in APC 0103 until more data are available for review. We proposed to accept the Panel's recommendation that CPT code 36860 remain in APC 0103 until more claims data become available for review. We will adopt this proposal for 2004.

*y. Angiography and Venography Except Extremity*

APC 0279: Level II Angiography and Venography except Extremity

APC 0280: Level III Angiography and Venography except Extremity

APC 0668: Level I Angiography and Venography except Extremity

A commenter requested that we move CPT code 75978 (Repair venous blockage) from APC 0668 to APC 0280 and that we move CPT code 75774 (Artery x-ray, each vessel) from APC 0668 to APC 0279. A presenter to the Panel testified that CPT code 75978 is commonly used for dialysis patients and often requires multiple intraoperative attempts to succeed; thus, it should be paid under APC 0280. The Panel believed that APCs 0279, 0280, and 0668 were clinically homogenous and recommended that we only make changes after consulting with experts in the field. We proposed to accept the Panel's recommendation to make no changes to APCs 0279, 0280, and 0668 until we have consulted with experts in the field. We plan to place these APCs on the Panel's agenda for the 2005 update.

*z. Computed Tomography (CT), Magnetic Resonance (MR), and Ultrasound Guidance Procedures Currently Packaged*

APC 0332: Computerized Axial Tomography and Computerized Angiography without Contrast Material

APC 0335: Magnetic Resonance Imaging, Miscellaneous

APC 0268: Ultrasound Guidance Procedures

A presenter to the Panel expressed concern that the packaging of guidance procedures for tissue ablation does not recognize the significant difference in cost and time required to perform each procedure (for example, MRI vs. CT). This presenter believed that hospitals needed more education on the appropriate application of these codes. Another commenter requested that CPT codes 76362, 76394, and 76490 be changed from a status indicator of N to a status indicator of S and be included in an appropriate clinical or new technology APC.

The Panel agreed with the above comments and stated that the packaging of these three procedures made it difficult for hospitals to track their use for the purpose of allocating funds. The Panel recommended changing the following CPT codes from a packaged status (N status indicator) to a separately payable status (S status indicator) within the indicated APCs:

TABLE 3.—HCPCS CODES TO BE DESIGNATED AS SEPARATELY PAYABLE

| HCPCS | Description | 2003 SI | 2004 SI | 2004 APC |
|---|---|---|---|---|
| 76362 | CT scan for tissue ablation | N | S | 0332 |
| 76394 | MRI for tissue ablation | N | S | 0335 |
| 76490 | US for tissue ablation | N | S | 0268 |

We proposed to accept the Panel's recommendation to change HCPCS codes 76362, 76394, and 76490 from a packaged status to a separately payable status as indicated above. HCPCS 76490 has been deleted for 2004. However, we will pay for it under APC 0268 during the grace period from January through March 2004.

*aa. Magnetic Resonance Imaging and Magnetic Resonance Angiography Without Contrast*

APC 0336: Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast

A commenter requested that we change CPT code 76393 (MR guidance for needle placement) from a packaged status to a separately payable status within APC 0336. Based on clinical homogeneity considerations, the Panel agreed with the commenter and recommended that CPT code 76393 be changed from a status indicator of N to a status indicator of S and placed in APC 0335. We proposed to accept the Panel's recommendation.

*bb. Plain Film Except Teeth; Plain Film Except Teeth Including Bone Density Measurement*

APC 0260: Level I Plain Film Except Teeth

APC 0261: Level II Plain Film Except Teeth Including Bone Density Measurement

APC 0272: Level I Fluoroscopy

A commenter requested that we move CPT codes 76120 (Cine/video x-rays) and 76125 (Cine/video x-rays add-on) from APC 0260 to APC 0261. However, a presenter to the Panel argued that these CPT codes are fluoroscopic procedures that should not be grouped with Level I radiography procedures. The Panel recommended that we move CPT code 76120 from APC 0260 to APC 0272 and that CPT code 76125 remain in APC 0260. This change makes the APCs more clinically coherent. We proposed to accept the Panel's recommendation, and we will adopt the proposal for 2004.

*cc. Chemotherapy Administration by Other Technique Except Infusion*

APC 0116: Chemotherapy Administration by Other Technique Except Infusion

A presenter to the Panel requested that we split APC 0116 into three APCs according to the method of administration: (a) Subcutaneous or intramuscular administration (CPT code 96400); (b) ''push'' administration (CPT code 96408); and (c) central nervous system administration (CPT code 96450). The presenter also requested that existing CPT codes should replace the more nonspecific Q codes for administration of chemotherapy because the CPT codes will provide more detailed data on methods of chemotherapy administration, which could be used for future payment policy decisions. Another presenter agreed with this request and stated that CPT codes are preferable to Q codes because other payers require CPT codes.

The Panel agreed with the above suggestions to split APC 0116 into 3 APCs according to the method of

administration. The Panel recommended that we require hospitals to use the existing CPT codes (for example, 96400, 96408, and 96450) for administration of chemotherapy and map them to APCs 0116, 0117, and 0118, as appropriate. The Panel also recommended that payment rates be based on current Q code cost data until cost data for the CPT codes are available. These cost data will be used to determine whether to change the APC structure for chemotherapy administration.

We proposed not to accept the Panel's recommendations to split APC 0116 into three APCs and to use CPT codes for administration of chemotherapy. We will consider such a split in the future but would like to first address the administration of drugs issue. Based on the comments we received on our proposed drug administration coding, we believe that making a change in APC 0116 will be too complicated and burdensome for hospitals at this time. (See a full discussion of this in section VI.B.4 of this final rule.)

We will consider such a split for APC 0116 for CY 2005. We also believe the use of CPT codes will be burdensome to hospitals, will require extensive education, and will result in a significant amount of miscoding. The CPT codes for infusion therapy are based on the service furnished per hour. We do not believe that all hospitals routinely record the start and stop time for infusion therapy and that doing so in order to be able to bill the proper number of hours of infusion therapy could be very burdensome for them. Moreover, the historic cost data on which we base the payment for the service are reported on a per visit basis (much easier to cull from the record than the number of hours of service) and if we changed to CPT codes for these services, we will be unable to convert the charge/cost data now on a per visit basis to a per hour basis (as required by the CPT code) for budget neutrality purposes. *See* section VI of this final rule for further discussion on payments for drugs and drug administration.

*dd. Capturing the Costs of Drugs, Biologicals and Radiopharmaceuticals Packaged Into APCs*

APC 0290: Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans

APC 0291: Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans

APC 0292: Level III Diagnostic Nuclear Medicine Excluding Myocardial Scans

APC 0294: Level II Therapeutic Nuclear Medicine

APC 0666: Myocardial Add-on Scans

At the January 2003 meeting, we told the Panel that APCs 0290 and 0291 appear to violate the 2 times rule. Several presenters to the Panel expressed concern that our cost data are inadequate because of confusion over coding due to changes in codes and coding instructions for these procedures, poor hospital reporting of radiopharmaceutical use, and the use of single (not multiple) claims in determining costs. One presenter claimed that the current cost data used for CPT code 78122 (Whole blood volume determination) underestimated real costs because of confusion about whether to code radiopharmaceuticals on a ''per dose'' basis or ''per millicurie'' basis. This presenter requested that we move CPT code 78122 from APC 0290 to the higher paying APC 0292.

Other presenters agreed with these concerns and stated they were applicable to payments for all drugs, not just radiopharmaceuticals. These commenters were also concerned about the loss of drug-specific data due to packaging because hospitals will have no incentive to code, and thereby identify, packaged drugs.

Pass-through payments for 236 drugs, biologicals, and radiopharmaceuticals expired as of 2003, were then paid either separately or packaged with the procedures with which they are associated. Drugs and radiopharmaceuticals with median costs for administration of $150 or less were packaged. Beginning in 2003, claims data do not provide specific cost information for packaged items. We requested input from the Panel on methods for determining drug costs in the future.

Panel members were concerned that packaging the costs of radiopharmaceuticals into procedures would result in underpayments for the service because we lack adequate data on the cost of radiopharmaceuticals. They were also concerned about creating incentives to use radiopharmaceuticals based on cost rather than clinical efficacy. The Panel recommended that we consider grouping drugs and radiopharmaceuticals into new APCs taking into account both their cost and clinical use. The Panel further recommended that, if new APCs for radionuclides are created, the descriptors should be as simple as possible and use of confusing units of measure should be limited.

Due to the packaging of radiopharmaceuticals into the APC payments for nuclear medicine procedures, we, along with commenters have expressed concern to the Panel regarding whether the current nuclear medicine APC structure is homogeneous in terms of resource consumption. We have reviewed information about the use and cost of various radiopharmaceuticals and believe that restructuring the APCs for nuclear medicine will result in greater clinical and resource homogeneity. Therefore, we proposed to eliminate APCs 0286, 0290, 0291, 0292, 0294, and 0666 and create 20 new APCs for nuclear medicine.

*Comment:* We received many comments about the proposed nuclear medicine APCs. Generally, commenters supported our proposal for the new APCs but had suggestions for modifications to improve clinical and resource use homogeneity. The suggested modifications are:

- Split APC 0398 into three levels to account for differences in the number of sessions provided and type and amount of radiopharmaceutical used with these procedures.
- Split APC 0401 into two levels to account for the different number of sessions, type and amount of radiopharmaceuticals used, and whether or not ventilation imaging and perfusion imaging are part of the procedure.
- Delete codes G0273 and G0274 and use the newly created CPT codes 78804 and 79403. They recommended that we assign 78804 to a new APC 0406T, Tumor/Infection Imaging Level II and that we assign 79403 to the new APC for Radionucliide Therapy APC, created by combining proposed APCs 0407 and 0408.
- Move codes 78015, 78016, and 78018 from APC 0390 to APC 0406 because they are for metastatic tumor imaging rather than for one organ system.
- Move all of the nuclear medicine ''add-on'' codes into one APC to be named ''Nuclear Medicine Add-On Imaging.'' Three of the codes, 78478, Heart wall motion add-on, 78480 Heart function add-on, and 78496, Heart function first pass add-on, are assigned to proposed APC 0399. They recommended moving the remaining add-on code, 78020, Thyroid carcinoma metastases uptake, to proposed APC 0399 with the other three add-on codes, to create an APC comprised of add-on codes with a status indicator ''X.''
- Move each of the codes in the series of codes, 78X99 into the appropriate APCs based on the organ system to be consistent with the proposed APC structure.
- Reassign codes 78270, 78271, and 78272 to APC 0389 because they are

non-imaging nuclear medicine procedures with resource use more similar to the procedures in APC 0389.

• Combine APCs 0390, 0391, and 0392 to create two new APCs composed of thyroid, parathyroid, and adrenal systems. They suggest that the codes should be reassigned to two levels of endocrine imaging based on the number of sessions and radiopharmaceuticals used in the procedure. The titles suggested for the new APCs are ''Endocrine Level I'' and ''Endocrine Level II.''

• Combine proposed APCs 0407 and 0408 into one APC because hospital claims data do not reflect any logical division between the two proposed APCs. Further, they request that all of the nuclear medicine therapy codes in the new APC should be paid separately since they know of no nuclear medicine therapeutic radiopharmaceutical that has costs below the proposed $150 threshold for packaging.

• Collapse and redistribute code assignments in APCs 0404 and 0405 to create two new APCs for Level I and Level II Renal and Genitourinary Studies. They recommended assigning only one code, 78709, Kidney imaging, multiple studies, with and without pharmaceutical intervention, to the Level II APC.

*Response:* After careful review of the recommendations, with one exception, we concur with the commenters that their recommended modifications to the proposed APC classifications improve clinical homogeneity and payment equity. The shifts in median cost that result from the adjustments are minor in most cases and overall, the increased cost is not significant.

The one exception to our agreement with the commenters' recommendation is regarding the assignment of 78708, Kidney imaging with vascular flow and function, single study. Commenters recommended that it be assigned to APC 0404. We believe that it is more appropriately assigned to APC 0405 based on both clinical and resource use considerations.

Although we do not disagree with the commenters' suggestions, we also will not assign the new code 78804, pre-treatment planning, non-Hodgkins to the APC suggested by the commenters. Instead, we will assign it to new technology APC 1508. A detailed discussion of this assignment and other issues related to Zevalin is below in section VI.B.

Thus, we will finalize the nuclear medicine APCs as shown below.

APC 0376: CARDIAC IMAGING LEVEL II

| HCPCS | Description |
|---|---|
| 78473 | Gated heart, multiple. |
| 78483 | Heart first pass, multiple. |

APC 0377: CARDIAC IMAGING LEVEL III

| HCPCS | Description |
|---|---|
| 78461 | Heart muscle blood, multiple. |
| 78465 | Heart image (3D), multiple. |

APC 0378: PULMONARY IMAGING LEVEL II

| HCPCS | Description |
|---|---|
| 78584 | Lung V/Q image gas, single breath. |
| 78585 | Lung V/Q imaging gas. |
| 78588 | Lung V/Q imaging aerosol. |
| 78596 | Lung differential function. |

APC 0389: NON-IMAGING NUCLEAR MEDICINE

| HCPCS | Description |
|---|---|
| 78000 | Thyroid, single uptake. |
| 78001 | Thyroid, multiple uptakes. |
| 78003 | Thyroid suppress/stimuli. |
| 78190 | Platelet survival, kinetics. |
| 78191 | Platelet survival. |
| 78270 | Vitamin B–12 absorption exam. |
| 78271 | Vitamin B–12 absorp. exam, intrin. Fac. |
| 78272 | Vitamin B–12 absorp, combined. |
| 78725 | Kidney function study. |

APC 0390: ENDOCRINE LEVEL I

| HCPCS | Description |
|---|---|
| 78006 | Thyroid imaging with uptake. |
| 78010 | Thyroid imaging. |
| 78011 | Thyroid imaging with flow. |
| 78099 | Endocrine nuclear procedure. |

APC 0391: ENDOCRINE LEVEL II

| HCPCS | Description |
|---|---|
| 78007 | Thyroid image, mult uptakes. |
| 78070 | Parathyroid nuclear imaging. |
| 78075 | Adrenal nuclear imaging. |

APC 0393: RED CELL/PLASMA STUDIES

| HCPCS | Description |
|---|---|
| 78110 | Plasma volume, single. |
| 78111 | Plasma volume, multiple. |
| 78120 | Red cell mass, single. |
| 78121 | Red cell mass, multiple. |
| 78122 | Blood volume. |
| 78130 | Red cell survival study. |
| 78135 | Red cell survival kinetics. |
| 78140 | Red cell sequestration. |
| 78160 | Plasma iron turnover. |
| 78162 | Radioiron absorption exam. |
| 78170 | Red cell iron utilization. |
| 78172 | Total body iron estimation. |

APC 0394: HEPATOBILIARY IMAGING

| HCPCS | Description |
|---|---|
| 78201 | Liver imaging. |
| 78202 | Liver imaging with flow. |
| 78205 | Liver imaging (3D). |
| 78206 | Liver image (3D) with flow. |
| 78215 | Liver and spleen imaging. |
| 78216 | Liver & spleen image/flow. |
| 78220 | Liver function study. |
| 78223 | Hepatobiliary imaging. |

APC 0395: GASTROINTESTINAL IMAGING

| HCPCS | Description |
|---|---|
| 78230 | Salivary gland imaging. |
| 78231 | Serial salivary imaging. |
| 78232 | Salivary gland function exam. |
| 78258 | Esophageal motility study. |
| 78261 | Gastric mucosa imaging. |
| 78262 | Gastroesophageal reflux exam. |
| 78264 | Gastric emptying study. |
| 78278 | Acute GI blood loss imaging. |
| 78282 | GI protein loss exam. |
| 78290 | Meckel's divert exam. |
| 78291 | Leveen/shunt patency exam. |
| 78299 | GI nuclear procedure. |

APC 0396: BONE IMAGING

| HCPCS | Description |
|---|---|
| 78300 | Bone imaging, limited area. |
| 78305 | Bone imaging, multiple areas. |
| 78306 | Bone imaging, whole body. |
| 78315 | Bone imaging, 3 phase. |
| 78320 | Bone imaging (3D). |
| 78399 | Musculoskeletal nuclear exam. |

APC 0397: VASCULAR IMAGING

| HCPCS | Description |
|---|---|
| 78445 | Venous thrombosis study. |
| 78455 | Venous thrombosis study. |

APC 0397: VASCULAR IMAGING—Continued

| HCPCS | Description |
|---|---|
| 78456 | Acute venous thrombus image. |
| 78457 | Venous thrombosis imaging. |
| 78458 | Ven thrombosis images, bilat. |

APC 0398: CARDIAC IMAGING LEVEL I

| HCPCS | Description |
|---|---|
| 78414 | Non-imaging heart function. |
| 78428 | Cardiac shunt imaging. |
| 78460 | Heart muscle blood, single. |
| 78464 | Heart image (3D), single. |
| 78466 | Heart infarct image. |
| 78468 | Heart infarct image (ef). |
| 78469 | Heart infarct image (3D). |
| 78472 | Gated heart, planar, single. |
| 78481 | Heart first pass, single. |
| 78494 | Heart image, spect. |
| 78499 | Unlisted cardiovascular. |

APC 0399: NUCLEAR MEDICINE ADD-ON IMAGING

| HCPCS | Description |
|---|---|
| 78020 | Thyroid met uptake. |
| 78478 | Heart wall motion add-on. |
| 78480 | Heart function add-on. |
| 78496 | Heart first pass add-on. |

APC 0400: HEMATOPOIETIC IMAGING

| HCPCS | Description |
|---|---|
| 78102 | Bone marrow imaging, ltd. |
| 78103 | Bone marrow imaging, mult. |
| 78104 | Bone marrow imaging, body. |
| 78185 | Spleen imaging. |
| 78195 | Lymph system imaging. |
| 78199 | Blood/lymph nuclear exam. |

APC 0401: PULMONARY IMAGING, LEVEL 1

| HCPCS | Description |
|---|---|
| 78580 | Lung perfusion imaging. |
| 78586 | Aerosol lung image, single. |
| 78587 | Aerosol lung image, multiple. |
| 78591 | Vent image, 1 breath, 1 proj. |
| 78593 | Vent image, 1 proj, gas. |
| 78594 | Vent image, mult proj, gas. |
| 78599 | Respiratory Nuclear Exam. |

APC 0402: BRAIN IMAGING

| HCPCS | Description |
|---|---|
| 78600 | Brain imaging, ltd static. |
| 78601 | Brain imaging, ltd w/flow. |
| 78605 | Brain imaging, complete. |
| 78606 | Brain imaging, compl w/flow. |
| 78607 | Brain imaging (3D). |

APC 0402: BRAIN IMAGING—Continued

| HCPCS | Description |
|---|---|
| 78610 | Brain flow imaging only. |
| 78615 | Cerebral vascular flow image. |
| 78699 | Nervous system nuclear exam. |

APC 0403: CSF IMAGING

| HCPCS | Description |
|---|---|
| 78630 | Cerebrospinal fluid scan. |
| 78635 | CSF ventriculography. |
| 78645 | CSF shunt evaluation. |
| 78647 | Cerebrospinal fluid scan. |
| 78650 | CSF leakage imaging. |
| 78660 | Nuclear exam of tear flow. |

APC 0404: RENAL & GENITOURINARY STUDIES LEVEL I

| HCPCS | Description |
|---|---|
| 78700 | Kidney imaging, static. |
| 78701 | Kidney imaging with flow. |
| 78704 | Imaging renogram. |
| 78707 | Kidney flow/function image. |
| 78710 | Kidney imaging (3D). |
| 78715 | Renal vascular flow exam. |

APC 0405: RENAL & GENITOURINARY STUDIES LEVEL II

| HCPCS | Description |
|---|---|
| 78708 | Kidney flow/function image. |
| 78709 | Kidney flow/function image. |

APC 0406: TUMOR/INFECTION IMAGING

| HCPCS | Description |
|---|---|
| 78015 | Thyroid metastases imaging. |
| 78016 | Thyroid metastases imaging/studies. |
| 78018 | Thyroid metastases imaging/body. |
| 78800 | Tumor imaging, limited area. |
| 78801 | Tumor imaging, mult areas. |
| 78802 | Tumor imaging, whole body. |
| 78803 | Tumor imaging, whole body. |
| 78805 | Abscess imaging, ltd area. |
| 78806 | Abscess imaging, whole body. |
| 78807 | Nuclear localization/abscess. |

APC 0407: RADIONUCLIIDE THERAPY

| HCPCS | Description |
|---|---|
| 79000 | Init hyperthyroid therapy. |
| 79001 | Repeat hyperthyroid therapy. |
| 79020 | Thyroid ablation. |
| 79030 | Thyroid ablation, carcinoma. |
| 79035 | Thyroid metastatic therapy. |

APC 0407: RADIONUCLIIDE THERAPY—Continued

| HCPCS | Description |
|---|---|
| 79100 | Hematopoetic nuclear therapy. |
| 79200 | Intracavitary nuclear treatment. |
| 79300 | Interstitial nuclear therapy. |
| 79400 | Nonhemato nuclear therapy. |
| 79420 | Intravascular nuclear therapy. |
| 79440 | Nuclear joint therapy. |
| 79999 | Nuclear medicine therapy. |

APC 1507: NEW TECHNOLOGY LEVEL VII ($500–$600)

| | |
|---|---|
| 79403 | Hematopoetic nuclear therapy. |

APC 1508: TUMOR/INFECTION IMAGING LEVEL II

| HCPCS | Description |
|---|---|
| 78804 | Pre-tx planning, non-Hodgkins. |

We believe that the final APC structure, which takes into account the organ(s) being examined (or treated) as well as the type and complexity of the procedure, is more homogeneous both clinically and in terms of resource consumption than the current APC structure.

*ee. Endoscopy Lower Airway*

APC 0076: Endoscopy Lower Airway

A presenter to the Panel expressed concern that APC 0076 apparently violates the 2 times rule and requested that we move CPT code 31631 (bronchoscopy with tracheal stent placement) from APC 0076 and into a new APC.

The Panel suggested that a new APC comprised of the four most costly procedures in APC 0076 will result in a more homogenous grouping, and recommended that we move the following CPT codes from APC 0076 and into newly created APC 0415.

| HCPCS | Description |
|---|---|
| 31630 | Bronchoscopy dilate/fracture reduction. |
| 31631 | Bronchoscopy, dilate w/stent. |
| 31640 | Bronchoscopy w/tumor excise. |
| 31641 | Bronchoscopy, treat blockage. |

We proposed to accept the Panel's recommendation that we move CPT codes 31630, 31631, 31640, and 31641 from APC 0076 to new APC 0415. We

received no comments disagreeing with this proposal and will adopt this recommendation for 2004.

*ff. Gastrointestinal Endoscopic Stenting Procedures*

APC 0141: Upper GI Procedures
APC 0142: Small Intestine Endoscopy
APC 0143: Lower GI Endoscopy
APC 0147: Level II Sigmoidoscopy

A commenter requested that we create a new APC that will be comprised of all the gastrointestinal endoscopic stent codes. The Panel agreed with the commenter's suggestion because the resource requirements for all gastrointestinal endoscopic stents appear to be similar. The Panel recommended that we move the following CPT codes from their 2003 APCs to newly created APC 0384 for 2004:

TABLE 4.—HCPCS CODES TO BE MOVED INTO NEW APC 0384

| HCPCS | Description | 2003 APC | 2004 APC |
|---|---|---|---|
| 43219 | Esophagus endoscopy | 0141 | 0384 |
| 43256 | Upper GI endoscopy w/stent | 0141 | 0384 |
| 44370 | Small bowel endoscopy w/stent | 0142 | 0384 |
| 44379 | Small bowel endoscopy w/stent | 0142 | 0384 |
| 44383 | Small bowel endoscopy | 0142 | 0384 |
| 44397 | Colonoscopy w/stent | 0143 | 0384 |
| 45387 | Colonoscopy w/stent | 0143 | 0384 |
| 45327 | Proctosigmoidoscopy w/stent | 0147 | 0384 |
| 45345 | Sigmoidoscopy w/stent | 0147 | 0384 |

We proposed to accept the Panel's recommendation to move the following gastrointestinal endoscopic stent CPT codes into newly created APC 0384: 43219, 43256 (from APC 0141); 44370, 44379, 44383 (from APC 0142); 44397, 45387 (from APC 0143); 45327, 45345 (from APC 0147). We received no comments disagreeing with this proposal, and we will adopt it for 2004.

*gg. Capturing the Costs of Devices That Are Packaged Into APCs*

APC 0081: Non-Coronary Angioplasty or Atherectomy
APC 0083: Coronary Angioplasty and Percutaneous Valvuloplasty
APC 0104: Transcatheter Placement of Intracoronary Stents
APC 0222: Implantation of Neurological Device
APC 0223: Implantation of Pain Management Device
APC 0227: Implantation of Drug Infusion Device
APC 0229: Transcatheter Placement of Intravascular Shunts

Several commenters requested that the status indicators for the above APCs (all of which include high-cost devices) be changed from T (multiple-procedure discount applies) to S (multiple-procedure discount does not apply). Two presenters to the Panel stated that hospitals do not pay less for devices when they are used in the context of a multiple-procedure claim and suggested that we apply the multiple-procedure reduction to the non-device portion of the claim only. Alternatively, these presenters recommended that we apply the discount policy only when the device cost is below a predetermined proportion of the APC cost. Another presenter to the Panel requested that APCs 0222, 0223, and 0227 be exempt from the multiple-procedure discount policy because the cost of the devices used in these procedures makes up more than 50 percent of the APC cost.

We sought the Panel's input as to whether there are situations in which we should not apply our multiple procedure discount policy. The Panel recommended no changes to the status indicators for any of the device-related APCs discussed because they were concerned that exemptions from the discount policy could result in incentives to use more devices than necessary. However, the Panel asked that we analyze our data to determine if we may be underpaying for devices when the multiple procedure discounting policy is applied and recommended that we develop some methodology to track device costs. In section II.B of this preamble, we discuss the issue of device costs and multiple procedure reductions and our progress to date in developing ''combination APCs'' to address the Panel's concern.

*hh. Discussion of Ways To Increase the Use of Multiple Claims To Set APC Payment Rates*

A presenter to the Panel suggested that we use dates of service on multiple procedure claims to increase the number of claims we use to set payment rates. Another presenter suggested that we could further increase the number of multiple procedure claims that could be used to set payment rates by ignoring codes with status indicator K. Other suggestions were to exclude from consideration those APCs with small dollar values and to create a new code or APC specifically for the insertion and removal of devices.

The Panel recommended that our staff explore ways to increase the number of claims used to set payment rates, including the following methodologies: sort multiple claims by date of service; exclude codes with K status indicator from evaluation; exclude those APCs with nominal costs (the definition of ''nominal'' can be determined by modeling a variety of possible dollar amounts). In addition, the Panel recommended that we not create G codes as part of the effort to use multiple procedure claims for developing relative weights. If new codes are needed, the Panel suggested that our staff work with the American Medical Association's CPT Board to identify possible new codes.

*B. Other Changes Affecting the APCs*

1. Limit on Variation of Costs of Services Classified Within an APC Group

Section 1833(t)(2) of the Act provides that the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest cost item or service within an APC group is more than 2 times greater than the lowest cost item or service within the same group. However, the statute authorizes the Secretary to make exceptions to this limit on the variation of costs within each APC group in unusual cases such as low volume items and services. No exception may be made in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug, and Cosmetic Act.

Taking into account the proposed APC changes discussed in relation to the APC Panel recommendations in section II.A.4 of this preamble and the use of 2002 claims data to calculate the

median cost of procedures classified to APCs, we reviewed all the APCs to determine which of them would not meet the 2 times limit. We use the following criteria when deciding whether to make exceptions to the 2 times rule for affected APCs:

- Resource homogeneity.
- Clinical homogeneity.
- Hospital concentration.
- Frequency of service (volume).
- Opportunity for upcoding and code fragmentation. For a detailed discussion of these criteria, refer to the April 7, 2000 final rule (65 FR 18457).

The following table contains the final list of APCs that we exempt from the 2 times rule based on the criteria cited above. In cases in which a recommendation of the APC Panel appeared to result in or allow a violation of the 2 times rule, we generally accepted the Panel recommendation because Panel recommendations were based on explicit consideration of resource use, clinical homogeneity, hospital specialization, and the quality of the data used to determine payment rates.

The median cost for hospital outpatient services for these and all other APCs can be found at Web site: *http://www.cms.hhs.gov.*

TABLE 5.—APCS EXEMPTED FROM 2 TIMES RULE

| Final Rule APC | Description |
|---|---|
| 0006 | Level I Incision & Drainage. |
| 0012 | Level I Debridement & Destruction. |
| 0018 | Biopsy of Skin/Puncture of Lesion. |
| 0019 | Level I Excision/Biopsy. |
| 0020 | Level II Excision/Biopsy. |
| 0043 | Closed Treatment Fracture Finger/Toe/Trunk. |
| 0046 | Open/Percutaneous Treatment Fracture or Dislocation. |
| 0058 | Level I Strapping and Cast Application. |
| 0060 | Manipulation Therapy. |
| 0071 | Level I Endoscopy Upper Airway. |
| 0074 | Level IV Endoscopy Upper Airway. |
| 0084 | Level I Electrophysiologic Evaluation. |
| 0093 | Vascular Reconstruction/Fistula Repair without Device. |
| 0097 | Cardiac and Ambulatory Blood Pressure Monitoring. |
| 0099 | Electrocardiograms. |
| 0103 | Miscellaneous Vascular Procedures. |
| 0105 | Revision/Removal of Pacemakers, AICD, or Vascular. |
| 0109 | Removal of Implanted Devices. |
| 0130 | Level I Laparoscopy. |
| 0147 | Level II Sigmoidoscopy. |
| 0148 | Level I Anal/Rectal Procedure. |
| 0155 | Level II Anal/Rectal Procedure. |
| 0165 | Level III Urinary and Anal Procedures. |
| 0192 | Level IV Female Reproductive Proc. |
| 0203 | Level IV Nerve Injections. |
| 0204 | Level I Nerve Injections. |
| 0207 | Level III Nerve Injections. |
| 0213 | Extended EEG Studies and Sleep Studies, Level I. |
| 0214 | Electroencephalogram. |
| 0218 | Level II Nerve and Muscle Tests. |
| 0231 | Level III Eye Tests & Treatments. |
| 0233 | Level II Anterior Segment Eye Procedures. |
| 0235 | Level I Posterior Segment Eye Procedures. |
| 0239 | Level II Repair and Plastic Eye Procedures. |
| 0245 | Level I Cataract Procedures without IOL Insert. |
| 0252 | Level II ENT Procedures. |
| 0262 | Plain Film of Teeth. |
| 0266 | Level II Diagnostic Ultrasound Except Vascular. |
| 0274 | Myelography. |
| 0279 | Level II Angiography and Venography except Extremity. |
| 0297 | Level II Therapeutic Radiologic Procedures. |
| 0303 | Treatment Device Construction. |
| 0314 | Hyperthermic Therapies. |
| 0323 | Extended Individual Psychotherapy. |
| 0340 | Minor Ancillary Procedures. |
| 0341 | Skin Tests. |
| 0344 | Level III Pathology. |
| 0355 | Level III Immunizations. |
| 0356 | Level IV Immunizations. |
| 0363 | Level I Otorhinolaryngologic Function Tests. |
| 0364 | Level I Audiometry. |
| 0367 | Level I Pulmonary Test. |
| 0368 | Level II Pulmonary Tests. |
| 0370 | Allergy Tests. |
| 0373 | Neuropsychological Testing. |
| 0397 | Vascular Imaging. |
| 0398 | Level I Cardiac Imaging. |
| 0402 | Brain Imaging. |
| 0404 | Renal and Genitourinary Studies Level I. |

TABLE 5.—APCS EXEMPTED FROM 2 TIMES RULE—Continued

| Final Rule APC | Description |
|---|---|
| 0407 | Radionuclide Therapy. |
| 0409 | Red Blood Cell Tests. |
| 0688 | Revision/Removal of Neurostimulator Pulse Generator Receiver. |
| 0692 | Electronic Analysis of Neurostimulator Pulse Generators. |
| 0698 | Level II Eye Tests & Treatments. |
| 0699 | Level IV Eye Tests & Treatments. |
| 1528 | New Technology—Level XXVIII ($5000-$5500). |

2. Procedures Moved From New Technology APCs to Clinically Appropriate APCs

In the November 30, 2001 final rule (66 FR 59903), we made final our proposal to change the period of time during which a service may be paid under a new technology APC. Beginning in 2002, the policy is to retain a service within a new technology APC group until we have acquired adequate data that allow us to assign the service to a clinically appropriate APC. This policy allows us to move a service from a new technology APC in less than 2 years if sufficient data are available, and it also allows us to retain a service in a new technology APC for more than 3 years if sufficient data upon which to base a decision for reassignment have not been collected.

In the context of new technology procedures, we create HCPCS codes for services only. We do not create HCPCS codes for equipment that is used in the course of providing an item or service (except in the case of ''C'' codes for devices that meet the criteria for transitional pass-through payments). Equipment that is used to provide an item or service is not separately coded because it is a resource required to furnish the service. Like other resources that are required to furnish a service (for example, cost of a room, cost of staff, cost of supplies), the hospital should show charges either as part of its charge for the procedure or with a revenue code.

As described below, we proposed to delete four HCPCS codes that are currently paid in new technology APCs. We believed that these four HCPCS codes do not conform to our current policy to not create HCPCS codes for equipment used to provide a service. In addition, we stated that there soon would exist, CPT codes to describe all of the services being furnished, including any equipment that is needed to perform them, so we believe it is appropriate at this time to delete the HCPCS codes. The HCPCS codes which we proposed to delete effective January 1, 2004 were:

C1088; Laser Optic Treatment System, Indigo Laseroptic Treatment System

C9701; Stretta System

C9703; Bard Endoscopic Suturing System, and C9711; H.E.L.P. Apheresis System.

A full description of these HCPCS is available in the proposed rule (67 FR 47978).

We received no comments in response to this proposal. However, we have determined that our proposal to delete codes C9701 and C9703 was in error. Upon further review of this issue, we have determined that these codes were in fact established to represent complete procedures. Therefore, we will retain codes C9701 and C9703.

*Comment:* A provider of treatment planning software submitted several comments regarding this service. In their first set of comments on the 2003 OPPS final rule with comment, the commenter agreed with our decision to create a new G-code, G0288, for their product, Preview, and other similar treatment planning software and to assign this service to new technology APC 0975. G0288 was created and assigned to new technology APC 0975 for the 2003 final rule and was subject to comment after its publication. In their comments in response to the 2003 final rule with comment, they indicated that the $625 payment rate associated with new technology APC 0975 appropriately reflected the costs of Preview to providers. However, this party recommended that we pay for G0288 under certain circumstances. These included payment only for treatment planning imaging services that are FDA approved; that is, to follow FDA's determinations concerning which imaging software programs are sufficiently comprehensive and accurate. Further, the commenter recommended that we pay for both pre-surgical and post-surgical imaging, claiming optimum effectiveness of the related endovascular repair procedures only occurs when imaging studies are performed both before and after surgery. Third, this party recommended that we use G0288 in the OPPS but not in other Medicare payment systems until cost data were more complete. The commenter believed that we should encourage use of the CPT process to develop codes that describe a wide range of applications for the treatment planning imaging that may develop.

The commenter also commented on our August 12, 2003 proposed rule, in which we proposed assigning G0288 to new APC 0414, with a payment rate of $260.65. This commenter stated that the proposed payment is inadequate and based on flawed, imputed cost data. It also asserted that the descriptors for APC 0414 and G0288 do not restrict the use of this code to services that meet the ''recognized standards and specifications'' for three-dimensional computer-aided measurement planning simulation (''3D–CAMPS'') services and recommended that we revise the proposed payment for APC 0414 based on hospital acquisition cost data that they provided. The commenter also recommended that we create a revenue code specifically for APC 0414 to enable more rational charge determination for the service and that we revise the descriptors for APC 0414 and G0288 to ensure that the codes only are used for the 3D–CAMPS systems, and to clarify that the service may be applied pre- or post-surgically. The recommended descriptor is: ''Three-dimensional computer-aided measurement simulation (3D–CAMPS) services for pre-surgical and post-surgical imaging.''

*Response:* We proposed to move G0288 from new technology APC 0975 to APC 0414 because we believe that we had sufficient 2002 claims data for our analysis. The predecessor C-code for Preview, C9708, was reported approximately 1,300 times in 2002, with a median cost of $272.48. However, we have reviewed the hospital cost data that the commenting party provided, and believe that there may be some claims in our data that understate the cost of the treatment planning software. We have decided to give equal weight to the median cost based on our claims data and the median cost of $625 provided by the commenter, based on its analysis. Therefore, we are establishing the appropriate cost

amount as $448.74. As a result, we are assigning G0288 to new technology service APC 1506, for a payment rate of $450.00. We are continuing the assignment of G0288 to a new technology APC because this is still a relatively new procedure and we still have concerns regarding our cost data.

We agree that this can be used for treatment planning prior to surgery and for post-surgical monitoring and have revised the code descriptor to clarify this point. The descriptor for this code is revised as follows: G0288 Reconstruction, computed tomographic angiography of aorta for preoperative planning and evaluation post vascular surgery. We assume that hospitals providing this service will abide by the FDA labeling requirements for equipment used in providing this service.

3. Revision of Cost Bands and Payment Amounts for New Technology APCs

We proposed to implement a comprehensive restructuring of all the new technology APCs. First, the cost intervals in the current new technology APCs are inconsistent, ranging from $50 to $1,500. Secondly, as the number of procedures assigned to new technology APCs increases, we believe that narrower cost bands are required to avoid inaccurate payment for new technology services. The increased number of new technology APCs that would result from narrowing the cost bands cannot be accommodated within the current sequence of available APC numbers. Therefore, we proposed to dedicate two new series of APC numbers to the restructured new technology APCs, which would allow us to narrow the cost bands and also afford us flexibility in creating additional bands as future needs may dictate.

We proposed to establish cost bands from $0 to $100 in increments of $50, from $100 through $2,000 in intervals of $100, and from $2,000 through $6,000 in intervals of $500. We believe that these intervals would allow us to price new technology services more appropriately and consistently. We also propose to retain two parallel sets of new technology APCs, one with status indicator ''S'' and the other with status indicator ''T.'' We solicited comments on the hierarchy of cost levels of the restructured new technology APCs.

The final list of restructured new technology APCs is in Addendum A.

We received a number of comments in support of this proposal to restructure the new technology APC bands. Therefore, we will finalize our proposal.

4. Creation of APCs for Combinations of Device Procedures

In the August 12, 2003 proposed rule, we discussed data development that we had undertaken to create median costs for combinations of HCPCS codes in different APCs that we believed were frequently performed on the same day. We focused our work on pairs of APCs, one of which contained a service that required an expensive device. See 68 FR 47979 for a complete description of the data development. We undertook this activity to see if creating larger classification groups of this type might increase the number of multiple procedure claims that we could use to set payment rates for these services. We also thought that the analysis might yield useful information regarding the appropriateness of the multiple procedure reduction for combinations of services that include at least one APC with an expensive device, that are commonly performed on the same date. In many cases, we found that the combination APC medians closely approximated the median that results under the current policy (that is, the sum of single medians for each APC, reducing the median for the lower cost procedure by 50 percent). In other cases, the data revealed combination APC median costs that were considerably higher or lower than under our current policy.

We concluded in the proposed rule that the results of the study provided no compelling reason to change our payment policy. We asked for comment on all aspects of the methodology, analysis, and payment options. We also asked for discussion of how we could use more multiple procedure claims were we not to create combination APCs and for an explanation of why external data should be used in lieu of our single or multiple procedure claims data to set median costs for APCs with large device costs. However, we did not propose to create combination APCs or to make payment based on the combination APC medians for 2004.

We received only a few comments on the combination APC methodology and these were in the context of why we should not apply multiple procedure reductions to specific combinations of APCs. See the discussion of multiple procedure reduction in V.D.2 for a summary of these comments and our responses.

## III. Recalibration of APC Weights for CY 2004

Section 1833(t)(9)(A) of the Act requires that the Secretary review and revise the relative payment weights for APCs at least annually, beginning in 2001. In the April 7, 2000 final rule (65 FR 18482), we explained in detail how we calculated the relative payment weights that were implemented on August 1, 2000 for each APC group. Except for some reweighting due to APC changes, these relative weights continued to be in effect for CY 2001. (See the November 13, 2000 interim final rule (65 FR 67824 to 67827)).

To recalibrate the relative APC weights for services furnished on or after January 1, 2004 and before January 1, 2005, we used the same basic methodology that we described in the April 7, 2000 final rule. That is, we recalibrated the weights based on claims and cost report data for outpatient services. We used the most recent available data to construct the database for calculating APC group weights. For the purpose of recalibrating APC relative weights for CY 2004, the most recent available claims data are the approximately 127 million final action claims for hospital outpatient department services furnished on or after April 1, 2002 and before January 1, 2003. We eliminated 2.6 million claims for bill types other than OPPS bill types and claims for services furnished in Maryland, Guam, and the Virgin Islands. We matched the remaining claims that were paid under the OPPS to the most recent cost report filed by the individual hospitals represented in our claims data. We were left with about 75 million claims for which we could identify cost report data. The APC relative weights continue to be based on the median hospital costs for services in the APC groups.

*A. Data Issues*

1. Period of Claims Data Used

We used claims for the period beginning April 1, 2002 through and including December 31, 2002 as the basis for the CY 2004 OPPS. The statute requires that we take into account new cost data and other relevant information and factors in reviewing and revising the weights, and we believe that this period will give us the most recent costs. We chose not to include the claims for the period beginning on January 1, 2002 through March 31, 2002 because they were used to set the payment rates for the 2003 OPPS and we believe that the most recent 9 months of claims data will result in payment rates that are most representative of the current relative costs of hospital outpatient services.

*Comment:* Some commenters supported our use of claims for this 9-month period for setting the weights for

the 2004 OPPS. Other commenters wanted us to use external data in lieu of claims data for specified APCs because they believed that the payments that result from the median costs developed using claims data were inadequate. Other commenters objected to the use of 2002 claims data because they stated that 2002 costs would not be an appropriate proxy for the relative costs of drugs, biologicals, and radiopharmaceuticals in 2004 and they urged us to use hospital acquisition costs instead of claims data.

*Response:* We used 2002 claims data for services furnished from April 1, 2002 through December 31, 2002 as the basis for the relative weights used to create payment amounts for the 2004 OPPS. Our established policy is to use the most recent claims data available. For the August 12, 2003 proposed rule and this final rule, those data are for services in the last 3 quarters of 2002. These data are used to calculate median costs upon which to base our relative weights. The OPPS seeks and uses relative costs to create weights that are used to distribute a fixed amount of Medicare payment for OPPS services appropriately among hospitals. Therefore, the accuracy of the relativity is more important than whether the median costs derived from the claims data accurately reflect the costs of the services. *See* section III.B for our discussion of the use of external data.

2. Treatment of ''Multiple Procedure'' Claims

Since the inception of the OPPS, we have received many requests asking that we ensure that the data from claims that contain charges for multiple procedures are included in the data from which we calculate the OPPS relative payment weights. Those making the requests believe that relying solely on single-procedure claims to recalibrate APC weights fails to take into account data for many frequently performed and complex procedures, particularly those commonly performed in combination with other procedures.

We agree that it is desirable to use the data from as many claims as possible to recalibrate the relative payment weights, including those with multiple procedures. For CY 2003, we identified a number of multiple-procedure claims that could be treated as single-procedure claims, enabling us to greatly increase the number of claims used to develop the APC payment weights. However, there remain several inherent features of multiple procedure claims that prevent us from using all of them to recalibrate the payment weights. We discussed these obstacles in detail in the August 9, 2002 proposed rule (67 FR 52092, 52108 through 52111), and the November 1, 2002 final rule (67 FR 66718, 66743 through 66746).

To enable us to use more claims in the creation of median costs upon which our payment weights and rates are based, we proposed several changes to how we use claims data for the CY 2004 OPPS. Specifically, we proposed to expand the number of HCPCS codes that we ''ignore'' for the purpose of creating pseudo single claims from claims that contain other separately payable HCPCS codes. We also looked at dates of service on packaged HCPCS codes and packaged revenue centers, and proposed where possible, to attribute the charges to major, separately payable HCPCS codes based on the codes' dates of service. We also considered creating combination APCs for procedures that have a significant device component. Our complete discussion of the use of data to set the weights for CY 2004 OPPS follows in section III.B of this preamble.

*Expansion of the List of Codes To Be Ignored in Creation of Single Claims*

For CY 2003 OPPS, we ignored the presence of HCPCS codes 93005, 71010, and 71020 to create pseudo-single claims where there was only one remaining separately paid, major HCPCS code on the claim. Ignoring these codes enabled us to attribute the costs of packaged HCPCS codes and packaged revenue centers to the remaining separately paid, major HCPCS codes and, thereby, create a useable psuedo single claim. We did this because we believed that the charges found in the packaged HCPCS or packaged revenue centers would be appropriately associated with the only other separately payable HCPCS that remained on the claim once the ignored codes were bypassed.

For CY 2004 OPPS, we proposed to expand the list of HCPCS codes to be ignored for purposes of creating pseudo-single claims. On claims that contain other separately payable HCPCS, we proposed to bypass the HCPCS codes in the APCs identified in Table 6. As with the previously ignored HCPCS codes 93005, 71010, and 71020, we believe that there are additional codes that are highly unlikely to have charges that are found in packaged HCPCS or in packaged revenue centers. Therefore, we believe that they also can be ignored for the purpose of creating pseudo-single claims from the remaining charges on the claim. We solicited comments on the proposed methodology to create pseudo-single claims, on the list of codes that we proposed to ignore (Table 6), and whether there are other low-cost services that we could ignore using this methodology. We also requested comments on whether we should use the charges for the codes in the APCs in Table 6 to create pseudo singles for these codes from these claims.

*Use of Dates of Service To Create Single Claims*

For CY 2004, we used dates of service on HCPCS codes and on packaged revenue centers to attribute charges to a major payable HCPCS code where the dates of service match. We could only use this approach where there are different dates of service for the separately payable major HCPCS codes. Where there are multiple major payable HCPCS codes on a claim with the same date, we could not use this approach because there was no way to tell to which major payable HCPCS code the charges from the packaged HCPCS or packaged revenue center belonged. Moreover, where the hospital did not provide dates for all packaged revenue centers, we could not attribute charges based on the date of service.

*Use of Single Procedure Claims*

*Comment:* Some commenters objected to the use of single procedure claims as the basis for setting weights for all APCs. The commenters are concerned that even with the changes we made to use more claims for 2004 OPPS, some of the APCs had medians based on less than 10 percent of their true claims volume. They believe that this methodology results in the use of claims only for simple, low-cost cases from small, relatively non-busy centers with low levels of technological complexity and inappropriately low costs and charges. They urged us to use external data, whether proprietary or not, in place of the claims-derived medians when the medians would otherwise be based on a small number of claims.

Some commenters urged us to ignore codes for procedures performed on the same day as procedures of interest to them and to package all revenue center charges and charges for packaged HCPCS codes into the code for which they were seeking a median. Some commenters gave us relatively elaborate strategies for creating pseduo-single claims out of multiple procedure claims for particular services or groups of services that were of interest to them. Some of these related to special packaging for chemotherapy services and nuclear medicine services. The commenters urged us to model our data for the 2005 OPPS according to the specifications they provided.

*Response:* We would certainly prefer to use all claims in the setting of weights for APCs, if it were possible to do so validly. However, we continue to be plagued by our inability to allocate revenue center charges when there are multiple major procedure codes for services performed on the same day. We are unable to determine how to accurately split some costs (for example, recovery room time) among the major procedures. We have received no comments that offer alternatives that would enable us to do so with confidence.

We did not accept the service-specific strategies for acquiring more single claims that were submitted in comments because none of them could be generalized to the entire claims population in such a way that we could be sure that they would not distort the relativity of all services. We set weights for hundreds of APCs in this system and we think it is important that the same rules governing creation of pseudo single claims from multiple procedure claims be applied across all services so that packaging occurs uniformly and the relativity of services is maintained. It is a practical impossibility to have different strategies for creating pseudo singles for each category of services.

We did not use the line items that were ignored in the calculation of medians for the APC into which they would fall because we lacked confidence that they would accurately represent the full cost of the service. We asked for comments on this in the proposed rule. Based on the comments that indicate that the data for these line items should be used in median setting, we expect to use these line items for median setting for the 2005 proposed rule.

*APCs to be Ignored To Create More Single Claims*

*Comment:* Commenters supported the expansion of the list of APCs that we ignored to create single procedure claims from multiple procedure claims to enable us to use more claims data in weight setting. A commenter asked that we confirm that the line items that were ignored to create pseudo-single claims (See Table 6) are used in the weight setting process. A commenter asked that we implement the combination APC approach as a way of using more claims data for multiple procedure claims. One commenter asked that we add evaluation and management codes to the list of codes ignored for purposes of creating pseudo-singles. Other commenters provided lists of additional codes that could be ignored to create more pseudo-single claims.

Commenters also supported the use of dates of service on lines with revenue code charges where they could be used to attribute charges to HCPCS codes for weight setting. Some commenters advised that we should use the date of service aggregation at the beginning of the pseudo-single claim creation to achieve the best effects. Some commenters asked that we require all hospitals to use dates of service on all lines (but not before July 1, 2004), even where only revenue codes are on the lines, so that more claims could be used in future years.

Several commenters asked that we eliminate the requirement for series bills for certain services if we require a date of service for each line because the claim will grow in size as charges for multiple dates of service that are now combined on a single line with no date of service will now have to be split into multiple lines to show the date of service. The commenters fear that the increase in the lines on the claim may result in errors on the claim and there may be cashflow problems if more claims are returned to the provider. The commenters indicated that delays in payment for series bills covering 30 days of service are significant.

*Response:* For the 2004 OPPS, we did make progress in using more claims by looking to the dates on revenue center charges, where they exist, to assign them to a single major procedure on the same date. We applied the date of service criteria before we ignored APCs to create single claims. Moreover, we were able to create more single procedure claims by ignoring procedures for which we thought no revenue center charges or packaged HCPCS charges would be appropriately assigned. We appreciate the information provided in comments and hope that the public will continue to furnish us with an expanded list of codes that they believe can be considered ''stand alone'' codes, which we could properly ignore in creating pseudo single claims from claims containing multiple major procedures. We did not add evaluation and management service codes to the list because we believe that drugs and supplies are often used during such services and that it would not be correct to assume that all of the supply and drug charges on the claim were for items and services used with the procedure that also is billed also on the same claim. We would like to further explore the issue of which claims to ignore for pseudo single creation with the APC Panel in its winter meeting and to seek the Panel's views on the specific code to be added to the list of codes to be ignored for this purpose.

While we did not apply the combination APC approach, we expect to continue to explore whether this would, upon further refinement, have value in establishing correct weights for procedures performed in combination with one another. We hope to improve both of these processes next year and to develop other methods of using multiple procedure claims.

We did not use the line items for the HCPCS codes we ignored in the calculation of medians for those HCPCS codes. We asked for public comment on the issue. In view of the public comments supporting the concept of ignoring certain codes for creation of pseudo singles and supporting the validity of using these line items in the median setting for these codes, we will propose to use them for median setting for the 2005 proposed rule.

Our requirement for series bills creates efficiencies in claims processing that enable us to provide better provider service. In view of the decision to not implement the drug administration option, which would have required coding of all drugs, and seemed to be the impetus for the comment, we do not expect to revise our series bill policy.

*B. Description of Our Calculation of Weights for CY 2004*

The methodology we followed to calculate the APC relative payment weights proposed for CY 2004 is as follows:

- We excluded from the data claims for those bill and claim types that would not be paid under the OPPS (for example, bill type 72X for dialysis services for patients with end-stage renal disease (ESRD)).
- We eliminated claims from hospitals located in Maryland, Guam, and the U.S. Virgin Islands.
- Using the most recent available cost report from each hospital, we converted billed charges to costs and aggregated them to the procedure or visit level first by identifying the cost-to-charge ratio specific to each hospital's cost centers (''cost center specific cost-to-charge ratios'' or CCRs) and then by matching the CCRs to revenue centers used on the hospital's CY 2001 outpatient bills. The CCRs include operating and capital costs but exclude items paid on a reasonable cost basis.
- We eliminated from the hospital CCR data 287 hospitals that we identified as having reported charges on their cost reports that were not actual charges (for example, a uniform charge applied to all services). Of these, 206 hospitals had claims data.
- We eliminated from our data claims for critical access hospitals that are not

paid under OPPS and whose claims are therefore not suitable for use in setting weights for services paid under OPPS.

- We calculated the geometric mean of the total operating CCRs of hospitals remaining in the CCR data. We removed from the CCR data 56 hospitals whose total operating CCR deviated from the geometric mean by more than three standard deviations.
- We excluded from our data approximately 3.11 million claims submitted by the hospitals that we removed or trimmed from the hospital CCR data.
- We matched revenue centers from the remaining universe of claims to hospital CCRs.
- We separated the remaining claims that we had matched with a cost report into the following three distinct groups: (1) Single-procedure claims; (2) multiple-procedure claims; and (3) claims on which we could not identify at least one OPPS covered service. Single-procedure claims are those that include only one HCPCS code (other than laboratory and incidentals such as packaged drugs and venipuncture) that could be grouped to an APC. Multiple-procedure claims include more than one HCPCS code that could be mapped to an APC. Dividing the claims yielded approximately 24.43 million single-procedure claims and 16.86 million multiple-procedure claims.

We converted 9.833 million multiple-procedure claims to single-procedure claims using the following criteria: (1) If a multiple-procedure claim contained lines with a HCPCS code in the pathology series (that is, CPT 80000 series of codes), we treated each of those lines as a single claim. (2) For multiple-procedure claims with a packaged HCPCS code (status indicator ''N'') on the claim, we ignored line items for preoperative procedures and for those services in the APCs identified in Table 6. These are services with payment amounts below $50 (under the CY 2003 OPPS) for which we believe the charge represents the totality of the charges associated with the service (that is, that there are no packaged HCPCS or packaged revenue centers attributable to the service). If only one procedure (other than HCPCS codes in Table 6) existed on the claim, we treated it as a single-procedure claim. (3) If the claim had no packaged HCPCS codes and if there were no packaged revenue centers on the claim, we treated each line with a procedure as a single-procedure claim if billed with single units. (4) If the claim had no packaged HCPCS codes but had packaged revenue centers for the procedure, we ignored the line item for codes in the APCs identified in Table 6. If only one HCPCS code remained, we treated the claim as a single-procedure claim.

TABLE 6.—APCS THAT WERE IGNORED TO CREATE PSEUDO SINGLE PROCEDURE CLAIMS

| APC | APC Description | Status indicator |
|---|---|---|
| 0001 | Level I Photochemotherapy | S |
| 0060 | Manipulation Therapy | S |
| 0077 | Level I Pulmonary Treatment | S |
| 0099 | Electrocardiograms | S |
| 0215 | Level I Nerve and Muscle Tests | S |
| 0215 | Level I Nerve and Muscle Tests | S |
| 0230 | Level I Eye Tests & Treatments | S |
| 0260 | Level I Plain Film Except Teeth | X |
| 0262 | Plain Film of Teeth | X |
| 0271 | Mammography | S |
| 0341 | Skin Tests and Miscellaneous Red Blood Cell Tests | X |
| 0342 | Level I Pathology | X |
| 0343 | Level II Pathology | X |
| 0344 | Level III Pathology | X |
| 0345 | Level I Transfusion Laboratory Procedures | X |
| 0364 | Level I Audiometry | X |
| 0367 | Level I Pulmonary Test | X |
| 0669 | Digital Mammography | S |
| 0690 | Electronic Analysis of Pacemakers and other Cardiac Devices. | S |
| 0706 | New Technology—Level I ($0–$50) | S |

In addition, we assessed the dates of service for HCPCS codes and packaged revenue centers on each claim that contained more than one major code. Where it was possible to attribute charges for packaged HCPCS and packaged revenue centers to HCPCS codes for major procedures by matching unique dates of service, we did this and created single claims by packaging charges into the charge for the major service on the same date. We were only able to do this if the multiple major procedures had different dates of service and if there were dates of service on all of the packaged revenue centers. Dates of service on revenue centers are not required and, therefore, only claims from hospitals that submitted dates of service on revenue centers in CY 2002 could be used in this process for maximizing the number of single-procedure claims to be used for weight setting.

- To calculate median costs for services within an APC, we used only single-procedure bills and those multiple-procedure bills that we converted into single claims. If a claim had a single code with a zero charge (that would have been considered a single-procedure claim), we did not use it. As we discussed in section III.A.2 of this final rule, we did not use multiple-procedure claims that billed more than one separately payable HCPCS code with charges for packaged items and services such as anesthesia, recovery room, or supplies that could not be reliably allocated or apportioned among the primary HCPCS codes on the claim. We have not yet developed what we regard as an acceptable method of using multiple procedure bills to recalibrate APC weights that minimizes the risk of improperly assigning charges to the wrong procedure or visit.

For APCs in Table 7, we required that there be a C code on the claim for the claim to be used. These APCs require the use of a device in the provision of the service. Moreover, in 2002, hospitals were required to bill the C code in order for the device to receive pass-through

payment for the device. Therefore, if no C code was billed on the claim, we presumed that the claim was incorrectly coded, and we did not use it. For some of these APCs, we further required that specific devices be on the claim.

TABLE 7.—APCS FOR WHICH A HCPCS FOR A DEVICE WAS REQUIRED TO BE ON A CLAIM USED FOR WEIGHT SETTING

| APC | APC Description | Status |
|---|---|---|
| 0032 | Insertion of Central Venous/Arterial Catheter | T |
| 0039 | Implant Neurostim, One Array | S |
| 0048 | Arthroplasty with Prosthesis | T |
| 0080 | Diagnostic Cardiac Catheterization | T |
| 0081 | Non-Coronary Angioplasty or Atherectomy | T |
| 0082 | Coronary Atherectomy | T |
| 0083 | Coronary Angioplasty and Percutaneous Valvuloplasty | T |
| 0085 | Level II Electrophysiologic Evaluation | T |
| 0086 | Ablate Heart Dysrhythm Focus | T |
| 0087 | Cardiac Electrophysiologic Recording/Mapping | T |
| 0089 | Insertion/Replacement of Permanent Pacemaker and Electrodes | T |
| 0090 | Insertion/Replacement of Pacemaker Pulse Generator | T |
| 0104 | Transcatheter Placement of Intracoronary Stents | T |
| 0106 | Insertion/Replacement/Repair of Pacemaker and/or Electrodes | T |
| 0107 | Insertion of Cardioverter-Defibrillator | T |
| 0108 | Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads | T |
| 0115 | Cannula/Access Device Procedures | T |
| 0119 | Implantation of Devices | T |
| 0122 | Level II Tube Changes and Repositioning | T |
| 0167 | Level III Urethral Procedures | T |
| 0202 | Level VIII Female Reproductive Proc | T |
| 0222 | Implantation of Neurological Device | T |
| 0225 | Implantation of Neurostimulator Electrodes | S |
| 0226 | Implantation of Drug Infusion Reservoir | T |
| 0227 | Implantation of Drug Infusion Device | T |
| 0229 | Transcatheter Placement of Intravascular Shunts | T |
| 0259 | Level VI ENT Procedures | T |
| 0313 | Brachytherapy | S |
| 0384 | GI Procedures with Stents | T |
| 0385 | Level I Prosthetic Urological Procedures | T |
| 0386 | Level II Prosthetic Urological Procedures | T |
| 0648 | Breast Reconstruction with Prosthesis | T |
| 0652 | Insertion of Intraperitoneal Catheters | T |
| 0653 | Vascular Reconstruction/Fistula Repair with Device | T |
| 0654 | Insertion/Replacement of a Permanent Dual Chamber Pacemaker | T |
| 0655 | Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker | T |
| 0670 | Intravenous and Intracardiac Ultrasound | S |
| 0674 | Prostate Cryoablation | T |
| 0680 | Insertion of Patient Activated Event Recorders | S |
| 0681 | Knee Arthroplasty | T |

• For each single-procedure claim, we calculated a cost for every billed line item charge by multiplying each revenue center charge by the appropriate hospital-specific CCR. We used the most recent settled or submitted cost reports. Using the most recent ''submitted to settled ratio,'' we adjusted CCRs for the submitted cost reports but not the settled ones. If an appropriate cost center did not exist for a given hospital, we crosswalked the revenue center to a secondary cost center when possible, or used the hospital's overall CCR for outpatient department services. We excluded from this calculation all charges associated with HCPCS codes previously defined as not paid under the OPPS (for example, laboratory, ambulance, and therapy services). We included all charges associated with HCPCS codes that are designated as packaged services (that is, HCPCS codes with the status indicator of ''N'').

• To calculate per-service costs, we used the charges shown in revenue centers that contained items integral to performing services. Table 8 contains a list of the revenue centers that we packaged into major HCPCS codes when they appeared on the same claim. This is a change to the packaging of revenue centers by category of service that had been done since the inception of the OPPS in the April 7, 2000 final rule (65 FR 18457). In all prior years of the OPPS, we had specific subsets of revenue centers that we packaged into major HCPCS codes based on the type of service we assigned to the HCPCS code for this purpose. For example, we had a set of revenue centers that could be packaged into visit codes and a different, but overlapping, set of revenue centers that could be packaged into surgery codes. For 2004 OPPS, we converted these categories to a single set of revenue codes (see Table 8) that would be packaged into the major HCPCS code with which it appears on a claim. We believe that this will increase the likelihood that the total charge for the major HCPCS code will capture all of the costs attributed to the services furnished. Table 8 lists packaged services by revenue center that we are proposing to use to calculate per-service costs for outpatient services furnished in CY 2004.

TABLE 8.—PACKAGED SERVICES BY REVENUE CODE

| Revenue code | Description |
|---|---|
| 250 | Pharmacy. |
| 251 | Generic. |
| 252 | Nongeneric. |

TABLE 8.—PACKAGED SERVICES BY REVENUE CODE—Continued

| Revenue code | Description |
|---|---|
| 254 | Pharmacy Incident to Other Diagnostic. |
| 255 | Pharmacy Incident to Radiology. |
| 257 | Nonprescription Drugs. |
| 258 | IV Solutions. |
| 259 | Other Pharmacy. |
| 260 | IV Therapy, General Class. |
| 262 | IV Therapy/Pharmacy Services. |
| 263 | Supply/Delivery. |
| 264 | IV Therapy/Supplies. |
| 269 | Other IV Therapy. |
| 270 | M&S Supplies. |
| 271 | Nonsterile Supplies. |
| 272 | Sterile Supplies. |
| 274 | Prosthetic/Orthotic Devices. |
| 275 | Pacemaker Drug. |
| 276 | Intraocular Lens Source Drug. |
| 278 | Other Implants. |
| 279 | Other M&S Supplies. |
| 280 | Oncology. |
| 289 | Other Oncology. |
| 290 | Durable Medical Equipment. |
| 370 | Anesthesia. |
| 371 | Anesthesia Incident to Radiology. |
| 372 | Anesthesia Incident to Other Diagnostic. |
| 379 | Other Anesthesia. |
| 390 | Blood Storage and Processing. |
| 399 | Other Blood Storage and Processing. |
| 560 | Medical Social Services. |
| 569 | Other Medical Social Services. |
| 621 | Supplies Incident to Radiology. |
| 622 | Supplies Incident to Other Diagnostic. |
| 624 | Investigational Device (IDE). |
| 630 | Drugs Requiring Specific Identification, General Class. |
| 631 | Single Source. |
| 632 | Multiple. |
| 633 | Restrictive Prescription. |
| 637 | Self-Administered Drug (Insulin Admin. in Emergency Diabetic. COMA) . |
| 700 | Cast Room. |
| 709 | Other Cast Room. |
| 710 | Recovery Room. |
| 719 | Other Recovery Room. |
| 720 | Labor Room. |
| 721 | Labor. |
| 762 | Observation Room. |
| 810 | Organ Acquisition. |

TABLE 8.—PACKAGED SERVICES BY REVENUE CODE—Continued

| Revenue code | Description |
|---|---|
| 819 | Other Organ Acquisition. |
| 942 | Education/Training. |

- We standardized costs for geographic wage variation by dividing the labor-related portion of the operating and capital costs for each billed item by the proposed FY 2004 hospital inpatient prospective payment system (IPPS) wage index published in the **Federal Register** on May 9, 2002 (67 FR 31602). We used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. We have used this estimate since the inception of the OPPS and continue to believe that it is appropriate. (*See* the April 7, 2000 final rule (65 FR 18496) for a complete description of how we derived this percentage).
- We summed the standardized labor-related cost and the nonlabor-related cost component for each billed item to derive the total standardized cost for each procedure or medical visit.
- We removed extremely unusual costs that appeared to be errors in the data using a trimming methodology analogous to what we use in calculating the diagnosis-related group (DRG) weights for the hospital IPPS. That is, we eliminated any bills with costs outside of three standard deviations from the geometric mean.
- After trimming the procedure and visit level costs, we mapped each procedure or visit cost to its assigned APC, including, to the extent possible, the proposed APC changes.
- We calculated the median cost for each APC.

To develop the median cost for observation (APC 339, HCPCS code G0244), we selected claims containing HCPCS code G0244 (Observation care provided by a facility to a patient with CHF, chest pain, or asthma, minimum eight hours, maximum forty-eight hours) that also showed one or more of the ICD–9 (International Classification of Diseases, Ninth Edition) diagnosis codes required for payment of APC 339. We ignored other separately payable codes so that the claims with G0244 would not be excluded for having multiple major procedures on a single claim. We packaged the costs of allowable revenue centers and HCPCS codes with status indicator ''N'' into the cost of G0244, and trimmed as was done for the calculation of the median costs for other APCs.

- Using the median APC costs, we calculated the relative payment weights for each APC. As in prior years, we scaled all the relative payment weights to APC 0601, Mid-level clinic visit, because it is one of the most frequently performed services in the hospital outpatient setting. We assigned APC 0601 a relative payment weight of 1.00 and divided the median cost for each APC by the median cost for APC 0601 to derive the relative payment weight for each APC. Using 2002 data, the median cost for APC 0601 is $58.78.

Section 1833(t)(9)(B) of the Act requires that APC revisions, relative payment weight revisions, and wage index and other adjustments be made in a manner that ensures that estimated aggregate payments under the OPPS for 2004 are neither greater than nor less than the estimated aggregate payments that would have been made without the changes. To comply with this requirement concerning the APC changes, we compared aggregate payments using the CY 2003 relative weights to aggregate payments using the CY 2004 proposed weights. Based on this comparison, we made an adjustment of 0.981635942 to the weights. The weights that we developed for 2004 OPPS, which incorporate the recalibration adjustments explained in this section, are listed in Addendum A and Addendum B.

*Impact of Allocation of Equipment and Capital Costs*

*Comment:* Several commenters indicated that the weight setting methodology may have a disproportionately adverse effect on procedures performed in departments with higher medical equipment and capital costs such as radiology and nuclear medicine. The commenters indicated that the capital costs incurred by these departments are generally spread among all hospital departments on a square foot or other basis, rather than being specifically allocated to the departments that incur the costs involved. This would distort the cost to charge ratios for these departments, resulting in under-weighting of the APCs for the services they furnish. Commenters indicated that we recognized this in the preamble to the 2000 OPPS rule (65 FR 18485, April 7, 2002) but indicated that it did not have the data necessary to make the appropriate adjustment due to hospital reporting processes. The commenter indicated that it would be appropriate for us to re-evaluate mechanisms that could be used to ameliorate the distortion.

*Response:* We recognize that the allocation of capital and equipment costs to revenue centers that do not use the equipment could distort cost to charge ratios for the revenue centers that use the equipment (and presumably whose charges reflect those costs). It is not clear how cost to charge ratios could be adjusted for such allocations. However, for the 2005 OPPS, we hope to explore the effect and impact of basing relative weights on relative hospital charges, rather than costs. If weights are based on relative charges, then presumably, the charges for services with high cost equipment and capital expenses would reflect those costs relative to other services without such costs.

*Dates of Service on Revenue Code Lines*

*Comment:* Commenters supported requiring dates of service on lines with revenue code charges but asked that the requirement not be enforced until June 2004 to enable hospitals to have sufficient time to adjust their systems to provide this information.

*Response:* Subsequent to the proposed rule, we learned that the X 12N 837 standard transaction with which covered entities had to be in compliance on October 16, 2003, requires a date of service on each line item containing a charge.

*Single Revenue Code List for Packaging*

*Comment:* One commenter supported the use of a single revenue code list for packaging costs into separately paid HCPCS codes. The commenter indicated that this change would result in more accurately attributing costs to services. Another commenter objected to our proposed changes for packaging revenue centers. This commenter is concerned that the use of a single set of revenue codes for packaging into the major procedure on a claim may inappropriately allocate charges not associated with the major service on the claim. For example, the commenter stated that revenue code 254 and revenue code 255 should continue to map to a radiological APC, and charges in these revenue centers should not be assigned to a major non-radiological procedure.

*Response:* We proposed to combine the multiple lists of revenue codes into one because there was significant overlap in them and our physicians believed that the risk of not picking up appropriate charges was greater than the risk of picking up charges that were not appropriate. In the case cited by the commenter, we are depending on hospital billing and our reliance on single procedure claims to preclude us from packaging a charge for a radiological service into a HCPCS code for a non-radiological service. We have never had a complaint that we have packaged more costs than were appropriate into a HCPCS code, although we frequently are told that we neglected to pick up all related charges. For the final rule, we retained the single set of revenue codes for packaging into separately payable major HCPCS codes.

*Need for Stability in Relative Weights*

*Comment:* Commenters stated that significant changes in weights for services from year to year are difficult for hospitals because not all hospitals provide all services and if the APC rates fall for the particular service mix the hospital furnishes, this can mean significant shifts in total payment for outpatient services from Medicare from year to year. Commenters indicated that we should adjust medians derived from claims data to limit the amount of change that occurs from year to year. Commenters indicated that hospitals are limiting availability of services based on declining Medicare OPPS revenues and that once a service is curtailed or eliminated, it is not likely to be reintroduced again because the hospital will cease monitoring the costs of the device and equipment needed to offer the service once it is no longer provided in the hospital and, therefore, even if it would be cost effective to reintroduce the service, it is not likely to occur. Commenters indicated that the pattern of revenue changes is a factor in hospital decisions regarding whether to acquire state-of-the-art equipment. Therefore, reductions in payments for equipment-intense services discourage hospitals from acquiring the equipment necessary to provide state-of-the-art services to Medicare beneficiaries. Commenters also indicated that the cumulative effects of the reductions from 2002 payment rates, particularly for procedures to implant medical devices, have resulted in significant payment cuts for many of these procedures and will discourage acquisition of the items necessary to provide the highest quality care.

A commenter stated that we should stabilize the APC rate when a device comes off of pass-through status. Several commenters stated that the proposed rates reverse the progress that was made in 2002 by using the manufacturer prices in the setting of medians for 2002. Commenters indicated that we should adjust the medians from claims data to ensure that no APC's median falls more than 5 percent compared to the medians used for payment in 2003. A commenter suggested that we adjust the medians whenever there is more than a 20 percent reduction from one year to the next. Another commenter indicated that all APCs that decline more than 10 percent compared to 2003 adjusted medians should be adjusted in the same way that we proposed to adjust medians for drugs, biologicals and radiopharmaceuticals and that these adjustments also should apply to brachytherapy sources.

Another commenter asked that we let no median cost used in weight setting fall more than half the difference between the loss and 15 percent because this methodology offers a buffer for hospitals to minimize annual changes. Another commenter indicated that we should freeze the 2003 payment rates, particularly for brachytherapy services and should educate providers to show all of the charges for all of the ancillary services on the claim so that they will be included in the development of relative weights for future years.

*Response:* We are sympathetic with the concerns of hospitals that the OPPS should be sufficiently stable that hospitals would have the capacity to plan and budget for future years. We recognize that the early years of a payment system may result in shifts in payment across services. However, a prospective payment system is a system of averaging in which the payment to the hospital becomes an overall amount that the hospital has at its disposal to use in the way it finds to be most efficient and effective. The payments for individual services are the means by which the amount of money to be spent on OPPS is distributed among hospitals but the hospitals have the right to use that payment as they choose across all services they choose to furnish. The OPPS is a system that attempts to calibrate payments for a service or procedure to best approximate the costs that an efficient provider would incur in providing the service or procedure in order to give providers incentives for efficient procurement and service delivery.

As we indicated in the proposed rule, for 2004, some of the same services had significant declines in median costs compared to the 2003 adjusted median but not compared to the 2003 median before adjustment. We did not propose to adjust the 2004 medians for procedural APCs compared to the 2003 adjusted median. Instead, we indicated that we would consider using external data that could be made publicly available if we were convinced that the medians for 2004 would result in payment rates that were grossly aberrant in the context of the service.

After reviewing the comments, and our final claims data for 2004, we decided that we would not adjust the medians for procedural APCs but that we would adjust medians for certain APCs for which we were given external data that could be made public because we were convinced that the medians from our claims data resulted in median costs that were grossly variant. We adjusted the medians for the following APCs using external data: APC 0107 (insertion of cardioverter-defibrilator), APC 0108 (Insertion/replacement/repair of cardioverter defibrillator leads and insertion of pulse generator), APC 0222 (implantation of neurostimulator), APC 0039 (which was broken out of APC 0222) and APC 0674 (prostate cryoablation). For each of these APCs we calculated an adjusted device portion of the median by taking one part of the device cost from our data and one part of the device cost supplied by external data. We added the adjusted device median to the nondevice median from our data to acquire the adjusted median. In the case of APC 0108, we used the external device cost data that was used to set the median for the 2003 OPPS because we received no outside data for the 2004 OPPS for this APC and because the proposed median of $28,685.30 set forth in the proposed rule was considerably higher than the final rule data median of $23,944.80, which resulted when additional claims were used to calculate the median cost. In other cases, we found that corrections in the APC assignment or splitting an APC into two APCs resulted in more accurate median costs.

For 2004, we will adjust median costs for drugs, biologicals and radiopharmaceuticals as proposed for reasons discussed in section VI.B.3. We will freeze payments for blood and blood products at the 2003 rates for reasons discussed in section VI.B.8. We will pay single indication orphan drugs at 88 percent AWP for reasons discussed in section VI.B.6.

*Comparison of Procedural APC Medians for the 2004 OPPS to Adjusted Medians for 2003 OPPS*

Using the data available to us at the time we developed the proposed rule, we identified APCs that showed decreases in median cost of more than 10 percent compared to the adjusted medians on which their payments were based for 2003. We discussed specific APC medians to the extent that we understood the reason for the decreases or were particularly puzzled by the change. We requested comments on the medians and provided a set of criteria for external data that could be used to supplement the median costs derived from our claims data. The criteria we provided regarding the use of external data included a stipulation that the data must not be confidential because any data we use must be available to the public. We also provided a list of preferred (but not required) criteria that addressed our preferences for characteristics of the data. We indicated that to be of optimal use, the external data should represent a divergent group of hospitals by location and type, identify the number of devices billed to Medicare as well as rebates or reductions for bulk purchases, identify the HCPCS codes with which the devices would be used, identify the source of the data and include both charges and costs for each hospital by quarter for the last 3 quarters of 2002 (68 FR 47987). We did not propose to adjust the medians for procedural APCs in the manner that they were adjusted for the 2003 OPPS. For 2004 we did not apply a systematic adjustment to all medians that declined more than a specified percentage in comparison with the medians for 2003. Instead, as discussed previously, we adjusted the medians of 5 APCs based on external data where we thought it was necessary and we have split some APCs where we thought doing so would result in more accurate relative weights.

*Use of External Data*

*Comment:* Some commenters opposed the use of external data on the basis that they believe that they will result in unfair imbalances in payment. They recognized that the application of cost-to-charge ratios will not result in amounts that are equal to full acquisition costs but they believe that as long as the same standard methodology is used across all services, the relative payments will be correct. They indicated that in a system of averaging, it is not necessary or even expected that each item and service will be paid at acquisition cost. They encouraged us to remain faithful to the averaging process inherent in a prospective payment system and not to rely on external data. Some commenters opposed use of external data and supported the requirement that they be publicly disclosable. Other commenters stated that we should use our claims data to set weights because they accurately reflect the relative hospital costs of providing outpatient services. However, these commenters were concerned with how different rates for some services in the 2004 proposed rule are from the rates for the same services in 2003.

Some commenters said that we should use external data that are proprietary and maintain the confidentiality of such data. Several commenters indicated that the prices for medical devices are often covered by agreements that preclude the parties from disclosing the price of the device and that we should use the data to set prices, notwithstanding that they cannot be made available for inspection by the parties whose payments may be reduced by their use. Several commenters stated that we used external data that were proprietary for setting of 2002 weights, and for some 2003 weights and that we should do so again because data from manufacturer price lists and invoices more accurately reflect the costs attained by applying the cost-to-charge ratios for hospital departments to the charges for the devices to get costs to package into the APC medians. These commenters stated that external data should be used more widely than data based on the criteria that were used for the 2003 OPPS for the use of external data (that is, that the device-cost portion of the APC exceeded 80 percent of the total APC cost for external data to be used). These commenters stated that external data should be used for all APCs that show significant reductions since the 2002 OPPS. In particular, they cited the APC Panel recommendation that outside data be used to set the median cost for APC 107.

Some commenters had specific comments on the criteria we provided for use of external data. One commenter stated that its members did not have and could not easily acquire the data that would ensure that the data represent a diverse group of hospitals by location and type nor could they identify specific hospitals that used their devices. The commenter also stated that its members could not provide the information on discounts and rebates against their price lists that we requested. The commenter indicated that its members did not want to provide the HCPCS codes in which their products were used but instead, wanted us to require the typical applications that they feel are most appropriate. The commenters agreed that they could provide the source of the data. The commenters stated that its members could not provide data that corresponded with the same period of time being used to set the relative weights for all APCs.

*Response:* In the proposed rule, we indicated that external data should cover services furnished during the last 3 quarters of 2002 (68 FR 47987). We appreciate that manufacturers and wholesalers would not want to disclose negotiated prices for 2003 or 2004 for competitive reasons. However, we fail to

understand how they could be harmed by publicly disclosing prices that were applicable in 2002 but have now been obsolete for a year. Moreover, since upward adjustment of any median cost results in reduction of payments for all other items and services, we believe that, in a governmental payment program, the parties whose payments are reduced by the use of external data should be able to examine all elements of the payment system.

We do not believe that widespread use of external data to set median costs for selected APCs is appropriate in a system that relies on relativity to establish payment amounts. We are sympathetic with the concerns of some commenters that widespread use of external data will result in payment inequities rather than appropriate payments to hospitals based on the relative weights of the services they furnish. However, we are also concerned about circumstances in which we are convinced that the payment amounts that would result from the medians from our data will discourage hospitals to provide access to needed care. Therefore, in the case of several APCs as discussed elsewhere, we used external data to adjust the medians. In general, however, we continue to have confidence in the integrity of our claims data with respect to the procedural APCs. For the future, we prefer to seek ways to refine the methodologies that we apply to our own data, such as the use of a greater percentage of claims to set the weights for certain APCs.

*Comment:* Several commenters stated that we should work with them to set the methodology for the 2005 medians in view of the absence of device codes in the 2003 data and should pursue a study of the acquisition costs of devices in particular, so that there will be valid device related data for setting the 2005 OPPS.

*Response:* We are always interested in hearing the proposals of outside parties with regard to our methodology for setting OPPS weights. We recognize the concern that the absence of device codes for 2003 claims may lead to median costs that fail to fully incorporate the costs of the devices used in the applicable APCs and we are interested in all ideas for preventing this problem. Our proposed methodology will be presented in the proposed rule for the 2005 OPPS and will be open to public comment.

*General Comments About Payment*

*Comment:* A commenter asked that we base the relative weights on the geometric mean that we use for trimming the data. The commenter indicated that the use of the geometric mean is the industry standard for both trimming aberrant data, as we use it, and also for calculating relative weights when costs are not distributed symmetrically. The commenter stated that the use of the geometric mean is particularly useful in circumstances that mirror those of OPPS: the first years of a new system and with low-volume high-cost services. The commenter noted that we agreed to move forward with analyses to look at the use of a mean versus median cost for weight setting in the November 1, 2002 final rule published in the **Federal Register**, but believes that not much analysis is needed since the use of the geometric mean is an industry standard for setting relative weights.

*Response:* We appreciate the thoughtful comments on this issue and other suggestions on how we might improve our rate setting methodology. We will continue to explore these options in 2004. Our efforts in 2003 were limited to creating unscaled weights from the means used for the 2003 OPPS and comparing them to the unscaled weights for medians for 2003 OPPS. Our preliminary comparison revealed that there would be many swings in payments. Hence, for the 2004 OPPS, we continued our use of the median cost.

In preparation for 2005 OPPS, we hope to calculate OPPS amounts using the mean costs, and also mean and median charges (to circumvent the effects of cost-to-charge ratios), and the 2004 OPPS conversion factor. This should give us a more complete view of the impact of revising our methodology in this way.

*Charge Compression and Cost Finding*

*Comment:* A commenter indicated that the use of cost to charge ratios is consistent with the concept of averaging that underpins a prospective payment system and that the system should not seek to micro-cost individual items or services but rather should rely upon the hospital charging patterns irrespective of Medicare policy to base relativity. The commenter indicated that while some items have different markups than others, the use of a standardized methodology to establish relative weights for all services should result in appropriate relative payments. The commenter strongly objected to any additional burdens that would be imposed in order to fine tune the pass-through payment system or weights at the expense of all other APC payments. The commenter specifically objected to CMS overriding the claims data to alter the ratio for new technology devices because the commenter believes that such adjustments will make the OPPS unduly administratively complex and create unfair imbalances in payment.

Other commenters opposed the use of cost-to-charge ratios applied to charges to acquire cost data. They indicated that in many cases, we had to use overall hospital cost-to-charge ratios that had no relevance to the costs of the services being determined and therefore resulted in invalid representations of median costs. They also indicated that both the departmental and the hospital specific cost-to-charge ratios were derived in part from costs that are commingled between inpatient and outpatient services and therefore are not necessarily representative of a ratio that could be applied to outpatient services alone, as we do. Some commenters indicated that we ignore studies that demonstrate that charges are compressed, with low-cost services being marked up more than high-cost services, thus resulting in systematic underpayment of high-cost items and diminishing beneficiary access to high-cost services. A commenter suggested that, for drugs, biologicals and radiopharmaceuticals, we set a minimum payment based on the Federal Supply Schedule price plus a percentage markup to ensure that payment for drugs, biologicals, and radiopharmaceuticals was sufficient to make them available to Medicare beneficiaries who need them.

Several commenters indicated that the application of hospital specific cost-to-charge ratios at the department level where available, otherwise at the hospital level will always result in incorrect costs because hospitals do not have a consistent markup for all items and services within a department. They indicated that hospitals markup low-cost items more than high-cost items and that therefore, the application of a cost-to-charge ratio, even at the department level, will never result in the hospital acquisition cost for an item. They indicated that there is no easy adjustment to correct for charge compression and they urge us to explore using external data, developing surveys or doing studies to acquire hospital cost data that can be used in place of the median costs acquired from claims data.

*Response:* We recognize that the application of cost-to-charge ratios to charges for individual items as needed to develop median costs for APCs is imperfect. However, the only means at our disposal for determining costs from the charges on the claims was to calculate a cost-to-charge ratio using the cost report data that we believe is

applicable to the OPD (for example, excluding room and board). We acknowledge that this system for determining relative values is imperfect, but we believe that it continues to be preferable to total reliance for particular items on external data which could inappropriately inflate Medicare payments for those items to the detriment of general hospital services. As indicated above, we hope to explore use of mean costs, and mean and median charges in preparation for the 2005 OPPS to determine if such a change would result in better relative weights and less instability in OPPS payments for particular services from year to year. However for 2004, we based relative weights on median costs derived through the application of a cost-to-charge ratio to the charges for the services.

*General Concerns About Decreases*

*Comment:* We received many comments objecting to proposed decreases in the proposed payment rates for specific services. These commenters indicated that the service has become more expensive rather than less expensive over the year, or indicated that the payment for the service declined for 2003 and should not decline for 2004. In some cases, the comments indicated that the payment should remain at the 2003 rate so that hospitals will not consider discontinuing the service.

*Response:* The OPPS is a relative payment system based upon the relative median costs of services. We calculate the costs of services by applying a cost to charge ratio to the charges for the services and then packaging the costs together for major HCPCS codes. We then calculate the median of the array of costs across all claims for HCPCS codes in an APC. There are many factors that can affect whether the cost of services rises or falls from one year to the next. In general, for the 2004 OPPS, about half the APC median costs increased and about half decreased compared to the 2003 median costs. In most cases, the changes were modest and such changes from year to year are to be expected as hospitals find ways to reduce costs for some services and incur higher costs for others. Because we do not expect the mix of services furnished in hospitals to vary hugely from year to year across the universe of hospitals, we do not expect that the changes in relative costs to create enormous impacts either.

*Disparity in Payments for Overhead Costs for the Same Service*

*Comment:* A commenter indicated that OPPS provides disparate payment for the overhead costs associated with services that are furnished both in physician offices and in hospital outpatient departments. As an example, the commenter indicated that CMS attributes $25.36 in physician practice expense to CPT code 99213 (office or outpatient mid level evaluation and management service for an established patient) but pays a hospital $54.46 (the amount set forth in the proposed rule) for the overhead for the same service and indicated that for other services the OPPS payment is as much as 4 times the amount paid to physicians for practice expense for the same service. The commenter asked that CMS establish payment equity for the same service furnished in these respective settings.

*Response:* The method for calculating payment for physicians' practice expenses under the Medicare physician fee schedule is established by law, as is the method we use for the outpatient setting. The application of the different methodologies results in different payment amounts in the two settings.

Comments and responses on payment amounts for specific APCs are included in section II.B.

*Source of Data for Weight Setting*

*Comment:* One commenter stated that we should conduct a study to establish a source for cost data other than claims data on which to base APC weights. Another commenter strongly objected to use of survey data because the commenter did not believe that it could ever fully capture all hospital costs for services and that therefore, the survey data would be used only for items and would have to be integrated with claims data for services. The commenter did not believe that the two could be integrated in a way that would properly reflect the relative costs.

*Response:* We believe that relative weights should generally be based on claims data because, notwithstanding the weaknesses, claims data are the most complete and accurate source of information about all services furnished by all providers paid under OPPS. We believe that it would be unreasonably expensive to acquire survey data that would be representative of the entire population of Medicare hospitals and all OPPS services furnished in them. We do not support the idea of using only selected hospitals and/or selected services because we think data from a limited survey would not be representative of the whole population of Medicare hospitals and services and would not be accurate to reflect relative costs of all services.

*Incomplete Hospital Bills*

*Comment:* Commenters indicated that when OPPS was implemented, hospitals no longer had a payment incentive to ensure that all charges were shown on the claim because there was no longer a direct relationship between the amount of charges on the claim and the interim payment they would receive for services. Therefore they ceased to complete the claim as fully as when the charges were directly related to the Medicare interim payment. Several commenters indicated that in some cases, hospitals went as far as to remove items from the chargemaster so that a charge was no longer created when an item or service was used, particularly if the item or service were from a department other than the department billing the CPT code. A commenter said that in many cases, hospitals ceased to bill all charges for services if the completion of the claim with all charges would delay the submission of the claim to Medicare and therefore delay the Medicare payment to the hospital. Commenters indicated that hospitals did this particularly for services like brachytherapy in which the services were furnished from multiple departments of the hospital and the claim could be delayed significantly to accumulate all charges. Commenters indicated that the absence of all charges for services could result in poor data and instability in median costs from year to year, particularly when we use only single procedure claims.

*Response:* We encourage hospitals to report all charges for all services on claims for Medicare payment so that the data on which relative weights are set will fully reflect the relative costs of all services. However, where all charges are not included on the claim but the costs exist in the cost centers, the cost-to-charge ratios would increase and, to some extent, offset the effect of the absence of charges. Hence, while we would prefer that hospitals bill all charges for the services they furnish, where they do not do so, it does not necessarily mean that the costs derived from applying the hospital's cost-to-charge ratio to charges would result in improper relative weights for the services.

*C. Discussion of Relative Weights for Specific Procedural APCs*

New APC for Antepartum Care

We proposed rule to split APC 0199, Obstetrical Care Service, into two APCs.

For this final rule, new APC 0700, Antepartum Care Service, was created and 59412 (external cephalic version) was assigned to it. The two remaining HCPCS code 59409 (vaginal delivery only) and 59612 (vaginal delivery only, after previous cesarean delivery) will remain in APC 0199, Obstetrical Care Service. We received no comments about this APC and will finalize our proposal.

*Implantation of Neurostimulators and Implantation of Neurostimulator Leads (APCs 0222 and 225)*

*Comment:* Commenters encouraged us to use a ''dampening'' approach to increase the median costs for these APCs and to use external data to set the payment weights for APCs 0222 and 0225. Commenters indicated that the proposed payment amounts do not cover the cost of the device, much less the hospital services to furnish it. Commenters indicated that our policy of calculating median weights based on single claims or pseudo single claims disadvantages these services by resulting in the use of only the simplest and lowest cost services. A commenter indicated that these services have had relative weights that were too low since the inception of OPPS and that the cumulative effect of multiple years of payment reductions will cause hospitals to cease to provide these services to Medicare beneficiaries. A commenter suggested that we split these APCs to reflect the different resources used in implanting one device versus another device in the same APC. A commenter also asked that we establish a separate APC for the NeuroCybernetic Prosthesis System.

*Response:* We also are concerned that the median costs for these APCs appear to be so low relative to other OPPS median costs. Both of these APCs are ones for which we require that selected C codes be on the claims that are used in calculation of the median to increase the likelihood that we are using correctly coded claims for these services. We recognize that the need to use single procedure claims and the need to further select claims that appear to be correctly coded reduce the number of claims used in median calculation. However, if we did not require that selected C codes were on the claims used, the median costs would be even lower than those calculated. Hence, using more single procedure claims would, in this case, result in even lower median costs.

For 2004, we have made changes to both of these APCs. In the case of APC 0222, we removed HCPCS code 61885 from APC 0222 and we placed it in its own APC 0039 because the APC Panel recommended that its status indicator be changed from a ''T'' to an ''S'' in order to not apply the multiple procedure reduction when two devices are implanted, as is often the case. Moreover, for both APC 0222 and APC 0039, we accepted external data for the device cost and used one part external data and one part claims data for the device portion of the APC's median cost to which we added the nondevice portion of the median cost. This increased the median cost for APC 0222 from a final data median of $11,050.90 to an adjusted median cost of $13,383.79. This increased the median cost for APC 0039 from a final data median cost of $10,741.66 to an adjusted median cost of $13,555.80. We believe that this more accurately reflects the relative cost of these services to other OPPS services.

In the case of APC 0225, we split the APC into two APCs, (APC 0225) and (APC 0040). APC 0225 contains CPT codes 63655, 64553, 64573, 64580 and 64577 and for this final rule, has a median cost of $11,873.72. APC 0040 contains CPT codes 64560, 64555, 63650, 64561, 64575, 64581, and 64565 and, for this final rule, has a median cost of $3,002.98. Both APCs have a status indicator ''S'' (to which multiple procedure discounts do not apply).

We believe that these changes will result in more appropriate relative weights for these services in relation to other OPPS services.

Brachytherapy Issues

*High Dose Rate Brachytherapy (APC 0313)*

*Comment:* Commenters objected to the proposed payment amounts for this APC and indicated that the costs of the procedure could not be fully included in it. Commenters indicated that they did not believe that hospitals were billing for both the needles and the catheters. These commenters recommended that we use only claims that contain the primary procedure code, the HDR Iridium source code, and codes for catheters and needles. A commenter indicated that the direct costs for the practice expense in physician offices for the codes in this APC average $1,130.16 and that it is inconceivable to the commenter that hospital costs could be any less. The commenter believes that the faulty data are attributable to hospital billing errors and urged us to educate hospitals regarding how to bill the service properly. A commenter asked us to issue a program instruction requiring hospitals to report both the cost of the HDR source and the needles or catheters needed to administer the treatment by date of service to facilitate setting of a correct median cost. The commenter is concerned that the actual cost of brachytherapy needles and catheters has not been captured and is not incorporated into any of the related APCs. Commenters also indicated that the discussion of the APC in the August 12, 2003 proposed rule was confusing and did not fit the services furnished in this APC.

*Response:* Upon receipt of comments and after listening to the concerns of outside groups during the comment period, we explored the circumstances surrounding the development of the median cost for the APC that resulted in the weights and payments in the August 12, 2003 proposed rule. We found that, while the APC was on the list of APCs for which claims were required to contain C codes and although the criteria required that there be both a brachytherapy source (C1717) and either needles (C1715) or catheters (C1728), no claims that met all of those criteria were found among the single procedure claims for that APC. Therefore, the system defaulted to using all single procedure claims, for which there were no sources or needles/catheters on the claim. Hence, APC 0313 was erroneously included in Table 7 as an APC for which C codes were required. Moreover, our discussion of the median for the APC was in error to say that there had been sources packaged into the payment for 2002 and that this accounted for the reduction in proposed payment for 2003.

For the final rule, we acquired more single procedure claims but again, none of the single procedure claims contained both sources and needles or catheters. We then revised our criteria to require only that the claims must contain sources (C1717). This gave us 27 single procedure claims that we used to acquire a median cost of $936.52, a significant increase over the median for all claims of $795.83.

In the course of discussions regarding this APC, some parties suggested that we ignore other procedure codes, such as dosimetry codes, that are typically found on claims for these services because the commenters believe that no charges billed under packaged revenue codes or packaged HCPCS should be allocated to those other procedures. We plan to explore the expansion of the codes we ignore for selection of single procedure claims for the 2005 OPPS. However, we did not believe we had sufficient information or data to make such a change for the final rule for 2004. We again note that it is important for

hospitals to include charges for all services they furnish on the claim so that we can better ensure that the relative weights are based on the most accurate data possible.

*Low Dose Rate Brachytherapy (APCs 312 and 651)*

*Comment:* We received several comments regarding payment for low dose, non-prostate brachytherapy (APCs 312 and 651). Commenters cited the proposed reduction in payment for APC 0312 and expressed concern that our methodology that excludes a number of multiple procedure bills results in our use of data from atypical encounters such as those in small centers with minimal technological complexity and inappropriate costs and charges. Commenters indicated that typically other services would be furnished on the same day and that the presence of these services on the claim would likely result in the claim not being used. Commenters indicated that the resources used for the services in these APCs are highly variable depending on the part of the body being treated and the nature of the equipment involved. They indicated that some hospitals ceased billing charges for all of the services furnished when OPPS was implemented because showing the charges on the claim would no longer result in more payment but showing all charges on the claim was costly, burdensome, and slowed billing. Commenters indicated that we should educate providers in the correct way to bill for the catheters, needles, and sources used for this service and that in the absence of acceptable median costs, we should adjust the medians to result in reasonable payments for the service. Commenters indicated that we should select only claims that contain device costs and ignore claims that do not contain such costs, setting the median cost on the subset of selected claims.

*Response:* We used the medians from our final data to set the relative weights on which the payments will be based for 2004. We were not convinced by comments that the data did not reflect a median cost that was appropriate relative to the costs of other OPPS services. We recognize that our methodology excludes a large number of claims because there were multiple procedures on the claim and as we indicated in the discussion of multiple procedure claims, we are continuing to work on ways to use more claims data. We will closely examine expanding the list of CPT and HCPCS codes that could be ignored to create pseudo single claims for use in calculating median costs to set relative weights. For future years, we will consider whether to impose criteria for correctly coded claims, such as requiring that the claims contain either any C code or specified C codes for brachytherapy sources and needles or catheters that are necessary to insert the sources. We were not able to do this for the 2004 OPPS. For the 2005 OPPS, we will use the claims data from 2003, for which there is no coding of brachytherapy needles or catheters, although there is coding of sources that can be used to select correctly coded claims.

As we previously indicated, for the 2004 OPPS, we will pay for prostate brachytherapy using the CPT codes and the HCPCS codes for brachytherapy sources used. We expect that the majority of the CPT codes billed will be 77778 (APC 0651) and 55859 (APC 0163) and that the HCPCS codes billed will be C1718 (brachytherapy source, iodine 125) or C1720 (brachy source, palladium 103). When we calculate the total median cost on which the payment to the hospital for the services involved in prostate brachytherapy will be based, we determine that paying under APC 0651 and APC 0163 with separate payment for the sources (APC 1718 or APC 1720) will result in more payment than would be the case under the packaged payment we proposed. For example, if we assume that 100 sources are implanted during a prostate brachytherapy procedure, we would expect the hospital to bill 77778, 55859, and 100 units of either C1718 or C1720. The sum of the applicable medians will be $6,486.54 if using iodine sources and $7,261.54 if using palladium sources. This is a considerable increase over the payments in 2003, which were $5,154.34 with iodine sources and $5,998.24 with palladium sources. We believe that this circumstance will be the predominant use of APC 0651 and that the total median for the service will result in appropriate relative weights on which to set the payments.

APC 0312 was billed just over 850 times for the 9 months of data used in the final rule. Of the five CPT codes in this APC, four have median costs for the CPT code of less than $400 and one code, 77776, Interstitial radiation source application, simple has a median of $2,218.18. However, that code does not meet the test of being significant, which we define as having a frequency greater than 1,000 or a frequency lower than 99 and a percentage of larger than or equal to 2 percent. Therefore, we have not moved it from the APC.

*Separate Payment for All Brachytherapy Sources*

*Comment:* Commenters indicated that we should provide separate payment for all brachytherapy sources but that the current payment structure and amounts are inadequate. Commenters indicated that we should create two new permanent separate brachytherapy source APCs for high activity iodine 125 and high activity palladium 103 sources that should be paid on a per source, per patient basis in addition to the procedure code. Commenters indicated that the proposed rates for iodine 125 and palladium 103 sources do not capture the costs of loose low dose seeds, much less the costs of high activity sources, which typically cost in excess of $150 per source.

*Response:* For 2004, we will pay separately for implantable brachytherapy sources based on the median costs from our claims data. We were not convinced by comments that the relative weights that will result from these median costs are inappropriate.

*Prostate Brachytherapy*

*Comment:* Commenters indicated that the creation of the new G codes (G0256 and G0261) for prostate brachytherapy imposes an unneeded burden on hospitals and that it conflict with the reporting of the service by other payers. Additionally, commenters stated that the use of the codes will preclude us from capturing the costs of the service in the future. The commenters encouraged us to eliminate the G codes and pay using the CPT codes for the procedures and the HCPCS codes for the sources on a per source, per case basis. They indicated that this would allow us to capture the true costs of the procedures to set rates in the future and that this approach is consistent with the APC Panel recommendation to us. A commenter requested that we eliminate APC 0649 (Prostate Brachytherapy Palladium Seeds) and APC 0684 (Prostate Brachytherapy Iodine Seeds) and reinstate the previous policy that allowed hospitals to bill the prostate brachytherapy procedures with two separate APCs; one for urology CPT code 55859 and one for the radiation oncology CPT code 77778. The commenter stated that this elimination would be consistent with our decision to pay for the sources on an individual basis. The commenter believed that creation of the G codes has caused unnecessary confusion for hospitals. The procedure is now described with a single G code; however, only one revenue center can be selected, causing confusion since these APCs have both a

urology CPT code as well as a radiation oncology CPT code. The commenter requested that we eliminate these two APC groups and institute a system that would allow the two procedures to be reported in separate APC groups.

*Response:* We agree and have deleted the alphanumeric HCPCS codes for packaged prostate brachytherapy and will pay using CPT codes for the procedures and the HCPCS codes for the sources. We have deleted the G codes (G0256 and G0261) and APCs 0649 and 0684; and for 2004, we will pay prostate brachytherapy procedures under APCs 0163 and 0651. Brachytherapy sources used for prostate brachytherapy will be paid on a per source basis using APCs 1718 (iodine) and 1720 (palladium).

*Cryoablation of the Prostate (APC 0674)*

*Comment:* Commenters indicated that the proposed payment was too low to pay for both the hospital services and the cost of the probes used in the procedure. They indicated that 92 percent of the procedures use 6 or more probes (64 percent use 6 probes and 28 percent use more than 6 probes). They indicated that a kit of 6 probes costs $5,000 and asked that we set a payment amount no less than the minimum cost a hospital incurs to provide the service, which they stated is $6,750. Commenters indicated that charges for this new technology were not properly reported by hospitals and that therefore the data do not properly reflect the costs of the service.

Response: We recognize that with the device being paid as a pass-through for the first time effective April 1, 2001, it is likely that there are irregularities in the claims data regarding the number of units of the device that have probably led to a median cost that is not representative of the relative cost of the procedure with the device packaged. Therefore, for 2004, we used one part of the acquisition cost of 6 probes ($5,000 for 6 probes which are used in 64 percent of the procedures) and one part of the device cost from our claims data to create an adjusted device cost median to which we added the nondevice cost from our claims data to acquire an adjusted median of $6,915.08 on which we based the relative weight for the 2004 OPPS. This compares favorably to the median of $5,925.41 on which the August 12, 2003 proposed rule was based and also compares favorably to the final rule data median of $6,283.49 on which the payment weights would have been based had we not used external data to adjust the device portion of the median.

*Payment for Cesium-131*

A new brachytherapy source, Cesium-131, came to our attention during the latter part of this year, through the pass-through device application process. We reached a decision on this application after publication of the August 12, 2003 proposed rule. We determined that this source did not meet our criteria for creation of a new pass-through category for devices. However, we believe that separate payment for a substantially equivalent new brachytherapy source is warranted, since we pay separately for other sources. The indications presented to us for Cesium-131 were substantially the same as those for Palladium-103 and Iodine-125. As such, the reasons for separate payment of brachytherapy sources, for example, variation in the number of seeds or other source forms make packaging into a clinical APC an undesirable option. Therefore, we have decided to create a separate APC so that the costs of this new source may be tracked like those of other brachytherapy sources. The payment rate for this source is $44.67 per seed. This payment rate is close to the reported price of the Cesium-131 seed and equal to our payment rate based on claims for Palladium-103, a source that is used for similar clinical indications.

*Cardiopulmonary Resuscitation*

*Comment:* A commenter indicated that a 28 percent drop in payment for this service is unwarranted because of the number of people and the level of training needed when this service is furnished.

*Response:* We were not convinced that the relative weight that would result from the use of the median cost for this APC would be inappropriate in relation to other OPPS services. Therefore, we will use the median cost from the final rule data to set the weight for this APC.

*Computer Aided Detection for Diagnostic Mammography*

*Comment:* A commenter expressed concern about our proposal to reassign Computer-Aided Detection for Diagnostic Mammography from a New Technology APC to APC 0410. The commenter stated that the proposed reassignment is premature and would result in a reduced payment rate that would be approximately half of the payment rate for the technical component of procedures performed in other settings. The commenter recommended that we retain this procedure in New Technology APC 1501 until we have greater claims experience.

*Response:* The alphanumeric HCPCS code for this service (G0236) is being replaced by a CPT code for the same service for 2004 (CPT code 76082). We found over 43,000 claims for this service in the 2002 data on which we are basing the 2004 relative weights. We believe that this volume of services is sufficient to justify setting a relative weight based on cost information rather than keeping the service in a new technology APC. Moreover, the practice expense portion of payment for this service is not relevant to the setting of relative weights for OPPS services, in which the relativity is established within the context of services paid under OPPS and not with regard to the practice expense for services under the Medicare physician fee schedule.

*Orthopedic Fracture Fixation Procedures*

*Comment:* Commenters stated that APCs 0043, 0046, 0047, 0048, 0049, and 0050 are not clinically similar and they violate the 2 times rule. They asked that we separate out the more costly procedures that involve fracture fixation devices because they involve additional time, resources, and significant costs of fixation devices. They recommended that we either create two new APCs with corresponding HCPCS codes for upper (at a payment of approximately $2,000) and lower fracture fixation devices (at a payment of approximately $3,000) or create two code modifiers (for upper and lower fixation devices) and multiple new APCs.

*Response:* For the 2004 OPPS, services that require an external fixation device will continue to be paid in APCs that also provide payment for fractures that do not require external fixation devices. While we are sympathetic to the commenters' concerns, we are not able to identify CPT codes that always require use of an external fixation device or the extent to which such devices are required for other codes. Nor did the information we received from the commenters provide a convincing breakdown of the differences in costs for procedures using external fixation devices. To create new APCs or new APC relative weights to provide additional payment for external fixation devices where such APCs would also contain procedures that do not routinely require use of an external fixation device, would result in overpayment of those procedures. Moreover, since most services in these APCs do not require an external fixation device, it may be appropriate to continue to pay for them in these APCs to encourage hospitals to use them only when required. Furthermore, we would be reluctant to

impose an additional burden on hospitals by establishing ''G'' codes or modifiers to use in reporting procedures with or without external fixation devices. However, as we state elsewhere, we would support interested specialty societies' decisions to request the CPT to consider this coding issue.

*APC 0680 Reveal ILR*

*Comment:* A commenter indicated that the proposed payment rate is about 95 percent of the hospital acquisition cost of the device, leaving the hospital at an immediate loss if it implants this device. The commenter indicated that it is the only manufacturer of the device and therefore the only source of acquisition cost for the device. They indicated that in 2002, the cost was $3,495 and recommended that we re-evaluate and re-price the APC to provide sufficient payment that beneficiaries will have access to the device when needed. They indicated that the predominant site of service is in the hospital outpatient department and that if payment is below hospital cost, beneficiary access will eventually be limited.

*Response:* The final rule data for APC 0680 reveals a median cost of $3,691.15 for this APC, on which the relative weights for 2004 are based. We were not convinced by comments that this median cost would result in a relative weight that would be inappropriate relative to the payments for other services under OPPS.

*Fractional Flow Reserve (FFR)*

*Comment:* A commenter indicated that fractional flow reserve (CPT codes 93571, Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement * * * during coronary angiography, initial vessel and 93572, each additional vessel) should be paid separately in addition to the procedure with which they are performed, rather than being packaged into the payment for the primary procedure. The commenter indicated that FFR should be paid separately because it is an expensive service with higher device and equipment costs and takes more time and staff than if it is not used. They also indicated that we pay separately for Intravascular ultrasound (IVUS) which is also deployed via guidewires. They stated that the principal difference is that IVUS describes the anatomy of the vessels while FFR describes the blood flow through the vessels. They indicated that it is inequitable to treat them differently. Payment for IVUS but not FFR creates inappropriate financial incentives for hospitals in determining which procedures to provide.

*Response:* Currently, where FFR is provided, the costs for it are packaged with the principal service to which FFR is an addition, which we expect to be coronary angiography. If we were to pay separately for this service, we would need to remove the costs for this service from the cost for services with which it was packaged (that is, coronary arteriography), which would reduce the medians on which the payments for those services are based. This would reduce the median and therefore the payment for coronary angiography. We are concerned with the circumstances under which this service would be appropriately paid under Medicare and will consider development of a national coverage decision regarding when it is medically necessary to treat illness or injury. After such a coverage decision is made, we will reconsider whether it is appropriate to pay separately for the service.

*Cataract Surgery With IOL Implantation (APC 0246)*

*Comment:* A manufacturer of intraocular lenses was concerned that on claims for the procedures in APC 246, the median charge of claims for which no charge is reported using revenue code 276 (Intraocular lens) is one-third lower than the median charge of claims where a charge is reported using revenue code 276. The commenter believes that when charges are not listed in revenue center 0276, they are omitted from the claim altogether, rather than being placed in a different revenue center. The commenter recommended that we adopt a policy of using only claims for APC 0246 that report charges for revenue code 276, which would be consistent with our proposal to calculate relative weights for certain device-related APCs using only claims that included a separate and correctly coded charge for a device.

*Response:* For the 2004 OPPS, payment for cataract surgery with IOL insertion is based on the median cost for the procedure from the final data. A review of the 2002 claims for procedures in APC 246, which includes CPT code 66984, one of the highest volume outpatient surgical procedures paid under the OPPS, indicates that the vast majority are billed with revenue code 276. Long-standing instructions require hospitals to report the IOL charge under revenue code 276 when billing for a procedure in APC 246.

In our implementing instructions for the 2004 OPPS update, we will remind hospitals and the contractors who process OPPS claims that, in order to receive payment for a procedure in APC 246, hospitals are required to report the associated IOL charge under revenue code 276. We will also consider for the 2005 OPPS update the commenter's recommendation that we use only claims with revenue code 276 to recalibrate the relative payment weight for APC 246. Our data are extremely robust for this APC (with a frequency of nearly 520,000), and they indicate that the preponderance of the claims used to establish the 2004 median does include revenue code 276.

*Transcatheter Placement of Intracoronary Drug-Eluting Stent Procedures (APC 0656)*

*Comment:* One commenter supported our recognition of the new drug-eluting stent technology through the creation of two ''G'' codes (G0290 and G0291) and their placement in new APC 0656. However, the commenter questioned how we calculated the proposed payment rate for 2004. The commenter stated that some patients classically considered at higher risk for percutaneous interventions, including diabetics and patients with multi-vessel disease, are being referred for drug-eluting stent procedures. The commenter stated that the clinical disposition of these patients makes them more complex and more resource-intensive than the average patient. The commenter further noted that, while the reporting of a second main coronary vessel procedure would result in a second, reduced APC payment, that our payment for the single vessel should be based on an average of 1.7 stents per vessel. Finally, the commenter recommended that we add APC 0656 to the list of APCs for which a device was required to be on the claim for weight setting.

*Response:* For the 2004 OPPS, we will continue to base the payment for transcatheter placement of intracoronary drug eluting stents on the median for APC 0104, transcatheter placement of intracoronary stents. We increased the median for APC 0104 ($4,765.05) by $1,200 to acquire the median we used for APC 0656. We are using the same adjustment amount used for a single stent in the inpatient prospective payment system. We received no comments that are sufficiently compelling to convince us that more than one stent per vessel typically will be used when this service is furnished in the outpatient department or that the adjustment amount of $1,200 per stent is inappropriate. We will consider including this on the agenda for the next APC Panel meeting.

With respect to the comment that we should add APC 0656 to the list of APCs for which a device was required to be on the claim for weight setting, we believe it would be inappropriate to do so for the 2004 OPPS. This is because the drug-eluting stent was not approved by the FDA until 2003, and, therefore, it did not appear in the 2002 data. Moreover, since there are no device codes for coronary stents for use on claims in 2003, the 2003 data will not contain the device codes that would be needed to create a subset of stent device claims to use for the 2005 OPPS. However, in view of the reinstitution of device coding for 2004, we will consider this comment in our work to develop the 2006 OPPS. Moreover, as we indicated above, we based the payment for APC 0656 on the median for APC 0104, which was calculated from claims that contained C codes for stents.

*Cardioverter Defibrillator (APC 0107)*

*Comment:* Commenters indicated that the proposed payment for this APC was too low to pay for the device, much less the cost of the services to implant it. They indicated that the cost of the device in 2002 varied between $19,160 and $21,410 among major group purchasers, considerably more than the proposed payment of $15,773.28. They asked that we use the external data to set the device portion of the hospital cost.

*Response:* We reviewed the data for this APC and considered the comments of the APC Panel at its August 2003 meeting on the August 12, 2003 proposed rule. We were convinced that the median for this device is too low to be appropriate relative to other median costs. We used external data that had been presented to the APC Panel to calculate a mean external acquisition cost and used one part external cost to one part median cost from our claims data to acquire an adjusted cost for the device. We then added the nondevice median from our claims data to the adjusted device acquisition cost to acquire an adjusted median that we used to set the relative weight for this APC. Effective for October 1, 2003, we established codes to be used for reporting the services assigned to APCs 107 and 108. Specifically, CPT code 33240 (Insertion of cardioverter defibrillator) is no longer recognized as a valid code for OPPS. Instead, hospitals now report either G0297 (Insertion of single chamber pacing cardioverter defibrillator pulse generator) or G0298 (Insertion of dual chamber pacing cardioverter defibrillator pulse generator). Also effective for October 1, 2003, CPT code 33249 (Insertion/replacement/repair of cardioverter defibrillator and insertion of pulse generator) is no longer recognized as a valid code for OPPS. Instead, hospitals will report either G0299 (Insertion or repositioning of electrode lead for single chamber pacing cardioverter defibrillator and insertion of pulse generator) or G0300 (Insertion or repositioning of electrode lead for dual chamber pacing cardioverter defibrillator and insertion of pulse generator). These codes were created to capture differential costs related to single and dual chamber cardioverter defibrillators. Claims containing the CPT codes we no longer recognize for OPPS (CPT codes 33240 and 33249) are being returned to providers to be coded correctly and resubmitted.

*Insertion of Pacemaker Dual Chamber (APC 0655) and Insertion of Pacemaker Single Chamber (APC 0089)*

*Comment:* A commenter indicated that the proposed payment rates for these APCs are only slightly more than the lowest median hospital acquisition cost of the device leaving a hospital little or no payment for the services to implant it. They asked that we re-evaluate and price these APCs at a level that pays the full cost of the device and services.

*Response:* We carefully reviewed the data for these APCs. We were not convinced that there was a need to adjust the median for either of these APCs. The median cost for APC 0655 is about 12 percent higher than the adjusted median on which the 2003 payment weights were based (2003 adjusted median of $7,298.52 versus the final rule median of $8,225.23). The median cost for APC 0089 is slightly higher than the adjusted median on which the 2003 weights were based (2003 adjusted median of $6,686.16 versus the final rule median of $6,754.63). The comment was not convincing that these median costs were inappropriate in relation to the other median costs that will be used to set the relative weights. Moreover, since median costs for both APCs rose above the amounts achieved by upward adjustments for these APCs in 2003, we believe that the medians are appropriately relative to the costs for other services that will be used to set the relative weights.

*Insertion of Pacemaker, Dual Chamber Generator Only (APC 0654)*

*Comment:* A commenter indicated that the proposed payment rate is about 95 percent of the hospital acquisition cost of the device, leaving the hospital at an immediate loss if it implants this device. They asked that we re-evaluate and price these APCs at a level that pays the full cost of the device and services.

*Response:* The median cost for this APC is about 19 percent higher than the adjusted median on which the 2003 payment weight was based (2003 adjusted median of $5,456.63 versus the final rule median of $6,495.61). We saw no reason to further adjust the median on which the relative weights for 2004 are based. The comment was not convincing that these median costs were inappropriate in relation to the other median costs that will be used to set the relative weights. Moreover, since the median cost for the APC rose above the amounts achieved by upward adjustments for the APC in 2003, we believe that the median is appropriately relative to the costs for other services that will be used to set the relative weights.

*INTEGRA Wound Products and Other Wound Products*

*Comment:* We received a comment concerning INTEGRA Dermal Regeneration Template and INTEGRA Bilayer Wound Matrix in which the commenter stated that there is a payment disparity between the INTEGRA products and APLIGRAF, DERMAGRAFT and TRANSCYTE, which are eligible for separate payment as biologicals. The commenter noted that hospitals that use APLIGRAF, DERMAGRAFT, and TRANSCYTE receive an extra payment in the form of a pass-through or other separately paid APC payment in addition to the APC payment for the skin repair procedures (APC 0025), while users of the aforementioned INTEGRA products receive only the regular payment associated with skin repair CPT codes. The commenter stated that this payment differentiation provides a financial incentive to hospitals to use the other skin replacement products, and places INTEGRA at a competitive disadvantage. The commenter recommended that we create a product-specific APC for INTEGRA to provide comparable payment for ''this class of products.'' Alternatively, the commenter recommended that we establish a single APC that includes the cost of all or most skin replacement technologies. The manufacturer noted that hospitals using INTEGRA would receive only $340.41 under our proposed rate for APC 0025, while total payments for APC 0025 plus the product-specific codes for APLIGRAF, DERMAGRAFT, and TRANSCYTE would be between $770.86 and $1,072.86.

*Response:* TRANSCYTE was approved for transitional pass-through

payment as a biological as of July 1, 2003; DERMAGRAFT continues in pass-through status through 2004; and APLIGRAF is a former pass-through biological proposed to be paid separately as non-pass-through biological, that is, status indicator ''K.'' Since no party has yet applied for transitional pass-through payment for INTEGRA along with relevant documentation in order to evaluate Integra as a biological for pass-through payment, we have not been able to evaluate pass-through payment status as a biological for this product. We are sympathetic to the commenter's concern, and we find merit in the recommendation to group a class of skin replacement products into the same APC. However, we do not believe that we have sufficient information at present upon which to determine the appropriate payment rate for such an APC. Furthermore, we would want to allow the public an opportunity to provide input on such a proposal. Therefore, we will consider the recommendation of a common APC for skin repair using new skin replacement technologies for 2005. We will also consider referring this issue for consideration by the APC Panel at its next meeting. Meanwhile, we invite public comment on the concept of grouping payment for skin repair procedures using new skin repair technologies such as INTEGRA, DERMAGRAFT, and APLIGRAF into a common APC.

*Stereotactic Radiosurgery*

*Comment:* A commenter urged that we continue to consider stereotactic radiosurgery (SRS) to be a radiation procedure and that we not reopen the revenue code of surgery for SRS, stating that a radiation oncologist is a critical component to the delivery of SRS. The commenter expressed concern for unintended consequences that may result from unbundling of services associated with this procedure.

*Response:* We appreciate the commenter's concern for accurately capturing the costs of stereotactic radiosurgery. As a matter of policy, however, we do not generally mandate the reporting of services under specific revenue centers but leave that decision up to the hospitals.

*Comment:* We received several comments regarding stereotactic radiosurgery (SRS). Commenters were concerned that the current G code descriptors do not appropriately recognize the differences among the various forms of SRS. Commenters explained that there are two basic methods in which SRS can be delivered to patients, linear accelerator-based treatment (often referred to as ''Linac'') and multi-source photon-based treatment (often referred to as Cobalt 60). Advances in technology have further distinguished these treatment modalities. Linear accelerator-based treatment can be performed using various types of SRS systems, two of which include gantry-based systems and image-guided robotic SRS systems. Commenters stated that the existing G codes do not accurately describe the unique differences among these services and therefore do not accurately capture the costs involved in providing these services.

For example, several commenters expressed concern regarding the limitation imposed by the code descriptor for HCPCS code G0242, which restricts its use to planning for Cobalt 60-based treatment. While some commenters stated that planning costs for linear accelerator-based treatment and Cobalt 60-based treatment are identical, other commenters asserted that planning costs for these services differ significantly.

Commenters recommended the following options to resolve the issue:

(1) Create another G code to distinguish between linear accelerator-based SRS and Cobalt 60-based SRS, which would be consistent with the two G codes (G0173 for linear accelerator-based and G0243 for Cobalt 60-based) for SRS treatment delivery; or

(2) Modify the descriptor for HCPCS code G0242 to describe treatment planning for both linear accelerator-based and Cobalt 60-based SRS treatments. For clarification purposes, the current G codes for SRS treatment delivery services are as follows:

G codes for linear accelerator-based SRS treatment delivery:

HCPCS code G0173—Stereotactic radiosurgery, complete course of therapy in one session.

HCPCS code G0251—Linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum 5 sessions per course of treatment.

G code for Cobalt 60-based SRS treatment delivery:

HCPCS code G0243—Multi-source photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions. The current G code for Cobalt 60-based SRS treatment planning is as follows:

HCPCS code G0242—Multi-source photon stereotactic radiosurgery (Cobalt 60 multi-source converging beams) plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment.

*Response:* We agree with commenters that the current description for HCPCS code G0242 is limited to the planning of Cobalt 60-based SRS treatment and does not account for the planning of linear accelerator-based SRS treatment. To be consistent with the two G codes we created for treatment delivery, we will create a new G code (G0338) to distinguish linear accelerator-based SRS treatment planning from Cobalt 60-based SRS treatment planning. We will place G0338 in APC 1516 at a payment rate of $1,450. The new G code for linear accelerator-based SRS treatment planning will be as follows:

HCPCS code G0338—Linear-accelerator-based stereotactic radiosurgery plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment.

*Comment:* Several commenters expressed concern that our current code descriptors for HCPCS codes G0173 and G0251 do not distinguish between the various types of linear accelerator-based SRS treatment. Currently, image-guided robotic linear accelerator-based SRS systems are grouped with other forms of linear accelerator-based SRS systems using HCPCS codes G0173 and G0251. Commenters requested that we modify the code descriptors to distinguish image-guided robotic systems from other forms of linear accelerator-based SRS systems to account for the wide cost variation in delivering these services.

*Response:* We agree with commenters that the descriptors for HCPCS codes G0173 and G0251 do not distinguish image-guided robotic SRS systems from other forms of linear accelerator-based SRS systems to account for the cost variation of delivering these services. To more accurately capture the true costs of these services, we will create two new G codes (G0339 and G0340) to describe complete and fractionated image-guided robotic linear accelerator-based SRS treatment. Please see response to below comment for code descriptors.

*Comment:* Commenters urged that we modify the code descriptor for the delivery of image-guided robotic SRS to include both complete and fractionated courses of therapy in one code, resulting in the same payment amount for both types of therapy. Commenters explained

that the per-session costs of delivering image-guided robotic linear accelerator-based SRS are the same, regardless of whether the patient's disease requires one treatment or multiple treatments.

*Response:* Our claims data do not support the assertion that the per-session costs of delivering image-guided robotic linear accelerator-based SRS is equal to the costs of delivering a complete course of image-guided robotic linear accelerator-based SRS treatment. However, we acknowledge the possibility that claims data for G0173 and G0251 may include both image-guided robotic linear accelerator-based SRS treatments as well as other forms of linear accelerator-based SRS treatments and, as a result, the median cost may not accurately reflect the true costs of delivering image-guided robotic linear accelerator-based SRS therapy. As stated in our response to the above comment, we will create two new G codes (G0339 and G0340) to distinguish complete and fractionated image-guided robotic linear accelerator-based SRS treatment from other forms of complete and fractionated linear accelerator-based SRS treatment. We will place HCPCS code G0339 (complete session) in APC 1528 at a payment rate of $5250. The APC placement of HCPCS code G0340 is discussed below.

While we recognize the costs to provide multi-session image-guided robotic SRS therapy may be greater than the current payment rate for HCPCS code G0251, we received no convincing cost data supporting commenters' claims that the costs of performing each additional session subsequent to the first session of a fractionated treatment is equivalent to the costs of performing a complete session. Rather, we believe that certain economies of scale are realized when performing each additional session subsequent to the first session of a fractionated treatment. That is, based on our understanding of the therapy, we do not believe that the same exact amount of hospital resources would be utilized for each subsequent session.

Statements provided by various interested parties indicate that the costs of providing each session of a fractionated treatment range from $2700 to $9000. However, we received no convincing data to substantiate these statements. We have estimated that approximately 75 percent of the costs of a complete session would be required to provide each additional session subsequent to the first session of a fractionated treatment. Therefore, we will place HCPCS code G0340 in new technology APC 1525, which covers procedures ranging from $3500 to $4000 in payment and which pays $3750. This new technology APC range pays approximately seventy-five percent of the payment for HCPCS code G0339. We will modify the descriptor for HCPCS code 0340 to describe additional sessions (second through fifth sessions) subsequent to the first session of a fractionated treatment. In addition, we will expand the descriptor for a complete session (HCPCS code G0339) to include the first session of a multi-session treatment. To further clarify, when providers perform multi-session image-guided robotic SRS therapy, they should bill using HCPCS code G0339 for the first session. For each additional session subsequent to the first session, providers should bill using only HCPCS code G0340 up to a maximum of five sessions.

Although we received no clinical data to substantiate the use of a single session versus multiple fractionations up to five sessions, a few commenters stated that a maximum of five sessions may be utilized to treat certain conditions; therefore, we will continue to pay for the delivery of multi-session therapy (HCPCS code G0340) up to a maximum of five sessions per course of treatment. When additional data is submitted, we may reconsider this payment decision.

As described above, we will create the following new G codes to identify image-guided robotic linear accelerator-based SRS treatment delivery:

HCPCS code G0339—Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session, or first session of fractionated treatment.

HCPCS code G0340—Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment.

*SIRTeX Medical (RE: SIR-Spheres Brachytherapy Source)*

*Comment:* The manufacturer of a brachytherapy source to treat liver cancer commented that our proposed payment of $8,870.88 for APC 2616 was inadequate to pay for its product, which it reported costs $14,000 per treatment dose. This commenter stated that there are only two products that would fit this APC, which is for Yttrium-90 brachytherapy source. Moreover, this party claimed that there were significant clinical differences between its product and another Yttrium-90 source, and that these differences necessitated the price differential between the two products. The commenter requested establishment of a separate alpha-numeric HCPCS code for its product, in order to account for the cost differences between the two Yttrium-90 products and to set more equitable payment rates for the two products.

*Response:* We appreciate the concerns of the commenter. We would first note that payment to APC 2616 has increased to $9,615.50 per dose compared to the 2003 payment of $6,485.37. The information provided in the comment did not convince us that the payment rate resulting from the 2002 claims data is inadequate to pay hospitals for the Yttrium-90 products. We are uncertain whether or not there are other Yttrium-90 sources in addition to the two discussed in this comment that would need to be considered in any analysis of the relative costs of the products. Therefore, until we have additional data, we believe that code C2616 and APC 2616 adequately describes and pays for Yttrium-90 brachytherapy sources.

*Low Osmolar Contrast Media*

*Comment:* A radiology specialty society expressed disappointment because we did not address payment for low osmolar contrast media (LOCM) in the proposed rule. The commenter believes that the variability in usage and Medicare's restricted coverage of LOCM warrant payment in a separate APC in the 2004 final rule. The commenter recommends that we increase the relative weights of APCs that include codes that involve the use of LOCM agents to reflect the additional costs of these agents if we do not establish a separate APC to pay for LOCM.

*Response:* We issued a program memorandum on November 22, 2002 (Transmittal A–02–120, Change Request 2185) in which we removed all requirements differentiating payment between high osmolar contrast material and LOCM as well as restrictions that would limit payment for LOCM only to patients with specific diagnoses. In that program memorandum, we instructed our contractors to discontinue any edits that would prohibit payment for LOCM if specific diagnoses were not reflected on the claim, effective for services furnished on or after January 1, 2003. We further directed contractors to instruct hospitals to include charges for LOCM in the charge for the diagnostic procedure or, if LOCM is billed as a separate charge, to use revenue code 254 or 255 as appropriate. These instructions applied only to hospitals subject to the OPPS.

We disagree with the commenter's recommendation that a separate APC

should be established to bill for LOCM for several reasons. Prior to issuance of Transmittal A–02–120, covered LOCM costs would have been reflected either in an appropriate revenue code or within the hospital's charge for a diagnostic procedure or in a charge with an appropriate HCPCS code (A4644, A4645, or A4646). To the extent that hospitals submitted covered charges for LOCM in 2002, those costs are packaged into the cost of the procedure with which the LOCM was used. We expect that claims for services involving the use of LOCM furnished during CY 2003 will reflect even more fully costs associated with LOCM in light of the instructions that were issued in Transmittal A–02–120. These costs will be reflected in the 2005 update of the OPPS. Finally, without verifiable information that demonstrates the actual market-based price that a broadly based national sample of hospitals are routinely required to pay in order to procure LOCM, we have no data upon which to base a determination that a separate APC for LOCM would be appropriate.

*Prosthetic Urology*

*Comment:* Several commenters supported the proposed restructuring of the prosthetic urology procedures into APCs 385 and 386. However, the commenters urged us to consider further refinements to increase the payment rates for these APCs. The commenters expressed concern about the use of a single departmental cost-to-charge ratio for devices and recommended for calendar year 2005 that we implement edits in our development of median costs to benchmark cost data for device procedures so that charges for expensive devices are not reduced below a designated point. The commenters also stated that hospitals charged for only one component of a prosthetic urology device for multi-component prosthetic urology devices. The commenters believe this resulted in under-reporting of charges for the entire procedure. The commenters recommended that we use external data to adjust the level of payment for multi-component devices and exclude claims with device costs less than $5,000 from the rate-setting database. Commenters stated that hospitals in the States of California, Colorado, Florida, Illinois, North Dakota, New York, and Oklahoma have closed their prosthetic urology programs because Medicare OPPS payments are too low.

*Response:* APCs 385 and 386 were created by splitting APC 0182 into two APCs for higher cost and lower cost devices (penile prostheses and urinary sphincters). The payment for these procedures in 2003 is $4,975.96. As a result of splitting former APC 0182 into two APCs, the payment amount for 2004 is $3,663.93 for APC 0385 and $6,342.07 for APC 0386. This is a relatively small reduction for APC 0385 with the lower cost devices and a very significant increase for APC 0386, with the higher cost devices. Moreover, as discussed in more detail elsewhere, we decided to change the status indicator for these APCs from ''T'' to an ''S'' so that the multiple procedure reduction will not apply to them (or other procedures with a ''T'' status indicator) on the same day. These changes together result in significantly more payment for these services in 2004 than in 2003. Therefore, we did not use external data to further adjust the median cost on which the payment was based.

*Intensity Modulation Radiation Therapy*

*Comment:* Commenters urged that we withdraw our proposal to move intensity modulation radiation therapy (IMRT) treatment planning (CPT code 77301) from new technology APC 1510 (previously APC 0712 in 2003) to APC 0413 and IMRT treatment delivery (CPT code 77418) from new technology APC 1506 (previously APC 0710 in 2003) to APC 0412. Commenters indicated that the payments proposed for APCs 0412 and 0413 are too low to adequately compensate hospitals for the costs of the services. One commenter further explained that part of the problem behind the low median cost may be that, according to CMS PM A–02–26, hospitals are precluded from billing for all of the services involved in this treatment. The commenter indicated that hospitals should be able to bill and be paid for the simulations (CPT codes 77280–77295), dosimetry calculations (CPT code 77300), an isodose plan (CPT codes 77305–77315), special teletherapy port plan (CPT code 77321), continuing medical physics (CPT code 77336) and special medical physics (CPT code 77370). Commenters requested that CPT codes 77301 and 77418 be retained in their current new technology APCs (APCs 1510 and 1506, respectively) for another year to provide additional time for provider education about the proper coding of these services and to enable the data to mature.

*Response:* We agree with commenters that the payment rate for APC 0413 does not adequately cover the costs of providing IMRT treatment planning (CPT code 77301). As noted by one commenter, PM A–02–26 instructs that services identified by CPT codes 77280 through 77295, 77300, and 77305 through 77321, 77336, and 77370 are included in the APC payment for IMRT and SR planning. The low median for CPT code 77301 appears to be a result of miscoding. Therefore, we will retain CPT code 77301 in new technology APC 1510 to allow additional time for provider education and to enable the data to mature. We believe, however, that the significant volume of single claims (93 percent of total claims) used to set the payment rate for IMRT treatment delivery (CPT code 77418) accurately reflects the costs hospitals are reporting for this service. Based on this robust claims data, we will move CPT 77418 from new technology APC 1506 (previously APC 0710 in 2003) to APC 0412 (IMRT Treatment Delivery).

*Comment:* One commenter requested that we allow the use of existing IMRT CPT codes 77301 and 77418 for compensator-based IMRT technology in the hospital outpatient setting. The commenter states that Medicare beneficiaries may be denied access to compensator-based IMRT as a result of inadequate payment for this service.

*Response:* We do not prohibit the use of existing IMRT CPT codes 77301 and 77418 to be billed for compensator-based IMRT technology in the hospital outpatient setting. Rather, we believe the confusion may pertain to billing instructions for CPT codes 77301 and 77334 billed on the same day. CMS PM A–02–26 instructs that ''payment for IMRT and SR planning does not include payment for services described by CPT codes 77332 through 77334. When provided, these services should be billed in addition to the IMRT and SR planning codes 77301 and G0242.'' Providers billing for both CPT codes 77301 (IMRT treatment planning) and 77334 (design and construction of complex treatment devices) on the same day should append a 59 modifier to receive accurate payment.

Proton Beam Therapy

*Comment:* Several commenters indicated that proton beam therapy, intermediate and complex should be moved from APC 0650 to a new technology APC (as it appears in Addendum B). However, commenters stated that these two codes should not be placed in the same APC due to a significant difference in resource utilization. We received several other comments supporting our proposal to maintain simple proton beam therapy (CPT codes 77520 and 77522) in APC 0664 and intermediate and complex proton beam therapies (CPT codes 77523 and 77525, respectively) in APC 1511 (previously APC 0712 in 2003).

*Response:* We agree with commenters that codes for simple proton beam

radiation therapy (CPT codes 77520 and 77522) should be placed in a different APC than codes for intermediary (CPT code 77523) and complex (CPT code 77525) radiation therapy. As we stated in the correction notice of February 10, 2003 (68 FR 6636), we also agree with commenters that it would be inappropriate to return codes for simple proton beam therapy to a new technology APC due to having sufficient claims data to integrate these codes into the OPPS. We continue to believe that the placement of these codes in APC 0664 is appropriate based on having used 98 percent of total claims for simple proton beam therapy to set the 2004 median for APC 0664. Therefore, CPT codes 77520 and 77522 will remain in APC 0664.

The placement of intermediate (CPT code 77523) and complex (CPT code 77525) proton beam therapies in APC 650 in the November 1, 2002 final rule (67 FR 66718) for the 2003 OPPS was an error that was corrected in the correction notice of February 10, 2003 (68 FR 6636). We clarified in the correction notice that these CPT codes were placed in new technology APC 0712 for CY 2003 because they lacked sufficient cost data to confidently move these codes out of a new technology APC. We continue to lack sufficient cost data to move these codes into a clinical APC; therefore, we will crosswalk CPT codes 77523 and 77525 from new technology APC 0712 to the corresponding new technology APC 1511 for CY 2004. Once sufficient data is available, we will be able to determine whether intermediate and complex proton beam therapies should be placed in the same APC.

*FDG PET Procedures*

*Comment:* Several commenters commended us for our proposed rates for FDG PET procedures. They were pleased that the proposed 2004 rates for the FDG PET procedure and the radiopharmaceutical when combined are nearly identical to the rates for the combined procedure and radiopharmaceutical for 2003. Commenters stated that the retention of FDG PET procedures in a new technology APC will allow providers an additional year to improve their reporting practices, while providing us with another year of more accurate claims data.

*Response:* We agree with commenters that the retention of FDG PET procedures in a new technology APC for an additional year will allow providers a reasonable amount of time to improve their reporting practices, while providing us with another year of claims experience. Therefore, we will retain FDG PET procedures in new technology APC 1516.

*Comment:* One commenter expressed concern that HCPCS code G0296 did not appear in Addendum B of the August 12, 2003 proposed rule. The commenter urged us to place this new code in APC 1516 with other FDG PET procedures.

*Response:* We thank the commenter for bringing to our attention the absence of HCPCS code G0296 from addendum B of the proposed rule. We agree with the commenter's recommendation to place this code in the same APC as other FDG PET procedures. Therefore, we will place HCPCS code G0296 in new technology APC 1516.

*Comment:* One commenter recommended the establishment of a revenue code dedicated solely to PET procedures.

*Response:* Revenue codes exist for hospital accounting purposes and, in general we do not require that particular services be billed with particular revenue codes. We are not convinced that adding specific requirements for revenue coding or expanding the revenue codes to acquire more specific information will result in better data or that the end result would be cost effective in terms of its potential effect on hospital operations.

## IV. Transitional Pass-Through and Related Payment Issues

### *A. Background*

Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain medical devices, drugs, and biological agents. As originally enacted by the BBRA, this provision required the Secretary to make additional payments to hospitals for current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act, Pub. L. 107–186; current drugs, biological agents, and brachytherapy devices used for the treatment of cancer; and current drugs and biological products.

For those drugs, biological agents, and devices referred to as ''current,'' the transitional pass-through payment began on the first date the hospital OPPS was implemented (before enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), Pub. L. 106–554, enacted December 21, 2000).

Transitional pass-through payments are also required for certain ''new'' medical devices, drugs, and biological agents that were not being paid for as a hospital outpatient service as of December 31, 1996 and whose cost is ''not insignificant'' in relation to the OPPS payment for the procedures or services associated with the new device, drug, or biological. Under the statute, transitional pass-through payments can be made for at least 2 years but not more than 3 years.

Section 1833(t)(6)(B)(i) of the Act required that we establish by April 1, 2001, initial categories to be used for purposes of determining which medical devices are eligible for transitional pass-through payments. Section 1833(t)(6)(B)(i)(II) of the Act explicitly authorized us to establish initial categories by program memorandum (PM). On March 22, 2001, we issued two PMs, Transmittals A–01–40 and A–01–41 that established the initial categories. We posted them on our Web site at: *http://www.hcfa.gov/pubforms/transmit/A0140.pdf* and *http://www.hcfa.gov/pubforms/transmit/A0141.pdf,* respectively.

Transmittal A–01–41 includes a list of the initial device categories, a crosswalk of all the item-specific codes for individual devices that were approved for transitional pass-through payments, and the initial category code by which the cross-walked individual device was to be billed beginning April 1, 2001. Items eligible for transitional pass-through payments are generally coded using a Level II HCPCS code with an alpha prefix of ''C.'' Pass-through device categories are identified by status indicator ''H'' and pass-through drugs and biological agents are identified by status indicator ''G.'' Subsequently, we added a number of additional categories, retired 95 categories effective January 1, 2003, and made clarifications to some of the categories' long descriptors found in various program transmittals. A list of current device category codes can be found below, in Table 10.

Section 1833(t)(6)(B)(ii) of the Act also requires us to establish, through rulemaking, criteria that will be used to create additional device categories for transitional pass-through payment. The criteria for new categories were the subject of a separate interim final rule with comment period published in the **Federal Register** on November 2, 2001 (66 FR 55850) and made final in the November 1, 2002 **Federal Register** (67 FR 66781) announcing the 2003 update to the OPPS.

Transitional pass-through categories are for devices only; they do not apply to drugs or biological agents. The regulations at § 419.64 governing transitional pass-through payments for eligible drugs and biological agents are unaffected by the creation of categories.

The process to apply for transitional pass-through payment for eligible drugs and biological agents or for additional device categories can be found on respective pages on our Web site at *http://www.cms.gov.* If we revise the application instructions in any way, we will post the revisions on our Web site and submit the changes for approval by the Office of Management and Budget (OMB) as required under the Paperwork Reduction Act (PRA). Notification of new drug, biological, or device category application processes is generally posted on the OPPS Web site at *http://www.cms.gov.*

*B. Discussion of Pro Rata Reduction*

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for a given year to an ''applicable percentage'' of projected total Medicare and beneficiary payments under the hospital OPPS. For a year before 2004, the applicable percentage is 2.5 percent; for 2004 and subsequent years, we specify the applicable percentage up to 2.0 percent. We proposed to set the percentage at 2.0 percent for the 2004 OPPS.

If we estimate before the beginning of the calendar year that the total amount of pass-through payments in that year would exceed the applicable percentage, section 1833(t)(6)(E)(iii) of the Act requires a prospective uniform reduction in the amount of each of the transitional pass-through payments made in that year to ensure that the limit is not exceeded. We make an estimate of pass-through spending to determine not only whether payment exceeds the applicable percentage but also to determine the appropriate reduction to the conversion factor.

In the August 12, 2003 proposed rule, we described in the detail the methodology we used to make an estimate of pass-through spending in 2004 (68 FR 47992). In general, we specified that after using the respective methodologies described in the proposed rule, to determine projected 2004 pass-through spending for the groups of devices, drugs, and biological agents, we would calculate total projected 2004 pass-through spending as a percentage of the total projected payments (Medicare and beneficiary payments) under OPPS to determine if the pro rata reduction would be required.

Table 9 shows our current estimate of 2004 pass-through spending for known pass-through drugs, biologicals, and devices based on information available at the time this table was developed. We specified in the proposed rule that we were uncertain whether estimated pass-through spending in 2004 would exceed $456 million (2.0 percent of total estimated OPPS spending) because we had not yet completed the estimate of pass-through spending for a number of drugs and devices. In particular, we did not have estimates for those drugs still under agency review for additional pass-through payments beginning October 2003 or the changes in pass-through spending that could result from quarterly rather than annual updates of AWP for pass-through drugs. Finally, we would incorporate an estimate of pass-through spending for items for which pass-through payment becomes effective later in 2004 (that is, April 1, 2004; July 1, 2004; and October 1, 2004) based on estimates of items that become eligible for pass-through payment on October 1, 2003 and January 1, 2004. Specifically, we would assume a proportionate amount of spending for items that become eligible later in the year while making an adjustment to account for the fact that items made eligible later in the year will not receive pass-through payments for the entire year. We invited comments on the methodology we proposed and the estimates for utilization that appeared in Table 12 of the August 12, 2003 proposed rule. We received several comments on this proposal, which are summarized below along with our responses.

TABLE 9.—ESTIMATE OF PASS-THROUGH SPENDING IN 2004

| HCPC | APC | Drug biological | 2004 pass-through payment portion | 2004 estimated utilization | 2004 anticipated pass-through payments |
|---|---|---|---|---|---|
| | | **Existing Pass-through Drugs/biologicals** | | | |
| J0583 | 9111 | Injectin Bivalrudin, per 1 mg | $0.40 | $5,278,000 | $2,111,200 |
| C9112 | 9112 | Injection, Perflutren lipid microsphere, per 2 ml | 37.44 | 67,000 | 2,508,480 |
| C9113 | 9113 | Injection, Pantoprazole sodium, per vial | 6.34 | 20,000 | 126,800 |
| J1335 | 9116 | Injection, Ertapenum sodium, per 500 mg | 6.00 | 14,400 | 86,400 |
| J2505 | 9119 | Injection, Pegfilgrastim, per 6 mg single dose vial | 708.00 | 110,344 | 78,123,329 |
| J9395 | 9120 | Injection, Fluvestrant, per 25 mg | 22.13 | 274,156 | 6,067,072 |
| C9121 | 9121 | Injection, Argatroban, per 5 mg | 4.13 | 50,000 | 206,500 |
| C9200 | 9200 | Orcel, per 36 cm2 | 286.80 | 1,000 | 286,800 |
| C9123 | 9123 | Transcyte, per 247 sq cm | 194.76 | 100 | 19,476 |
| C9203 | 9203 | Injection Perflexane lipid microspheres, per 10 ml vial | 36.00 | 82,400 | 2,966,400 |
| J2324 | 9114 | Injection, Nesiritide, per 0.5 mg vial | 38.30 | 60,000 | 2,298,000 |
| J3315 | 9122 | Injection, Triptorelin pamoate, per 3.75 mg | 100.70 | 307,440 | 30,959,208 |
| J3487 | 9115 | Injection, Zoledronic acid, per 1 mg | 54.93 | 539,000 | 29,607,270 |
| J3486 | 9204 | Injectionm Ziprasidone mesylate, per 10 mg | 5.25 | 234,286 | 1,230,000 |
| C9205 | 9205 | Injection, Oxaliplatin, per 5 mg | 23.86 | 280,756 | 6,698,845 |
| C9208 | 9208 | Injection, IV, Agalsidase beta, per 1 mg | 31.27 | 194,533 | 6,083,040 |
| C9201 | 9201 | Dermagraft, per 37.5 square centimeters | 145.92 | 9,264 | 1,351,803 |
| C9209 | 9209 | Injection, IV, Laronidase, per 2.9 mg | 162.72 | 2,612 | 425,092 |
| | | **Pass-through Drugs/Biologicals Effective January 2004** | | | |
| C9207 | 9207 | Injection, IV, Bortezomib, per 3.5 mg | 262.66 | 102,680 | 26,970,000 |
| C9210 | 9210 | Injection, IV, Palonosetron HCI, per 0.25 mg (250 micrograms) | 77.76 | 37,500 | 2,916,000 |
| C9211 | 9211 | Injection, alefacept, for intravenous use, per 7.5 mg | 168.00 | 13,775 | 2,314,200 |
| C9212 | 9212 | Injection, alefacept, for intramuscular use, per 7.5 mg | 119.40 | 27,550 | 3,289,470 |
| | | **Existing Pass-through Devices** | | | |
| C1783 | 1783 | Ocular implant, aqueous drainage assist device | | 324 | 160,250 |
| C1814 | 1814 | Retinal tamponade device, silicone oil | | 35,173 | 13,675,262 |
| C1884 | 1884 | Embolization Protective System | | 25,000 | 38,601,544 |
| C1888 | 1888 | Catheter, ablation, non-cardiac, endovascular (implantable) | | 215 | 129,731 |

TABLE 9.—ESTIMATE OF PASS-THROUGH SPENDING IN 2004—Continued

| HCPC | APC | Drug biological | 2004 pass-through payment portion | 2004 estimated utilization | 2004 anticipated pass-through payments |
|---|---|---|---|---|---|
| C1900 | 1900 | Lead, left ventricular coronary venous system | | 2,095 | 2,819,912 |
| C2614 | 2614 | Probe, percutaneous lumbar discectomy | | 901 | 1,752,445 |
| C2632 | 2632 | Brachytherapy solution, iodine—125, per mCi | | 225 | 1,890,000 |
| C1818 | 1818 | Integrated keratoprosthesis | | 4 | 27,800 |
| | | **Pass-through Devices Effective January 2004** | | | |
| C1819 | 1819 | Tissue localization-excision dev | | 9,858 | 1,823,730 |
| | | **Other Items Expected To Be Determined Eligible for 2004** | | | |
| | | Spending for future approved drugs | | | 22,466,959 |
| | | Spending for future approved devices | | | 12,791,197 |
| | | Total Spending for Pass-through Drugs/biologicals, and devices 2004. | | | 302,784,216 |

*Comment:* Several commenters objected to the methods used to project pass-through drug spending, especially those techniques used to estimate future products that are first eligible for pass-through payments beginning in April 2004 or later in the year. They are concerned that pass-through expenditures in 2004 will exceed the statutory cap and cause us to impose a pro rata reduction. Several hospital associations propose that we limit the funds allocated for the pass-through pool to one percent and use the remaining 1.0 percent to fund all other APCs. They suggest that we over-estimate pass-through spending, which results in the reduction of payment rates for other critical care services.

*Response:* Section 1833(t)(6)(E)(i) of the Act requires that the Secretary estimate the total pass-through payments to be made for the forthcoming year (which allows us to determine the amount of the conversion factor for the forthcoming year) and to the extent the estimate exceeds the statutory limit, reduce the amount of each pass-through payment. For 2004, the statutory limit is 2.0 percent of total estimated program payments. In the August 12, 2003 proposed rule, we provided our best estimate at that time of pass-through payments for the drugs and devices for which we expected to make pass-through payments in 2004, and we explained our methodology for determining the estimate for the final rule. We provided a list of the devices and drugs we either knew would be paid under pass-through next year or which we believed may be paid as pass-through items in 2004.

We finalized our estimate of 2004 pass-through spending and, for the reasons discussed below, we have determined that no pro rata reduction will be required in 2004. As discussed below the estimate falls under the statutory limit of 2.0 percent. Therefore, the conversion factor has been increased correspondingly from the proposed rule by 0.7 percent.

*Pass-Through Devices Effective January 2004*

*Comment:* One commenter recommended that we not impose a pro rata reduction on pass-through devices if the estimated pass-through expenditures increase appreciably. A device manufacturers' association was concerned that new drugs will take an increasing share of the pass-through pool. They suggested that the shift to more pass-through spending on drugs will increase under the easier qualifications for drug pass-through payments and encouraged us to reconsider the issue to determine how to ensure that devices maintain an ''adequate'' share of the pass-through pool.

*Response:* Section 1833(t)(6)(E)(iii) of the Act requires a prospective uniform reduction (pro rata) of the amount of each of the transitional pass-through payments made in that year, if it is expected that pass-through payments will exceed the cap set for OPPS pass-through expenditures. Therefore, if any pro rata reduction applies, we are required to apply it to pass-through devices as well as drugs and biological agents. For 2004, we do not expect the total payments for pass-through drugs and devices to exceed the statutory limit. Therefore, as discussed elsewhere, we will not impose a pro rata adjustment on any pass-through items in 2004.

## V. Payment for Devices

### *A. Pass-Through Devices*

Section 1833(t)(6)(B)(iii) of the Act requires that a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3, years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category. We proposed that two device categories currently in effect would expire effective January 1, 2004. Our proposed payment methodology for devices that have been paid by means of pass-through categories, and for which pass-through status would expire effective January 1, 2004, is discussed in the section below.

Although the device category codes became effective April 1, 2001, most of the item-specific ''C'' codes for pass-through devices that were crosswalked to the new category codes were approved for pass-through payment in CY 2000 and as of January 1, 2001. (The crosswalk for item-specific ''C'' codes to category codes was issued in Transmittals A–01–41 and A–01–97). We based the expiration dates for the category codes listed in Table 10, on when a category was first created, or when the item-specific devices that are described by, and included in, the initial categories were first paid as pass-through devices, before the implementation of device categories. The device category expiration dates are listed in Table 10. We proposed to base the expiration date for a device category on the earliest effective date of pass-through payment status of the devices that populate that category. There are two categories for devices that will have been eligible for pass-through payments for more than 2½ years as of December 31, 2003, and we proposed that they would not be eligible for pass-through payments effective January 1, 2004. The two categories we proposed for expiration are C1765 and C2618, as indicated in Table 10. Each category includes devices for which pass-through payment was first made under OPPS in 2000 or 2001.

A comprehensive list of all currently effective pass-through device categories is displayed in Table 10. Also displayed

are the dates the devices described by the category were populated and their respective expiration dates. For devices continuing on pass-through status after 2003, expiration dates were set forth in the August 12, proposed rule and are finalized here. Newly added code C1819 is first announced in this final rule and is given a December 31, 2005 expiration date.

The methodology used to base expiration of a device category is the same as that used to determine the 95 initial categories that expired as of January 1, 2003. A list including those 95 categories that expired as of January 1, 2003 (as well as 5 categories that continued to be paid in 2003) is found in the November 1, 2002 final rule (67 FR 66761 through 66763).

TABLE 10.—LIST OF CURRENT PASS—THROUGH DEVICE CATEGORIES WITH EXPIRATION DATES

| HCPCS codes | Category long descriptor | Date(s) populated | Expiration date |
|---|---|---|---|
| C1765 | Adhesion Barrier | 10/1/00–3/31/01; 7/1/01. | 12/31/03 |
| C2618 | Probe, cryoblation | 4/1/01 | 12/31/03 |
| C1888 | Catheter, ablation, non-cardiac, endovascular (implantable) | 7/1/02 | 12/31/04 |
| C1900 | Lead, left ventricular coronary venous system | 7/1/02 | 12/31/04 |
| C1783 | Ocular implant, aqueous drainage assist device | 7/1/02 | 12/31/04 |
| C1884 | Embolization protective system | 1/1/03 | 12/31/04 |
| C2614 | Probe, percutaneous lumbar discectomy | 1/1/03 | 12/31/04 |
| C2632 | Brachytherapy solution, iodine-125, per mCi | 1/1/03 | 12/31/04 |
| C1814 | Retinal tamponade device, silicone oil | 4/1/03 | 12/31/05 |
| C1818 | Integrated keratoprosthesis | 7/1/03 | 12/31/05 |
| C1819 | Tissue localization excision device | 1/1/04 | 12/31/05 |

We received several comments on this proposal, which are summarized below along with our responses.

*Comment:* A few parties provided comments on our criteria for eligibility for a new device category for pass-through payment as published in the November 1, 2002 **Federal Register** (67 FR 66781).

*Response:* We made no proposal to modify our criteria for establishment of a new category for transitional pass-through payment, so the criteria were not subject to comment in this rulemaking period. However, we will take note of these comments as considerations in our ongoing evaluation of the new device category process.

*New Technology Treatment for New Devices for Brachytherapy Catheters and Needles*

*Comment:* A commenter asked that we consider pass-through payment or new technology payment for new devices of brachytherapy catheters and needles when they are approved by FDA for new indications and treatment protocols.

*Response:* We have a process for applying for pass-through new technology APC status. See *http://www.cms.hhs.gov* for instructions. If a provider or other party believes that an item or service meets the criteria for pass-through or new technology status, the interested party should submit an application, and we will then make a judgement based on the individual circumstances described in the application.

*B. Expiration of Transitional Pass-Through Payments in CY 2004*

In the November 1, 2002 final rule, we established a policy for payment of devices included in pass-through categories that are due to expire (67 FR 66763). We stated that we would package the costs of the devices no longer eligible for pass-through payments in 2003 into the costs of the clinical APCs with which the devices were billed in 2001. There were very few exceptions to the policy (for example, brachytherapy sources for other than prostate brachytherapy), and we proposed to make no changes. Therefore, we proposed that payment for the devices that populate C1765 and C2618, which we proposed would cease to be eligible for pass-through payment on January 1, 2004, would be made as part of the payment for the APCs with which they are billed.

The methodology that we proposed to use to package expiring pass-through device costs is consistent with the packaging methodology that we describe in section II.B.5. For the codes in APCs displayed in Table 10 of the proposed rule, we proposed to use only those claims on which the hospital included the ''C'' code and to discard the claims on which no ''C'' code is billed. We proposed to limit our analysis to the claims with ''C'' codes because we are not confident that the claims for the relevant APCs include the charges for the devices unless the ''C'' codes are specifically billed.

To calculate the total cost for a service on a per-service basis, we included all charges billed with the service in a revenue center in addition to packaged HCPCS codes with status indicator ''N.'' We also packaged the costs of devices that we proposed would no longer be eligible for pass-through payment in 2004 into the HCPCS codes with which the devices were billed.

We received several comments on this proposal, which are summarized below along with our responses.

*Comment:* A commenter supported packaging the cost of expiring pass-through codes C2618 and CC1765 into the payment for the procedure in which they are used because they believe that packaging minimizes payment incentive to use these devices over other appropriate devices. The commenter urged CMS to release the crosswalk it will use to assign pass-through device costs to specific APCs so that they can confirm the appropriateness of the assignment.

*Response:* There is no such crosswalk. Devices and packaged drugs (that is, those with a per day median cost of $50 or less) are packaged into the HCPCS code on the single procedure claim (natural single or pseudo single) with which they are billed. The packaging is controlled solely by what the hospital bills on the claim. To determine what drugs and devices were packaged into an APC, one would need to undertake an extensive analysis of all single and pseudo single claims used in weight setting. The only time that judgment was used to attribute a device to an APC was not for purposes of packaging charges into APCs but rather was in the setting of median costs for 5 APCs in which external data on acquisition costs was used in a one to one proportion

with claims data to set the device cost for an APC as discussed above.

*C. Reinstitution of C Codes for Expired Device Categories*

*Comment:* Some commenters strongly objected to reinstatement of the C codes for devices because of the burden that it would impose on hospitals without a corresponding benefit in immediate payment. They indicated that charges for devices are included in the revenue code charges for the services furnished and that using C codes will increase administrative costs significantly without any benefit to patient care or hospital revenues. They indicated that hospital staffs would not be able to differentiate between devices that should be reported and those that should not. One commenter said that widespread confusion over what device to code and what device to not code is the reason that the claims for services that require pass-through devices often do not show codes for the devices. The commenter indicates that most hospitals could not comply with this requirement by January 1, 2004 in any case because of extensive changes to chargemasters that would be needed. Moreover, given that many hospitals did not comply even when the use of the code would have resulted in separate payment is a strong indication that they would be unlikely to comply when no additional payment will result from coding devices. Commenters indicated that reintroducing C codes for devices will result in continuation of improper coding and will lead to a false sense of confidence in the data for procedures that require devices. A commenter said that if CMS decided to reintroduce C codes for devices, CMS should reinstate the same C codes that were used for device coding in 2002 because it would minimize confusion.

Other commenters said that CMS should reinstate the C codes for reporting of devices so that CMS and others can ensure that only correctly coded claims are used to set medians for APCs into which device costs are packaged. They said that coding for devices is needed so that CMS can be assured that the costs of the devices are packaged into the costs for the procedure when the medians for the procedure are set. They urged us to continue to use the presence of an appropriate device code as a criterion for claims used to set medians for devices.

*Response:* For 2004, we are reactivating the C codes for device categories as they existed on December 31, 2002. The use of the code is not required and will not be enforced. However, hospitals should understand that providing complete and accurate information on the claims about the services that were furnished and the charges for those services is fundamental to our establishment of relative weights on which the payment for their services is based.

*Comment:* Commenters that supported the reinstitution of C codes for devices said that CMS should continue to restrict the claims used for APCs with a device to claims that contain the charges for the devices used in the APC. In particular, a commenter said that the median for APC 0246 (Cataract removal with intraocular lens) should be based only on claims that contain charges under revenue center 0276 and that claims for APC 0246 that do not contain charges in revenue center 0276 should not be used to set the median. In the case of this APC, the commenter asked that we adopt the 2004 proposed payment at a minimum. Other commenters opposed the reinstitution of C codes for devices, which would preclude us from restricting claims used to set weights for device APCs to claims containing such codes.

*Response:* We restricted the claims used to set the medians for the APCs contained in Table 7 to claims for which there was a line item containing a device category code that was in use for services furnished on April 1, 2002 through and including December 31, 2002. We believed that restricting the claims used to set median costs to those that met this criterion resulted in median costs that more accurately reflected relative costs of these services. Moreover, for the APCs in Table 7 we required that the claim not only contain a device code that was valid during the period specified but we also required that the claim must have a particular device code or combination of device codes.

For APC 0313 (high dose rate brachytherapy), we attempted to require both brachytherapy sources HDR Iridium 192 (C1717) and either a catheter (C1728) or needle (C1715) but we found that no single procedure claims met those criteria. Hence, the median for APC 0313 that appeared in the 2003 OPPS final rule was the median for claims that did not meet the specified criteria and it was mistakenly included in Table 10 in the NPRM. For this final rule, we again began by applying the criteria including source and needle or catheter codes, but still no claims met the criteria. Therefore, we sought only single procedure claims that contained brachytherapy sources. We found 27 single procedure claims that met the revised criteria and we used the median cost of $936.52 that resulted from those claims.

*D. Other Policy Issues Relating to Pass-Through Device Categories*

1. Reducing Transitional Pass-Through Payments To Offset Costs Packaged Into APC Groups

In the November 30, 2001 final rule, we explained the methodology we used to estimate the portion of each APC rate that could reasonably be attributed to the cost of associated devices that are eligible for pass-through payments (66 FR 59904). Beginning with the implementation of the 2002 OPPS update (April 1, 2002), we deduct from the pass-through payments for the identified devices an amount that offsets the portion of the APC payment amount that we determine is associated with the device, as required by section 1833(t)(6)(D)(ii) of the Act. In the November 1, 2002 final rule, we published the applicable offset amounts for 2003 (67 FR 66801).

For the 2002 and 2003 OPPS updates, we estimated the portion of each APC rate that could reasonably be attributed to the cost of an associated pass-through device that is eligible for pass-through payment using claims data from the period used for recalibration of the APC rates. Using these claims, we calculated a median cost for every APC without packaging the costs of associated C codes for device categories that were billed with the APC. We then calculated a median cost for every APC with the costs of associated device category C codes that were billed with the APC packaged into the median. Comparing the median APC cost minus device packaging to the median APC cost including device packaging enables us to determine the percentage of the median APC cost that is attributable to associated pass-through devices. By applying these percentages to final APC rates, we determined the applicable offset amount. We included any APC on the offset list for which the device cost was at least 1 percent of the APC's cost.

As we discussed in our November 1, 2002 final rule (67 FR 66801), the listed offsets are those that may potentially be used because we do not know which procedures would be billed with newly created categories.

After publication of the November 1, 2002 final rule, we received a comment indicating that in some cases it may be inappropriate to apply an offset to a new device category because the device category is not replacing any device whose costs have been packaged into the APC. We agree with this comment

and proposed to modify our policy for applying offsets. Specifically, we proposed to apply an offset to a new device category only when we can determine that an APC contains costs associated with the device. We specified in the proposed rule that we would continue our existing methodology for determining the offset amount, described above. However, we solicited comments for alternative methodologies for determining the offset amounts that potentially could be applied to the payment amounts for new device categories.

We added that we could use this methodology to establish the device offset amounts for the 2004 OPPS because we are using 2002 claims on which device codes are reported. However, for the 2005 update to OPPS, we proposed to use 2003 claims that would not include device coding. Thus, for 2005, we are considering whether or not to use the charges from lines on the claim having no HCPCS code but have charges under revenue codes 272, 275, 276, 278, 279, 280, 289, and 624 as proxies for the device charges that would have been billed with HCPCS codes for these devices in previous years. We are also considering the reinstitution of the C codes for expired device categories and requiring hospitals to use one or more newly created C codes for identification of devices and costs on claims. *See* section VI.B of this final rule for further discussion.

We proposed to review each new device category on a case-by-case basis to determine whether device costs associated with the new category are packaged into the existing APC structure.

We reviewed the device categories eligible for continuing pass-through payment in 2004 to determine whether the costs associated with the device categories are packaged into the existing APCs. For the categories existing as of publication of the proposed rule, we determined that there are no close or identifiable costs associated with the devices in our data related to the respective APCs that are normally billed with those devices. Therefore, for these categories we proposed to set the offset to $0 for 2004.

If we create a new device category and determine that our data contain identifiable costs associated with the devices in any APC, we would apply an offset. We proposed, if any offsets apply, for new categories, to announce the offsets in a transmittal that announces the information regarding the new category.

We received several comments on the proposal, which are summarized below along with our responses.

*Comment:* Device manufacturers and associations generally supported our proposal to modify our policy in applying offsets to only those device categories where we can determine that an APC contains costs associated with the device category. One commenter also recommended that we not apply offsets to those categories that do not replace current devices found in the APC costs.

*Response:* We will apply an offset to a new device category only when we are able to determine that an APC contains costs associated with the new device. We will also continue our existing methodology for determining any offset amount, if we find that device costs associated with a new device category are packaged into the APCs. We will include information about any applicable offset in the transmittal we issue to announce information regarding the new category.

We also will publish the device percentages related to APCs on our web site. We believe this information is useful to the public even if we do not use the information to apply any particular offset to new device categories, because we use this information to apply the tests of ''not insignificant cost'' to a proposed new device category application. A transitional pass-through device category must have an average cost that is not insignificant in relation to the OPD fee schedule amount, according to section 1833(t)(6)(A)(iv)(II) of the Act.

2. Multiple Procedure Reduction for Devices

In our discussion in the proposed rule of recommendations of the Advisory Panel, we noted that the Panel asked us to analyze our data to determine if we may be underpaying for devices when the multiple procedure policy is applied (68 FR 47976). We made no proposal to change our policy regarding the multiple procedure reduction for device-related APCs, but we did receive a number of comments on the topic.

*Comment:* Commenters stated that we should change the status indicator (SI) from ''T'' to ''S'' for APCs with packaged device costs so that the multiple procedure discount will not adversely affect the payment for APCs that contain high cost devices. One commenter indicated that no APC for which the device percentage is 50 percent or more should be subjected to a multiple procedure reduction because any such reduction would reduce the Medicare payment below the hospital's cost for the device. The commenter offered to work with us to develop a list of device percentages of APC payments that would not be subject to the multiple procedure reduction. Another commenter suggested that we create a modifier that could be used to override the multiple procedure reduction for certain codes with SI ''T''. Some commenters said that any code that is not subject to the multiple procedure modifier under the Medicare physician fee schedule should be subjected to a multiple procedure modifier under OPPS.

*Response:* We are concerned that the application of the multiple procedure reduction has been a recurring theme among commenters with regard to APCs that contain significant device costs. We continue to believe that for most cases, including many cases with devices, the payment reductions for the second and subsequent payments are appropriate. This is particularly true given that there must be two procedures with SI=T for the reduction to occur. Hence, if a device procedure is performed with a non-device procedure, the non-device procedure will not be reduced if the device procedure has an SI=S, even if the non-device procedure is less costly because it was done at the same time as the device intense procedure. We are reluctant to change the SIs for device procedures because of the increase that will occur for non-device procedures. The shift in median costs will be picked up in the scaling of relative weights for budget neutrality and will result in some reduction for all services, shifting payment to procedures and away from other services types (for example, E&M, diagnostic tests).

Decisions regarding the application of the multiple procedure SIs are made independently for the Medicare physician fee schedule and the OPPS. The physician fee schedule decision is heavily dependent upon the work performed by the physician and the OPPS decision is made only with regard to the resources the hospital supplies for the service to be performed. There is no reason to believe that a decision to reduce or not reduce for multiple procedures in one system would necessarily justify that same decision in the other system.

For 2004 OPPS we have not changed the policy. However, as we did for 2003 OPPS, we have changed the SI for certain APCs for which we were convinced that the application of the multiple procedure reduction would result in inappropriate payment. For 2005, we hope to analyze the effects of a more systematic approach to determining when we should apply the

multiple procedure reduction to APCs with high device costs. We hope to develop these possible approaches and discuss them with the APC Panel at its winter meeting.

*Prosthetic Urology (APCs 0385 and 0386)*

*Comment:* Commenters said that APCs 0385 and 0386 should be changed from SI=S to SI=T and that the APC Panel agreed and recommended these changes in its August 22, 2003 meeting. The commenters indicated that when a penile prosthesis and a urinary sphincter are both implanted at the same time, while there is some cost efficiency (for example, OR time, recovery room time, drugs, supplies), the cost of the prostheses are such a large part of the cost of the APC that the reduction of the second APC by 50 percent results in less than cost being paid.

*Response:* For the 2004 OPPS, we have changed the SI for these APCs from T to S, so that when both the prosthesis and sphincter are implanted on the same date, the multiple procedure reduction will not apply to the second device. These APCs each contain a combination of penile prostheses and sphincters. Our data analysis shows that it is not a rare occurrence for both to be implanted on the same day and that each APC has a device percentage in excess of 60 percent. For these reasons, we have changed the SI for these APCs to ''S'' for 2004.

*Electrophysiology APCs (APCs 0085, 0086 and 0087)*

*Comment:* Commenters said that APCs 0085, 0086, and 0087 should not be subject to the multiple procedure reduction because the devices used in these procedures are not less costly when the second procedure is done on the same day. Commenters said that these procedures have become so advanced that they now are commonly done on the same day and that the multiple procedure reduction significantly reduces the payments below what they were paid when they were done on subsequent days. A commenter suggested that we should create a combination APC for APCs 0085, 0086 and 0087 or for APCs 0085 and 0086 since these are often performed on the same day and the commenter believes that the multiple procedure reduction improperly reduces payment for them.

*Response:* We have not changed the SI for these APCs because we do not believe that such a change is warranted. Although devices are integral to these APCs, the device portion of the median is not very significant. Each has a device percent lower than 35 percent (APC 0085 = 25.61 percent, APC 0086=34.77 percent, APC 0087= 30 percent). Moreover, we believe that there is efficiency in performing these procedures on the same day in the outpatient setting, which is why hospital practice has changed. Therefore, we are retaining these procedures as SI=T for 2004.

*Implantation or Revision of Pain Management Catheter; Implantation of Drug Infusion Device (APCs 0223 and 0227)*

*Comment:* A commenter indicated that the same rationale that applies to implantation of neurostimulators (discussed immediately preceding) applies to APCs 0223 and 0227 and that therefore, the multiple procedure reduction should not apply.

*Response:* We are not convinced by the comment that it would be appropriate to change the SI for APCs 0223 and 0227 from ''T'' to ''S''. We believe that there are economies of scale that cause these procedures to allow for appropriate payment when they are performed with other procedures.

*Left Ventricular Leads (APCs 0105, 1547 and 1550)*

*Comment:* A commenter indicated that placement of a Left ventricular lead (CPT code 33224, 33225, and 33226, APCs 0105, 1547 and 1550 respectively) should not be subjected to the multiple procedure reduction.

*Response:* We have reviewed the codes contained in these APCs and we are not convinced that it would be appropriate to change the SI for these APCs.

## VI. Payment for Drugs, Biologicals, Radiopharmaceutical Agents, Blood, and Blood Products

### *A. Pass-Through Drugs and Biologicals*

In the proposed rule, we expressed concern about the extent to which Medicare pays more for pass-through drugs than other payers and more than the market-based price of drugs. To address this problem of how to pay appropriately for drugs that are priced using the AWP, we are developing regulations that would revise the current payment methodology for Part B covered drugs paid under section 1842(o) of the Act. We proposed to adopt and apply the provisions of the final AWP rule to establish the AWP of pass-through drugs payable under the OPPS. If implementation of the AWP final rule necessitates mid-year changes in the 2004 OPPS payment rates for pass-through drugs, we proposed to make those changes on a prospective payment basis through our regular OPPS Transmittal process and PRICER quarterly updates. We further proposed to issue instructions by program memorandum regarding implementation of the provisions of the AWP final rule to set payment rates for pass-through drugs under the OPPS.

We stated that if the AWP final rule is not issued in time to permit us to apply its provisions to price pass-through drugs furnished on or after January 1, 2004, we proposed to use 95 percent of the AWP listed in the most recent quarterly update of the Single Drug Pricer (SDP). If a drug with pass-through status is not included in the SDP, we proposed to forward to the SDP contractor the AWP information submitted as part of the pass-through application for calculation of an allowed payment amount.

Because the January SDP would not be available in time, we proposed to announce the January 1, 2004 prices for pass-through drugs in our January 2004 OPPS implementing instructions to fiscal intermediaries and in the January 2004 OPPS PRICER rather than in the 2004 final rule, which is to be published in the **Federal Register** by November 1, 2003. We further proposed to update the AWP for pass-through drugs paid under the OPPS on a quarterly basis in accordance with the quarterly updates of the SDP. The updated rates for pass-through drugs and biologicals would also be issued through our quarterly OPPS program memoranda and PRICER updates.

*Comment:* A national hospital association supported our proposal to use the SDP to determine the payment amount for pass-through drugs and biologicals. However, the same commenter expressed concern about not having accurate 2004 information on AWP until after the 2004 OPPS is implemented, which would make it impossible to predict pass-through spending and not give hospitals enough time to update their billing systems. The commenter also opposed our proposal to update the AWP for pass-through drugs on a quarterly basis because it would result in increased confusion and burden on hospitals to make quarterly price changes and could result in CMS having to make quarterly adjustments to the pass-through pool to recalculate the relative payment weights for all APCs.

A provider expressed reservations about the impact of the AWP rule, which could precipitate a shift in care from physicians' offices to hospitals. This commenter recommended that we determine pass-through payment

amounts using market applications by drug manufacturers and acquisition data solicited from the hospital industry through group purchasing organizations and individual hospitals and systems. The same commenter encouraged us to delay changes in pass-through payments pending an assessment of the impact of the AWP rule on physician practices.

*Response:* We wish to clarify how our use of the SDP to price pass-through drugs will affect the OPPS in 2004. The payment rates for pass-through drugs and biologicals that are shown in Addendum B are based on the April 1, 2003 SDP, which was the update that was available when we recalibrated the relative payment weights for this final rule. We also used these payment rates as the basis for estimating pass-through spending in 2004, which is discussed in section IV of this preamble.

We have carefully considered the commenter's concern about the confusion that could result if we were to revise the payment amounts for pass-through drugs and biologicals by installing prices from the January 2004 update of the SDP in the OPPS PRICER for implementation beginning January 1, 2004. We agree with the commenter that, because of the timing, this proposal could create operational problems both for providers and for our claims processing systems. Therefore, we will retain the payment amounts published in this final rule as the payment amounts for pass-through drugs effective January 1, 2004.

Further, to keep quarterly changes to a minimum, we have decided not to implement at this time our proposal to update the AWP for pass-through drugs paid under the OPPS on a quarterly basis in accordance with quarterly SDP updates.

At this time, we are not implementing the AWP rule. Therefore, we are not making final the OPPS changes we proposed that would have resulted from the AWP rule.

*Comment:* Several commenters were concerned about the delay in processing pass-through applications and assigning c-codes for new drugs and biologicals. Commenters believed that the lack of immediate payment under OPPS for new FDA-approved drugs and biologicals may drive hospitals to discontinue providing innovative life-saving therapies to Medicare beneficiaries until pass-through payments are established. Another commenter suggested that CMS create and regularly update a central on-line listing of all current codes for pass-through drugs, biologicals, and devices. The Web site should also list all pass-through drug and device applications under review, and their status in the review process.

*Response:* We understand the concerns expressed by commenters about the impact of the time gap from FDA approval to our c-code assignment and payment for new pass-through items; however, our position on this issue remains the same as that described in the November 1, 2002 final rule (67 FR 66780–81).

*B. Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status*

1. Background

Under the OPPS, we currently pay for radiopharmaceuticals, drugs, and biologicals including blood, and blood products, which do not have pass-through status, in one of three ways: packaged payment, separate payment (individual APCs), and reasonable cost. As we explained in the April 7, 2000 final rule (65 FR 18450), we generally package the cost of drugs and radiopharmaceuticals into the APC payment rate for the procedure or treatment with which the products are usually furnished. Hospitals do not receive separate payment from Medicare for packaged items and supplies, and hospitals may not bill beneficiaries separately for any such packaged items and supplies whose costs are recognized and paid for within the national OPPS payment rate for the associated procedure or service. (Transmittal A–01–133, a Program Memorandum issued to Intermediaries on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services). As we explained in the November 1, 2002 final rule (67 FR 66757), we do not classify diagnostic and therapeutic radiopharmaceutical agents as drugs or biologicals as described in section 1861(t) of the Act.

*Comment:* Several trade associations and manufacturers urged CMS to revise its policy that radiopharmaceuticals are not drugs. They emphasized that radiopharmaceuticals go through the same FDA approval process as drugs, are approved for inclusion in the United States Pharmacopoeia Drug Indication, and have historically been considered drugs under OPPS. They indicated that Congress is considering a legislative clarification that under OPPS radiopharmaceuticals will continue to be treated and paid as drugs.

*Response:* We appreciate the comments on this issue. We do not intend, by our designation of radiopharmaceuticals for purposes of determining which items are eligible for pass-through status, to imply that radiopharmaceuticals are not considered drugs under the Food, Drug, and Cosmetic Act or that they are not subject to the same FDA approval process as those items that we have designated as drugs. However, we will continue to consider radiopharmaceuticals as neither a drug nor biological. Our reasons were set forth in the November 1, 2002 final rule (67 FR 66757). In that rule, we stated that a careful reading of the statutory language in section 1861(t)(1) convinces us that inclusion of an item in, for example, the USPDI, does not necessarily mean that the item is a drug or biological. Inclusion in such a reference (or approval by a hospital committee) is a necessary condition for us to call a product a drug or biological, but it is not enough. CMS must make its own determination that a product is a drug or biological for OPPS purposes under its governing statutes, and this determination is different from and does not affect FDA's determination that a product is a drug or biological under the Food, Drug, and Cosmetic Act.

While we have determined that radiopharmaceuticals are not drugs under the OPPS, we have chosen to establish separate payment for radiopharmaceuticals under the same packaging threshold policy that we apply to drugs and biologicals. We have also determined that we will apply the same adjustments to the median costs for radiopharmaceuticals that will apply to non-pass-through, separately paid drugs and biologicals.

*Payment for New Radionucliide Therapy for Certain Forms of Non-Hodgkins Lymphoma*

Currently, payment for the radiopharmaceutical Zevalin (Ibritumomab Tiuxetan) is packaged into the payment for HCPCS codes G0273 (Pretx planning, non-Hodgkins) and G0274 (Radiopharm tx, non-Hodgkins). To ensure consistency with our payment policy for other radiopharmaceuticals (that is, making separate payment for radiopharmaceuticals whose costs are greater than $150 per episode of care), we proposed to make payment for Zevalin (ibritumomab tiuxetan) separately from payment for the procedures with which Zevalin (ibritumomab tiuxetan) is used.

We proposed to use HCPCS A9522 (Indium 111 ibritumomab tiuxetan) to report the use of In-111 Zevalin (In-111 Ibritumomab Tiuxetan) and HCPCS A9523 (Yttrium 90 ibritumomab tiuxetan) to report the use of Y90 Zevalin (Y90 Ibritumomab Tiuxetan). We proposed to place HCPCS A9522 in

APC 9118 with a payment amount of $2,084.55 and HCPCS A9523 in APC 9117 with a payment amount of $18,066.09. We note that payment rates for radiopharmaceuticals are not subject to wage index adjustments because no portion of the payment is attributed to labor-related costs.

Because we proposed that payment for G0273 and G0274 no longer include payment for Zevalin, we also proposed to place G0273 into newly created APC 0406 and G0274 into newly created APC 0408. These APCs include procedures that are similar clinically and in terms of resource consumption to G0274 and G0273, respectively.

Zevalin (ibritumomab tiuxetan) is a radioimmunotherapy that is used to treat patients with certain forms of non-Hodgkin's lymphoma (NHL). Medicare began payment under the OPPS for Zevalin services furnished on or after October 1, 2002.

On June 27, 2003, the FDA approved the manufacture and sale of Bexxar (tositumomab and Iodine I 131 tositumomab), which is another radioimmunotherapy used to treat patients with certain forms of non-Hodgkin's lymphoma. Both Zevalin and Bexxar are therapeutic regimens administered in two separate steps: The first step is diagnostic to determine radiopharmaceutical biodistribution of radiolabeled antibodies; the second step is the therapeutic administration of targeted radiolabeled antibodies.

On September 8, 2003, we issued a One Time Notification (Transmittal 1, Change Request 2914) to implement payment for Bexxar effective for services furnished on or after July 1, 2003. We instructed hospitals to bill for Bexxar using HCPCS codes G0273 (Pretx planning, non-Hodgkins), G0274 (Radiopharm tx, non-Hodgkins), and G3001 (Administration and supply of tositumomab, 450mg). Publication deadlines precluded our being able to address payment for Bexxar in the August 12, 2003 proposed rule.

*Comment:* A major hospital association, a nuclear medicine specialty organization, several providers that treat cancer patients, and two radiopharmaceutical manufacturers submitted comments regarding the changes we proposed to the coding and payment for Zevalin (ibritumomab tiuxetan) under the 2004 OPPS. The commenters agree with our proposal to separate payment for Zevalin from the payment for the procedure and to pay for Zevalin using HCPCS codes A9522 and A9523, which would not be subject to a wage index adjustment. One commenter noted that the HCPCS descriptors for A9522 and A9523 define the unit of service as ''per millicurie,'' but that the payment we proposed for these two codes appeared to be a total payment amount rather than a per millicurie rate. Several commenters recommended that the code descriptors for A9522 and A9523 be revised to read ''per dose'' rather than ''per millicurie.''

*Response:* We appreciate the commenters'' support of our proposal to pay for Zevalin separately from its administration. We also agree with the commenter who suggested that the payment rate proposed for A9522 and A9523 was incorrectly shown as a total payment amount rather than a per millicure rate, and we have made certain that the final payment amounts implemented in the 2004 update are consistent with the code descriptor for the service. We further agree with the recommendation of commenters that the HCPCS descriptors for Indium 111 ibritumomab tiuxetan and Yttrium 90 ibritumomab tiuxetan would be less confusing if expressed in terms of dose rather than millicuries. However, the descriptors for A9522 and A9523 were established by the HCPCS National Panel through the process described on our Web site at *http://www.cms.hhs.gov/medicare/hcpcs/,* and such a descriptor change could not be applied for in time for January 1, 2004 implementation of the OPPS. Therefore, we are establishing two temporary C-codes for hospitals to use to bill under the OPPS for Indium 111 ibritumomab tiuxetan and Yttrium 90 ibritumomab tiuxetan, for services furnished beginning January 1, 2004, as follows:

C1082, Supply of radiopharmaceutical diagnostic imaging agent, indium-111 ibritumomab tiuxetan, per dose

C1083, Supply of radiopharmaceutical therapeutic imaging agent, Yttrium 90 ibritumomab tiuxetan, per dose

*Comment:* One commenter recommended that we create separate codes that parallel A9522 and A9523 to bill for Bexxar (tositumomab and I–131 tositumomab).

*Response:* We are establishing two temporary C-codes for hospitals to use to bill under the OPPS for I–131 tositumomab for services furnished beginning January 1, 2004, as follows:

C1080, Supply of radiopharmaceutical diagnostic imaging agent, I–131 tositumomab, per dose

C1081, Supply of radiopharmaceutical therapeutic imaging agent, I–131 tositumomab, per dose

*Comment:* Several commenters recommended that we discontinue use of HCPCS codes G0273 and G0274 to describe the administration of Zevalin and that, instead, we instruct hospitals to report new CPT code 78804, Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging, and new CPT code 79403, Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion. One commenter expressed concern about our proposal to assign G0273 for pre-treatment planning and administration of the diagnostic dose to APC 0406, Tumor/Infection Imaging because the payment rate proposed for APC 0406 ($258.10) is inadequate to pay for the cost of the scans required to measure the distribution of the radiopharmaceutical agent. The same commenter agreed with our proposal to assign G0274 for administration of the therapeutic dose to APC 0408, with a proposed payment rate of $217.16.

*Response:* We agree with the commenters' recommendations that we replace HCPCS codes G0273 and G0274 with CPT codes 78804 and 79403, respectively. We will direct our contractors to instruct hospitals to use CPT code 78804 to report administration of the diagnostic dose of ibritumomab tiuxetan and I–131 tositumomab and to report CPT code 79403 to report administration of the therapeutic dose of ibritumomab tiuxetan and I–131 tositumomab. We also agree with the concern of commenters that the payment amount for APC 0406 in the final rule is insufficient for administration of the diagnostic radiolabeled antibodies plus the imaging required to determine radiopharmaceutical localization of tumor(s) and distribution of the radiopharmaceutical agent. Therefore, we are assigning CPT code 78804 to New Technology APC 1508, which has a payment rate of $650. After we have had an opportunity to collect claims data that indicate hospital costs for this procedure, we will re-evaluate its APC assignment. Further, there are several additional expenses associated with these innovative radioimmunotherapies used to treat patients with certain forms of non-Hodgkin's lymphoma, which we discuss below. We are therefore assigning CPT code 70403 to New Technology APC 1507, until we have collected sufficient data to confirm the appropriate clinical APC for this service.

*Comment:* Several commenters expressed concern that our proposed payment for Zevalin ($2,084.55 for the diagnostic dose of indium and $18,066.09 for the therapeutic dose of

yttrium) would be approximately $2,000 less than what it costs a hospital to purchase Zevalin from a nuclear pharmacy, thereby jeopardizing beneficiary access to this therapy. One commenter submitted information from a nuclear pharmacy attesting that it has dispensed 2,068 patient-specific doses of Zevalin nationwide (1,071 Indium doses and 997 Yttrium doses) and that its current charges are $2,260 per dose of Indium-111 Zevalin and $19,565 per dose of Yttrium-90 Zevalin. The commenter stated that this represents nearly 80 percent of all Zevalin doses dispensed between product launch in April 2002 through June 30, 2003.

Another commenter expressed concern about the adverse impact that the proposed reduction in payments for Zevalin could have on payment for Bexxar in 2004. The commenter urged us not to base payment for Bexxar on what we proposed for Zevalin but, rather, on hospital acquisition costs for Bexxar, which approximate the wholesale acquisition cost (WAC) of $2,250 for the diagnostic dose and $19,500 for the therapeutic dose.

*Response:* Although we established a code to enable hospitals to bill for and receive separate payment for Zevalin effective October 1, 2002, hospitals could only report this code through December 31, 2002. (Effective January 1, 2003, we combined payment for Zevalin with its administration, using HCPCS codes G0273 and G0274.) Our 2002 claims data are insufficient to allow us to calculate a median cost for Zevalin. Because Bexxar was approved by the FDA in June 2003, it was not billed at all in 2002. Therefore, we cannot determine payment rates for either radiopharmaceutical based on the standard methodology that we use to calculate the other APC relative payment weights and rates. In instances where we lack adequate data upon which to base a payment rate, we have relied wholly or in part on external data as the basis for rate setting. For example, in the absence of claims data, we use data submitted in applications for new technology status to enable us to assign a service to an appropriate new technology APC. Elsewhere in this final rule, we discuss how we are using external data to set 2004 payment rates for certain other services and procedures.

We received information consistent with our request for verifiable data (68 FR 47998) that indicates the payment amounts we proposed for A9522 and A9523 in the proposed rule do not reflect the price for Zevalin that is widely available to the hospital market.

Therefore, we are making final the following payments, effective for services furnished on or after January 1, 2004:

For HCPCS code C1080 (APC 1080) the payment is $2,260;

For HCPCS code C1081 (APC 1081) the payment is $19,565; For HCPCS code C1082 (APC 9118) the payment is $2,260;

For HCPCS code C1083 (APC 9117) the payment is $19,565.

*Comment:* One commenter expressed concern about the inadequacy of the 2003 payment rate ($2,159) that we established for HCPCS code G3001, Administration and supply of tositumomab, 450mg. The commenter noted that the WAC for unlabeled tositumomab is $2,125, and that a payment amount of $2,159 is not sufficient to pay hospitals for both the acquisition of unlabeled tositumomab and its administration. The commenter was also concerned that packaging the unlabeled antibody tositumomab with its administration and assigning it to an APC that is subject to wage adjustment would result in large payment differences across the country. The commenter noted that the unlabeled antibody rituximab, which is used with Zevalin therapy, is a separately payable drug and therefore not subject to wage index adjustments. The commenter recommended that we either increase the payment rate for G3001 and exempt it from wage adjustment or that we create a new code for unlabeled tositumomab, assign a payment rate that reflects its acquisition cost, and pay separately for its administration using HCPCS code Q0084.

*Response:* After carefully reviewing the commenter's concerns, we have assigned HCPCS code G3001 to New Technology APC 1522, which has a payment rate of $2,250. Unlabeled tositumomab is not approved as either a drug or a radiopharmaceutical, but is a supply that is required as part of the Bexxar treatment regimen. Therefore, we do not agree with the commenter's recommendation that we assign a separate new code to unlabeled tositumomab. Moreover, administration of unlabeled tositumomab is a complete service that qualifies it for assignment to a New Technology APC. We believe that the increased payment resulting from assignment of G3001 to New Technology APC 1522 will be sufficient to enable hospitals to acquire and administer unlabeled tositumomab, notwithstanding application of a wage adjustment.

*Comment:* One commenter recommended that we modify the payment amounts for the existing codes used to bill for Bexxar or that we establish new codes to recognize the costs of patient evaluation, education, and clearance for radiation safety purposes as well as the costs of compounding Bexxar by radiopharmacies. The same commenter suggested that, as an alternative to establishing a new code for the costs associated with the procedures required for patient safety and education when Bexxar is used, we allow hospitals to report an appropriate Evaluation and Management code for patient evaluation, education, and clearance when receiving diagnostic or therapeutic services involving radioisotopes.

*Response:* We disagree with the commenter's recommendation that an additional code is needed to pay for radiopharmacy compounding costs or that an allowance of $1,000 should be added to the payment for the both diagnostic and therapeutic doses of Bexxar to offset these costs. We believe that the rates we are implementing in this final rule, as discussed above, provide sufficient payment for radiopharmacy compounding or delivery costs that hospitals may incur when using Bexxar or Zevalin. We have carefully considered the commenter's recommendation that hospitals be allowed to bill an appropriate evaluation and management code for patient evaluation, education, and clearance following procedures involving radioisotopes. We recognize that special requirements may have to be met before releasing a patient following exposure to a high dose of radiation. We would expect the patient's physician to provide, and bill for separately with appropriate documentation, a significant portion of the preparation and education needed by a patient being treated with Zevalin or Bexxar. However, to the extent that qualified hospital staff are required to provide additional face-to-face patient education and instructions before the patient's release following radioimmunotherapy, the hospital may bill an appropriate evaluation and management code as long as the medical record documents that the services are medically necessary and that they constitute a distinct, separately identifiable evaluation and management service that is consistent with the hospital's criteria for that service.

*Drugs and Biologicals for Which Pass-Through Status Will Expire in 2004*

Section 1833(t)(6)(C)(i) of the Act specifies that the duration of transitional pass-through payments for drugs and biologicals must be no less

than 2 years nor any longer than 3 years. The drugs and biologicals that are due to expire on December 31, 2003 meet that criterion. Table 11 lists the drugs and biologicals for which pass-through status will expire on December 31, 2003.

TABLE 11.—LIST OF DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS EXPIRES CY 2004

| HCPCS | APC | Long descriptor | Trade name | Pass-through expiration date |
|---|---|---|---|---|
| C9202 | 9202 | Injection, suspension of microspheres of human serum albumin with octafluoropropane, per 3ml. | Optison (single source) | 12–31–03 |
| J0587 | 9018 | Injection, Botulinum toxin, type B, per 100 units | Myobloc (single source) | 12–31–03 |
| J0637 | 9019 | Injection, Caspofungin acetate, 5 mg | Cancidas (single source) | 12–31–03 |
| J7517 | 9015 | Mycophenolate mofetil, oral per 250 mg | CellCept (single source) | 12–31–03 |
| J9010 | 9110 | Injection, Alemtuzumab, per 10 mg | Campath (single source) | 12–31–03 |
| J9017 | 9012 | Injection, Arsenic trioxide, per 1 mg | Trisenox (single source) | 12–31–03 |
| J9219 | 7051 | Implant, Leuprolide acetate, per 65 mg implant | Viadur (single source) | 12–31–03 |

*Comment:* A commenter requested that we maintain transitional pass-through status for this biological through calendar year 2004. The commenter indicated that Dermagraft was approved as a pass-through device effective October 1, 2000 through March 31, 2001, by which time CMS had concluded that Dermagraft should be classified as a biological for payment purposes. Dermagraft later re-qualified for pass-through status as a biological effective April 1, 2002. The commenter stated that CMS should not count the time Dermagraft was on the pass-through list as a device to determine whether this product received a minimum of 2 years under pass-through status.

*Response:* We agree with the commenter and will retain Dermagraft in pass-through status through December 2004.

*Comment:* The manufacturer of an ultrasound contrast agent, Optison (APC 9202, C9202), expressed concern about our decision to retire their product from pass-through status on December 31, 2003. The manufacturer indicated that two of Optison's competitors, Definity (C9112) and Imagent (C9203) will remain pass-throughs in 2004 and receive higher payments, while payment for Optison will be based on median cost calculated from hospital claims data. The commenter was concerned about differential OPPS payments to hospitals for clinically similar products and recommended that we should either allow all of these agents to remain on pass-through status until December 31, 2004, or remove them and use claims data to establish a uniform payment rate for 2004.

*Response:* As stated above, section 1833(t)(6)(C)(i) of the Act specifies that transitional pass-through payments for drugs and biologicals must be made for at least for 2 years but not more than 3 years. Pass-through payment for Optison was established on April 1, 2001, while Definity and Imagent received pass-through status on April 1, 2002 and April 1, 2003, respectively. Since hospitals have been billing for and receiving pass-through payments for Optison for at least 2 years, we have the statutory authority to remove this item from pass-through status. Since pass-through payments for Definity and Imagent have not exceeded the minimum 2-year period yet, these products will retain their special status in 2004. In the absence of verifiable external data, the 2004 payment rate for Optison was calculated using hospital claims data from April through December 2002 and was eligible for dampening.

2. Criteria for Packaging Payment for Drugs, Biologicals, and Radiopharmaceuticals

To the maximum extent possible, our intention is to package into the APC payment the costs of any items and supplies that are furnished with an outpatient procedure. For 2004, we proposed to continue with our policy of paying separately for drugs and radiopharmaceuticals whose median cost per day exceeds $150 and packaging the cost of drugs and radiopharmaceuticals with median cost per day of less than $150 into the procedures with which they are billed. In the proposed rule, we set forth the methodology we used to calculate the median cost per day for drugs, biologicals, and radiopharmaceuticals (68 FR 47996–47997).

We proposed to provide an exception in 2004 to the packaging rule for drugs and radiopharmaceuticals whose payment status would change as a result of using newer data. For 2004, we proposed that:

- Currently packaged drugs and radiopharmaceuticals with median costs per day at or above $150 would receive separate payment in 2004.
- Currently separately payable drugs and radiopharmaceuticals with median costs per day under $150 would continue to receive separate payment in CY 2004.
- Drugs whose pass-through status would expire on December 31, 2003, and whose median costs per day are under $150 would receive separate payment in 2004.
- Currently packaged drugs and radiopharmaceuticals with median costs per day below $150 would remain packaged in 2004.

We requested comments on the methodology we used to determine the median cost per day, on the threshold we proposed to use for packaging drugs and radiopharmaceuticals, and on the proposal to pay separately for drugs and radiopharmaceuticals whose payment status would change based on use of recent claims data and our proposed methodology. We also requested comments on alternatives to packaging.

We received many comments on our proposals, which are summarized below along with our responses.

*Comment:* We received many comments from patient advocates, individual clinicians, physician and nursing professional associations, individual hospitals, and manufacturers and their representatives that expressed significant concerns over our proposal to continue the 2003 policy under which we package the cost of most drugs, biologicals and radiopharmaceuticals that cost $150 or less. We also received several comments from major provider groups in support of the packaging proposal and recommending a higher threshold. One such organization recommends that we study this issue further to develop a more appropriate long-term solution.

Commenters who disagreed with the proposal to package drugs, biologicals and radiopharmaceuticals costing $150 or less believe that the proposed rates for the drug administration codes do not adequately address the costs of hospitals to administer these drugs. Several commenters conducted their own analyses of this issue in conjunction

with the proposals for drug administration discussed elsewhere in this final rule. For many of these commenters, the issues of packaging, drug payment rates and our discussion of drug administration in the proposed rule were intertwined. Some commenters that disagreed with our $150 packaging threshold asserted that most visits involve delivery of drugs that had been designated as packaged and that overpayment for visits with no packaged drugs is small compared to the overall underpayment of both packaged and separately payable drugs. Particular concern was expressed about the packaging of cancer chemotherapy drugs. One commenter stated that the dosages may vary significantly, and where given in high doses the cost for a single drug alone may exceed the total packaged payment. Also, commenters stated that several packaged drugs are often administered during a single infusion, and where the cost of a single packaged drug may be less than $150 the cost of multiple packaged drugs is often greater than $150.

Several commenters indicated that the methodology and cost data we used to calculate the median cost per day for drugs and radiopharmaceuticals were based on incorrectly coded claims where the wrong number of units were reported and a very limited number of single claims were captured which failed to portray the hospitals' charges appropriately. Therefore, certain high cost items fell below the $150 threshold.

Commenters expressed concern about patient access to effective but lower cost drugs and the disincentive we may create by paying separately for those over $150 per day. One organization stated that cancer centers have reported that they have taken or are considering steps to restrict patient access to those drugs that we have packaged. One hospital estimated that it would lose approximately $490 per visit for a patient receiving chemotherapy due to the $150 packaging rule and the proposed reductions in payments for certain drugs. While some commenters expressed general concerns about packaging the costs of any drugs, biologicals or radiopharmaceuticals, other commenters recommended that we apply a $50 threshold in lieu of the proposed $150 threshold in determining which items to pay for separately. Some of the commenters recommending a $50 threshold cited statutory changes under consideration by Congress that would mandate a $50 threshold.

*Response:* For 2004, we have established a $50 median cost per day threshold in determining whether drugs, biologicals and radiopharmaceuticals will be packaged. Those items that fall below the threshold will be packaged into the costs of the service or procedure with which they are billed; those items with median costs above the threshold will be paid for separately in 2004.

We analyzed our data in determining our final drug administration coding and payment policy, as discussed elsewhere in this final rule, and reviewed the median costs of all APCs under both a $150 and a $50 packaging rule. We concluded that there was not a sufficient difference in the median costs under those two scenarios, resulting in inadequate payment when drugs, biologicals and radiopharmaceuticals costing between $50 and $150 would be used by the hospital. Therefore, we agree with the majority of commenters that, for 2004, the appropriate threshold should be $50.

We also recognize, as several commenters did, that packaging creates incentives for hospital efficiencies and will continue to apply that concept to devices, most supplies and equipment associated with a procedural APC, and low cost drugs. However, we are convinced that under our current methodology for establishing relative weights, that packaging drugs, biologicals and radiopharmaceuticals costing in excess of the $50 threshold per patient per day would not provide adequate payment in 2004 and could adversely affect beneficiary access to important therapies. Nevertheless, our final decision for 2004 does not mean that a change in our methodology for establishing relative weights in the future could not cause us to revisit our packaging policy in the future. Since we have lowered the packaging threshold from $150 to $50, we will not adopt the proposal to provide an exception to the packaging rule for drugs and radiopharmaceuticals whose payment status would change from 2003 to 2004 as a result of using newer 2002 data.

However, we note several exceptions to our policy of packaging drugs, biologicals and radiopharmaceuticals for which the median per day cost is less than the $50 threshold. As discussed elsewhere in this final rule, we will allow separate payment under the OPPS for all blood and blood products and for single indication orphan drugs. We will also allow separate payment for hepatitis B vaccine under the OPPS. While the median per day costs for several hepatitis B vaccine codes fell below the $50 threshold using the final rule data, we believe that continued separate payment for these codes is warranted given the special, separate benefit category established by Congress. Separate payment for influenza and pneumococcal vaccines will continue to be made outside of the OPPS on a reasonable cost basis.

3. Payment for Drugs, Biologicals, and Radiopharmaceuticals That Are Not Packaged

In order to establish payment rates for separately payable drugs and radiopharmaceuticals for the 2004 OPPS, we first determined median cost for each drug and radiopharmaceutical per unit. When we compared the median cost per unit used for determining the 2003 payment rate (for example, the true or dampened median cost) for separately payable drugs and radiopharmaceuticals with their 2004 median cost per unit, we found fluctuations in costs from 2003 to 2004.

We solicited comments concerning the reasons for the fluctuations in median costs from 2003 to 2004. We stated our interest in determining whether these fluctuations reflect changes in the market prices of these drugs and radiopharmaceuticals or problems in the hospital claims data (for example, inaccurate coding, improper charges) that we use for setting payment rates.

In the proposed rule, we discussed in detail several options we considered to address the fluctuations in median costs for separately payable drugs and radiopharmaceuticals (68 FR 47997–47998). The option that we proposed for 2004 was a variation of the methodology used for the 2003 OPPS. For separately payable drugs and radiopharmaceuticals whose 2004 median costs decreased by more than 15 percent from the applicable 2003 median cost, we proposed to limit the reduction in median costs to one fourth of the difference between the value derived from claims data and a 15 percent reduction (for example, for a drug whose cost decreased by 35 percent from the applicable 2003 median cost, the allowed reduction from 2003 to 2004 would be 15 percent + (¼ times 35 − 15) percent = 20 percent). For separately payable drugs and radiopharmaceuticals whose median costs decreased by less than 15 percent from 2003 to 2004, we proposed to establish their payment rates using the median costs derived from the 2002 claims data. We stated that, based on more complete claims data we expected to have for the final rule and on the comments from the public, we would re-evaluate the appropriateness of adjusting median costs for drugs for which median costs would decline in 2004.

We also proposed a separate payment policy for drugs, biologicals, and radiopharmaceuticals for which generic alternatives have been approved by the Food and Drug Administration (FDA) between October 2001 and December 2002.

We solicited comment on both our proposed methodology and payment rates for separately payable drugs and radiopharmaceuticals for 2004. We requested that commenters who disagree with the proposed rate for a drug or radiopharmaceutical submit verifiable information to support their opinions that the proposed rate is inaccurate and does not reflect the price that is widely available to the hospital market.

We received a number of comments on our payment methodology options for separately payable drugs, biologicals, and radiopharmaceuticals. Those comments are summarized below along with our responses.

*Comment:* We received a number of comments noting disagreement with the proposed payment rates for separately paid drugs, biologicals and radiopharmaceuticals overall. Many of these comments were included in the comments on our packaging proposal, summarized above, and expressed some of the same concerns, such as restrictions to patient access, particularly to cancer chemotherapy drugs. One hospital commenting on the proposed rates stated that, as with most hospitals, they continually attempt to leverage buying power to reduce the costs of drugs but, like most hospitals, have been unable to do so for certain drugs. Commenters asked that we critically review the data used to establish the payment rates including consideration of the charge compression issue. Commenters stated that the proposed payments would not cover the direct acquisition costs of certain items.

A number of commenters objecting to our proposed payment rates stated that the hospital data that we use to calculate those rates are flawed and that the methodology we employ to convert hospital claims data to relative weights is problematic. Commenters attributed these concerns to issues such as hospital billing practices that result in inaccurate reporting of units or charges, HCPCS coding changes, and the use of cost-to-charge ratios across all products regardless of whether an item is high or low cost.

We received numerous comments on alternatives to our proposed policies for separately payable drugs and radiopharmaceuticals. One commenter suggested that we pay the amount of the hospital's acquisition cost plus an additional 25 percent to pay for costs of receiving, processing and storing the items. Other comments suggested that we limit the decreases for all separately paid drugs to a reduction of 10 percent in the payment rates, as we proposed for blood and blood products, instead of our proposed policy of limiting reductions in median costs for those separately paid items with median costs with reductions greater than 15 percent. Another suggestion was that we establish a payment rate floor for a product that could be raised if a manufacturer submitted information demonstrating that the rate should be higher than the floor.

Several commenters indicated that we should use only claims that have the appropriate administration or procedure code and the HCPCS code for a particular drug or radiopharmaceutical when determining the median cost for that drug or radiopharmaceutical. One commenter recommended that we pay for drugs and biologicals at 95% AWP to standardize payments for drugs and biologicals across different practice settings. Another commenter requested that we establish payment floors that are equal to those in the pending Congressional Medicare legislation (for example, certain sole source drugs would be paid at least 88 percent of AWP in 2004); whereas another drug manufacturer recommended that we use the Federal Supply Schedule price plus a certain percentage (for example, 12.5 percent) as an absolute minimum payment amount for drugs and radiopharmaceuticals.

In addition to the comments regarding our proposed payment rates for drugs, biologicals and radiopharmaceuticals overall, we received comments concerning the proposed rate for specific items. For a few of those items, we received external cost data that met the preferred criteria we set forth in our proposed rule (for example, non-proprietary data that demonstrates actual, market-based prices at which a broadly-based national sample of hospitals were able to procure the item). Several commenters suggested that we substitute external data on hospital acquisition cost for median costs calculated from our claims data when determining the payment rate for drugs and radiopharmaceuticals for which we have received such data. Others recommended that we use external data to benchmark payment for drugs and radiopharmaceuticals and make appropriate adjustments to the proposed 2004 payment levels. Even though most commenters supported the use of external data in place of hospital claims data, a national hospital association expressed concern about the use of external data in OPPS. The commenter indicated that if external data is used for rate setting in 2004, then we may have to continue to collect data on acquisition cost for future years to be able to continue to adjust the weights. Instead, the commenter was supportive of using claims data to set payment rates without the use of external data and urged us to remain committed to the averaging process inherent in the prospective payment system.

*Response:* We have decided to adopt the general principle proposed in our August 12, 2003 proposed rule limiting the reduction in median costs to one-fourth of the difference between the value derived from our claims data and a 15 percent reduction. For example, a drug whose median cost decreased by 35 percent from the median cost used to establish the separate payment rate for 2003 would be 15 percent + (¼ times 35–15) percent, or 20 percent. However, we will not apply this methodology to the medians of those drugs, biologicals and radiopharmaceuticals that are packaged in 2003 but for which we will allow separate payment in 2004. Payment for drugs, biologicals and radiopharmaceuticals that emerge from packaged status in 2004 because their median per day costs are greater than $50 per day will be based on the unadjusted median cost derived from our April–December 2002 claims data. Since these items are packaged in 2003, we did not calculate any adjusted medians on which to base their payments on for 2003. Thus, we are unable to determine the extent to which their median costs fluctuate from 2003 to 2004.

As discussed in our proposed rule and elsewhere in this final rule, we used a more complete set of claims for the April–December 2002 claims period and the most recently submitted cost report data to calculate median costs for all currently separately paid drugs, biologicals and radiopharmaceuticals. Our analysis of the later and more complete data revealed that a number of these items continued to experience a decline of more than 15% in median cost. We again considered several options to address the fluctuations in medians, which for some items would result in wide fluctuations in payments to hospitals. One option was to do nothing to adjust for the fluctuations; another option was to apply a more modest give-back (for example, 50 percent instead of 75 percent, after allowing for the 15 percent reduction.) We also considered the comments we received on drug payments in general and for specific items.

We did not adopt the options that would allow no adjustments for items separately paid in 2003 where the costs declined because we were convinced by the many commenters on this topic that such fluctuations create problems for the hospitals. We were also convinced by the commenters that a less generous give-back, such as 50 percent, would not adequately address the very real concerns about patient access to some of these drugs, particularly for cancer chemotherapy. We believe that, for the majority of items paid separately in 2003 for which the more recent hospital data indicates a reduction in excess of 15 percent, the adjustment methodology we proposed and that we are adopting for this final rule provides an adequate buffer for the hospitals against dramatic fluctuations in payment amounts while at the same time not significantly affecting the budget neutrality scalar applied to the relative weights for all services.

We believe that either the use of our unadjusted medians or, where applicable, a median adjusted to limit reductions greater than 15 percent methodology, will not adversely impact beneficiary access. However, we were convinced by the external data meeting our preferred criteria and the related comments that we received for several items, the payment rates resulting from our data alone could provide a disincentive for hospitals to provide these particular therapies. Therefore, we have determined that we will use this credible and relevant external data to establish a median cost for the following items listed in table 15. For these items, as with the few device-related APCs for which we are considering external data, we have calculated an adjusted median cost by blending the median cost derived from our dampening methodology with the cost data from the external sources on a one-to-one ratio.

TABLE 12.—LIST OF DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS FOR WHICH BLENDED DATA WERE USED TO DETERMINE 2004 PAYMENT RATES

| APC | HCPCS | Short descriptor | 2004 adjusted median cost | External acquisition cost | 2004 1:1 Blended median cost |
|---|---|---|---|---|---|
| 0909 | J1825 | Interferon beta-1a | $159.16 | $231.25 | $195.21 |
| 9022 | Q3025 | IM inj interferon beta-1a | 53.05 | 77.08 | 65.07 |
| 0902 | J0585 | Botulinum toxin a | 2.86 | 3.92 | 3.39 |
| 7000 | J0207 | Amifostine | 241.95 | 369.49 | 305.72 |
| 1624 | Q3007 | Sodium phosphate p32 | 49.18 | 100.00 | 74.59 |
| 1625 | Q3008 | Indium 111-in pentetreotide | 400.41 | 550.00 | 475.21 |
| 1305 | C1305 | Apligraf | 659.55 | 1,077.57 | 868.56 |

We note that we also received external data for other items, which we did not use for rate setting. In those cases, we determined the data was not reliable because the data did not meet the preferred criteria set forth in the August 12, 2003 proposed rule.

*Comment:* One commenter raised a concern about our proposal to limit reductions in the median costs of non-pass-through drugs and biologicals to one-fourth of the difference between the actual decline and 15% less than the 2003 adjusted median. While expressing support for an initiative that reduces significant fluctuation in APC payment rates from one year to the next, the commenter expressed uncertainty about the size of the reduction limitation and suggested that CMS consider a less generous dampening approach since the budget-neutral dampening would negatively affect other APCs.

*Response:* While we believe that a general limitation on reductions in payments for certain drugs and biologicals is warranted for reasons discussed elsewhere in this final rule, we also recognize the commenter's concerns about the effect that such a policy would have on other APCs. We have decided to address the commenter's concern by placing an upper limit on adjustments to the median costs used to calculate the 2004 payment rates. We believe that it is reasonable to place such an upper limit on the dampening so that the resulting adjusted median is no greater than 95 percent of AWP or the 2004 unadjusted median. We reviewed the drugs, biologicals, and radiopharmaceuticals whose median costs decreased by more than 15 percent from 2003 to 2004. We then compared the adjusted median (after dampening) to 95 percent of AWP for each of the items. In cases where 95 percent of AWP was higher than the adjusted median, we capped the adjusted median at a value that was the higher of 95 percent of AWP or the 2004 unadjusted median. The 95 percent of AWPs for these drugs and radiopharmaceuticals were calculated using AWP values from the Redbook that were effective as of April 1, 2003. We reviewed the drugs, biologicals, and radiopharmaceuticals whose median costs decreased by more than 15 percent from 2003 to 2004. We then compared the adjusted median (after dampening) to 95 percent of AWP for each of the items. In cases where 95 percent of AWP was higher than the adjusted median, we capped the adjusted median at a value that was the higher of 95 percent of the AWP or the 2004 unadjusted median. The drugs, biologicals, and radiopharmaceuticals affected by this policy are listed in the table below.

TABLE 13.—ITEMS WHOSE 2004 ADJUSTED MEDIANS ARE CAPPED AT THE HIGHER OF 95 PERCENT OF AWP OR THEIR 2004 UNADJUSTED MEDIAN

| APC | Description | 2004 adjusted median | 95% AWP | 2004 unadjusted median |
|---|---|---|---|---|
| 1095 | Technetium TC 99m depreotide | $216.26 | $40.00 | $17.18 |
| 0820 | Daunorubicin | 89.80 | 78.14 | 65.81 |
| 0961 | Albumin (human), 5%, 50 ml | 41.86 | 15.31 | 16.15 |
| 0963 | Albumin (human), 5%, 250 ml | 204.03 | 58.00 | 62.83 |
| 0964 | Albumin (human), 25%, 20 ml | 46.10 | 15.31 | 21.86 |
| 0965 | Albumin (human), 25%, 50 ml | 114.36 | 30.63 | 51.12 |

4. Payment for Drug Administration

In order to facilitate accurate payments for drugs and drug administration, we considered whether to make several changes in our current payment policy with regard to payment for Q0081, Q0083, Q0084, and Q0085.

We proposed to continue our current policy of packaging drugs and radiopharmaceuticals that cost less than $150 per episode of care into the APC with which they are associated (for example, nuclear medicine scans, drug administration).

In the proposed rule, we presented data that showed that paying based on a median cost for the APC for each of the four current codes generally results in underpayment when packaged drugs are billed on the claim and overpayment when separately paid drugs are billed on the claim. In the proposed rule we discussed our data analysis in detail. We also discussed four alternatives to the current codes and APC payments in detail (68 FR 47999–48003). In summary, the 4 alternatives presented were:

1. Maintain the current codes and APCs with payments based on the median costs of all claims in the APC.

2. Eliminate the four current codes and create eight new codes to enable hospitals to report that they administered a packaged drug or a separately paid drug. We would pay a different APC amount for each of the eight new codes. The new code descriptors would parallel those of the current codes. This would retain the concept of using one code rather than two when both ''infusion'' and administration of chemotherapy by ''other than infusion'' occurred (as exists under the current codes). Coders would have to look up the drugs administered to know which code to bill.

3. Eliminate the four current codes and create six new codes to enable hospitals to report that they administered a packaged drug or separately paid drug and pay a different APC amount for each of the six new codes. In this option, no code equivalent to Q0085 would exist. Therefore, when administering chemotherapy by ''infusion'' or ''other than infusion,'' hospitals would report two codes, one for administration by ''infusion'' and one for administration by ''other than infusion.'' This would eliminate the need to use one code when both infusion and another method of administration of chemotherapy occurred. Coders would have to look up the drugs administered to know which code to bill.

4. Retain three of the current codes (Q0081, Q0083, and Q0084) but delete Q0085 (infusion and other administration of chemotherapy) and modify the OCE to use the drugs billed on the claim to assign an APC for packaged drugs or an APC for separately paid drugs. No drug administration code could be paid without a drug also being reported on the claim. We solicited comments on each of the options in the proposed rule.

For 2004 OPPS we will continue the use of Q0081, Q0083 and Q0084 to pay for drug administration, for both packaged drugs and separately paid drugs. These drug administration codes will continue to describe the administration of drugs per visit. As recommended by the APC Panel, we will cease to make payment under OPPS for Q0085 and will instead permit the services described by Q0085 to be billed using both Q0083 and Q0084. We believe that this will result in appropriate payment for drug administration because for 2004 OPPS we will pay separately for drugs for which the per day median cost is in excess of $50 per day.

*Comment:* Commenters stated that appropriate payment for drug administration is very important but the options provided for making changes would be extremely burdensome and cannot be done for 2004, if ever. They indicated that the risk of incorrect coding and the adverse consequences of incorrect coding for options 2, 3 or 4 are severe and that the payment changes do not justify the change in codes or policy. Commenters indicated that options 2–4 would increase operational costs that would eliminate any benefit from higher payments; decrease accuracy of coding for drug administration; increase improper payments due to decreased accuracy of coding; increase inaccuracies in claims data due to decreased accuracy of coding. The commenters indicated that they believe that there were many errors in the addenda (Addenda L, M, N, O, P, and Q) in the proposed rule that would be used for option 4 and that it would be virtually impossible to create mutually exclusive lists of drugs as would be required to implement option 4.

Commenters indicated that they believed the options as presented in the NPRM would violate the HIPAA requirements that the same service be coded the same way for all payers. They urged CMS to eliminate the Q codes for drug administration and in favor of use of the CPT codes to code drugs administration. Commenters asked that CMS engage the APC Panel in a discussion of the best way to code drug administration.

One of the commenters indicated that its analysis showed that options 2, 3 or 4 have considerable financial risk for Medicare. Specifically, the commenter indicated that its analysis revealed that option 2 would result in additional payments of $107.1 million for 2004. A commenter asked that CMS create a task force to study the most appropriate methodology for payment for drug administration and for setting payment rates. A commenter supported option 4, which would continue the current coding and map the combination of a drug administration code and drug codes to the appropriate APC. One commenter suggested that we continue the current coding for drug administration, set payment rates at the packaged drug rate for the APC but offset the payment by the difference if no appropriate drug is billed for the same date of service. The commenter indicated that this would simplify the coding and the payment for drug administration and should result in greater accuracy of payment. A commenter supported options 2 or 3 as the most accurate for payment of drugs furnished in the emergency department.

*Response:* For the reasons discussed earlier in this section, for 2004, CMS will continue use of Q0081, Q0083 and Q0084. Q0085 will not be recognized as a valid OPPS code for 2004. Instead, when a hospital furnishes chemotherapy infusion and chemotherapy via another route, the hospital will bill and be paid for both Q0083 and Q0084. Coding for drug administration is discussed in greater detail below in the context of other comments.

As discussed in elsewhere in this final rule, for 2004, CMS will pay separately for all drugs, biologicals and radiopharmaceuticals that have a per day median cost in excess of $50. Therefore, only drugs, biologicals and radiopharmaceuticals that have a per day median cost of $50 or less will be packaged into the payment for the services. Therefore, the payment for drug administration codes Q0081, Q0083 and Q0084 will be based on the median costs for drug administration with only drugs having a median per day cost of $50 or less packaged into the cost of the administration code. We believe that separate payment for drugs with a median cost in excess of $50 will result in the drug administration codes being paid more accurately and will result in more equitable payment for both the drugs and their administration.

*Edits To Ensure Correct Billing for Drugs*

*Comment:* A commenter asked that CMS create a series of edits in the OCE that would facilitate the collection of better data on drug costs and drug administration. Specifically, the commenter wants the OCE to edit out claims where a drug administration code is billed with no drug code on the claim; where a chemotherapy drug administration code is billed with a revenue code 25X and no specific HCPS code; and where multiple units of a drug administration code are billed on the same line.

*Response:* We will consider what edits may be appropriate for inclusion in the OCE with regard to drug administration to facilitate collection of better data. However, we are concerned that edits of the type requested by the commenter may both impose greater billing burden on hospitals and create complexities that could delay claims processing.

*Discounting of Non-Chemotherapy Administration*

*Comment:* Commenters indicated that no multiple procedure reduction should be applied to Q0081 (infusion of drugs other than chemotherapy) or its successor codes under any of the options. They indicated that payment is already too low to cover the cost of the infusion and that reducing it further when there are more costly procedures on the claim will only further under pay the service.

*Response:* We have retained the status indicator of ''T'' for Q0081. This status indicator means that the code will be reduced by 50 percent if it is the lower priced service on the same claim with another procedure with the status indicator ''T''. In most cases, we expect that this reduction would occur when there is a separate procedure performed on the same day as the infusion and that there will be significant efficiencies in administering an infusion. If the infusion is performed by itself or with a visit, or with a service with status code ''S'', the multiple procedure reduction will not apply.

*Payment for Drug Administration on a Per Day Versus a Per Visit Basis*

*Comment:* Commenters indicated that it would be incorrect to revise the definition of the drug administration codes to be per day instead of per visit, as they are currently defined. They referred to many cases in which it is necessary for a patient to have more than one administration of non-chemotherapy drugs in a day and that hospitals should be able to bill multiple units of the applicable code when that occurs. They noted that the APC Panel supported this view with regard to Q0081, infusion of non-chemotherapy drugs. They asked that CMS provide explicit instructions regarding billing for drug administration and ensure that fiscal intermediaries are bound to comply with the national instructions. One commenter asked that CMS create modifiers or specific HCPCS codes to reflect administration of multiple chemotherapy agents during a single session and that CMS permit payment for more than one chemotherapy administration on the same day of service, with a new modifier to reflect truly separate administrations.

*Response:* We acknowledge the commenters' concerns about our proposal to change the drug administration codes from a per visit basis to a per day basis and have not revised the definition of the drug administration codes from per day to per visit.

*CPT Codes for Drug Administration*

*Comment:* Many commenters suggested that CMS should delete the HCPCS alphanumeric codes for drug administration and should use existing CPT codes. They indicated that the APC Panel supports this change and that it would be less burdensome for providers than using the HCPCS alphanumeric codes. One commenter presented a crosswalk that could be used to pay under the current drug administration APCs while permitting hospitals to bill using CPT codes. A commenter indicated that hospitals already maintain start and stop times for infusion therapies and that, therefore, the use of CPT codes for infusion would not be more burdensome than the current HCPCS codes.

*Response:* For the reasons discussed earlier in this section, for 2004 OPPS, administration of infusion of non-chemotherapy drugs, infusion of chemotherapy drugs and administration of chemotherapy by other than infusion, will continue to be billed and paid based on Q0081, Q0083 and Q0084. However, we take seriously the requests of the commenters and the APC Panel that we should use the CPT codes to pay for drug administration. We will seriously consider the crosswalk submitted and will discuss it with the APC Panel at its winter meeting. We also will pursue a means by which the existing data from 2003 hospital claims, which exist only for the Q codes, which are per visit, can be used to pay for services billed under the CPT infusion codes, which are on a per hour basis.

*Elimination of Q0085 Chemotherapy Administration by Both Infusion and Other Technique*

*Comment:* Several commenters supported elimination of Q0085 and the continued use of Q0083 and Q0084 in place of Q0085.

*Response:* As indicated above, we will no longer recognize Q0085 for payment of drug administration services for 2004. The code could not be deleted from HCPCS because the 2004 HCPCS was complete before the NPRM comment period closed. Instead, hospitals will bill and be paid for both Q0083 and Q0084 when they furnish chemotherapy by both infusion and another route.

*Charge Compression Reduction Through Revenue Code Requirements and Expansion of Revenue Codes*

*Comment:* A commenter indicated that CMS could reduce charge compression effects by requiring hospitals to do detailed coding of drugs using the most specific categories of revenue codes. The commenter indicated that CMS would also need to create additional revenue codes to collect more specific information. The commenter indicated that collection of drug charge information at such detailed levels would both reduce charge compression and give CMS more information when determining which drugs to package to specific drug administration services.

*Response:* CMS will not require that specific revenue codes be used for drugs and will not ask the National Uniform Billing Committee to create additional revenue codes to collect more specific information. Revenue codes exist for hospital accounting purposes and, in general CMS does not require that particular services be billed with particular revenue codes. We are not convinced that adding specific requirements for revenue coding or expanding the revenue codes to acquire more specific information will result in better data or that the end result would be cost effective in terms of its potential effect on hospital operations. We believe that such requests to the NUBC should be generated by the provider community if it believes such changes would be in their overall best interest.

*Request for Clarification of Instructions*

*Comment:* Commenters said that CMS needs to develop and issue clear national instructions on how drug administration in the OPD should be billed and to ensure that fiscal intermediaries all comply uniformly with the instructions. They said that in the absence of national instructions,

fiscal intermediary medical directors have developed and enforced local medical review policies that vary considerably from one another, resulting in very different interpretations of how services should be billed and of the amount of payment for the same set of circumstances. They specifically recommend that we address issues including how often drug administration codes can be billed in a day, billing for piggyback infusions, how to bill units of service, billing for pain control pump services, double infusions, and use of chemotherapy administration codes for patients with non-cancer diagnoses. The commenter also asked for clarification of the use of 90782 (IM injection) and 90784 (IVP injection) when used for sedation before surgery, Q0081 when used to keep a vein open, and Q0083 with regard to whether it should be billed each time a chemotherapy drug is administered. A commenter also asked that CMS clarify whether HCCPS codes Q0081, Q0083, Q0084 and Q0085, CPT codes 90783, 90784 and 90788 may be billed more than once per visit. The commenter indicated that CMS previously said that CPT codes 90782–90788 may be billed separately for each injection and asked if this is a change to CMS policy in this regard.

*Response:* CMS will develop program instructions regarding how the drug administration codes should be used. We will attempt to address the specific questions identified in the comments in the course of developing those instructions. When the instructions are issued, they will be binding on all Medicare fiscal intermediaries under their contract with CMS. In the absence of national instructions, Medicare fiscal intermediaries have authority to develop local medical review policies governing billing, coverage and payment.

With regard to the issue of how often in a day Q0081, Q0083 and Q0084 may be billed, each of these codes is to be used to report all services in a single visit, regardless of the number of drugs administered during that visit. Therefore, if two chemotherapy drugs are administered by intravenous injection and 3 chemotherapy drugs are administered by infusion, the hospital would bill 1 unit of Q0083 and 1 unit of Q0084. A second unit of either code would only be billed if the patient left the OPD after completion of the first administration and then returned later for a separate encounter for administration of another chemotherapy drug. If the patient leaves the OPD and returns later in the day suffering from dehydration and requires infusion of fluids and infusion of antiemetics, the hospital would bill Q0081 for those services. If the patient returns later in the same day for another infusion of one or more chemotherapy drugs that could not be administered at the earlier infusion for medical reasons, the hospital may bill 2 units of Q0084.

CPT codes 90782–90788 each represent an injection and as such, one unit of the code may be billed each time there is a separate injection that meets the definition of the code.

As indicated above, drugs for which the median cost per day is greater than $50 are paid separately and are not packaged into the payment for the drug administration codes with which they are billed. *See* Addendum B for the 2004 OPPS payment amount for separately paid drugs, which are indicated with both payment amounts and status indicator ''K.''

*Proposed Payment Rates for Drug Administration*

*Comment:* Commenters indicated that the proposed payment rates for drug administration are too low to adequately compensate hospitals for the costs of packaged drugs. They indicated that there is some confusion over the resultant decrease in drug administration medians after low cost drugs ($50–$150) were packaged into the drug administration codes. The expectation was that the addition of the drug costs would result in increases. Moreover, they stated that the payment rates for drug administration services that include drugs that cost $50 to $150 per day, are so low that none of the rates are adequate to cover cases for which multiple drugs of $100 each are administered.

A commenter who is particularly concerned with immunosuppressive drugs that are needed by beneficiaries following organ transplants, indicated that in 2000, Congress directed the Secretary of HHS to prepare a report to Congress containing recommendations regarding a cost effective way of providing coverage for immunosuppressive drugs to promote the objectives of improving health outcomes by decreasing transplant rejection rates attributable to failure to comply with immunosuppressive drug therapy and to achieve Medicare cost savings by preventing the need for secondary transplants and other care related to post transplant complications (Pub. L. 106–113). The commenter believes that packaging transplant drugs into the payment for drug administration and the proposal of such a low amount of payment defeats Congress's stated intention in this case and will decrease beneficiary access to immunosuppressive drug therapy following transplant surgery.

*Response:* We believe that making separate payment for both the procedure and drugs for which there is a median per day cost in excess of $50, will result in appropriate payment for the procedure with which the drug is billed. In the case of the HCPCS codes for administration of drugs per visit (Q0081, Q0083 and Q0084), compared to the proposed payments published in the NPRM, payments for the procedures do not decline by much when calculated without packaged drugs that have medians of $50 to $150. Therefore, we believe that total payments will be more appropriate for these drugs in 2004.

With respect to post-transplant immunosuppressive drugs, we would note that take-home supplies of such drugs are billed to the Durable Medical Equipment Regional Carriers and paid for separately outside of the OPPS. To the extent that such drugs fall below the $50 median cost per day, we expect the frequency of administration in the hospital outpatient setting to be low.

*Coding for Drugs*

*Comment:* A trade association representing drug manufacturers supported our proposal to require hospitals to report individual codes for all drugs, including those that are packaged, on the grounds that it would improve the quality of our data. Most commenters representing hospitals and hospital associations opposed the proposal. They indicated that the operational impact on hospitals would be significant, if we were to implement such a requirement. It would take a year or more to update chargemasters and train staff, and many more codes would have to be established for drugs that are administered but not identified in the current HCPCS. Hospitals and hospital groups did not support detailed reporting of routine, low cost drugs and supplies that are currently reported only using a packaged revenue code. A commenter stated that if CMS were to choose to require drug and/or device coding, CMS should give hospitals at least a year to prepare to implement the requirement and work with hospitals to identify all drugs and devices that would require codes, develop HCPCS codes with dosage descriptions that match the administered or purchased dose, assign HCPS to all administered drugs, clarify reporting of self-administered drugs and drugs considered integral to a procedure under OPPS, and identify applicable drugs and devices in hospital

chargemasters. Commenters indicated that the use of ''unclassified drugs'' and ''unclassified biologicals'' would increase if hospitals are required to bill all drugs and that such a requirement would result in less reliable data for CMS at great cost to hospitals, with no measurable benefit. Some commenters indicated that the use of unclassified codes would create significantly more work for hospital staff and Medicare contractors. One commenter was concerned that this requirement would force hospitals to contort internal ordering and billing systems in order to match HCPCS codes to unrelated packaged dosage amounts, thereby significantly increasing the potential for error in the administration of drugs and putting patient safety at risk.

*Response:* Because we are not implementing any of the new drug administration coding requirements that we proposed, the need for more detailed drug coding is removed. Therefore, we are not requiring hospitals to report with a HCPCS code every drug that is administered to a patient. However, in order to receive payment for a drug for which a separate payment is provided, hospitals will have to continue to bill for the drug using revenue code 636, ''Drugs requiring detail coding,'' and report the appropriate HCPCS code for the drug. Drugs for which separate payment is allowed are designated by status indicator ''K'' in Addendum B. Hospitals should continue to bill for packaged drugs, which are assigned status indicator ''N,'' using any of the drug revenue codes that are packaged revenue codes under the OPPS: 250, 251, 252, 254, 255, 257, 258, 259, 631, 632, or 633. Hospitals are not required to use HCPCS codes when billing for packaged drugs, unless revenue code 636 is used. Although we are not requiring hospitals to report HCPCS codes for packaged drugs, it is essential that hospitals continue to bill charges for packaged drugs by including the charge for packaged drugs in the charge for the procedure or service with which the drug is used, or as a separate drug charge (whether or not it is separately payable). Reporting charges for packaged drugs is critical because packaged drug costs are used for calculating outlier payments and are also identified when we calculate hospital costs for the procedures and services with which the drugs are used in the course of the annual OPPS updates.

*Comment:* Several commenters recommended that CMS establish a unique revenue code for radiopharmaceuticals that hospitals would be required to use when reporting all radiopharmaceuticals, whether packaged or separately payable. They indicated that establishing a unique revenue code would assist CMS in tracking costs for the radiopharmaceuticals and contribute to more accurate cost data collection.

*Response:* We do not establish revenue codes. Rather, the National Uniform Billing Committee (NUBC) receives and considers such requests from multiple sources, including providers and other members of the public. While we continue to examine cost-to-charge and cost compression issues, we will consider whether such an approach would assist CMS in refining our methods of establishing relative weights. We would also note that the commenters and other interested parties may also request that the NUBC consider the creation of new revenue codes.

*Comment:* Several commenters expressed concern about the frequent coding changes implemented for radiopharmaceuticals over the past two years. They recommended that CMS revise the HCPCS coding descriptors for products that do not currently have ''per dose'' or ''per study'' descriptors to reflect the products as they are administered to the patient. They emphasized that creating these new descriptors and corresponding payment rates will improve data collection and help to ensure equitable payment to hospitals.

*Response:* We recognize the concerns expressed by these commenters. However, we are striving to achieve stability in descriptor changes, and we believe that in changing descriptors to ''per dose'', we will lose specificity with respect to the data we will receive from hospitals. We are not convinced that there is a programmatic need to change the radiopharmaceutical code descriptors to ''per dose'' and that our claims data are problematic for setting payment rates for these products; however, we will continue to work with industry representatives to ensure that the current HCPCS descriptors are appropriate and review this issue in the future, if needed. Furthermore, we stress the importance of proper coding by providers so that we can get accurate data for future rate setting.

*Comment:* One drug manufacturer urged CMS to advise hospitals that it is appropriate for them to set charges for drugs submitted to Medicare for OPPS services so that the charges reflect actual product costs when charges are multiplied by hospital and cost-center-specific ratios of cost-to-charges. The commenter also requested CMS to not rely on data obtained in the absence of such advice. A comment from a national hospital organization, however, advised CMS to permit hospitals to continue to establish their charge structures and mark-up policies separate and apart from CMS's payment policies. The commenter indicated that only in this manner would prospective payments appropriately reflect general trends in charges and mark-ups across all hospitals.

*Response:* We do not regulate what hospitals charge for hospital services and will not advise hospitals regarding how to determine the charge for an item or service. Hospital charges have fundamental uses and the use of charges to determine relative costs for OPPS should not be the determining factor in how a hospital sets its charge for any item or service. The OPPS is a system based upon the relative costs of services and these costs are developed by applying the hospital's most recent cost to charge ratio to the charges of the hospital for the item. While we recognize that the system is imperfect, we believe that on average, it results in appropriate relative weights. However we recognize that on occasion, this is not true and therefore, as discussed elsewhere, we have used external data where we believe that the median derived from claims data does not appropriately reflect the relative cost of the item or service.

*Comment:* One commenter requested that we change the status indicator for HCPCS code J7599 (Immunosuppressive drug, not otherwise classified) from ''E'' to ''N'' so that new immunosuppresives can be identified on claims forms as a separate line item until a unique pass-through ''C'' code can be assigned to the product.

*Response:* We agree that the status indicator for J7599 should be ''N'' and have made that change for CY 2004. As for other new drugs and biologicals, interested parties may submit an application for pass-through status for new immunosuppressives.

*Coding for Drugs Billed as Supplies*

*Comment:* Commenters said that CMS significantly complicated the issue of billing for drugs when it indicated that drugs that are an integral part of the procedure should be billed as supplies (revenue code 270) rather than as pharmaceuticals (revenue code 250).

*Response:* We did not issue instructions to require that drugs that are an integral part of a surgical procedure be billed using revenue code 270 (supplies) rather than revenue code 250 (pharmaceuticals). Rather, we instructed hospitals to report drugs that are treated as supplies because they are

an integral part of a procedure or treatment under the revenue code associated with the cost center under which the hospital accumulates the costs for the drugs. (See section XXIV.D of Transmittal A–02–129, issued on January 3, 2003.)

In general, supplies that are an integral component of a procedure or treatment are not reported with a HCPCS code. The charges for such supplies are typically reflected either in the charges on the line for the HCPCS for the procedure or on another line with a revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.

*Correct Coding Initiative Edits*

5. Generic Drugs, and Radiopharmaceuticals

In general, hospital acquisition costs for drugs, biologicals, and radiopharmaceutical agents with generic competitors are lower than the acquisition costs for sole source or multi-source drugs. In order to ensure that Medicare recognizes these lower costs in a timely manner, we proposed a new method of calculating payment amounts for drugs, biologicals, and radiopharmaceuticals that are separately paid under the OPPS and for which the Food and Drug Administration (FDA) has recently approved generic alternatives.

Because many hospitals have long term purchasing arrangements for drugs and radiopharmaceuticals, we believe that there is generally a 12-month lag between the time that generic items are made available and when our claims data will accurately reflect the costs associated with the availability of the generic alternative. Therefore, during the interval between FDA approval of a generic item and the time when we would reasonably expect claims data to reflect the cost of generic alternatives, we proposed to adopt the following methodology to price the affected drugs, biologicals, and radiopharmaceuticals under the OPPS.

We proposed to identify items approved for generic availability by the FDA during the 6 months before the first day of the claims period we use as the basis for an annual OPPS update. Where we determine that our claims data do not reflect the costs of generic alternatives for a separately payable drug, biological, or radiopharmaceutical, we proposed to base our payment rate on 43 percent of the AWP for the drug, biological, or radiopharmaceutical.

To apply this payment methodology to the 2004 OPPS update, we reviewed FDA approvals for generic drugs, biologicals, and radiopharmaceuticals issued between October 2001 and December 2002. We found six drugs, which we proposed to be separately paid under the 2004 OPPS that had generic alternatives approved during that time. These drugs are: Daunorubicin, Bleomycin, Pamidronate, Paclitaxel, Ifosfomide, and Idarubicin. Table 21 shows the dates when the FDA approved generic alternatives for these drugs.

We solicited comments on this proposed method of calculating payment for drugs, biologicals, and radiopharmaceuticals for which generic alternatives have recently been approved. Specifically, we were interested in comments concerning our proposed methodology for identifying these items, whether we properly identified all the items, and whether our proposed payment policy for these generic alternatives is appropriate.

We received many comments on our proposal regarding generic drugs and radiopharmaceuticals, which are summarized below along with our responses.

*Comment:* One commenter applauded CMS's efforts to lower payment for generic products to an amount more closely aligned with hospital acquisition cost. However, the commenter indicated that payment for generic cancer products would continue to be excessive and contribute to an environment where hospitals may offer treatments using less effective chemotherapy products. Alternatively, comments from a national hospital association and numerous manufacturers stated that the presence of generic alternatives in the market does not necessarily result in cost savings for hospitals. They indicated that established multi-year contracts may prevent providers from switching immediately to generic alternatives. As a result, providers would not realize any cost savings from buying the generic products until the conclusion of their existing contract, which in some cases may be a few years after the generics are available in the market. Commenters also indicated that it is quite common for shortages of generic equivalents to occur when they first appear in the market. Thus, there is no guarantee that sufficient quantities of generic alternatives will be available in the marketplace for all providers to purchase them. Furthermore, adoption of generic drugs by hospitals is also affected by whether the providers determine they are safe to use in comparison to the brand name products. One commenter recommended that CMS continue to use its 2002 claims data to set the payment rated for these drugs.

*Response:* We appreciate these insightful comments and agree with the commenters that the time it takes for hospitals to realize cost savings (or price decreases) from purchasing generic products is longer than we initially expected because of the various reasons described by the commenters. Further research on this issue also shows that cost savings due to competition between generic and name brand drugs can vary. One reason is that in some cases regulations allow the first generic marketed to compete with a name brand drug to have a period of exclusivity during which time no other generics may come on the market. This period of exclusivity may mean that cost savings during this period of exclusivity are less than cost savings that occur once more than one generic is put on the market. For 2004, we believe that calculating payment rates for generics according to the methodology discussed above would not sufficiently take into consideration the true costs incurred by hospitals for purchasing generic products. Therefore, we believe that it is appropriate to calculate the payment rates for generics according to the same methodology used for other separately payable drugs and radiopharmaceuticals.

6. Orphan Drugs

In the proposed rule we stated that we no longer believe that paying for orphan drugs at reasonable cost, outside of OPPS is appropriate, and we proposed the following payment policy:

- We proposed to continue using the same criteria to identify single indication orphan drugs (67 FR 66772).
- We proposed to discontinue retrospective cost payments and to make prospective payments under the OPPS for those identified single indication orphan drugs.
- We proposed to base payments on the same methodology we use to pay for other drugs including any limitation on payment reductions (as described above).
- We proposed to make separate payment for the single indication orphan drugs and place them in APCs.

The 11 single indication orphan drugs that would be affected by our proposal are: (J0205 Injection, alglucerase, per 10 units; J0256 Injection, alpha 1-proteinase inhibitor, 10 mg; J9300 Gemtuzumab ozogamicin, 5 mg; and J1785 Injection, imiglucerase, per unit); J2355 Injection, oprelvekin, 5 mg; J3240 Injection, thyrotropin alpha, 0.9 mg;

J7513 Daclizumab parenteral, 25 mg; J9015 Aldesleukin, per vial; J9160 Denileukin diftitox, 300 mcg; J9216 Interferon, gamma 1–b, 3 million units; and Q2019 Injection, basiliximab, 20 mg.

We solicited comments on these proposals and requested that commenters submit information meeting the same criteria as comments for other drugs (as discussed above). We received numerous comments, all of which were in opposition to our proposals regarding payment for orphan drugs.

*Comment:* Every commenter who commented on the changes we proposed regarding payments for single indication orphan drugs opposed our proposal to discontinue payment for orphan drugs on a reasonable cost basis and to instead use the same methodology to set payment amounts for the single indication orphan drugs that we use to set rates for other drugs. Commenters stated that doing so would create serious access problems for patients who rely on an orphan drug for treatment of a rare disease because hospitals would no longer be able to afford to treat them. A number of commenters were particularly concerned by the decreased payment rate proposed for alpha-1-proteinase inhibitor. Some pointed out that the data we used to calculate payments for orphan drugs are especially flawed because of the low volume, high cost characteristics of orphan drugs, complicated by errors in the way hospitals bill for drugs generally. Recommendations from commenters included: applying the dampening rule to limit decreases to 10% of reasonable cost payments in 2003; establishing a payment floor; and, continuing to pay for orphan drugs on a reasonable cost basis.

*Response:* We carefully reviewed commenters' concerns about the impact our proposal would have on patient access to orphan drugs. We do not dispute that orphan drugs used solely to treat an orphan condition are generally expensive and, by definition, are rarely used. We also recognize that coding changes may have resulted in questionable billing data. However, we believe that it is important to balance these concerns with maintaining a consistent payment system for hospital outpatient department services overall, and to limit to the maximum possible extent payment for services or items outside the OPPS. We also discussed in the August 12 proposed rule our concerns about the increased number of drugs that meet our criteria for special payment status as single indication orphan drugs and the resulting increase in the number of hospital outpatient services that would be paid outside the OPPS were we to continue to pay for these drugs on a reasonable cost basis. It was in light of these factors that we proposed to discontinue payment for single indication orphan drugs on a reasonable cost basis outside the OPPS and to use our claims data as the basis for setting payment rates for those drugs that we have identified as meeting our criteria for special payment status as single indication orphan drugs. We also proposed to pay separately for the single indication orphan drugs and to assign each of them to an APC.

Having weighed the concerns raised by commenters and our concerns about the increasing number of outpatient services that would be paid outside the OPPS were we to continue the current policy of paying for single indication orphan drugs on a reasonable cost basis, we have decided that beneficiaries, hospitals, and the Medicare program will be best served over the long term by our making payment for the single indication orphan drugs under the OPPS at 88 percent of the AWP. We arrived at 88 percent based on our analysis of claims data, and our intent that payment be sufficient to ensure that all beneficiaries have access to needed drugs. Among the 11 orphan drugs, the highest median cost in the claims data was approximately 78 percent of the AWP. After considering comments we received on the proposed rule, we were concerned that merely adopting the existing highest percentage of the AWP may not ensure that a sufficient payment amount is established in all cases prospectively. We therefore have provided for an additional margin of ten percentage points to account for possible future increases, and ensure sufficient payment. This results in the percentage of 88 percent that we have adopted in this final rule.

However, we received information consistent with our request for verifiable data (68 FR 47998) that indicates the payment amounts we proposed for alpha-1 proteinase inhibitor, for imiglucerase, and for alglucerase do not reflect the price at which these drugs are widely available to the hospital market. This information, combined with the concerns expressed by commenters generally that the payment amounts we proposed for the 11 drugs that meet our criteria for special payment as single indication orphan drugs are too low and may threaten beneficiary access to the drugs, have persuaded us to make final one modification to the method we proposed for setting payment rates for drugs that are paid as single indication orphan drugs under the OPPS. That is, rather than using claims data to calculate payment rates for single indication orphan drugs that meet our criteria for special payment under the OPPS, we are setting payment for all but two of these drugs at 88 percent of their AWP as established in the April 1, 2003 single drug pricer (SDP). As discussed above, we received information about the widely available market price for imiglucerase and alglucerase, and, based on that information, we have priced these two drugs at 94 percent of their AWP.

We believe that this policy is a reasonable compromise. It enables us to set a prospective payment amount under the OPPS for qualified single indication orphan drugs. But, by increasing payment levels for these low volume drugs, we minimize the risk of compromising beneficiary access to treatment for life-threatening, rare diseases.

Therefore, we have set payment rates for single indication orphan drugs in accordance with the following policy, effective January 1, 2004:

- We are using the same criteria that we implemented in CY 2003 to identify single indication orphan drugs used solely for an orphan condition for special payment under the OPPS;
- We are discontinuing payment on a reasonable cost basis for single indication orphan drugs furnished in the outpatient department of hospital that is subject to the OPPS;
- We are making separate payment for single indication orphan drugs and assigning them to APCs;
- We are setting payment under the 2004 OPPS for single indication orphan drugs at 88 percent of the AWP listed for these drugs in the April 1, 2003 single drug pricer unless we are presented with verifiable information that shows that our payment rate does not reflect the price that is widely available to the hospital market.

*Comment:* Several commenters objected to our special treatment for only 11 orphan drugs, rather than including all of the drugs that the FDA designates as having orphan status. A few commenters recommended that we set the criteria for special treatment based on claims volume instead of our current criteria. That is, CMS would set a criterion for ''high volume'' drugs based on a threshold of 30,000 or more claims per year. Then, any FDA-designated orphan drug with less than the threshold volume of claims would be subject to special payment under the OPPS as an orphan drug.

*Response:* Using the statutory authority at section 1833(t)(1)(B)(i) of

the Act, which gives the Secretary broad authority to designate covered OPD services under the OPPS, we have established criteria which distinguish these 11 drugs from other drugs designated as orphan drugs by the FDA under the Orphan Drug Act. Our determination under this authority to provide special payment for a subset of FDA-designated orphan drugs does not affect FDA's classification of drugs under the Orphan Drug Act. Because these 11 drugs have a low volume of patient use, lack other indications, and have no other source of payment, we allow special treatment of them so beneficiaries can continue to have access to them. Because these 11 drugs are used solely to treat an orphan condition that affects a relatively low number of beneficiaries, hospitals receive payment for a low volume of cases by definition, and the cost of the drug is not spread across other uses. We are concerned that if we were to adopt the commenter's recommendation that we qualify all FDA-designated orphan drugs under a particular volume threshold for special payment under the OPPS, we could be expanding this special payment provision, which is meant to target the small number of orphan drugs that are used solely to treat rare diseases, to drugs that are used for other conditions and indications, for which hospitals would also be receiving payment. Therefore, we are not adding a volume threshold to our criteria for identifying orphan drugs that receive special payment under the OPPS in 2004.

7. Vaccines

Outpatient hospital departments administer large amounts of the vaccines for influenza (flu) and pneumococcal pneumonia (PPV), typically by participating in immunization programs. In recent years, the availability and cost of some vaccines (particularly the flu vaccine) have fluctuated considerably. As discussed in the November 1, 2002 final rule (67 FR 66718), we were advised by providers that OPPS payment was insufficient to cover the costs of the flu vaccine and that access of Medicare beneficiaries to flu vaccines might be limited. They cited the timing of updates to OPPS rates as a major concern. They said that our update methodology, which uses 2-year-old claims data to recalibrate payment rates would never be able to take into account yearly fluctuations in the cost of the flu vaccine. We agreed and decided to pay hospitals for influenza and pneumococcal pneumonia vaccines based on a reasonable cost methodology. As a result of this change, hospitals, home health agencies (HHAs), and hospices were paid at reasonable cost for these vaccines in 2003. We are aware that access concerns continue to exist for these vaccines; therefore, we proposed to continue paying for influenza and pneumococcal pneumonia vaccines under reasonable cost methodology.

We received no comments regarding our payment proposal for vaccines, and finalize our proposal in this rule.

8. Blood and Blood Products

Since the OPPS was first implemented in August 2000, separate payment has been made for blood and blood products in APCs rather than packaging them into payment for the procedures with which they were administered. We proposed to continue to pay separately for blood and blood products.

The list of APCs containing blood and blood products can be found in the November 1, 2002 final rule (67 FR 66750). We note that the APCs for these products are intended to make payment for the costs of the products. Costs for storage and other administrative expenses are packaged into the APCs for the procedures with which the products are used.

As described in the November 1, 2002 final rule (67 FR 66773), we applied a special dampening option to blood and blood products that had significant reductions in payment rates from 2002 to 2003. For 2003, we limited the decrease in payment rates for blood and blood products to approximately 15 percent.

After careful comparison of the 2003 dampened medians with the 2004 medians from our claims data, we determined that establishing payment rates based on the 2004 median costs would, for many blood and blood products, result in payments that are significantly lower than hospital acquisition costs. In order to mitigate any significant payment reductions and to minimize any compromise in access of beneficiaries to these products, we proposed a 10 percent limit to decreases in payment rates for blood and blood products from 2003 to 2004.

We solicited comment on this proposal, especially from hospitals. Specifically, we solicited comments that include verifiable information about the widely available acquisition cost of commonly used blood and blood products.

We received several comments on this proposal, which are summarized below along with our responses.

*Comment:* Several hospital groups supported the recommendation made by the APC Panel at its August 22, 2003 meeting and urged us to consider freezing 2004 payment rates for blood and blood products at the 2003 levels. A few commenters recommended that CMS use data provided by suppliers of blood and blood products to help set payment rates for 2004. Two commenters stated that major blood organizations are prepared to share the data for verification with CMS. Another commenter recommended that CMS base payments on either reasonable cost or external data.

*Response:* After carefully reviewing the concerns expressed by commenters and analyzing the further reductions in payment that would result from using our 2002 claims data, even with the 10 percent limit on payment decreases that we proposed, we are convinced that our payments would be considerably lower than what it costs hospitals to acquire blood and blood products. Further, we are mindful of the increasing number of tests required to ensure the safety of the nation's blood supply, which is adding to the cost of processing blood and blood products. Therefore, in order to ensure that our beneficiaries have uninterrupted access to safe blood and blood products, we agree with the recommendation of commenters and the APC Panel that we freeze payments for blood and blood products in 2004 at 2003 payment levels rather than implement our proposal to limit payment decreases to 10 percent. This will enable us to undertake further study of the issues raised by commenters and by presenters at the August APC Panel meeting, without putting beneficiary access to blood and blood products at risk. Therefore, effective for services furnished on or after January 1, 2004, the payment rates for blood and blood products will not change from their 2003 levels.

*Comment:* One commenter was concerned that while autologous blood and directed donor blood do not have separate CPT codes, hospitals' costs to obtain them are different. Hospitals can only report charges for the autologous blood unit if the patient receives it; otherwise, hospitals must absorb the cost of the autologous donation. The same commenter also suggested that CMS research the issue of whether providing blood to patients with special needs would increase hospital costs. The commenter stated that hospitals do not receive additional payment when conducting national searches to meet special blood needs. Another commenter was concerned that drugs and biologicals were dampened to a

lesser extent than blood and blood products. The commenter requested that CMS discontinue the differential dampening and apply the dampening rule equally.

*Response:* The commenter's concerns about rules governing payment for autologous blood and the costs associated with procuring blood for patients with special needs fall outside the scope of our proposed rule. These questions require further analysis and study, which we cannot undertake in time for implementation of the 2004 update of the OPPS. However, as we examine the current policies that affect payment for blood and blood products under the OPPS, we will consider both of the commenter's concerns.

As for the comment regarding adoption of a uniform dampening policy for both separately payable drugs as well as blood and blood products, this concern is no longer an issue because of our decision to freeze payment rates for blood and blood products at their 2003 levels for 2004.

*Comment:* Several commenters requested that CMS provide and promote guidance on correct coding and billing for blood and blood products to hospitals and other providers.

*Response:* We acknowledge the need for comprehensive billing and coding guidelines for hospitals and other providers. This is an area we expect to address in the near future.

9. Intravenous Immune Globulin

In the proposed rule, we discussed public comments suggesting that we reclassify intravenous immune globulin (IVIG) as a blood and blood product. We stated that after a review of claims data, we believe that payment for these products is appropriate using the methodology we proposed to implement for other drugs and biologicals. Therefore, we proposed to continue to classify IVIG as a biologic. We solicited comments on this proposal.

We received several comments on this proposal, which are summarized below along with our responses.

*Comment:* Several trade associations, manufacturers, patient organizations and individual commenters urged CMS to classify intravenous immune globulin (IVIG) under the ''blood and blood product category.'' They indicated that IVIG is derived from plasma fractionation similar to other products categorized as a blood and blood product by CMS; and, furthermore, IVIG falls within the FDA's definition of ''blood and blood product.'' Some of the commenters expressed concern about the potential negative impact on patient access as a result of our proposed payment policy. Another commenter requested that we consider all plasma-derived products and their recombinant analogs as blood products.

*Response:* We appreciate these comments. However, we continue to believe that IVIG and other plasma-derived therapies and their recombinant analogs are comparable to other drugs and biologicals, and they do not have the same access concerns as other blood and blood products. Our policy regarding IVIG and plasma therapies were described in the November 1, 2002 final rule (67 FR 66774). For 2004, IVIG will be a separately payable item, and its payment rate will be based on approximately 26,500 claims for approximately 1.5 million services. As mentioned in the August 12, 2003 proposed rule (68 FR 48005), analysis of the claims data indicated that hospital costs and billing practices for IVIG have been consistent over the past two years. Therefore, we believe that the 2002 claims data contain a sufficiently robust set of claims for IVIG on which to base the payment rate for this item using the methodology that will be used for other separately payable non-pass-through drugs, biologicals, and radiopharmaceuticals.

10. Payment for Split Unit of Blood

Since implementation of the OPPS, we have assigned status indicator ''E'' to HCPCS code P9011, blood (split unit). Status indicator ''E'' designates services for which payment is not allowed under the OPPS or services that are not covered by Medicare. P9011 was created to identify situations where one unit of red blood cells or whole blood, for example, is split and half of the unit is transfused to one patient and the other half to another patient. Because use of split units is not uncommon, we proposed to change the status indicator for P9011 from ''E'' to ''K'' and assign it to a blood and blood product APC that pays approximately 50 percent of the payment for the whole unit of blood. We proposed to assign P9011 to APC 0957 (Platelet concentrate) with a payment rate of $37.30. We invited comments on this proposed change in the status indicator and payment amount for P9011.

We received a few comments on this proposal, which are summarized below along with our responses.

*Comment:* Commenters pointed out that there was a typographical error in the proposed rule in which we referred to the split unit of blood as P9010 rather than P9011.

*Response:* We agree this was an error and have corrected it in this preamble and are making final our proposal to assign P9011 to APC 0957 (platelet concentrate).

11. Other Issues

We proposed to continue our payment policy for Procrit and Aranesp for calendar year 2004. As explained in detail in the November 1, 2002 final rule (67 FR 66758), Aranesp and Procrit are in separate APCs, and are paid at equivalent rates with the application of a ratio to convert the dosage units of Aranesp into units of Procrit. We indicated that we might refine the conversion ratio as soon as feasible based on information not available at the time we established the current conversion ratio.

We have continued to gather information regarding an appropriate conversion ratio by reviewing recent published studies and data from alternative sources. In the proposed rule, we stated that we remain open to establishing a different conversion ratio in the final rule if we conclude that a change is warranted based on public comments and information submitted during the public comment period and/or any other information we consider in developing the final rule. Therefore, we proposed to continue with the current policy regarding payment for Procrit and Aranesp, including the current conversion ratio. We solicited comments on this issue and we stated that we would base any changes to our current payment policy for these two drugs only on data that we could make available to the public.

We received several comments on this proposal, which are summarized below along with our responses.

*Comment:* We received several comments concerning payment under the OPPS for erythropoietin and an erythropoietin-like product. Specifically, the comments pertained to payment for Aranesp™ (marketed by Amgen) and Procrit™ (marketed by Ortho Biotech) under the OPPS and the decision we made for 2003 with respect to an appropriate conversion ratio to ensure that these products, which use the same biological mechanism to produce the same results, are paid at the same rate .

*Response:* Erythropoietin, a protein produced by the kidney, stimulates the bone marrow to produce red blood cells. In severe kidney disease, the kidney is not able to produce normal amounts of erythropoietin and this leads to the anemia. Additionally, certain chemotherapeutic agents used in the treatment of some cancers suppress the bone marrow and cause anemia. Treatment with exogenous erythropoietin can increase red blood

cell production in these patients and thus treat their anemia.

In the late 1980's, scientists used recombinant DNA technology to produce an erythropoietin-like protein called epoetin alfa. Epoetin alfa has exactly the same amino acid structure as the erythropoietin humans produce naturally and, when given to patients with anemia, stimulates red blood cell production.

Two commercial epoetin-alfa products are currently marketed in the United States: Epogen™ (marketed by Amgen) and Procrit™ (marketed by Ortho Biotech). These products are exactly the same but are marketed under two different trade names. Both Epogen™ and Procrit™ are approved by the FDA for marketing for the following conditions: (1) Treatment of anemia related to chronic renal failure (including patients on and not on dialysis), (2) treatment of Zidovudine-related anemia in HIV patients, (3) treatment of anemia in cancer patients on chemotherapy, and (4) treatment of anemia related to allogenic blood transfusions in surgery patients. Both products are given either intravenously or subcutaneously up to three times a week.

Amgen developed a new erythropoietin-like product, darbepoetin alfa, which it markets as Aranesp™. Also produced by recombinant DNA technology, darbepoetin alfa differs from epoetin alfa by the addition of two carbohydrate chains. The addition of these two carbohydrate chains affects the biologic half-life of the compound. This change, in turn, affects how often the biological can be administered, which yields a decreased dosing schedule for darbepoetin alfa by comparison to epoetin alfa. Amgen has received FDA approval to market Aranesp™ for treatment of anemia related to chronic renal failure (including patients on and not on dialysis) and for treatment of chemotherapy-related anemia in cancer patients.

Because darbepoetin alfa has two additional carbohydrate side-chains, it is not structurally identical to epoetin alfa. However, the two products use the same biological mechanism to produce the same clinical results—stimulation of the bone marrow to produce red blood cells.

These biologicals are dosed in different units. Epoetin alfa is dosed in Units per kilogram (U/kg) of patient weight and darbepoetin alfa in micrograms per kilogram (mcg/kg). The difference in dosing metric is due to changes in the accepted convention at the time of each product's development. At the time epoetin alfa was developed, biologicals (such as those developed through recombinant DNA) were typically dosed in International Units (IU or Units for short), a measure of the product's biologic activity. They were not dosed by weight (for example, micrograms) because of a concern that weight might not accurately reflect their standard biologic activity. The biologic activity of such products can now be accurately predicted by weight, however, and manufacturers have begun specifying the doses of such biologicals by weight. No standard formula exists for converting amounts of a biologic dosed in Units to amounts of a drug dosed by weight.

In the clinical management of individual patients, CMS recognizes that no precise method of converting an epoetin alfa dose to a darbepoetin alfa dose has yet been established for any of the approved clinical uses. There are general guidelines for conversion and clinicians modify the dose based on the patient's hematopoietic response after the start of treatment with the new biological. For the purpose of developing a payment policy, however, it is feasible to establish a method of converting the dose of each of these drugs to the other. This payment methodology is intended to reflect average dosing requirements for the entire Medicare target population, and is not intended to serve as a guide for dosing individual patients.

As part of the process to define and further refine a payment conversion ratio between these biologicals, CMS held a series of meetings with representatives from both Amgen and Ortho Biotech. Both companies provided substantial new data, both published and unpublished. We also reviewed the Food and Drug Administration labeling for each product (EpogenTM, ProcritTM, and AranespTM), hired an independent contractor to review the available clinical evidence, and performed an internal review of this evidence as well. CMS took into consideration both published and unpublished studies as well as abstracts, conference reports, clinical guidelines, marketing material, and other reports and materials provided by Amgen and Ortho Biotech.

As noted in the OPPS final rule for 2003, CMS was interested in having a ''head-to-head'' comparison of epoetin alfa to darbepoetin alfa either in patients with chronic kidney disease or in cancer patients with chemotherapy-induced anemia, and in which appropriate outcome measures were used. Because no head-to-head study has yet been completed, CMS also considered clinical studies that either compared both products to each other or that linked the dose of a particular product with an appropriate health outcome measure. For the 2003 OPPS, we held a series of meetings with both Amgen and Ortho Biotech. We examined the written and published information provided by both companies, reviewed the FDA labeling for each product, hired an independent contractor to review available clinical evidence and performed an internal review of the evidence as well. In our review, we placed the greatest emphasis on published, high quality clinical studies and looked for the best possible estimates based on an evaluation of the dosing of each product that, on average, produced the same clinical response. Based on our own review of the evidence, our consultation with the independent contractor who also reviewed the evidence, and our discussions with each company, we established a conversion ratio for purposes of payment in 2003 of 260 International Units of epoetin alfa to one microgram of darbepoetin alfa (260:1).

Since publication of the OPPS final rule for 2003, we have continued to review and refine our analysis of the appropriate conversion ratio between these biologicals. In order to facilitate analysis of the non-peer reviewed materials submitted by Amgen and Ortho Biotech, we initiated a process in July 2003, in which each company shared with CMS, our contractor, and each other, a detailed description of the methods used in each of their unpublished clinical studies. Each company was then asked to submit to us their comments as well as the responses to questions raised by the other company's review. Finally, based on our analysis of this information, CMS submitted questions to each company to clarify their views. The final payment conversion ratio is based on our analysis of the information submitted during the process described above, as well as claims analysis, and other publicly available information.

*Chemotherapy-induced anemia:* The articles submitted by the manufacturers regarding treatment of chemotherapy-induced anemia (CIA) were all observational, retrospective, cohort studies. Several of these studies were conducted with a high degree of attention to minimizing avoidable bias and maximizing data integrity. Observational studies are, however, unavoidably subject to patient selection bias since study subjects are not randomly assigned to the groups being compared. It is not possible to eliminate the possibility that the choice of

erythropoetic agent was somehow systematically linked to characteristics of the patients treated. Similarities or differences in clinical response may reflect either baseline patient characteristics or the effects of the therapy being studied.

Another major limitation of observational studies is that the researcher typically has no control over the manner in which the intervention under study has been delivered. In this instance, an additional difficulty with using observational studies to assess the equivalence of dosages of epoetin alfa and darbepoetin alfa in chemotherapy-induced anemia in cancer patients is that the response to these drugs may be disease-driven, dosage-driven, or both (depending for example, among other factors, on the individual cancer patient's level of endogenous erythropoietin). A large range of dosages of both epoetin alfa and darbepoetin alfa may show similar effects in any given patient and higher than necessary dosages may not be reflected in greater elevations of hemoglobin. More generally, the populations in the reported studies may show different results due to differences in demographics, health status, types of cancer, and cancer treatments.

Beyond these methodological concerns, the question of what constitutes the best indicator of drug effect remains unsettled. Studies in the literature have used one or more of the following end-points to analyze the effects of erythropoietic drugs:

1. Hemoglobin response—an increase from baseline of >2 g/dL (usually in the absence of transfusion in the preceding 28 days)
2. Hematopoietic response—Hemoglobin increase of >2g/dL from baseline or a hemoglobin >12g/dL
3. Mean change in hemoglobin ''the mean increase in hemoglobin from baseline (usually in the absence of transfusion in the preceding 28 days)
4. Transfusions of red blood cells ''the number (percent) of patients requiring transfusion measured at various time intervals.

Studies submitted by one of the manufacturers proposed additional measures such as ''early hemoglobin response'' (the hemoglobin rise from baseline at 4 or 5 weeks) and the ''area under the curve'' defined by hemoglobin increases from baseline. The FDA has not used these measures as criteria for registration (i.e., market approval) and they do not appear to be regularly used in the peer reviewed literature of erythropoietic drugs and their use either in kidney disease or in oncology. Therefore, their clinical significance is unclear at this time. They do, however, raise the question of how hemoglobin response patterns affect symptoms that matter most to patients. Both companies are conducting additional clinical studies to address further the potential importance of front-loaded regimens that provide high initial doses of erythropoietic drugs in order to stimulate a more rapid clinical response.

During the process of exchanging and critiquing study methods, Amgen and Ortho-Biotech each raised significant methodological concerns about the study designs used to obtain new data. In addition to the overall concern about the observational methodology and selection of the outcome chosen for purposes of comparison, the following concerns were raised:

—the use of survival curves to analyze clinical data in this context
—the possible effect of patient functional status on erythropoietic response
—the technique for calculating mean values for drug dosages (arithmetic vs geometric means)
—the strategy for deciding how to handle data from patients who received transfusions
—the significance of an early rise in hemoglobin, and/or the significance of measures of hemoglobin response over the entire 12–16 week treatment interval

Each company provided extensive and compelling discussions of these and other issues, highlighting the fact that conclusions regarding the relative potency of these products are inherently limited by the nature and quality of the clinical data that currently exist. Despite the limitations of the available studies, CMS believes that it has sufficient data to establish a reasonable conversion ratio for payment purposes.

Amgen submitted several observational studies, including one community-based study and three medication use evaluations (MUE). While interim results from two of these studies have been published in peer-reviewed journals, final results have not yet been subjected to full peer review. In one study (Vadhan-Raj, 2003), patients were started on darbepoetin at 3 mcg/kg every other week (QOW). The patients received up to 8 doses (16 weeks). The patients had hemoglobin (Hgb) responses comparable to that seen with epoetin 40,000–60,000 IU per week. The protocol allowed a dose increase and 43 percent of participants had their darbepoetin dose increased to 5 mcg/kg/QOW per the protocol. Virtually all of the Amgen studies produced results that suggested a conversion ratio of 400:1.

Ortho Biotech submitted early unpublished results from a multicenter head-to-head trial of 40,000 IU of epoetin weekly compared to 200 mcg of darbepoetin every other week. The primary end-point is the change in Hgb from baseline at week 5, and initial results show significantly greater increase in Hgb for patients treated with epoetin. Ortho Biotech also submitted data from several retrospective analyses of medical charts and electronic medial records, totaling several thousand patients. None of these studies have yet been peer-reviewed or published. All of the Ortho-sponsored studies provide results suggesting that the appropriate conversion ratio is 260:1 or less.

In the observational studies that directly compare Aranesp and Procrit for the treatment of CIA, and report total dose per patient per episode of both epoetin and darbepoetin, the ratio of mean total doses is 341:1 and the ratio of median total doses is 352:1. However, selection bias may affect the validity of these studies. CMS therefore believes that the above-mentioned ratios may still overestimate, at least modestly, the potency of darbepoetin alfa relative to epoetin alfa. An analysis of Medicare claims data from 2002 and 2003 determined that the ratio of utilization of Procrit to Aranesp in Medicare patients was 330:1 (units:mcg).

As noted above, a conversion ratio between the dosages of these two products is not meant to guide what should be done for individual patients in clinical practice. In addition, by using a conversion ratio CMS is not attempting to establish a lower or upper limit on the amount of either biological a physician can prescribe to a patient. CMS expects that physicians will continue to prescribe these biologicals based on their own clinical judgment of the needs of individual patients.

Based on our own review of the evidence, our consultation with the independent contactor who also reviewed the evidence, and our discussions with Amgen and Ortho Biotech, CMS concludes that an appropriate conversion ratio for the purposes of a payment policy is 330 International Units of epoetin alfa to one microgram of darbepoetin alfa (330:1) for the purpose of treating chemotherapy-induced anemia.

*Chronic Kidney Disease without dialysis:* It is well established that as a patient progresses through the stages of chronic kidney disease (CKD), erythropoietin levels decline and anemia tends to develop. Furthermore,

CKD patients are a very heterogeneous population, and it is likely that they will need varying doses of erythropoietic drugs as their CKD progresses to ESRD. At the present time there are no head-to-head randomized controlled clinical trials that look at erythropoietic drug needs across the spectrum of CKD.

Amgen presented studies that examined the effect of darbepoetin on hemoglobin in this population. Two studies showed a dose conversion ratio (DCR) range between 215–330. These were observational studies similarly affected by the methodological weaknesses of this study design previously discussed for chemotherapy-induced anemia. A third study submitted by Amgen showed a DCR of 168:1 and is the only study that prospectively looked at darbepoetin and epoetin.

We estimate that no more than 10 percent of the Medicare patients who receive darbepoetin in the hospital outpatient setting receive it solely because of CKD. As a result, at this time, we believe that it could be confusing and burdensome for hospitals as well as the Medicare claims processing systems to use different HCPCS codes assigned to different APCs in order to distinguish and pay different amounts for darbepoetin used by patients with CIA from darbepoetin used by patients with CKD. Therefore, given the heterogeneity of the population, the general paucity of scientific evidence on CKD, the estimated low incidence of CKD-only indications in the OPPS population, and the potential burden on providers of requiring different codes for different indications, we are not establishing a different payment rate for darbepoetin for CKD at this time. However, CMS invites the submission of peer reviewed clinical data to further illuminate the issue. Therefore, we are going to use a 330:1 conversion ratio for CKD also and, therefore, a single APC payment rate for darbepoetin alfa, in 2004.

## VII. Wage Index Changes for CY 2004

Section 1833(t)(2)(D) of the Act requires that we determine a wage adjustment factor to adjust for geographic wage differences, in a budget neutral manner, that portion of the OPPS payment rate and copayment amount that is attributable to labor and labor-related costs.

We used the proposed Federal fiscal year (FY) 2004 hospital inpatient PPS wage index to make wage adjustments in determining the proposed payment rates set forth in the proposed rule. We also proposed to use the final FY 2004 hospital inpatient wage index to calculate the final CY 2004 payment rates and coinsurance amounts for OPPS. Therefore, we have used the corrected final FY 2004 hospital inpatient wage index to make wage adjustments in determining the final payments rates set forth in this final rule. The corrected final FY 2004 hospital inpatient wage index published as Tables 4A, 4B, and 4C in the October 6, 2003 **Federal Register** (68 FR 57732 through 57758) is reprinted in this final rule as Addendum H—Wage Index for Urban Areas; Addendum I—Wage Index for Rural Areas; and Addendum J—Wage Index for Hospitals That Are Reclassified. We used the corrected final FY 2004 hospital inpatient wage index to calculate the payment rates and coinsurance amounts published in this final rule to implement the OPPS for CY 2004. We note however, that from time to time, there are mid-year corrections to these wage indices and that our contractors will adopt and implement the mid-year changes for OPPS in the same manner that they make mid-year changes for inpatient hospital prospective payment.

We received several comments on how we apply the wage index in setting rates.

*Comment:* Commenters stated that we should exempt the device portion of the median cost from wage adjustment. They indicated that the wage index reflects the variation in wages and that applying it to 60 percent of an APC payment where part of that payment is for devices, to which the wage index is not applicable, results in inappropriately low payments in rural areas and discourages the expansion of state of the art technologies to rural hospitals. A commenter indicated that we should work with the commenter to calculate and publish a list of the device percentages for each APC and that the wage index adjustment should not be applied to that portion of the APC.

*Response:* To apply the wage index only to the non-device portion of the APC payment will mean a significant revision to the methodology used to calculate the relative weights and the conversion factor as well as changes to the system that applies the wage index on individual claims. When we calculate median costs, we divide 60 percent of the cost by the wage index for the hospital to neutralize the cost for the effects of the wage index. In addition, when we determine the conversion factor, we calculate a wage adjustment scalar to adjust for any increase or decrease that may occur to total payments from changes in the wage index. Moreover, it cannot be assumed that not applying the wage index to the device portion of the APC payment will result in increased payment for APCs that require devices. In localities that have high wage indices, this change could result in reductions in payments for device APCs. For example, if the wage index is 1.5 and the national APC payment is $10,000, the wage index applied to 60 percent of the APC increases the payment to the high wage index hospital to $13,000. If the wage index is 0.9, the wage index applied to 60 percent of the APC decreases the payment to the hospital to $9,400. However, if the wage index is applied only to 20 percent of the APC payment because 80 percent of the cost of the APC is for the device, the hospital in the high wage index area will now get $11,000 (a $2,000 loss) and the hospital in the low wage index area will now get $9,800 (a $400 gain).

Also, because the wage index is used to neutralize costs derived from charges and is a factor in the conversion factor, the $10,000 payment in the example may change. To gauge the full impact of such a change, we would have to undertake significant statistical analysis. We will continue to apply the wage index to 60 percent of the APC for 2004. However, we recognize the need to reassess whether this percentage is correct in view of the packaging of high cost devices into APCs and will make every effort to do a reassessment for 2005 OPPS proposed rule. If we determine that a change to the percentage might be appropriate, we will propose it in the 2005 OPPS NPRM.

## VIII. Copayment for CY 2004

In the November 30, 2001 final rule (66 FR 59887), we adopted a methodology that applied five rules for calculating APC copayment amounts when payments for APC groups change because the APCs' relative weights are recalibrated or when individual services are reclassified from one APC group to another. In calculating the unadjusted copayment amounts for 2004, we encountered circumstances that the methodology in the November 30, 2001 final rule either did not address or whose applicability was ambiguous. Therefore, we proposed to revise and clarify the methodology we would follow to calculate unadjusted copayment amounts, including situations in which recalibration of the relative payment weight of an existing APC results in a change in the APC payment; situations in which reclassification of HCPCS codes from an existing APC to another APC results in a change in the APC payment; and situations in which newly created APCs are comprised of HCPCS codes from existing APCs.

As we stated in the August 12, 2003 proposed rule, as a general rule, we would seek to lower the coinsurance rate for the services in an APC from the prior year. This principle is consistent with section 1833(t)(8)(C)(ii) of the Act, which accelerates the reduction in the national unadjusted coinsurance rate so that beneficiary liability will eventually equal 20 percent of the OPPS payment rate for all OPPS services and with section 1833(t)(3)(B), which indicates the congressional goal of achieving 20 percent coinsurance when fully phased in and gives the Secretary the authority to set rules for determining copayment amounts to new services. However, in no event is the proposed 2004 unadjusted coinsurance amount for an APC group lower than 20 percent or greater than 50 percent of the payment rate.

We proposed to determine copayment amounts in 2004 and subsequent years in accordance with the following rules.

1. When an APC group consists solely of HCPCS codes that were not paid under the OPPS the prior year because they were packaged or excluded or are new codes, the unadjusted copayment amount would be 20 percent of the APC payment rate.

2. If a new APC that did not exist during the prior year is created and consists of HCPCS codes previously assigned to other APCs, the copayment amount is calculated as the product of the APC payment rate and the lowest coinsurance percentage of the codes comprising the new APC.

3. If no codes are added to or removed from an APC and, after recalibration of its relative payment weight, the new payment rate is equal to or *greater than* the prior year's rate, the copayment amount remains constant (unless the resulting coinsurance percentage is less than 20 percent).

4. If no codes are added to or removed from an APC and, after recalibration of its relative payment weight, the new payment rate is *less than* the prior year's rate, the copayment amount is calculated as the product of the new payment rate and the prior year's coinsurance percentage.

5. If HCPCS codes are added to or deleted from an APC, and, after recalibrating its relative payment weight, holding its unadjusted copayment amount constant results in a decrease in the coinsurance percentage for the reconfigured APC, the copayment amount would not change (unless retaining the copayment amount would result in a coinsurance rate less than 20 percent).

6. If HCPCS codes are added to an APC, and, after recalibrating its relative payment weight, holding its unadjusted copayment amount constant results in an increase in the coinsurance percentage for the reconfigured APC, the copayment amount would be calculated as the product of the payment rate of the reconfigured APC and the lowest coinsurance percentage of the codes being added to the reconfigured APC.

We stated in the proposed rule that this methodology would, in general, reduce the beneficiary coinsurance rate and copayment amount for APCs for which the payment rate changes as the result of the reconfiguration of APCs and/or the recalibration of relative payment weights. We received no comments from the public on our proposal for the calculation of beneficiary copayment amounts.

The unadjusted copayment amounts for services payable under the OPPS effective January 1, 2004 are shown in Addendum A and Addendum B.

## IX. Conversion Factor Update for CY 2004

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis.

Section 1833(t)(3)(C)(iv) of the Act provides that for 2004, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act.

The forecast of the hospital market basket increase for FY 2004 published in the inpatient PPS proposed rule on May 19, 2003 was 3.5 percent. To set the proposed OPPS conversion factor for 2004, we increased the 2003 conversion factor of $52.151 (the figure from the November 1, 2002 final rule (67 FR 66788) by 3.5 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the proposed conversion factor for 2004 to ensure that the revisions we proposed to update by means of the wage index are made on a budget-neutral basis. We calculated a budget neutrality factor of 1.003 for wage index changes by comparing total payments from our simulation model using the proposed FY 2004 hospital inpatient PPS wage index values to those payments using the current (FY 2003) wage index values. In addition, for CY 2004, allowed pass-through payments have decreased to 2 percent of total OPPS payments, down from 2.3 percent in CY 2003. The 0.3 percent was also used to adjust the conversion factor.

The proposed market basket increase factor of 3.5 percent for 2004, the required wage index budget neutrality adjustment of approximately 1.003, and the 0.3 percent adjustment to the pass-through estimate, resulted in a proposed conversion factor for 2004 of $54.289.

For purposes of updating the CY 2003 conversion factor to determine a final conversion factor for CY 2004 we applied an update factor based on the final hospital inpatient market basket increase for FY 2004 of 3.4 percent, as published in the final rule for IPPS on August 1, 2003. We further adjusted the conversion factor by applying a budget neutrality factor of 1.001 for wage index changes based on final FY 2004 hospital inpatient PPS wage index values as published in a correction notice to the IPPS final rule on October 6, 2003. In addition, for CY 2004, estimated pass-through payments have decreased to 1.3 percent of total OPPS payments, down from 2.3 percent in CY 2003. The conversion factor was further adjusted by the difference in estimated pass-through payments of 1.0 percent.

The increase factor of 3.4 percent for 2004, the required wage index budget neutrality adjustment of slightly more than 1.001 and the 1.0 percent adjustment to the pass-through estimate, result in a final conversion factor for 2004 of $54.561.

We received several comments concerning the conversion factor update for 2004, which are summarized below.

*Comment:* Several commenters stated that the OPPS has been underfunded since its inception. One commenter stated that the OPPS conversion factor has increased by less than the full market basket increase and urged that we work with Congress to enact an annual outpatient update for 2005 that corrects for the funding gap. Other commenters, noting the preliminary estimate of pass-through spending in our proposed rule of August 12 of 1.0 percent of total OPPS payments, strongly urged us to return the remaining 1.0 percent to the conversion factor to help fund all other APCs.

*Response:* As described elsewhere in this final rule, we have completed our estimate of pass-through spending for 2004. By statute, we are authorized to spend only 2.0 percent of total estimated OPPS payments on pass-through spending for 2004. According to the best information available to us at this time, we estimate the total pass-through spending to be 1.3 percent of total OPPS spending for 2004. For 2003, we estimated the total pass-through spending to be 2.3 percent of total. Thus, we have returned the additional 1.0 percent to the conversion factor.

**X. Outlier Policy and Elimination of Transitional Corridor Payments for CY 2004**

*A. Outlier Policy for CY 2004*

For OPPS services furnished between August 1, 2000 and April 1, 2002, we calculated outlier payments in the aggregate for all OPPS services that appear on a bill in accordance with section 1833(t)(5)(D) of the Act. In the November 30, 2001 final rule (66 FR 59856, 59888), we specified that beginning with 2002, we would calculate outlier payments based on each individual OPPS service. We revised the aggregate method that we had used to calculate outlier payments and began to determine outliers on a service-by-service basis.

As explained in the April 7, 2000 final rule (65 FR 18498), we set a target for outlier payments at 2.0 percent of total payments. For purposes of simulating payments to calculate outlier thresholds, we proposed to continue to set the target for outlier payments at 2.0 percent. For 2003, the outlier threshold is met when costs of furnishing a service or procedure exceed 2.75 times the APC payment amount, and the current outlier payment percentage is 45 percent of the amount of costs in excess of the threshold.

For the reasons discussed in detail in section XI.E of this preamble, we proposed to establish two separate outlier thresholds, one for community mental health centers (CMHCs) and one for hospitals. For CY 2004, we proposed to continue to set the target for outlier payments at 2.0 percent of total OPPS payments (a portion of that 2.0 percent, 0.36 percent, would be allocated to CMHCs for PHP services). Based on our simulations for 2004, we proposed to set the hospital threshold for 2004 at 2.75 times the APC payment amount, and the proposed 2004 payment percentage applicable to costs over the threshold at 50 percent. We proposed to set the threshold for CMHCs for 2004 at 11.75 times the APC payment amount and the 2004 outlier payment percentage applicable to costs over the threshold at 50 percent. In this final rule, we are setting the target amount for outlier payments at 2.6 times the APC payment for hospitals and 3.65 times the APC payment for CMHCs. For 2004, the hospital outlier threshold is met when costs of furnishing a service or procedure exceed 2.6 times the APC payment amount and the outlier payment percentage is 50 percent of the amount of costs in excess of the threshold. Similarly, for CMHCs the threshold is met when costs of furnishing a service or procedure exceed 3.65 times the APC payment amount and the outlier payment percentage is 50 percent of the amount of costs in excess of the threshold.

We received several comments concerning our proposal to establish two separate outlier pools, one for hospitals and another for CMHCs, and to determine eligibility for outlier payments by applying an outlier threshold of 2.75 times the APC payment for hospitals and 11.75 times the APC payment for CMHCs. The comments we received concerning that proposal are summarized in section XI E.3 along with our responses. Comments we received pertaining to other aspects of our proposal for outlier payments are summarized below:

*Comment:* One hospital association contended that outpatient services that qualify for outlier payments should receive 80 percent of their costs above the threshold, rather than the proposed level of 50 percent. The association stated that an increased payment level would help to ameliorate the level of losses incurred by hospitals, such as teaching hospitals, that provide complex outpatient services and would make OPPS policy consistent with the policy under the IPPS. The association also pointed out that because we apply an outlier threshold that is a multiple of the APC payment, rather than a fixed dollar amount, hospitals that provide certain costlier services must absorb significantly more costs before even qualifying for outlier payments, making it even more important to increase the outlier payment percentage. The association recognized that increasing the payment percentage would require additional funds and recommended that we seriously consider increasing the outlier payment pool from its current level of 2.0 percent of total OPPS payments to 3.0 percent, the maximum allowed by law for 2004 and beyond.

*Response:* Although we acknowledge the importance of outlier payments to providers, those payments are intended to ensure that the Medicare program shares, to some extent, in the extraordinarily high costs a provider may incur in caring for specific patients in unusual circumstances. Outlier payments are not intended to be paid on a routine or regular basis for treating the majority of Medicare beneficiaries. The APC payments are developed to be reasonable and adequate payment for all but the most extraordinary cases. At this time, we do not believe that it would be appropriate to shift additional funds from APC payments in order to increase the outlier payment percentage. Increasing the outlier pool would result in reduced payments for the majority of services providers furnish in order to make increased payments for the rare, extraordinarily high cost cases a provider may treat.

*Comment:* A hospital association commented that we have furnished very little data on actual outlier payments under the OPPS, so hospitals have no way of knowing whether actual payments were higher or lower than estimated outlier payments and are unable to comment on the proper outlier threshold for OPPS. The association pointed out that we have historically furnished data on actual outlier payments in the IPPS rule and recommended that we furnish data on OPPS outlier payments so that hospitals may be able to make informed comments on the proper threshold.

*Response:* Based on hospital and CMHC claims submitted for the period April 1, 2002 through December 31, 2002, outlier payments for that period amounted to 1.78 percent of total OPPS payments. The outlier target we were trying to achieve for that period was 1.5 percent of total OPPS payments. Outlier payments to hospitals alone amounted to 1.54 percent of total OPPS payments to hospitals, while outlier payments to CMHCs amounted to 49.8 percent of their total OPPS payments.

*B. Elimination of Transitional Corridor Payments for CY 2004*

Since the inception of the OPPS, providers have been eligible to receive additional transitional payments if the payments they received under the OPPS were less than the payments they would have received for the same services under the payment system in effect before the OPPS. Under 1833(t)(7) of the Act, most hospitals that realize lower payments under the OPPS received transitional corridor payments based on a percent of the decrease in payments. However, rural hospitals having 100 or fewer beds, as well as cancer hospitals and children's hospitals described in section 1886(d)(1)(B)(iii) and (v) of the Act, were held harmless under this provision and paid the full amount of the decrease in payments under the OPPS.

Transitional corridor payments were intended to be temporary payments to ease providers' transition from the prior cost-based payment system to the prospective payment system. Beginning January 1, 2004, in accordance with section 1833(t)(7) of the Act, transitional corridor payments will no longer be paid to providers other than cancer hospitals and children's hospitals. Cancer hospitals and children's hospitals are held harmless permanently

under the transitional corridor provisions of the statute.

Since small rural hospitals may not be able to achieve the same level of operating efficiencies as larger rural hospitals and urban hospitals, we were concerned that the possible decrease in payments to these hospitals resulting from the elimination of the transitional corridor payments could result in these hospitals having to decrease or altogether cease to provide certain outpatient services. A reduction of services could have consequences for Medicare beneficiaries and their continued access to care in rural areas. In light of these concerns, we stated in the August 12, 2003 proposed rule that one thing we could do is to provide increased APC payments for clinic and emergency room visits furnished by rural hospitals having 100 or fewer beds. Any adjustment to payments for these hospitals would be made under the authority granted to the Secretary under section 1833(t)(2)(E) of the Act, to establish in a budget neutral manner adjustments as determined to be necessary to ensure equitable payments, such as adjustments for certain classes of hospitals. In the August 12, 2003 proposed rule, we invited comments on whether we should provide an adjustment, such as the one described above, for small rural hospitals.

We received a few comments regarding the elimination of transitional corridor payments, which are summarized below along with our responses.

*Comment:* Two commenters stated that the loss of transitional corridor payments would dramatically affect revenues for rural hospitals; therefore, they supported increased payments to rural hospitals for clinic and emergency room visits. One hospital association recommended that we provide appropriate payment protections for small rural hospitals that provide emergency services to safeguard them from any adverse consequences stemming from the elimination of transitional corridor payments and to avoid life-threatening consequences by protecting beneficiaries' timely access to emergency services. Two additional commenters contended that our proposal would be inadequate and that to avoid curtailing services to Medicare beneficiaries relief is needed for small rural hospitals, sole community hospitals, and rural referral centers. They recommended that we continue transitional corridor payments using the authority we have to make adjustments under section 1833(t)(2)(E) of the Act. One commenter stated that our proposal failed to address other outpatient services that will be underpaid and suggested that transitional corridor payments be continued for a year while a more broad based payment methodology is developed for small rural hospitals. Another commenter recommended a rural APC add-on adjustment for all APCs paid to rural hospitals to acknowledge that these hospitals cannot achieve the same level of operating efficiencies as larger rural and urban hospitals. Another commenter argued that termination of transitional corridor payments was detrimental to all hospitals and recommended retaining transitional corridor payments for all hospitals.

One commenter opposed shifting payments from larger hospitals in order to increase payments to small rural hospitals. The commenter stated that all hospitals, regardless of size and location, struggle with gaining operating efficiencies under the OPPS. One hospital association indicated that transitional corridor payments have been a critical source of financial support for many teaching hospitals and payments to these hospitals deserve further analyses by us, which would likely result in the conclusion that a teaching hospital adjustment is warranted. Several hospital associations expressed concern about our proposal to create differential payment rates between urban and rural hospitals for clinic and emergency room visits, and one questioned our legal authority to pay differently for the same service. One of the associations added that as a preferred alternative, it is urging the Congress to allocate additional resources to extend the transitional corridor and hold harmless provisions to all providers as well as urging the Congress to increase payments for clinic and emergency room visits for all hospitals. Another of the hospital associations stated that it does not support a budget neutral, redistributive adjustment through regulation, but is instead urging the Congress to allocate additional resources to assist rural hospitals by increasing payment rates for clinic and emergency room visits for all hospitals.

The Medicare Payment Advisory Commission (MedPAC) commented that the August 12, 2003 proposed rule failed to provide a rationale for proposing increased payments for emergency room and clinic visits as a means of supporting small rural hospitals and recognized that only limited cost report data are available to assess the performance of small rural hospitals under the OPPS. MedPAC stated that we should consider other regulatory options to ensure access to care for rural beneficiaries, such as a low-volume adjustment and pointed out that any payment adjustment should be accompanied by an analysis of how small rural hospitals have fared under the OPPS, the impact of any payment adjustment, and the impact of other policies that affect rural hospitals such as conversion to critical access status. MedPAC also stated that legislative remedies could include extending the hold harmless policy or providing a transition from hold harmless status.

*Response:* Although we expressed concerns in the August 12, 2003 proposed rule that the sunsetting of transitional corridor payments might significantly impact small rural hospitals and we invited comments about whether we should provide for some type of adjustment to payments for these hospitals, we did not receive a large number of comments and the comments we did receive are mixed on the issue. Although some commenters called for an extension of hold harmless transitional corridor payments for small rural hospitals, we do not believe that is a viable option because any adjustment we would make under the authority of section 1833(t) of the Act would have to be made on a budget neutral basis and would result in decreased APC payments for all providers. Because we did not receive a strong response in favor of increased visit payments to small rural hospitals or compelling evidence that clearly supported the position that an adjustment for small rural hospitals is necessary to ensure access to hospital outpatient services in areas served by small rural hospitals, we will not adopt a payment adjustment for small rural hospitals. We will continue to seek information related to specific situations that demonstrate that access to care is a problem for Medicare beneficiaries.

## XI. Other Policy Decisions and Changes

### *A. Hospital Coding for Evaluation and Management (E/M) Services*

Facilities code clinic and emergency department visits using the same [Physicians'] Current Procedural Terminology (CPT) codes as physicians. For both clinic and emergency department visits, there are currently five levels of care. Because these codes were defined to reflect only the activities of physicians, they are inadequate to describe the range and mix of services provided to patients in the clinic and emergency department settings (for example, ongoing nursing care, preparation for diagnostic tests, and patient education).

In the April 7, 2000 final rule (65 FR 18434), we stated that in order to ensure proper payment to hospitals, it was important that emergency and clinic visits be coded properly. To facilitate proper coding, we required each hospital to create an internal set of guidelines to determine what level of visit to report for each patient. In the August 24, 2001 proposed rule (66 FR 44672), we asked for public comments regarding national guidelines for hospital coding of emergency and clinic visits. Commenters recommended that we keep the current E/M coding system until facility-specific E/M codes for emergency department and clinic visits, along with national coding guidelines, were established. Commenters also recommended that we convene a panel of experts to develop codes and guidelines that are simple to understand, implement, and that are compliant with the Health Insurance Portability and Accountability Act (HIPAA) requirements.

*Outcome of January 2002 APC Panel Meeting*

During its January 2002 meeting, the APC Panel made several recommendations regarding coding for evaluation and management services. After careful review and consideration of written comments, oral testimony, and the APC Panel's recommendations, we proposed the following in the August 9, 2002 proposed rule (for implementation no earlier than January 2004):

1. To develop five G codes to describe emergency department services:

GXXX1—Level 1 Facility Emergency Services;

GXXX2—Level 2 Facility Emergency Services;

GXXX3—Level 3 Facility Emergency Services;

GXXX4—Level 4 Facility Emergency Services; and

GXXX5—Level 5 Facility Emergency Services.

2. To develop five G codes to describe clinic services:

GXXX6—Level 1 Facility Clinic Services;

GXXX7—Level 2 Facility Clinic Services;

GXXX8—Level 3 Facility Clinic Services;

GXXX9—Level 4 Facility Clinic Services; and

GXXX10—Level 5 Facility Clinic Services.

3. To replace CPT Visit Codes with the 10 new G codes for OPPS payment purposes.

4. To establish separate documentation guidelines for emergency visits and clinic visits.

In our November 1, 2002 final rule (67 FR 66792), we stated that the most appropriate forum for development of new code definitions and guidelines would be an independent expert panel that would make recommendations to us. In light of the expertise of organizations such as the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA), we felt that these organizations were particularly well equipped to make recommendations to us and to provide ongoing education to providers.

On their own initiative, the AHA and the AHIMA convened an independent expert panel of individuals from various organizations to develop code descriptions and guidelines for hospital emergency department and clinic visits and to make recommendations to us.

The panel recommended the following to us.

1. We should make payment for emergency and clinic visits based on four levels of care.

2. We should create HCPCS codes to describe these levels of care as follows:

GXXX1—Level 1 Emergency Visit.

GXXX2—Level 2 Emergency Visit.

GXXX3—Level 3 Emergency Visit.

GXXX4—Critical Care provided in the emergency department.

GXXX5—Level 1 Clinic Visit.

GXXX6—Level 2 Clinic Visit.

GXXX7—Level 3 Clinic Visit.

GXXX8—Critical Care provided in the clinic.

3. We should replace all the HCPCS currently in APCs 600, 601, 602, 610, 611, 612, and 620 with GXXX1 through GXXX8.

4. Based on the above recommendations, we would crosswalk payments as follows: GXXX1 to APC 610, GXXX2 to APC 611, GXXX3 to APC 612, GXXX4 to APC 620, GXXX5 to APC600, GXXX6 to APC 601, GXXX7 to APC 602, and GXXX8 to APC 620. These crosswalks and code descriptions are listed in Table 14 below.

TABLE 14.—CROSSWALKS OF 2003 HCPCS CODES TO THE PROPOSED G CODES

| 2003 HCPCS description | 2004 G code description | 2003 HCPCS | 2004 Proposed G codes | APC | Payment amount |
|---|---|---|---|---|---|
| Emergency department visit | Level 1 Emergency Visit | 99281<br>99282 | GXXX1 | 0610 | $74.70 |
| Emergency department visit | Level 2 Emergency Visit | 99283 | GXXX2 | 0611 | 130.77 |
| Emergency department visit | Level 3 Emergency Visit | 99284<br>99285 | GXXX3 | 0612 | 226.30 |
| Critical care | Level 4 Critical Care provided in the emergency department. | 99291<br>99292 | GXXX4 | 0620 | 491.01 |
| Office/outpatient visit, new | Level 1 Clinic Visit | 99201<br>99202 | GXXX5 | 0600 | 50.62 |
| Office/outpatient visit, new | Level 2 Clinic Visit | 99203 | GXXX6 | 0601 | 53.56 |
| Office/outpatient visit, new | Level 3 Clinic Visit | 99204<br>99205 | GXXX7 | 0602 | 82.07 |
| Office/outpatient visit, established | Level 1 Clinic Visit | 99211<br>99212 | GXXX5 | 0600 | 50.62 |
| Office/outpatient visit, established | Level 2 Clinic Visit | 99213 | GXXX6 | 0601 | 53.56 |
| Office/outpatient visit, established | Level 3 Clinic Visit | 99214<br>99215 | GXXX7 | 0602 | 82.07 |
| Office consultation | Level 1 Clinic Visit | 99241<br>99242 | GXXX5 | 0600 | 50.62 |
| Office consultation | Level 2 Clinic Visit | 99243 | GXXX6 | 0601 | 53.56 |
| Office consultation | Level 3 Clinic Visit | 99244<br>99245 | GXXX7 | 0602 | 82.07 |

TABLE 14.—CROSSWALKS OF 2003 HCPCS CODES TO THE PROPOSED G CODES—Continued

| 2003 HCPCS description | 2004 G code description | 2003 HCPCS | 2004 Proposed G codes | APC | Payment amount |
|---|---|---|---|---|---|
| Critical care | Level 4 Critical Care provided in the clinic. | 99291 99292 | GXXX8 | 0620 | 491.01 |

The independent panel convened by the AHA and AHIMA recommended these levels in anticipation of the development of national coding guidelines for emergency and clinic visits that meet the following criteria we announced in the August 9, 2002 proposed rule (67 FR 52131):

1. Coding guidelines for emergency and clinic visits should be based on emergency department or clinic facility resource use, rather than physician resource use.

2. Coding guidelines should be clear, facilitate accurate payment, be usable for compliance purposes and audits, and comply with HIPAA.

3. Coding guidelines should only require documentation that is clinically necessary for patient care. Preferably, coding guidelines should be based on current hospital documentation requirements.

4. Coding guidelines should not create incentives for inappropriate coding (for example, up-coding).

We have received recommendations for a set of coding guidelines from the independent E/M panel comprised of members of the AHA and AHIMA. We proposed to implement new evaluation and management codes only when we are also ready to implement guidelines for their use, after allowing ample opportunity for public comment, systems change, and provider education. We also proposed to use cost data from the current HCPCS codes in these APCs to determine the relative weights of these APCs until cost data from GXXX1 through GXXX8 are available to set relative weights. We note that this proposal requires discontinuing the use of all HCPCS codes in these APCs and would not allow us to collect cost data for the five levels of emergency and clinic visits that are currently described by CPT codes. We further note that we would no longer be able to distinguish among the costs for visits by new patients, established patients, consultation patients, or patients being seen for more specialized care (for example, pelvic screening exams and glaucoma screening exams).

We would be using claims data from current HCPCS codes and crosswalking those data to the new codes in the same APCs; therefore, there would be no change in payment for any of these services as a result of these coding changes. Once cost data become available from the new HCPCS codes, we would use those data to set the relative weights, and, therefore, there should be no budgetary impact.

We are currently considering the set of proposed national coding guidelines for emergency and clinic visits recommended by the independent panel. We plan to make any proposed guidelines available to the public for comment on the OPPS web site as soon as they are complete. We will notify the public through our listserve when these proposed guidelines become available. To subscribe to this listserve, please go to the following Web site: *http://www.cms.hhs.gov/medlearn/listserv.asp* and follow the directions to the OPPS listserve. With regard to the development of these guidelines, our primary concerns are—

1. To make appropriate payment for medically necessary care;

2. To minimize the information collection and reporting burden on facilities;

3. To minimize any incentives to provide unnecessary or low quality care;

4. To minimize the extent to which separately billable services are counted as E/M services;

5. To develop coding guidelines that are consistent with facility resource use; and

6. To develop coding guidelines that are clear, facilitate accurate payment, are useful for compliance purposes and audits, and comply with HIPAA. Before adoption and implementation of any coding changes or coding guidelines, ample time will be provided for the public to comment on our proposal and, following announcement of any final decisions, for the education of clinicians and coders and for hospitals to make the necessary changes in their systems to accommodate the codes and guidelines. In the proposed rule, we requested comments on the amount of time hospitals believe would be adequate to implement these new codes and guidelines. We stated that we remain committed to working with appropriate organizations and stakeholders in our continuing development of a standard set of codes and national guidelines for facility coding of emergency and clinic visits.

We received comments on our proposal, which are summarized below with our responses.

*Comment:* Several physician societies objected to the creation of new G codes to replace existing CPT codes for facility coding of emergency and clinic visits. These commenters stated that new G codes for these services would add an unnecessary layer of complexity and confusion to the system, and that the existing CPT codes adequately and appropriately describe the services provided in the emergency and clinic settings. One physician society supported the creation of new G codes for facility coding of emergency and clinic visits, agreeing that CPT codes fail to accurately describe facility resources used to provide E/M services, but expressed concern that payers or auditors might refer to crosswalks made in establishing facility E/M code levels to determine appropriate level of coding for physician E/M services. This commenter urged CMS to clarify that the levels of visits for facility E/M services should not be used by payers or auditors to verify that physicians have billed for the appropriate level of visit.

Several commenters, including a hospital association and federation, commended CMS for proposing new G codes for facility coding of emergency and clinic visits, stating that existing CPT codes for E/M services correspond to different levels of physician effort and fail to adequately describe non-physician resources. These commenters stated that the proposed new G codes would appropriately capture facility resources, minimize confusion relative to physician versus facility E/M services, and adequately meet hospitals' need to comply with HIPAA regulations.

*Response:* We agree with those commenters who believe that CPT codes for E/M services describe different levels of physician effort, and therefore, fail to accurately describe facility resources used to provide E/M services. In the November 1, 2002 final rule (67 FR 66718), we explained that the development of new HCPCS codes for facility visits was necessary to address potential HIPAA compliance issues. We also agree with comments that the

proposed new G codes would appropriately capture facility resources and minimize confusion relative to physician versus facility E/M services. Therefore, we will continue to develop coding guidelines for facility E/M codes that are clear, facilitate accurate payment, are useful for compliance purposes and audits, and comply with HIPAA. For clarification purposes, levels of visits for facility E/M services should not be used by payers or auditors to verify that physicians have billed for the appropriate level of visit.

*Comment:* We received a number of comments regarding our proposal of three levels of care (plus critical care) for clinic and emergency department visits. Several commenters stated that variation in cost per visit warrants five levels of service mapping to five separate APCs to maintain reasonable steps in payment as treatment costs increase. These commenters expressed concern that the agency will no longer have the ability to collect cost data for the five levels of emergency and clinic visits currently described by CPT codes, and that an averaging of charges over only three levels of service will result in adverse effects (that is, overpayments and underpayments) at the low and high end of visit codes. Furthermore, these commenters stated that private payers require a five tiered system and may not recognize the new G codes for payment. In contrast, we received several comments supporting our proposal of three levels of care (plus critical care) for clinic and emergency department visits. These commenters stated that three levels would help reduce the coding complexity and would be a more appropriate and accurate mechanism for reporting emergency and clinic visits.

*Response:* We appreciate the commenters' concerns while at the same time recognizing merits in the independent expert panel's recommendation to create three levels of care (plus critical care) for clinic and emergency visits. Given the level of interest in this issue and the importance to Medicare and to hospitals of establishing the appropriate codes and payment levels for these services, we will continue to study the issue. Prior to implementation of new facility E/M codes we will carefully consider all commenters' concerns related to variation in visit costs and recognition of a three tiered system by private payers. We will also consider placing this issue on the agenda for the 2004 APC Panel meeting.

*Comment:* Several physician societies expressed concern about potential discrepancies in payment for the same services furnished in clinic and emergency departments versus physician offices. One commenter stated that the proposal lacked physician input. While acknowledging statutory requirements that dictate the structure of the payment system for non-physician resources required to support physician services and the payment system for outpatient facility resources, commenters stated that we should avoid adopting policies that further increase the inequity in Medicare's payment systems. These commenters urged us to establish payment equity for the same services furnished in these respective settings.

*Response:* As stated elsewhere, the statute contains different provisions for how payments are established under the physician fee schedule and how payments are established under the OPPS. With respect to the absence of physician input on the proposal, we welcome comments from all interested parties as we continue to develop our policy.

*Comment:* We received numerous and detailed comments in reference to the model guidelines proposed by the independent expert panel convened by the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA).

*Response:* We are appreciative of the detailed comments we received in reference to the model guidelines proposed by the independent expert panel convened by the AHA and AHIMA. While we will carefully consider these comments in our continued review of the independent panel's proposed guidelines, we will not be responding to such comments in this rule since CMS did not propose these coding guidelines in the August 12, 2003 proposed rule.

*Comment:* Several commenters supported our decision to delay implementation of new E/M codes for clinic and emergency department visits until we have established defined and uniform coding guidelines.

*Response:* To minimize confusion, we continue to believe that a national set of defined coding guidelines must be established and implemented in conjunction with any new E/M codes for clinic and emergency department visits.

*Comment:* Several commenters encouraged CMS to make any proposed guidelines for billing hospital emergency room and clinic visits publicly available with opportunity to comment as soon as they are complete.

*Response:* We plan to make any coding guidelines that we are considering available to the public for comment on the OPPS Web site as soon as they are complete. We will notify the public through our listserve when these proposed guidelines become available. To subscribe to this listserve, please go to the following Web site: *http://www.cms.hhs.gov/medlearn/listserv.asp* and follow the directions to the OPPS listserve. As stated elsewhere, we will provide ample opportunity for the public to comment on the proposal.

*Comment:* Several commenters requested that CMS provide adequate time for the education of clinicians and coders and for hospitals to make the necessary changes in their systems to accommodate new evaluation and management (E/M) codes and guidelines. While two commenters requested a minimum notice of three months prior to implementation, the majority of commenters requested a minimum notice of between six and twelve months prior to implementation of facility evaluation and management codes and guidelines.

*Response:* We will continue to be considerate of the time necessary to educate clinicians and coders and for hospitals to modify their systems to accommodate new codes and guidelines. Based on comments received, we will provide a minimum notice of between six and twelve months prior to implementation of facility evaluation and management codes and guidelines. We do not expect to implement these new codes and guidelines any earlier than January 2005.

### *B. Status Indicators and Issues Related to OCE Editing*

The status indicators we assign to HCPCS codes and APCs under the OPPS have an important role in payment for services under the OPPS because they indicate whether a service represented by an HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. We are providing our status indicator (SI) assignments for APCs in Addendum A, HCPCS codes in Addendum B, definitions of the status indicators in Addendum D1, and definitions of code condition indicators in Addendum D2.

The OPPS is based on HCPCS codes for medical and other health services. These codes are used for a wide variety of payment systems under Medicare, including, but not limited to, the Medicare fee schedule for physician services, the Medicare fee schedule for durable medical equipment and prosthetic devices, and the Medicare clinical laboratory fee schedule. For purposes of making payment under the

OPPS, we must be able to signal the claims processing system which HCPCS codes are paid under the OPPS and those codes to which particular OPPS payment policies apply. We accomplish this identification in the OPPS through a system of payment status indicators with specific meanings.

We assign one and only one status indicator to each APC and to each HCPCS code. Each HCPCS code that is assigned to an APC has the same status indicator as the APC to which it is assigned.

The software that controls Medicare payment looks to the status indicators attached to the HCPCS codes and APCs for direction in the processing of the claim. Therefore, the assignment of the status indicators has significance for the payment of services.

In the August 12, 2003 proposed rule, we listed the OPPS status indicators and described how we proposed to use them in the 2004 OPPS. We also solicited comments on the appropriateness of the status indicator that we proposed to assign to each APC in Addendum A and each HCPCS code in Addendum B. Because the assignment of a status indicator designates how a particular outpatient service will be paid, either under the OPPS or under another payment system, or why payment is not made for a code, the comments that we received regarding the status indicator assigned to a particular APC or HCPCS code are discussed elsewhere in this final rule, within the context of the payment policy or rule that affect how payment is determined for the APC or HCPCS code.

Since publication of the August 12 proposed rule, we have been preparing specifications for the January 1, 2004 outpatient code editor (OCE) and PRICER, which are pivotal in determining how hospital claims for outpatient services are processed and paid. In the course of discussions with the contractors and systems maintainers with whom we work to ensure that claims are processed appropriately and in accordance with the policies and changes that we are implementing in this final OPPS rule for 2004, several issues related to status indicator definitions and claims processing edits and dispositions have arisen. As a result of these discussions, we have determined that claims would be processed more accurately if we established two additional payment status indicators to designate with greater specificity the appropriate disposition of certain codes for which payment is not made under the OPPS. Therefore, we are adding two status indicators, status indicator ''B'' and status indicator ''Y,'' to Addendum D1, which lists all of the status indicators established as part of the OPPS and describes what they signify. We have also revised and refined the status indicator definitions and clarified the explanation of what each status indicator means. None of these changes affect how services are paid under the OPPS. Rather, the changes are intended to clarify how the status indicators relate to existing payment policy and rules and to assist hospitals and our contractors in determining the disposition of individual HCPCS codes when they are billed to Medicare.

In 2004, we are adding a new Status Indicator ''Y'' to designate codes for non-implantable Durable Medical Equipment (DME) to assist hospitals in identifying codes that they must bill directly to the Durable Medical Equipment Regional Carrier (DMERC) rather than to the fiscal intermediary. Codes assigned Status Indicator ''Y'' are listed in Addendum B.

Historically, we have used Status Indicator ''E'' to identify certain HCPCS codes that are recognized by Medicare but that are not payable under the OPPS when they are submitted on an outpatient hospital Part B bill type (bill type 12x, 13x, or 14x). Beginning with implementation of the 2004 final rule, we are assigning Status Indicator ''B'' to HCPCS codes that are not payable under OPPS when submitted on an outpatient hospital Part B bill type (12x, 13x, and 14x), but that may be payable by intermediaries to other provider types when submitted on an appropriate bill type, such as bill type 75x submitted by a CORF. In some cases, another code may be submitted by hospitals on an outpatient hospital Part B bill type (12x, 13x, and 14x) to receive payment for a service or code that is assigned status indicator ''B'' in Addendum B. Because we did not include these status indicator changes in the August 12, 2003 proposed rule, we invite comments on their addition to Addendum D1, and on the revised definitions and explanations that we included in Addendum D1.

Addendum D2 shows the indicators that we use to designate codes that are new in 2004 for which comments may be submitted as well as codes that are deleted in 2004 either with or without a grace period.

*C. Observation Services*

In the November 1, 2002 update to the OPPS (67 FR 66794), we summarized and clarified previously published guidance (Transmittal A–02–026) regarding payment requirements for HCPCS code G0244, Observation care provided by a facility to a patient with congestive heart failure, chest pain or asthma, minimum of 8 hours, maximum 48 hours. We also implemented HCPCS codes G0263 and G0264 to identify patients directly admitted to observation. In January 2003, we published Transmittal A–02–129, which provides further instructions regarding billing for observation services. In the proposed rule, we did not propose anything new with regard to observation services, nor did we seek public comment on observation issues. We stated that we would update by Program Memorandum any changes in the list of ICD–9–CM codes required for payment of HCPCS code G0244 resulting from the October 1 annual update of ICD–9–CM. We also stated in the proposed rule that we would include any changes in the 2004 final OPPS rule and allow the public an opportunity to comment.

We have had an opportunity to review the October 1, 2003 update of the ICD–9–CM and we have determined that there are not changes that affect the list of diagnosis codes required for payment of HCPCS code G0244. Therefore, we are not implementing any changes in the way we pay for observation services under the 2004 OPPS.

*D. Procedures That Will Be Paid Only as Inpatient Procedures*

Before implementation of the OPPS, Medicare paid reasonable costs for services provided in the outpatient department. The claims submitted were subject to medical review by the fiscal intermediaries to determine the appropriateness of providing certain services in the outpatient setting. We did not specify in regulations those services that were appropriate to be provided only in the inpatient setting and that, therefore, should be payable only when provided in that setting.

Section 1833(t)(1)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. In the April 7, 2000 final rule, we identified procedures that are typically provided only in an inpatient setting and, therefore, would not be paid by Medicare under the OPPS (65 FR 18455). These procedures comprise what is referred to as the ''inpatient list.'' The inpatient list specifies those services that are only paid when provided in an inpatient setting. These are services that require inpatient care because of the nature of the procedure, the need for at least 24 hours of post-operative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. As we

discussed in the April 7, 2000 and the November 30, 2001 final rules, we use the following criteria when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under the OPPS:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that we have already removed from the inpatient list.

In the November 1, 2002 final rule, we added the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS:

- We have determined that the procedure is being performed in multiple hospitals on an outpatient basis; or
- We have determined that the procedure can be appropriately and safely performed in an ASC and is on the list of approved ambulatory surgical center (ASC) procedures or proposed by us for addition to the ASC list.

At its January 2003 meeting, the APC Panel did not make recommendations regarding procedures on the inpatient list, and in the proposed rule, we did not propose to make any of the procedures that are currently on the inpatient list in Addendum E payable under the OPPS in 2004. We solicited comments on whether any procedures in Addendum E should be paid under the OPPS. We asked commenters recommending reclassification of a procedure to an APC to include evidence (preferably from peer-reviewed medical literature) that the procedure is being performed on an outpatient basis in a safe and effective manner. We also solicited comments on the appropriate APC assignment for the procedure in the event that we determine in the final rule, based on comments, that the procedure would be payable under the OPPS in 2004.

Following our review of any comments that we receive about the procedures in Addendum E, we indicated in the proposed rule that we would propose either to assign a CPT code to an APC for payment under the OPPS or, if the comments did not provide sufficient information and data to enable us to make a decision, to present the comments to the APC Panel at its 2004 meeting.

Procedures on the inpatient list can be found in Addendum E. CPT codes that are new in 2004 and that we believe are appropriately assigned status indicator ''C'' to designate that they are on the inpatient list can be found in Addendum B with condition code ''NI''. We invite comment on assignment of these codes to the inpatient list.

We received a few comments regarding the inpatient list, which are summarized below with our responses.

*Comment:* A group of providers representing 18 health care systems around the country requested that CMS clarify the intent of the inpatient list. The commenter expressed concern that some independent medical review criteria appear to equate codes with APC payments as procedures that CMS has determined must be outpatient services both because they are payable under the OPPS and because they are not included on the inpatient list. The commenter is concerned that hospitals will interpret these criteria to mean that any procedure or service not on the inpatient list must be furnished on an outpatient basis, regardless of the needs of the patient.

*Response:* We wish to clarify that assignment of an APC payment to a service or procedure does not mean that Medicare covers the service or procedure or that it may only be payable when furnished in an outpatient setting. In the November 1, 2002 final rule (67 FR 66739) as well as the April 7, 2000 and the November 30, 2001 final rules, we explain in detail our rationale for the inpatient list. Assignment of an APC payment to a service or procedure does not prohibit hospitals from providing these services on an inpatient basis when it is reasonable and necessary to admit the patient based on the patient's medical condition.

*Comment:* The same commenter repeated objections that have been submitted in comments to OPPS rules in prior years, that it is unfair to deny payment to hospitals for procedures on the inpatient list, but to pay physicians when they perform procedures on the inpatient list in a hospital outpatient setting. The commenter asserts that physicians are not responsive to hospital efforts to educate them regarding Medicare payment for procedures on the inpatient list performed on a patient who has not been admitted as an inpatient because the location that the physician chooses to perform a procedure has no impact on Medicare payment for the physician's professional services. Moreover, the commenter asserts that physicians disagree with assignment of procedures to the inpatient list because new technology or surgical advances allow the procedure to be appropriately performed on an outpatient basis. The commenter urged us to release the inpatient list as part of the physician's fee schedule in order to align hospital and physician incentives.

*Response:* In the November 1, 2002 final rule (67 FR 66740) we responded to similar comments regarding hospitals' concerns about physicians being paid for procedures on the inpatient list that are performed on an outpatient basis even though payment is denied to hospitals for those procedures. As we state above, the basis for the inpatient list is rooted in section 1833(t)(1)(B)(i) of the Act, which gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. The authority in this section of the Act does not extend to services that are covered and paid for under the Medicare physician fee schedule, which is a separate benefit and payment system. However, we believe that as hospitals and physicians continue to gain experience and become more knowledgeable about how Medicare pays for services under the OPPS, problems associated with the existence of the inpatient list will continue to diminish.

Moreover, we welcome at any time recommendations from hospitals and/or physicians regarding procedures currently on the inpatient list that are being safely and appropriately performed on an outpatient basis. Requests for review of a code or group of codes on the inpatient list should be sent to the Director, Division of Outpatient Care, Centers for Medicare & Medicaid Services, Mailstop C4–05–17, 7500 Security Boulevard, Baltimore, MD 21244–1850. Such requests should include supporting information and data to demonstrate that the code meets the five criteria for payment under the OPPS that are listed above, and that are also discussed in the November 1, 2002 final rule (67 FR 66739). In addition, we ask that evidence be submitted, including operative reports of actual cases and peer-reviewed medical literature, to demonstrate that the procedure is being performed on an outpatient basis in a safe and appropriate manner in a variety of different types of hospitals.

*Comment:* The same commenter recommended that we change our policy for OPPS payment of inpatient services when the patient is transferred to another hospital. They state that the current requirement creates unnecessary administrative burden when a hospital, in order to receive payment, must admit a patient simply to stabilize them prior to transfer. The commenter

recommended that, when procedures on the inpatient list are provided to patients in order to stabilize the patient immediately prior to transfer, we ignore the payment status indicator of ''C'' assigned to the procedure on a claim and allow the claim to be paid under the OPPS.

*Response:* Procedures on the inpatient list performed on patients whose status is that of outpatient are not payable under the OPPS. However, we recognize that there are occasions when a procedure on the inpatient list may have to be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient. We also recognize that, once stabilized, such a patient may subsequently require transfer to another facility in order to receive appropriate care. As we explain in the November 1, 2002 final rule (67 FR 66798), when a physician performs a procedure on the inpatient list to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient, we expect the physician to order that the patient be admitted following the procedure for the purpose of receiving inpatient hospital services and occupying an inpatient hospital bed. Or, the physician may order that the patient be admitted and then determine that the patient should be transferred to another provider. In the latter instance, Medicare allows payment for services furnished to a patient who is transferred to another provider. However, in order for the discharging hospital to receive payment in cases where it is determined that appropriate care for the patient necessitates transfer to another provider, long-standing Medicare rules provide that the patient has to have been admitted to the discharging hospital. Further, as we discuss in the November 1, 2002 final rule, it is important that the particular circumstances necessitating performance of a procedure on the inpatient list when the patient's status is that of an outpatient be thoroughly documented in the medical record. For these reasons, we disagree with and are not implementing the commenter's recommendation that we modify the outpatient code editor (OCE) to allow payment under the OPPS for services furnished to resuscitate or stabilize an outpatient with an emergent, life-threatening condition who is transferred to another facility following a procedure on the inpatient list.

*Comment:* One hospital requested that we remove CPT 37182, Insertion of transvenous intrahepatic protosystemic shunts(s) (TIPS), from the inpatient list. One health system requested that we remove CPT 20660, Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure) and CPT 49061, Drainage of retroperitoneal abscess; percutaneous, from the inpatient list.

*Response:* Our medical officers reviewed these recommendations and determined that these codes do not meet the criteria for removing a procedure from the inpatient list and assignment to an APC. We would expect patients whose medical condition requires these procedures to be admitted as inpatients in order to have these procedures performed. Our data indicate that these procedures are performed predominantly in the inpatient setting. Therefore, in the absence of evidence demonstrating that these procedures are being performed on an outpatient basis in a safe and appropriate manner in a variety of different types of hospitals and that the criteria for removing a procedure from the inpatient list are met, we are retaining these codes on the inpatient list.

*Comment:* A provider group requested that we change the status indicator of the following codes from ''N'' to ''C,'' because these are add-on codes for procedures already on the inpatient list: CPT 61316, Incision and subcutaneous placement of cranial bone graft; CPT 61517, Implantation of brain intracavitary chemotherapy agent; CPT 62148, Incision and retrieval of subcutaneous cranial bone graft for cranioplasty; and, CPT 62160, Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage.

*Response:* We thank the commenter for bringing these codes to our attention and we agree that the status indicator for these codes should be changed from ''N'' to ''C.''

*New APC To Pay for Services Furnished on Same Date as Service With Modifier -CA:*

In the 2003 update of the OPPS, we implemented a new modifier -CA, Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies before admission. In section VI of Transmittal A–02–129, issued on January 3, 2003, we instructed hospitals on the use of modifier -CA when submitting a claim on bill type 13x for a procedure that is on the inpatient list and that is assigned payment SI ''C.'' (Transmittal A–02–129 can be found on our web site at *cms.hhs.gov*.) We also implemented in the November 1, 2002 final rule (67 FR 66799) a new payment policy to allow payment, under certain conditions, for outpatient services on a claim that have the same date of service as the HCPCS code billed with modifier -CA. A single payment for outpatient services on the claim, other than those coded with SI ''C'' and modifier -CA, is currently made under APC 0977.

We reviewed this policy and determined that assigning payment for these services to APC 0977, which is a New Technology APC, is problematic because payment under New Technology APCs is a fixed amount that does not have a relative payment weight and is, therefore, not subject to recalibration based on hospital costs. We proposed to establish a new APC for which payment would be made under certain conditions for otherwise payable outpatient services furnished on the same date of service that a procedure with SI ''C'' is performed emergently on an outpatient who dies before admission to the hospital as an inpatient. Beginning in 2004, hospitals would be paid under APC 0375 instead of APC 0977 for services furnished on the same date of service that a procedure with SI ''C'' and modifier -CA is billed. We proposed at the outset to set the payment rate for APC 0375 in the amount of $1,150, which is the payment amount for the newly structured New Technology APC that would replace APC 0977. When the APC weights are recalibrated in 2005, we would use charge data from CY 2003 claims for line items that have the same date of service as the line with modifier -CA and that show a HCPCS code with status indicator ''V,'' ''S,'' ''T,'' ''X,'' ''N,'' or ''K'' to calculate a median cost and relative payment weight for APC 375. Once we have claims data, we would be able to determine whether it is appropriate to calculate a relative payment weight based on median costs from our claims data or to continue a fixed payment rate for these special cases. In the proposed rule, we invited comments on these proposed changes.

*Comment:* One commenter was concerned with the methodology for calculation of APC 375, Ancillary Outpatient Services when Patient Expires. The commenter stated that items such as pass-through devices and drugs and packaged items reported without HCPCS should be included in the calculation.

*Response:* It is conceivable that a pass-through drug or device could be furnished to a patient during the same encounter when a procedure billed with modifier -CA is performed. If that were the case, we would expect the hospital to include these services on the claim submitted for the encounter. Although

we would not pay separately for the pass-through items, we agree with the commenter that we should consider taking these costs into account when evaluating how best to establish the payment rate for APC 375 in future updates of the OPPS. We also agree that charges reported with a revenue code but without a HCPCS code should be considered as well.

*E. Partial Hospitalization Payment Methodology*

1. Background

As we discussed in the April 7, 2000 OPPS final rule (65 FR 18452), partial hospitalization is an intensive outpatient program of psychiatric services provided to patients in place of inpatient psychiatric care. A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a Medicare-certified community mental health center (CMHC). Payment to providers under the OPPS for PHPs represents the provider's overhead costs associated with the program. Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we established a per diem payment methodology for the PHP APC, effective for services furnished on or after August 1, 2000.

The analysis of hospital partial hospitalization claims resulted in a per diem payment of $202.19, effective August 1, 2000. This amount was updated effective January 1, 2001 and April 1, 2002 to $206.82 and $212.27, respectively.

Effective January 1, 2003, the PHP APC amount was $240.03, of which $48.17 is the beneficiary's coinsurance. In the proposed rule, we described the methodology we followed in developing the 2003 PHP payment rate.

2. PHP APC Update for CY 2004

For CY 2004, we analyzed hospital and CMHC PHP claims for services furnished between April 1, 2002 and December 31, 2002. We intended to propose to use the same methodology for computing median costs per day for CY 2004 that was used to compute the CY 2003 PHP median cost per day. However, when we applied the methodology to the CMHC claims, the CMHC median cost per day was determined to be significantly higher than the median cost per day for hospital outpatient departments to provide the same benefit. In addition, the difference in median costs per day was significantly larger than last year.

As a result, we proposed a per diem rate for PHP services furnished during CY 2004 based solely on hospital PHP data. The proposed PHP APC 0033 amount, after scaling, was determined to be $208.95, of which $41.69 is the beneficiary's coinsurance.

However, a Program Memorandum issued on January 17, 2003, directed the FIs to recalculate hospital and CMHC cost-to-charge ratios. We anticipated receipt of the updated ratios this summer, and indicated that if the updated cost-to-charge ratios resulted in a more reasonable median per diem rate, we would use the CMHC data in developing the final rate for CY 2004.

We received 42 public comments in response to this proposal. A summary of the comments is provided below along with our responses.

*Comment:* In general, the commenters expressed concern that a reduction in the PHP rate of this magnitude would lead to the closure of many PHPs and that limited access to this crucial service would result in more costly inpatient hospital care as the ony alternative. A hospital association commented that basing the rate on only hospital data is inconsistent with other prospective payment systems and recommended that we find an alternative method to secure reliable CMHC data. CMHCs commented that their costs are higher than hospitals', with most in the $300 to $400 range. One commenter provided summary information on the average per day costs for seven CMHCs. Although the average per day cost for these seven providers was $390, the costs for individual providers ranged from $216 to $725. Unfortunately, the commenter did not provide a breakdown of these costs. Another commenter indicated that a per day rate of $300 to $350 was more appropriate than our proposed amount.

Another commenter stated that our inability to process the data timely does not constitute an appropriate basis for excluding all CMHC data from the per diem calculations. The commenters suggested alternatives such as including prior years' CMHC data trended forward based on medical inflation or maintaining the CY 2003 payment rate for PHP services furnished in CY 2004. One commenter questioned why the median cost per day for hospitals was reported as $225 but the proposed rate was reduced to $208.95.

*Response:* As we stated in the August 12, 2003 proposed rule, we intended to review the PHP data using the updated cost-to-charge ratios to compute the final CY 2004 PHP APC. As expected, the updated ratios reduced the median cost per day for CMHCs. The revised medians are $440 for CMHCs and $206 for hospitals. Combining these files results in a median per diem PHP cost of $303. As with all APCs in the OPPS, the median cost for each APC is scaled to be relative to a mid-level office visit and the conversion factor is applied. The resulting APC amount for CY 2004 is $286.82 of which $57.36 is the beneficiary's coinsurance.

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

*Response:* We used the best available data in computing the APCs. The January 17, 2003 Program Memorandum directed FIs to update the cost-to-charge ratios on an ongoing basis whenever a more recent full year cost report is available. In this way, we hope to minimize the time lag between the cost-to-charge ratios and claims data.

*Comment:* One commenter provided links to certain data files that were used to establish the APC rates. Since APC 0033 and certain HCPCS codes that are only paid under OPPS when they are furnished as part of a PHP were not included in these data files, the commenter believed that the data used to establish the PHP APC amount is incomplete.

*Response:* These data files are provided so that interested parties can study the costs associated with the HCPCS codes that comprise each APC and other analyses. We are required to include the HCPCS codes within each APC that are similar in resource use. This is not the case with the PHP APC (0033) in which the day of care is the unit that defines the structure and scheduling of PHPs and the composition of the PHP APC consists of the cost of all services provided each day. Although we require that each PHP day include a psychotherapy service, we do not specify the specific mix of other services provided and have focused our analysis on the cost per day rather than the cost of each service furnished within the day. As a result, we will add APC 0033 to the file that displays the APC median costs, but not the PHP data that show medians by HCPCS codes. We will continue to analyze the PHP data and will reconsider this position in the future.

*Comment:* One commenter related that administrative costs for CMHCs continue to be a major impediment to operating PHPs for Medicare beneficiaries. Medicare does not cover transportation to and from programs and does not cover meals. Almost all programs offer transportation because in

most cases Medicare beneficiaries with serious mental illnesses would not be able to access these programs without the transportation. They also commented about the current Medicare bad debt policy, which is beyond the scope of the August 12, 2003 proposed rule.

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

*Comment:* Several commenters summed the median cost figures for various combinations of HCPCS codes 90853 (group psychotherapy), 90818 (individual psychotherapy, 45–50 minutes), and 90847 (family psychotherapy, with patient present) and concluded that the per diem amount is considerably less than the combined cost of these services.

*Response:* We believe that the figures cited by the commenters were taken from a file that shows the median cost for single bills, for example, where group psychotherapy was the only service furnished. We do not believe that this is an appropriate comparison. These amounts are provided to enable the public to identify the median cost of services before scaling. It is important to note that these services are not PHP services, but rather single outpatient therapeutic sessions. As stated earlier, we used data from PHP programs (both hospitals and CMHCs) to determine the median cost of a day of PHP. PHP is a program of services where savings can be realized by hospitals and CMHCs over delivering individual psychotherapy services.

*Comment:* Several commenters compared the proposed per diem amount to the cost of the minimum services mandated by us or by the local medical review policies (LMRP) used by their FIs.

*Response:* We have not specified the specific daily components of a PHP. However, there is an edit in our claims processing system to identify claims that do not have at least three services, with at least one psychotherapy service (individual, group, or family therapy) for each day of PHP care. We have implemented this edit to ensure that PHPs meet the statutory requirement that they be intensive treatment programs provided in lieu of inpatient psychiatric hospital services. Claims with fewer than three services per day undergo medical review by the FIs to ensure that the patient is receiving intensive treatment. There may be legitimate reasons for a day on a claim to have fewer services, for example, where the patient leaves the program early to receive medical care. Medical review of these claims verifies that the patient requires and is receiving a PHP level of care.

*Comment:* The commenters also questioned our requirement that psychotherapy services be conducted by a Master's level practitioner. One commenter questioned how a hospital could comply with the three services per day requirement when licensed clinical social worker (CSW) services are bundled into the per diem payment.

*Response:* We do not require that a Master's prepared practitioner furnish psychotherapy services in a PHP. However, in accordance with section 1861(ff)(2)(A) of the Act, we require that practitioners who furnish psychotherapy services are authorized to do so by their States, through licensure, certification, or other official State processes. When a service is furnished by a practitioner who is not authorized by the State to furnish psychotherapy services, the service would not be recognized as a PHP service.

With respect to billing by CSWs, the professional component of services furnished by CSWs to PHP patients is bundled into the per diem payment amount and no billing to the Part B carrier is permitted. The rationale for this policy was explained in the interim final regulation with comment period we published on February 11, 1994 (59 FR 6570).

The OPPS is intended to pay PHP providers for the resources associated with sponsoring a PHP, for example, building maintenance, utilities, and support staff, including the cost of CSWs. Thus, where a PHP provider utilizes CSWs for psychotherapy services to PHP patients, payment for the professional costs of the CSW is made through the OPPS per diem payment. However, if a PHP utilizes psychiatrists, clinical psychologists, nurse practitioners, physician assistants, or clinical nurse specialists to furnish therapeutic services to PHP patients, the physician or practitioner may bill the Part B carrier for payment under the physician fee schedule for their professional services. When this occurs, the PHP provider may bill the FI under the OPPS for the facility resources associated with the psychotherapy service.

We note that a physician or any of the practitioners specified in 42 CFR 410.43(b) (including CSWs) may bill the Part B carrier for their professional services furnished to hospital outpatients who are *not* in a PHP. In this case, the hospital would bill the FI under the OPPS for the facility resources associated with the service furnished.

*Comment:* Several commenters suggested alternative methodologies for paying PHP providers, such as linking per diem and outlier payments to the units of service furnished each day or paying providers the average of all PHP costs plus 40 percent, subject to final settlement based on the provider's cost.

*Response:* We plan further analysis of the PHP data and may propose changes to the payment methodology for CY 2005. We note that OPPS is a prospective system and a methodology with interim payments subject to cost settlement would not be allowable under the statute.

*Comment:* One commenter believes the sample used to determine the rates is skewed and represents a subset of the provider community that provides PHP services.

*Response:* We do not agree that the sample is skewed. All facilities that submit claims for PHP services have been included in the development of the final rate.

3. Outlier Payments for PHPs

In a related matter, the use of historical cost-to-charge ratios applied to current charges has resulted in an excessive amount of outlier payments being made to CMHCs. As a result of more in-depth analysis of the 2001 data files that were used to compute the CY 2003 PHP per diem amount, we discovered a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP.

In the August 12, 2003 proposed rule, we stated that given the difference in PHP charges between hospitals and CMHCs, we did not believe it was appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. Therefore, we proposed to designate a portion of the estimated 2.0 percent outlier target amount specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS in CY 2004, excluding outlier payments. Since CMHCs were projected to receive 0.36 percent of total OPPS payments in CY 2004, excluding outlier payments, we proposed to designate 0.36 percent of the estimated 2.0 percent outlier target amount for CMHCs and establish a threshold to achieve that level of outlier payments. Based on our simulations of CMHC payments in 2004, we proposed to set the threshold for CY 2004 at 11.75 times the PHP APC payment amount. We proposed to apply the same outlier payment percentage that applies to hospitals. Therefore, for CY 2004, we

proposed to pay 50 percent of CMHC and hospital per diem costs over the threshold.

*Comment:* Several commenters representing CMHCs suggested that in developing our proposed outlier policy, we made generalizations and overreacted to a few aberrant providers. Also, these commenters believe the per diem amount is insufficient and that outlier payments would provide the additional amounts they needed to stay in business until more representative data could be obtained and analyzed.

*Response:* Based on our analysis of PHP claims data, nearly half of the CMHCs billing for PHP services in 2002 received outlier payments. The total dollar amount of outlier payments received by these CMHCs was nearly equal to the total amount all CMHCs received in per diem payments. Of those CMHCs that received outlier payments, 56 percent received an average of more than $200 per day in outlier payments, 30 percent received more than $300 per day in outlier payments, 21 percent received more than $400 per day in outlier payments, and 11 percent received more than $500 per day in outlier payments.

The outlier policy is intended to compensate providers for treating exceptionally resource-intensive patients. Outlier payments were never intended to be made for all patients and used as a supplement to the per diem payment amount. Our analysis showed that the CMHC average charge per day increased by 31 percent from CY 2001 to CY 2002. We do not believe this increase in charges correlates to an equivalent increase in CMHC costs. Rather, our analysis indicates that the increase in charges was made in order to qualify for outlier payments to cover CMHC operating expenses, not for patients who are exceptionally resource-intensive. We are concerned that if CMHCs continue this pattern of escalating charges, CMHCs will receive a disproportionate share of outlier payments compared to non-CMHCs that do not artificially inflate their charges, thereby limiting outlier money for truly deserving cases.

*Comment:* Although one commenter supported our proposed outlier policy, most commenters, including major hospital associations, did not believe it was sound policy to create separate outlier thresholds based on site of service.

*Response:* Applying the updated cost-to-charge ratios reduced the CMHC charges to better reflect their costs. We are concerned, however, that the impact of updated cost-to-charge ratios may be mitigated by future increases in charges. We proposed an outlier policy in consideration of the charges on the claims, the cost report data available, and the payments made to CMHCs. Our analysis indicates that CMHCs have dramatically increased their charges between CY 2001 and CY 2002. Between CYs 2001 to 2002, CMHC average per diem charges increased by 31 percent. We believe that in most cases, these increases in charges were not related to a corresponding increase in costs, but rather were designed to enhance outlier payments. We believe the data may indicate a pattern of artificially inflated charges by CMHCs that needs to be addressed. Although we agree that establishing site of service differences is not generally the preferred approach, we continue to believe that establishing two separate outlier percentages is the most appropriate way to address the problem to account for the disparity between hospital and CMHC PHP per diem charges.

For these reasons, for CY 2004, we are establishing a separate CMHC threshold. The threshold is based on the proportion of total OPPS payments CMHCs are estimated to receive in CY 2004. As stated earlier in this section, our analysis indicated that CMHCs were projected to receive 0.36 percent of total OPPS payments in CY 2004, excluding outlier payments. Therefore, we proposed to designate 0.36 percent of the estimated 2.0 percent outlier target amount for CMHCs and establish a threshold to achieve that level of outlier payments. Based on our simulations of CMHC payments in 2004, we proposed to set the threshold for CY 2004 at 11.75 times the PHP APC payment amount. We have updated our simulations using the final CY 2004 PHP per diem rate. CMHCs are now projected to receive approximately 0.5 percent of estimated total OPPS payments in CY 2004, excluding outlier payments. We have calculated the CMHC outlier threshold to achieve that level of payment. The resulting threshold for CY 2004 is 3.65 percent times the APC 0033 payment amount. We will apply the same outlier payment percentage that applies to hospitals. Therefore, for CY 2004, we will pay 50 percent of the difference between CMHC per diem costs and the CMHC outlier threshold amount. We intend to analyze whether a separate CMHC outlier threshold will continue to be appropriate in future updates.

## XII. General Data, Billing, and Coding Issues

We received a number of general comments about OPPS data and related issues to which we respond below. Not all coding questions are addressed, however. We do not believe that the final rule is the appropriate venue in which to address specific inquiries about billing.

*OPPS Data*

*Comment:* A commenter indicated that it was difficult to model the August 12, 2003 proposed rule after its release and urged us to provide timely responses to questions about data, data files, and the specifics of the methodology used to generate relative weights, either by having data meetings or by clarifying the language in the final rule and median cost files. The commenter asked that we create a web-site to post responses to questions on data so that the information will be available for all to use. The commenter also asked that a number of data elements be added to the median cost file and the limited data set of claims that is available for public purchase.

*Response:* We have tried to respond to questions on data related issues on a flow basis. However, staff limitations and the need to develop the final rule greatly restrict the amount of time that our staff can devote to replying to these questions. Moreover, creation and maintenance of a web-site to post answers to questions from a few people with special interests is not a good use of our limited staff resources. We would encourage interested parties who have suggestions for improving our data file clarity to contact us with those specifics.

*Creation of a National Outpatient Coding Governing Body*

*Comment:* A commenter indicated that we should create an outpatient coding governing body that would educate providers regarding the correct use of codes, maintain a web-site on which all guidance on coding would be maintained, and oversee the Medicare fiscal intermediary interpretation of codes to ensure national uniformity across fiscal intermediaries.

*Response:* The HCPCS codes most often used for payment under OPPS are CPT codes, which are created and owned by the American Medical Association (AMA). Providers should look to the many resources available from the AMA for education regarding the correct use of CPT codes. The alphanumeric HCPCS codes are created and owned by us but they form a very limited portion of the services payable under OPPS and, as providers have frequently asked, we attempt to eliminate alphanumeric codes whenever possible and to work with the AMA to create CPT codes for use in both the physician fee schedule and the OPPS.

We attempt to provide coding guidance on alphanumeric codes, which are usually created only when there is a coverage or payment decision and when there is no CPT code that describes the service being covered or paid. However, providers must look to the AMA for education and support in the use of the CPT codes that form the bulk of OPPS.

*Comment:* We received one comment requesting that we publish updated addenda each quarter.

*Response:* The addenda that are published annually online are an official public record that cannot be changed without going through the **Federal Register**. We provide the Addenda in Excel format for the convenience of users since it is difficult to manipulate data in pdf format.

We also received a number of comments that were not relevant to the proposals made in the August 12, 2003 proposed rule. The commenters requested specific coding changes and requested clarification or guidance regarding certain billing requirements. Although we will provide answers to the questions raised, the final rule is not the appropriate venue for that guidance. We will consider the requests and suggestions provided, and will continue our ongoing efforts to formulate and publish billing instructions. Similarly, we will consult with our clinical experts regarding the suggestions made regarding coding of outpatient department procedures and other services.

*Revenue Code Edits*

*Comment:* A commenter asked whether we permit fiscal intermediaries to impose CPT to revenue code edits. The commenter believes that CMS has said that providers may choose the revenue code that applies to the item or service being billed but that some fiscal intermediaries have imposed revenue code to CPT edits that prevent hospitals from billing the service under the revenue code that they believe is appropriate and that cause unnecessary and unfair payment denials.

*Response:* We have issued some instructions that require that specific revenue codes be billed with certain HCPCS codes, such as specific revenues codes that must be used when billing for devices that qualify for pass-through payments. Where explicit instructions have not been issued, we instructed intermediaries to advise hospitals to report charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report. However, we have not explicitly prohibited intermediaries from installing the revenue code to HCPCS code edits, so it is possible that certain edits are applied by some intermediaries and not others. The commenter did not provide examples of the edits that are causing what the commenter considers to be unnecessary and unfair payment denials.

*New CPT Venous Access Codes*

*Comment:* A commenter indicated that CPT had revised its venous access codes and encouraged us to use external information to determine hospital acquisition costs for devices used in these procedures.

*Response:* We carefully reviewed the new CPT codes for insertion of venous access devices and we assigned the new CPT codes to APCs based on our clinicians' view of the relative amount of hospital resources that the services, as described by the new codes, would use. We note that the new CPT codes represent longstanding services, albeit with new code descriptions and code numbers. Since these are new CPT codes (albeit for existing services), the APC and status indicator assignments are interim and subject to comment.

*New ''NI'' Drug Codes*

There are several new HCPCS codes for drugs, biologicals, and radiopharmaceuticals that are new for 2004. Since these codes were not subject to public comment in the August 12, 2003 proposed rule, they have been assigned to code condition ''NI'' and are subject to public comments following the publication of this rule. Some of these new codes for drugs and radiopharmaceuticals are replacements for codes for which we have hospital cost data. In these cases, we cross-walked the data for the expired codes to the new codes to determine their packaging status and payment rates. For codes that did not have a predecessor, we had no means to determine associated hospital costs; therefore, we assigned the codes to packaged status for 2004. We reinforce the importance of billing for packaged codes with appropriate charges so that we can collect cost data on these codes to use for future rate setting. We invite comments on the status indicators that have been assigned to these codes. Commenters who would like us to consider their cost data for these codes may submit verifiable external information according to the criteria set forth in the August 12, 2003 proposed rule.

*Status Indicator Changes for Services Currently Packaged*

*Comment:* A commenter asked us to pay separately for the following services for which payment is currently packaged into payment for other services. Commenters asked that we change the SI for CPT code 36540, collection of blood from an implanted access device, to a payable SI because otherwise hospitals would be forced to bill an E&M code when this is the only service provided. Commenters asked that we change the SI for 36600, withdrawal of arterial blood, from an ''N'' to a ''T'' since it requires more effort and risk than a simple venipuncture (which is paid separately under the clinical laboratory fee schedule). Commenters asked that we change the SI for 90471 and 90472, vaccine administration and each subsequent administration, from N to X since patients may present only to receive the vaccine because otherwise hospitals must bill an E&M to receive any payment. Commenters asked that we change the SI for CPT codes 94760, 94761, and 94762, Pulse oximetry, multiple and continuous, from ''N'' to ''X'' because these may be the only services the patient receives and, in the case of CPT code 94762, the service continues for a long period of time. Commenters also asked that we change the SI for the following services from ''N'' to ''C'' since they are add-ons to services that are inpatient only: 61316, 61517, 62148, and 62160.

*Response:* We will carefully consider the status indicator changes for the currently packaged services for which the commenter wants separate payment for 2005 OPPS. The commenters did not provide enough information or empirical evidence to convince us of the need for these changes and so we would like to have the opportunity to receive input about this from the APC Panel. We have revised the SI for the following codes from ''N'' to a ''C'' in recognition that if there are charges for these codes which are add-ons to inpatient only procedures, they are billing errors and should not be packaged into the median costs for other procedures on the claim that can be paid in the outpatient department: 61316, 61517, 62148, and 62160.

## XIII. Provisions of the Final Rule With Comment Period for 2004

*A. Changes Required By Statute*

We made the following changes to implement statutory requirements:

- Added APCs, deleted APCs, and modified the composition of some existing APCs.

- Recalibrated the relative payment weights of the APCs.
- Updated the conversion factor and the wage index.
- Revised the APC payment amounts to reflect the APC reclassifications, the recalibration of payment weights, and the other required updates and adjustments.
- Ceased transitional pass-through payments for drugs and biologicals and devices that will have been paid under the transitional pass-through methodology for at least 2 years by January 1, 2004.
- Ceased transitional outpatient payments (TOPS payments) for all hospitals paid under OPPS except for cancer hospitals and children's hospitals.

*B. Additional Changes*

We made the following additional changes to the OPPS:

- Adjusted payment to moderate the effects of decreased median costs for non-pass-through drugs, biologicals, and radiopharmaceuticals.
- Changed status indicators for HCPCS codes.
- Listed midyear and proposed HCPCS codes that are paid under OPPS.
- Allocated a portion of the outlier percentage target amount to CMHCs and created a separate threshold for outlier payments for partial hospitalization services.
- Created methodology and payment rates for separately payable drugs and radiopharmaceuticals for 2004.
- Changed the status indicator and payment amount for P901 by assigning it to APC 0957 (Platelet concentrate) with a payment rate of $37.30.

*C. Major Changes From the Proposed Rule*

- We will apply a $50 threshold in lieu of the proposed $150 threshold in determining which drugs to pay for separately.
- We will set payment for all except two orphan drugs that meet our criteria for special payment under the OPPS at 88 percent of their AWP as established in the April 2003 single drug pricer (SDP). Based on widely available market prices for two orphan drugs, we will set the payment for these two orphan drugs at 94 percent of their AWP.
- We will set payment rates for 2004 for blood and blood products at 2003 payment rates.

## XIV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

The OPPS provisions set forth in this final rule do not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

## XV. Response to Public Comments

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

## XVI. Regulatory Impact Analysis

*A. General*

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We estimate the effects of the provisions that will be implemented by this final rule will result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from changes in the final rule as well as enrollment, utilization, and case mix changes) in expenditures under the OPPS for CY 2004 compared to CY 2003 to be approximately $0.607 billion. Therefore, this final rule is an economically significant rule under Executive Order 12866, and a major rule under 5 U.S.C. 804(2).

The RFA requires agencies to determine whether a rule will have a significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year (*see* 65 FR 69432).

For purposes of the RFA, we have determined that approximately 37 percent of hospitals will be considered small entities according to the Small Business Administration (SBA) size standards. We do not have data available to calculate the percentages of entities in the pharmaceutical preparation manufacturing, biological products, or medical instrument industries that will be considered to be small entities according to the SBA size standards. For the pharmaceutical preparation manufacturing industry (NAICS 325412), the size standard is 750 or fewer employees and $67.6 billion in annual sales (1997 business census). For biological products (except diagnostic) (NAICS 325414), with $5.7 billion in annual sales, and medical instruments (NAICS 339112), with $18.5 billion in annual sales, the standard is 50 or fewer employees (*see* the standards Web site at *http://www.sba.gov/regulations/siccodes/*). Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area (MSA) and has fewer than 100

beds (or New England County Metropolitan Area (NECMA)). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the OPPS, we classify these hospitals as urban hospitals. We believe that the changes in this final rule will affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. Therefore, we conclude that this final rule will have a significant impact on a substantial number of small entities.

Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule will not mandate any requirements for State, local, or tribal governments. This final rule will not impose unfunded mandates on the private sector of more than $110 million dollars.

Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes a final rule that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined this final rule in accordance with Executive Order 13132, Federalism, and have determined that it will not have an impact on the rights, roles, and responsibilities of State, local or tribal governments. The impact analysis (*see* Table 15) shows that payments to governmental hospitals (including State, local, and tribal governmental hospitals) will increase by 4.9 percent under the final rule.

*B. Changes in This Final Rule*

We are making several changes to the OPPS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We are also required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this final rule, we are updating the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2004 as we discuss in sections IX and VII, respectively, of this final rule. We are also revising the relative APC payment weights based on claims data from April 1, 2002 through December 31, 2002. Finally, we are removing two devices and eight drugs and biological agents from pass-through payment status. Alternatives to the changes we proposed and why we did not accept them are discussed throughout this final rule. In particular, see section V.B with regard to the expiration of pass-through payment for devices; see section VI.B with regard to the expiration of pass-through payment for drugs and biological agents.

Under this final rule, the change to the conversion factor as provided by statute will increase total OPPS payments by 4.5 percent in 2004. The changes to the wage index and to the APC weights (which incorporate the cessation of pass-through payments for many drugs and devices) will not increase OPPS payments because the OPPS is budget neutral. However, the wage index and APC weight changes will change the distribution of payments within the budget neutral system as shown in Table 15 and described in more detail in this section. The overall 4.5 percent increase does not take into account the expiration of transitional corridor payments or the end of the hold harmless provisions for small rural hospitals.

*A. Alternatives Considered*

Alternatives to the changes we are making and the reasons that we have chosen the options we have are discussed throughout this final rule. Some of the major issues discussed in this rule and the sections in which they are discussed follow:

| Issue | Preamble section |
|---|---|
| Drug packaging threshold | VI.B.2. |
| Drug administration | VI.B.4. |
| Adjustment of median costs | II.B. |
| Outlier policy | X.A. |
| Device coding | V.C. |
| Payment adjustment for small rural hospitals. | X.B. |
| Payment for orphan drugs, generic drugs and blood. | VI.B. |
| APC changes | II.A and III.C. |

Conclusion

It is clear that the changes in this final rule will affect both a substantial number of rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this final rule, constitutes a regulatory impact analysis.

The OPPS rates for CY 2004 will have, overall, a positive effect for every category of hospital. These changes in the OPPS for 2004 will result in an overall 4.5 percent increase in Medicare payments to hospitals, exclusive of outlier and transitional pass-through payments. We also noted that both the overall 4.5 percent increase and the percent changes to individual classes of hospitals depicted in Table 15 are exclusive of any impacts to those hospitals that would result from the expiration of the transitional corridor payments or the end of the hold harmless provision for small rural hospitals. As described in the preamble, budget neutrality adjustments are made to the conversion factor and the relative weights to ensure that the revisions in the wage index, APC groups, and relative weights do not affect aggregate payments. We also note that both the overall 4.5 percent increase and the percent changes to individual classes of hospitals depicted in Table 15 are exclusive of any impacts to those hospitals that would result from the expiration of the transitional corridor payments or the end of the hold harmless provision for small rural hospitals. The impact of the wage and recalibration changes does vary somewhat by hospital group. Estimates of these impacts are displayed on Table 15.

The overall projected increase in payments for urban hospitals is slightly lower (4.3 percent) than the average increase for all hospitals (4.5 percent) while the increase for rural hospitals is slightly greater (4.9 percent) than the average increase. Again, as noted above, these numbers do not include the effect of the expiration of the transitional hold harmless payments to small rural hospitals. The introduction of a new wage index combined with changes to the APC structure will result in small distributional changes for all categories of hospitals. Rural hospitals will gain 0.2 percent from the wage index change and another 0.2 percent as a result of APC changes. Large urban hospitals will lose 0.2 percent from the APC change, whereas ''other'' urban hospitals show an increase of 0.1 percent from the APC changes. A discussion of the distribution of outlier payments that we project under this final rule can be found under section XV.E below. Table 16 presents the outlier distribution that we expect to see under this final rule.

*C. Limitations of Our Analysis*

The distributional impacts represent the projected effects of the policy changes, as well as statutory changes effective for 2004, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per service while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our policy changes. In addition, we do not make adjustments for future changes in variables such as service volume, service mix, or number of encounters.

*D. Estimated Impacts of This Final Rule on Hospitals*

The OPPS is a budget neutral payment system under which the increase to the total payments made under OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The impact tables show the redistribution of hospital payments among providers as a result of a new wage index and APC structure. In some cases, under this final rule, hospitals will receive more total payment than in 2003 while in other cases they will receive less total payment than they received in 2003. The impact of this final rule will depend on a number of factors, most significant of which are the mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services will change) and the impact of the wage index changes on the hospital.

Column 4 in Table 15 represents the full impact on each hospital group of all the changes for 2004. Columns 2 and 3 in the table reflect the independent effects of the final change in the wage index and the APC reclassification and recalibration changes, respectively. We excluded critical access hospitals (CAHs) from the analysis of the impact of the final 2004 OPPS rates that is summarized in Table 15. For that reason, the total number of hospitals included in Table 15 (4,378) is lower than in previous years. CAHs are excluded from the OPPS.

To a very limited extent, wage index changes favor rural hospital categories. Large urban hospitals with greater than 500 beds show the largest percent decrease (−3.0) attributable to wage index changes. Rural hospitals show modest increases of 0.2 percent for most bed sizes but show the largest gains for categories with fewer than 50 beds or 150 to 199 beds where the wage index change results in a 0.4 percent increase. Rural hospitals located in Puerto Rico show the largest negative impact (−2.5 percent) due to changes in the wage index. Hospitals located in the Middle Atlantic region also experience a large negative impact −0.6 percent due to wage index changes regardless of urban or rural designation. However, this effect is somewhat lessened by the distribution of outlier payments as discussed in more detail below.

The APC reclassification and recalibration changes also favor rural hospitals with the exception of rural hospitals with 200 or more beds that show a negative effect (−0.8 percent). Conversely, urban hospitals with greater than 199 beds show a decrease attributed to APC recalibration. Urban hospitals in excess of 500 beds show a 0.5 percent decrease as a result of APC recalibration. In general, APC changes are small and result in very few distributional changes among hospital categories.

In both urban and rural areas, hospitals that provide a lower volume of outpatient services are projected to receive a larger increase in payments than higher volume hospitals. In rural areas, hospitals with volumes between 5,000 and 20,999 are projected to experience increases larger than 5.0 percent. Urban hospitals that provide low-volume services show similar rates of increases (5.0 percent). Conversely, urban and rural hospitals providing more than 21,000 services are projected to experience a rate of increase in the 4.0 to 4.7 percent range.

Major teaching hospitals are projected to experience a smaller increase in payments (3.7 percent) than the aggregate for all hospitals (4.5 percent) due to negative impacts from both the wage index (−0.4 percent) and APC recalibration (−0.4 percent). Hospitals with less intensive teaching programs are projected to experience an overall increase (4.5 percent) that is equal to the average for all hospitals. There is little difference in impact among hospitals that serve low-income patients where increases in payments range from 4.3 to 4.7 percent higher than in 2003.

Psychiatric hospitals and long term care facilities show the largest increase in payment rates among all categories of hospital providers. Psychiatric hospitals show an increase of 18.2 percent as a result of an increase in payment rates for partial hospitalization programs and for other services such as psychotherapy. Also, payments made to psychiatric facilities represent a small portion of total spending for OPPS, approximately 60.6 million dollars for 2004. Long-term care facilities show a growth rate of 7.5 percent over payments made in 2003. We believe this is the result of a policy change that removes payments made for therapy services from the physician fee schedule to the hospital outpatient prospective payment system. Payments made for long-term care account for a small amount of OPPS payments, approximately 14.5 million for 2004.

TABLE 15.—IMPACT OF CHANGE FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

[Percent change in total payments to hospital (program and beneficiary); does not include hold harmless, corridor, outlier or transitional pass-through payments]

| | Number of hospitals (1) | New Wage index (2) | APC changes (3) | All CY 2004 changes (4) |
|---|---|---|---|---|
| ALL HOSPITALS | 4,378 | 0 | 0 | 4.5 |
| NON-TEFRA HOSPITALS | 3,854 | 0 | −0.1 | 4.4 |
| URBAN HOSPS | 2,383 | −0.1 | −0.1 | 4.3 |
| LARGE URBAN (GT 1 MILL.) | 1,377 | 0 | −0.2 | 4.2 |
| OTHER URBAN (LE 1 MILL.) | 1,006 | −0.1 | 0.1 | 4.4 |
| RURAL HOSPS | 1,471 | 0.2 | 0.2 | 4.9 |
| BEDS (URBAN) | | | | |
| 0–99 BEDS | 538 | 0.1 | 0.6 | 5.2 |
| 100–199 BEDS | 878 | −0.1 | 0.3 | 4.8 |
| 200–299 BEDS | 454 | −0.1 | −0.1 | 4.3 |
| 300–499 BEDS | 363 | 0.1 | −0.4 | 4.2 |
| 500 + BEDS | 150 | −0.3 | −0.5 | 3.7 |
| BEDS (RURAL) | | | | |
| 0–49 BEDS | 699 | 0.4 | 0.6 | 5.6 |

TABLE 15.—IMPACT OF CHANGE FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent change in total payments to hospital (program and beneficiary); does not include hold harmless, corridor, outlier or transitional pass-through payments]

| | Number of hospitals (1) | New Wage index (2) | APC changes (3) | All CY 2004 changes (4) |
|---|---|---|---|---|
| 50–99 BEDS | 454 | 0.2 | 0.6 | 5.3 |
| 100–149 BEDS | 190 | 0.2 | 0 | 4.7 |
| 150–199 BEDS | 66 | 0.4 | 0.1 | 4.9 |
| 200 + BEDS | 62 | 0.1 | −0.8 | 3.7 |
| VOLUME (URBAN) | | | | |
| LT 5,000 Lines | 186 | 0.1 | 1 | 5.6 |
| 5,000–10,999 Lines | 350 | 0 | 0.9 | 5.4 |
| 11,000–20,999 Lines | 499 | −0.1 | 0.7 | 5.1 |
| 21,000–42,999 Lines | 720 | 0.1 | 0.1 | 4.6 |
| GT 42,999 Lines | 628 | −0.1 | −0.4 | 4 |
| VOLUME (RURAL) | | | | |
| LT 5,000 Lines | 364 | 0.3 | 0 | 4.8 |
| 5,000–10,999 Lines | 466 | 0.3 | 0.5 | 5.3 |
| 11,000–20,999 Lines | 346 | 0.2 | 0.7 | 5.4 |
| 21,000–42,999 Lines | 234 | 0.3 | 0 | 4.7 |
| GT 42,999 Lines | 61 | 0.1 | −0.4 | 4.2 |
| REGION (URBAN) | | | | |
| NEW ENGLAND | 128 | −0.3 | −0.3 | 3.9 |
| MIDDLE ATLANTIC | 369 | −0.6 | −0.5 | 3.4 |
| SOUTH ATLANTIC | 353 | 0 | 0 | 4.5 |
| EAST NORTH CENT. | 400 | −0.2 | −0.2 | 4 |
| EAST SOUTH CENT. | 149 | 0.3 | 0.2 | 5 |
| WEST NORTH CENT. | 163 | 0.2 | 0.5 | 5.1 |
| WEST SOUTH CENT. | 295 | 0.1 | 0.1 | 4.7 |
| MOUNTAIN | 122 | 0.8 | 0 | 5.3 |
| PACIFIC | 364 | 0.3 | −0.2 | 4.6 |
| PUERTO RICO | 40 | 0 | 4.8 | 9.5 |
| REGION (RURAL) | | | | |
| NEW ENGLAND | 36 | 0.4 | 1.7 | 6.7 |
| MIDDLE ATLANTIC | 65 | −0.6 | 0.9 | 4.9 |
| SOUTH ATLANTIC | 216 | 0.1 | 0 | 4.6 |
| EAST NORTH CENT. | 193 | 0.2 | 0 | 4.7 |
| EAST SOUTH CENT. | 227 | 0.2 | −0.2 | 4.5 |
| WEST NORTH CENT. | 247 | 0.8 | 0.5 | 5.8 |
| WEST SOUTH CENT. | 269 | 0.4 | 0.2 | 5.2 |
| MOUNTAIN | 123 | 0.2 | −0.1 | 4.6 |
| PACIFIC | 90 | 0.4 | −0.9 | 3.9 |
| PUERTO RICO | 5 | −2.5 | 0.3 | 2.2 |
| TEACHING STATUS | | | | |
| NON-TEACHING | 2,805 | 0.1 | 0.1 | 4.7 |
| MINOR | 761 | 0.1 | −0.1 | 4.5 |
| MAJOR | 288 | −0.4 | −0.4 | 3.7 |
| DSH PATIENT (PERCENT) | | | | |
| 0 | 10 | 3 | 3.8 | 11.6 |
| GT 0–0.10 | 897 | 0 | −0.2 | 4.3 |
| 0.10–0.16 | 837 | −0.1 | 0 | 4.4 |
| 0.16–0.23 | 787 | 0.1 | −0.2 | 4.3 |
| 0.23–0.35 | 744 | 0 | 0.1 | 4.5 |
| GE 0.35 | 579 | −0.1 | 0.2 | 4.7 |
| URBAN IME/DSH | | | | |
| IME & DSH | 965 | −0.1 | −0.2 | 4.1 |
| IME/NO DSH | 1 | −0.1 | 8.5 | 13.3 |
| NO IME/DSH | 1,409 | 0 | 0.1 | 4.6 |
| NO IME/NO DSH | 8 | 3 | 3.7 | 11.6 |
| RURAL HOSP. TYPES | | | | |
| NO SPECIAL STATUS | 469 | 0.1 | 0.2 | 4.9 |
| RRC | 161 | 0.3 | −0.5 | 4.3 |
| SCH/EACH | 489 | 0.3 | 0.5 | 5.4 |
| MDH | 250 | 0.3 | 1.6 | 6.5 |
| SCH AND RRC | 75 | 0.1 | −0.3 | 4.3 |
| TYPE OF OWNERSHIP | | | | |
| VOLUNTARY | 2,370 | −0.1 | −0.2 | 4.2 |
| PROPRIETARY | 696 | 0.2 | 0.5 | 5.2 |
| GOVERNMENT | 788 | 0.2 | 0.3 | 4.9 |
| SPECIALTY HOSPITALS | | | | |
| EYE AND EAR | 13 | −0.6 | 1.8 | 5.7 |
| CANCER | 11 | 0 | −1.2 | 3.2 |
| TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES) | | | | |
| REHAB | 155 | 0.5 | −1.1 | 3.9 |

TABLE 15.—IMPACT OF CHANGE FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent change in total payments to hospital (program and beneficiary); does not include hold harmless, corridor, outlier or transitional pass-through payments]

| | Number of hospitals (1) | New Wage index (2) | APC changes (3) | All CY 2004 changes (4) |
|---|---|---|---|---|
| PSYCH | 175 | 0.8 | 12.2 | 18.2 |
| LTC | 150 | 1.6 | 1.2 | 7.5 |
| CHILDREN | 44 | 0 | 0.5 | 4.9 |

1. Some data necessary to classify hospitals by category were missing; thus, the total number of hospitals in each category may not equal the national total.

2. This column shows the impact of updating the wage index used to calculate payment by applying the FY 2004 hospital inpatient wage index after geographic reclassification by the Medicare Geographic Classification Review Board. The appropriate hospital inpatient wage index appears in a correction notice published in the FEDERAL REGISTER on October 6, 2003 68FR 57732.

3. This column shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on 2002 hospital claims data.

4. This column shows changes in total payment from CY 2003 to CY 2004, excluding outlier and pass-through payments. It incorporates all of the changes reflected in columns 2 and 3. In addition, it shows the impact of the FY 2004 payment update. The sum of the columns may be different from the percentage changes shown here due to rounding.

5. Volume is expressed in terms of the number of lines that appear on a claim.

*E. Projected Distribution of Outlier Payments*

As stated elsewhere in this preamble, we have allocated 2 percent of the estimated 2004 expenditures to outlier payments. Table 16 below illustrates the percentage of outlier payments relative to the total projected payments for the categories of hospitals that we show in the impact table.

We project, based on the mix of services for the hospitals that will be paid under the OPPS in 2004, that approximately 95 percent of hospitals will receive outlier payments. For the majority of provider groups, the table shows outlier payments as a percent of total payments in the 1.5 to 3.5 percent range. Two categories, Rehabilitation and Children's hospitals are the exception with outlier to total payment ratios of 6.7 and 11.9 percent respectively. We would point out that these hospital types represent a small number of providers with a low volume of services. The anticipated outlier payments for urban hospitals can be expected to ameliorate the impact of the wage index and APC changes on payments to urban hospitals.

TABLE 16.—DISTRIBUTION OF OUTLIER PAYMENTS FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT

| | Number of hospitals | Percent of total hospitals | Number of hospitals with outliers | Outlier payments as a percent of total payments (percent) |
|---|---|---|---|---|
| ALL HOSPITALS | 4,378 | 100 | 4,144 | 2.0 |
| NON-TEFRA HOSPITALS | 3,854 | 88 | 3,841 | 2.0 |
| URBAN HOSPS | 2,383 | 54.4 | 2,372 | 2.1 |
| LARGE URBAN (GT 1 MILL.) | 1,377 | 31.4 | 1,371 | 2.3 |
| OTHER URBAN (LE 1 MILL.) | 1,006 | 23 | 1,001 | 1.8 |
| RURAL HOSPS | 1,471 | 33.6 | 1,469 | 1.7 |
| BEDS (URBAN) | | | | |
| 0–99 BEDS | 538 | 12.2 | 529 | 2.5 |
| 100–199 BEDS | 878 | 20 | 877 | 1.8 |
| 200–299 BEDS | 454 | 10.4 | 453 | 1.9 |
| 300–499 BEDS | 363 | 8.2 | 363 | 2.1 |
| 500 + BEDS | 150 | 3.4 | 150 | 2.6 |
| BEDS (RURAL) | | | | |
| 0–49 BEDS | 699 | 16 | 698 | 2.3 |
| 50–99 BEDS | 454 | 10.4 | 453 | 1.9 |
| 100–149 BEDS | 190 | 4.4 | 190 | 1.4 |
| 150–199 BEDS | 66 | 1.6 | 66 | 1.7 |
| 200 + BEDS | 62 | 1.4 | 62 | 1.4 |
| VOLUME (URBAN) | | | | |
| LT 5,000 | 186 | 4.2 | 175 | 3.2 |
| 5,000–10,999 | 350 | 8 | 350 | 3.0 |
| 11,000–20,999 | 499 | 11.4 | 499 | 2.1 |
| 21,000–42,999 | 720 | 16.4 | 720 | 2.0 |
| GT 42,999 | 628 | 14.4 | 628 | 2.1 |
| VOLUME (RURAL) | | | | |
| LT 5,000 | 364 | 8.4 | 362 | 3.1 |
| 5,000–10,999 | 466 | 10.6 | 466 | 2.2 |
| 11,000–20,999 | 346 | 8 | 346 | 1.8 |
| 21,000–42,999 | 234 | 5.4 | 234 | 1.5 |
| GT 42,999 | 61 | 1.4 | 61 | 1.5 |
| REGION (URBAN) | | | | |
| NEW ENGLAND | 128 | 3 | 127 | 1.8 |

TABLE 16.—DISTRIBUTION OF OUTLIER PAYMENTS FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT—Continued

| | Number of hospitals | Percent of total hospitals | Number of hospitals with outliers | Outlier payments as a percent of total payments (percent) |
|---|---|---|---|---|
| MIDDLE ATLANTIC | 369 | 8.4 | 369 | 3.1 |
| SOUTH ATLANTIC | 353 | 8 | 353 | 1.9 |
| EAST NORTH CENT. | 400 | 9.2 | 396 | 1.9 |
| EAST SOUTH CENT. | 149 | 3.4 | 148 | 1.4 |
| WEST NORTH CENT. | 163 | 3.8 | 163 | 1.6 |
| WEST SOUTH CENT. | 295 | 6.8 | 295 | 2.4 |
| MOUNTAIN | 122 | 2.8 | 120 | 1.9 |
| PACIFIC | 364 | 8.4 | 361 | 2.0 |
| PUERTO RICO | 40 | 1 | 40 | 0.6 |
| REGION (RURAL) | | | | |
| NEW ENGLAND | 36 | 0.8 | 36 | 2.2 |
| MIDDLE ATLANTIC | 65 | 1.4 | 65 | 1.6 |
| SOUTH ATLANTIC | 216 | 5 | 215 | 1.6 |
| EAST NORTH CENT. | 193 | 4.4 | 193 | 1.6 |
| EAST SOUTH CENT. | 227 | 5.2 | 227 | 1.2 |
| WEST NORTH CENT. | 247 | 5.6 | 246 | 1.8 |
| WEST SOUTH CENT. | 269 | 6.2 | 269 | 1.8 |
| MOUNTAIN | 123 | 2.8 | 123 | 2.8 |
| PACIFIC | 90 | 2 | 90 | 2.4 |
| PUERTO RICO | 5 | 0.2 | 5 | 1.0 |
| TEACHING STATUS | | | | |
| NON-TEACHING | 2,805 | 64 | 2,793 | 1.8 |
| MINOR | 761 | 17.4 | 760 | 1.7 |
| MAJOR | 288 | 6.6 | 288 | 3.0 |
| DSH PATIENT (PERCENT) | | | | |
| 0 | 10 | 0.2 | 8 | 3.5 |
| GT 0–0.10 | 897 | 20.4 | 892 | 1.9 |
| 0.10–0.16 | 837 | 19.2 | 837 | 1.8 |
| 0.16–0.23 | 787 | 18 | 787 | 1.7 |
| 0.23–0.35 | 744 | 17 | 741 | 2.3 |
| GE 0.35 | 579 | 13.2 | 576 | 2.9 |
| URBAN IME/DSH | | | | |
| IME & DSH | 965 | 22 | 965 | 2.3 |
| IME/NO DSH | 1 | 0 | 0 | 0.0 |
| NO IME/DSH | 1,409 | 32.2 | 1,400 | 1.8 |
| NO IME/NO DSH | 8 | 0.2 | 7 | 3.5 |
| RURAL HOSP. TYPES | | | | |
| NO SPECIAL STATUS | 469 | 10.8 | 467 | 1.8 |
| RRC | 161 | 3.6 | 161 | 1.4 |
| SCH/EACH | 489 | 11.2 | 489 | 2.1 |
| MDH | 250 | 5.8 | 250 | 2.0 |
| SCH AND RRC | 75 | 1.8 | 75 | 1.5 |
| TYPE OF OWNERSHIP | | | | |
| VOLUNTARY | 2,370 | 54.2 | 2,366 | 1.9 |
| PROPRIETARY | 696 | 15.8 | 689 | 2.0 |
| GOVERNMENT | 788 | 18 | 786 | 2.5 |
| SPECIALTY HOSPITALS | | | | |
| EYE AND EAR | 13 | 0.2 | 13 | 2.7 |
| CANCER | 11 | 0.2 | 11 | 3.9 |
| TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES) | | | | |
| REHAB | 155 | 3.6 | 103 | 6.7 |
| PSYCH | 175 | 4 | 59 | 0.5 |
| LTC | 150 | 3.4 | 98 | 2.5 |
| CHILDREN | 44 | 1 | 43 | 11.9 |

*F. Estimated Impacts of This Final Rule on Beneficiaries*

For services for which the beneficiary pays a coinsurance of 20 percent of the payment rate, the beneficiary share of payment will increase for services for which OPPS payments will rise and will decrease for services for which OPPS payments will fall. For example, for a mid-level office visit (APC 0601), the minimum unadjusted co-payment in 2003 was $10.11; under this final rule, the minimum unadjusted co-payment for APC 601 will be $10.71 because the OPPS payment for the service will increase under this final rule. For some services (those services for which a national unadjusted co-payment amount is shown in Addendum B) the beneficiary co-payment is frozen based on historic data and will not change, and will therefore present no potential impact on beneficiaries.

However, in all cases, the statute limits beneficiary liability for co-payment for a service to the inpatient hospital deductible for the applicable year. This amount is $876 for 2004. In general, the impact of this final rule on beneficiaries will vary based on the service the beneficiary receives and whether the co-payment for the service is one that is frozen under the OPPS.

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

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

Dated: October 27, 2003.

**Thomas A. Scully,**

*Administrator, Centers for Medicare & Medicaid Services.*

Approved: October 29, 2003.

**Tommy G. Thompson,**

*Secretary.*

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 0001 | Level I Photochemotherapy | S | 0.4237 | $23.12 | $7.09 | $4.62 |
| 0002 | Level I Fine Needle Biopsy/Aspiration | T | 0.8083 | $44.10 | ..... | $8.82 |
| 0003 | Bone Marrow Biopsy/Aspiration | T | 2.3229 | $126.74 | ..... | $25.35 |
| 0004 | Level I Needle Biopsy/ Aspiration Except Bone Marrow | T | 1.5882 | $86.65 | $22.36 | $17.33 |
| 0005 | Level II Needle Biopsy/Aspiration Except Bone Marrow | T | 3.2698 | $178.40 | $71.59 | $35.68 |
| 0006 | Level I Incision & Drainage | T | 1.6527 | $90.17 | $23.26 | $18.03 |
| 0007 | Level II Incision & Drainage | T | 11.8633 | $647.27 | ..... | $129.45 |
| 0008 | Level III Incision and Drainage | T | 19.4831 | $1,063.02 | ..... | $212.60 |
| 0009 | Nail Procedures | T | 0.6652 | $36.29 | $8.34 | $7.26 |
| 0010 | Level I Destruction of Lesion | T | 0.6480 | $35.36 | $10.08 | $7.07 |
| 0011 | Level II Destruction of Lesion | T | 2.2217 | $121.22 | $27.88 | $24.24 |
| 0012 | Level I Debridement & Destruction | T | 0.7694 | $41.98 | $11.18 | $8.40 |
| 0013 | Level II Debridement & Destruction | T | 1.1272 | $61.50 | $14.20 | $12.30 |
| 0015 | Level III Debridement & Destruction | T | 1.5968 | $87.12 | $20.35 | $17.42 |
| 0016 | Level IV Debridement & Destruction | T | 2.5724 | $140.35 | $57.31 | $28.07 |
| 0017 | Level VI Debridement & Destruction | T | 16.3697 | $893.15 | $227.84 | $178.63 |
| 0018 | Biopsy of Skin/Puncture of Lesion | T | 0.9178 | $50.08 | $16.04 | $10.02 |
| 0019 | Level I Excision/ Biopsy | T | 3.9493 | $215.48 | $71.87 | $43.10 |
| 0020 | Level II Excision/ Biopsy | T | 7.0842 | $386.52 | $113.25 | $77.30 |
| 0021 | Level III Excision/ Biopsy | T | 14.3594 | $783.46 | $219.48 | $156.69 |
| 0022 | Level IV Excision/ Biopsy | T | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 0023 | Exploration Penetrating Wound | T | 2.8141 | $153.54 | $40.37 | $30.71 |
| 0024 | Level I Skin Repair | T | 1.6850 | $91.94 | $33.10 | $18.39 |
| 0025 | Level II Skin Repair | T | 5.1912 | $283.24 | $107.00 | $56.65 |
| 0027 | Level IV Skin Repair | T | 15.8990 | $867.47 | $329.72 | $173.49 |
| 0028 | Level I Breast Surgery | T | 17.6584 | $963.46 | $303.74 | $192.69 |
| 0029 | Level II Breast Surgery | T | 30.1167 | $1,643.20 | $632.64 | $328.64 |
| 0030 | Level III Breast Surgery | T | 37.3083 | $2,035.58 | $763.55 | $407.12 |
| 0032 | Insertion of Central Venous/Arterial Catheter | T | 11.4907 | $626.94 | ..... | $125.39 |
| 0033 | Partial Hospitalization | P | 5.2569 | $286.82 | ..... | $57.36 |
| 0035 | Placement of Arterial or Central Venous Catheter | T | 0.1691 | $9.23 | $2.79 | $1.85 |
| 0036 | Level II Fine Needle Biopsy/Aspiration | T | 1.5170 | $82.77 | ..... | $16.55 |
| 0037 | Level III Needle Biopsy/Aspiration Except Bone Marrow | T | 9.8921 | $539.72 | $237.45 | $107.94 |
| 0039 | Implantation of Neurostimulator | S | 235.1866 | $12,832.02 | ..... | $2,566.40 |
| 0040 | Level II Implantation of Neurostimulator Electrodes | S | 52.1002 | $2,842.64 | ..... | $568.53 |
| 0041 | Level I Arthroscopy | T | 27.3819 | $1,493.98 | ..... | $298.80 |
| 0042 | Level II Arthroscopy | T | 43.0808 | $2,350.53 | $804.74 | $470.11 |
| 0043 | Closed Treatment Fracture Finger/Toe/Trunk | T | 1.9074 | $104.07 | ..... | $20.81 |
| 0045 | Bone/Joint Manipulation Under Anesthesia | T | 13.5889 | $741.42 | $268.47 | $148.28 |
| 0046 | Open/Percutaneous Treatment Fracture or Dislocation | T | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 0047 | Arthroplasty without Prosthesis | T | 29.9582 | $1,634.55 | $537.03 | $326.91 |
| 0048 | Arthroplasty with Prosthesis | T | 51.4609 | $2,807.76 | $695.60 | $561.55 |
| 0049 | Level I Musculoskeletal Procedures Except Hand and Foot | T | 19.6046 | $1,069.65 | ..... | $213.93 |
| 0050 | Level II Musculoskeletal Procedures Except Hand and Foot | T | 24.8651 | $1,356.66 | ..... | $271.33 |
| 0051 | Level III Musculoskeletal Procedures Except Hand and Foot | T | 34.5144 | $1,883.14 | ..... | $376.63 |
| 0052 | Level IV Musculoskeletal Procedures Except Hand and Foot. | T | 42.7126 | $2,330.44 | ..... | $466.09 |
| 0053 | Level I Hand Musculoskeletal Procedures | T | 14.8831 | $812.04 | $253.49 | $162.41 |
| 0054 | Level II Hand Musculoskeletal Procedures | T | 24.2456 | $1,322.86 | ..... | $264.57 |
| 0055 | Level I Foot Musculoskeletal Procedures | T | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 0056 | Level II Foot Musculoskeletal Procedures | T | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 0057 | Bunion Procedures | T | 25.5035 | $1,391.50 | $475.91 | $278.30 |
| 0058 | Level I Strapping and Cast Application | S | 1.0931 | $59.64 | ..... | $11.93 |
| 0060 | Manipulation Therapy | S | 0.2788 | $15.21 | ..... | $3.04 |
| 0068 | CPAP Initiation | S | 1.0807 | $58.96 | $29.48 | $11.79 |
| 0069 | Thoracoscopy | T | 28.9392 | $1,578.95 | $591.64 | $315.79 |
| 0070 | Thoracentesis/Lavage Procedures | T | 3.0717 | $167.60 | ..... | $33.52 |
| 0071 | Level I Endoscopy Upper Airway | T | 0.8799 | $48.01 | $12.89 | $9.60 |

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 0072 | Level II Endoscopy Upper Airway | T | 1.7613 | $96.10 | $26.68 | $19.22 |
| 0073 | Level III Endoscopy Upper Airway | T | 3.4541 | $188.46 | $73.38 | $37.69 |
| 0074 | Level IV Endoscopy Upper Airway | T | 13.9480 | $761.02 | $295.70 | $152.20 |
| 0075 | Level V Endoscopy Upper Airway | T | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 0076 | Level I Endoscopy Lower Airway | T | 9.2346 | $503.85 | $189.82 | $100.77 |
| 0077 | Level I Pulmonary Treatment | S | 0.2837 | $15.48 | $7.74 | $3.10 |
| 0078 | Level II Pulmonary Treatment | S | 0.7917 | $43.20 | $14.55 | $8.64 |
| 0079 | Ventilation Initiation and Management | S | 2.1494 | $117.27 | ..... | $23.45 |
| 0080 | Diagnostic Cardiac Catheterization | T | 36.0160 | $1,965.07 | $838.92 | $393.01 |
| 0081 | Non-Coronary Angioplasty or Atherectomy | T | 35.0285 | $1,911.19 | ..... | $382.24 |
| 0082 | Coronary Atherectomy | T | 110.2196 | $6,013.69 | $1,293.59 | $1,202.74 |
| 0083 | Coronary Angioplasty and Percutaneous Valvuloplasty | T | 59.2047 | $3,230.27 | ..... | $646.05 |
| 0084 | Level I Electrophysiologic Evaluation | S | 10.5226 | $574.12 | ..... | $114.82 |
| 0085 | Level II Electrophysiologic Evaluation | T | 35.4126 | $1,932.15 | $426.25 | $386.43 |
| 0086 | Ablate Heart Dysrhythm Focus | T | 44.9389 | $2,451.91 | $833.33 | $490.38 |
| 0087 | Cardiac Electrophysiologic Recording/Mapping | T | 39.8161 | $2,172.41 | ..... | $434.48 |
| 0088 | Thrombectomy | T | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 0089 | Insertion/Replacement of Permanent Pacemaker and Electrodes. | T | 117.1896 | $6,393.98 | $1,722.59 | $1,278.80 |
| 0090 | Insertion/Replacement of Pacemaker Pulse Generator | T | 96.8284 | $5,283.05 | $1,651.45 | $1,056.61 |
| 0091 | Level II Vascular Ligation | T | 28.8326 | $1,573.14 | $348.23 | $314.63 |
| 0092 | Level I Vascular Ligation | T | 25.0959 | $1,369.26 | $505.37 | $273.85 |
| 0093 | Vascular Reconstruction/Fistula Repair without Device | T | 21.3104 | $1,162.72 | $277.34 | $232.54 |
| 0094 | Level I Resuscitation and Cardioversion | S | 2.6345 | $143.74 | $48.58 | $28.75 |
| 0095 | Cardiac Rehabilitation | S | 0.5994 | $32.70 | $16.35 | $6.54 |
| 0096 | Non-Invasive Vascular Studies | S | 1.7176 | $93.71 | $46.85 | $18.74 |
| 0097 | Cardiac and Ambulatory Blood Pressure Monitoring | X | 1.0635 | $58.03 | $23.80 | $11.61 |
| 0098 | Injection of Sclerosing Solution | T | 1.0729 | $58.54 | $14.06 | $11.71 |
| 0099 | Electrocardiograms | S | 0.3703 | $20.20 | ..... | $4.04 |
| 0100 | Cardiac Stress Tests | X | 1.5862 | $86.54 | $41.44 | $17.31 |
| 0101 | Tilt Table Evaluation | S | 4.4040 | $240.29 | $105.27 | $48.06 |
| 0103 | Miscellaneous Vascular Procedures | T | 11.6202 | $634.01 | $223.63 | $126.80 |
| 0104 | Transcatheter Placement of Intracoronary Stents | T | 82.6713 | $4,510.63 | ..... | $902.13 |
| 0105 | Revision/Removal of Pacemakers, AICD, or Vascular | T | 19.1898 | $1,047.01 | $370.40 | $209.40 |
| 0106 | Insertion/Replacement/Repair of Pacemaker and/or Electrodes. | T | 58.9719 | $3,217.57 | ..... | $643.51 |
| 0107 | Insertion of Cardioverter-Defibrillator | T | 337.1304 | $18,394.17 | $3,699.14 | $3,678.83 |
| 0108 | Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads. | T | 433.2998 | $23,641.27 | ..... | $4,728.25 |
| 0109 | Removal of Implanted Devices | T | 7.4705 | $407.60 | $131.49 | $81.52 |
| 0110 | Transfusion | S | 3.6718 | $200.34 | ..... | $40.07 |
| 0111 | Blood Product Exchange | S | 13.1719 | $718.67 | $200.18 | $143.73 |
| 0112 | Apheresis, Photopheresis, and Plasmapheresis | S | 37.5832 | $2,050.58 | $612.47 | $410.12 |
| 0113 | Excision Lymphatic System | T | 19.9322 | $1,087.52 | ..... | $217.50 |
| 0114 | Thyroid/Lymphadenectomy Procedures | T | 37.5963 | $2,051.29 | $485.91 | $410.26 |
| 0115 | Cannula/Access Device Procedures | T | 25.6437 | $1,399.15 | $459.35 | $279.83 |
| 0116 | Chemotherapy Administration by Other Technique Except Infusion. | S | 0.7996 | $43.63 | ..... | $8.73 |
| 0117 | Chemotherapy Administration by Infusion Only | S | 3.0360 | $165.65 | $42.54 | $33.13 |
| 0119 | Implantation of Infusion Pump | T | 134.7194 | $7,350.43 | ..... | $1,470.09 |
| 0120 | Infusion Therapy Except Chemotherapy | T | 1.9114 | $104.29 | $28.21 | $20.86 |
| 0121 | Level I Tube changes and Repositioning | T | 2.1189 | $115.61 | $43.80 | $23.12 |
| 0122 | Level II Tube changes and Repositioning | T | 8.8621 | $483.53 | $99.16 | $96.71 |
| 0123 | Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant. | S | 5.2882 | $288.53 | ..... | $57.71 |
| 0124 | Revision of Implanted Infusion Pump | T | 23.8050 | $1,298.82 | ..... | $259.76 |
| 0125 | Refilling of Infusion Pump | T | 2.1606 | $117.88 | ..... | $23.58 |
| 0130 | Level I Laparoscopy | T | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 0131 | Level II Laparoscopy | T | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 0132 | Level III Laparoscopy | T | 57.2045 | $3,121.13 | $1,239.22 | $624.23 |
| 0140 | Esophageal Dilation without Endoscopy | T | 6.4525 | $352.05 | $107.24 | $70.41 |
| 0141 | Upper GI Procedures | T | 7.8206 | $426.70 | $143.38 | $85.34 |
| 0142 | Small Intestine Endoscopy | T | 8.7959 | $479.91 | $152.78 | $95.98 |
| 0143 | Lower GI Endoscopy | T | 8.2957 | $452.62 | $186.06 | $90.52 |
| 0146 | Level I Sigmoidoscopy | T | 3.9826 | $217.29 | $64.40 | $43.46 |
| 0147 | Level II Sigmoidoscopy | T | 7.6808 | $419.07 | ..... | $83.81 |
| 0148 | Level I Anal/Rectal Procedure | T | 3.8320 | $209.08 | $63.38 | $41.82 |
| 0149 | Level III Anal/Rectal Procedure | T | 17.1425 | $935.31 | $293.06 | $187.06 |
| 0150 | Level IV Anal/Rectal Procedure | T | 22.1919 | $1,210.81 | $437.12 | $242.16 |

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 0151 .... | Endoscopic Retrograde Cholangio-Pancreatography (ERCP). | T ..... | 17.9462 | $979.16 | $245.46 | $195.83 |
| 0152 .... | Percutaneous Abdominal and Biliary Procedures ..... | T ..... | 9.1474 | $499.09 | $125.28 | $99.82 |
| 0153 .... | Peritoneal and Abdominal Procedures ..... | T ..... | 20.8723 | $1,138.81 | $410.87 | $227.76 |
| 0154 .... | Hernia/Hydrocele Procedures ..... | T ..... | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 0155 .... | Level II Anal/Rectal Procedure ..... | T ..... | 10.0809 | $550.02 | $188.89 | $110.00 |
| 0156 .... | Level II Urinary and Anal Procedures ..... | T ..... | 2.4747 | $135.02 | $40.52 | $27.00 |
| 0157 .... | Colorectal Cancer Screening: Barium Enema ..... | S ..... | 2.5693 | $140.18 | ..... | $28.04 |
| 0158 .... | Colorectal Cancer Screening: Colonoscopy ..... | T ..... | 7.4244 | $405.08 | ..... | $101.27 |
| 0159 .... | Colorectal Cancer Screening: Flexible Sigmoidoscopy ..... | S ..... | 2.7823 | $151.81 | ..... | $37.95 |
| 0160 .... | Level I Cystourethroscopy and other Genitourinary Procedures. | T ..... | 6.8801 | $375.39 | $105.06 | $75.08 |
| 0161 .... | Level II Cystourethroscopy and other Genitourinary Procedures. | T ..... | 16.8407 | $918.85 | $249.36 | $183.77 |
| 0162 .... | Level III Cystourethroscopy and other Genitourinary Procedures. | T ..... | 21.9098 | $1,195.42 | ..... | $239.08 |
| 0163 .... | Level IV Cystourethroscopy and other Genitourinary Procedures. | T ..... | 33.8805 | $1,848.55 | ..... | $369.71 |
| 0164 .... | Level I Urinary and Anal Procedures ..... | T ..... | 1.2021 | $65.59 | $17.59 | $13.12 |
| 0165 .... | Level III Urinary and Anal Procedures ..... | T ..... | 14.6838 | $801.16 | ..... | $160.23 |
| 0166 .... | Level I Urethral Procedures ..... | T ..... | 16.7918 | $916.18 | $218.73 | $183.24 |
| 0167 .... | Level III Urethral Procedures ..... | T ..... | 30.0186 | $1,637.84 | $555.84 | $327.57 |
| 0168 .... | Level II Urethral Procedures ..... | T ..... | 30.0147 | $1,637.63 | $405.60 | $327.53 |
| 0169 .... | Lithotripsy ..... | T ..... | 45.1150 | $2,461.52 | $1,115.69 | $492.30 |
| 0170 .... | Dialysis ..... | S ..... | 5.9678 | $325.61 | ..... | $65.12 |
| 0180 .... | Circumcision ..... | T ..... | 18.6176 | $1,015.79 | $304.87 | $203.16 |
| 0181 .... | Penile Procedures ..... | T ..... | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 0183 .... | Testes/Epididymis Procedures ..... | T ..... | 21.6724 | $1,182.47 | ..... | $236.49 |
| 0184 .... | Prostate Biopsy ..... | T ..... | 3.8995 | $212.76 | $96.27 | $42.55 |
| 0187 .... | Miscellaneous Placement/Repositioning ..... | X ..... | 4.4288 | $241.64 | $90.71 | $48.33 |
| 0188 .... | Level II Female Reproductive Proc ..... | T ..... | 1.1365 | $62.01 | ..... | $12.40 |
| 0189 .... | Level III Female Reproductive Proc ..... | T ..... | 1.4232 | $77.65 | $18.09 | $15.53 |
| 0190 .... | Level I Hysteroscopy ..... | T ..... | 19.6922 | $1,074.43 | $424.28 | $214.89 |
| 0191 .... | Level I Female Reproductive Proc ..... | T ..... | 0.1853 | $10.11 | $2.93 | $2.02 |
| 0192 .... | Level IV Female Reproductive Proc ..... | T ..... | 2.7121 | $147.97 | $39.11 | $29.59 |
| 0193 .... | Level V Female Reproductive Proc ..... | T ..... | 15.0453 | $820.89 | $171.13 | $164.18 |
| 0194 .... | Level VIII Female Reproductive Proc ..... | T ..... | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 0195 .... | Level IX Female Reproductive Proc ..... | T ..... | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 0196 .... | Dilation and Curettage ..... | T ..... | 16.1219 | $879.63 | $338.23 | $175.93 |
| 0197 .... | Infertility Procedures ..... | T ..... | 4.8280 | $263.42 | ..... | $52.68 |
| 0198 .... | Pregnancy and Neonatal Care Procedures ..... | T ..... | 1.3578 | $74.08 | $32.19 | $14.82 |
| 0199 .... | Obstetrical Care Service ..... | T ..... | 17.2831 | $942.98 | ..... | $188.60 |
| 0200 .... | Level VII Female Reproductive Proc ..... | T ..... | 17.9920 | $981.66 | $307.83 | $196.33 |
| 0201 .... | Level VI Female Reproductive Proc ..... | T ..... | 16.8660 | $920.23 | $329.65 | $184.05 |
| 0202 .... | Level X Female Reproductive Proc ..... | T ..... | 38.9821 | $2,126.90 | $1,042.18 | $425.38 |
| 0203 .... | Level IV Nerve Injections ..... | T ..... | 11.5969 | $632.74 | $276.76 | $126.55 |
| 0204 .... | Level I Nerve Injections ..... | T ..... | 2.1711 | $118.46 | $40.13 | $23.69 |
| 0206 .... | Level II Nerve Injections ..... | T ..... | 5.2875 | $288.49 | $75.55 | $57.70 |
| 0207 .... | Level III Nerve Injections ..... | T ..... | 6.4554 | $352.21 | $123.69 | $70.44 |
| 0208 .... | Laminotomies and Laminectomies ..... | T ..... | 40.2830 | $2,197.88 | ..... | $439.58 |
| 0209 .... | Extended EEG Studies and Sleep Studies, Level II ..... | S ..... | 11.5435 | $629.82 | $280.58 | $125.96 |
| 0212 .... | Nervous System Injections ..... | T ..... | 2.9739 | $162.26 | $74.67 | $32.45 |
| 0213 .... | Extended EEG Studies and Sleep Studies, Level I ..... | S ..... | 2.9055 | $158.53 | $65.74 | $31.71 |
| 0214 .... | Electroencephalogram ..... | S ..... | 2.2176 | $120.99 | $58.12 | $24.20 |
| 0215 .... | Level I Nerve and Muscle Tests ..... | S ..... | 0.6457 | $35.23 | $15.76 | $7.05 |
| 0216 .... | Level III Nerve and Muscle Tests ..... | S ..... | 2.8535 | $155.69 | $67.98 | $31.14 |
| 0218 .... | Level II Nerve and Muscle Tests ..... | S ..... | 1.1404 | $62.22 | ..... | $12.44 |
| 0220 .... | Level I Nerve Procedures ..... | T ..... | 16.5554 | $903.28 | ..... | $180.66 |
| 0221 .... | Level II Nerve Procedures ..... | T ..... | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 0222 .... | Implantation of Neurological Device ..... | T ..... | 232.2024 | $12,669.20 | ..... | $2,533.84 |
| 0223 .... | Implantation or Revision of Pain Management Catheter ..... | T ..... | 26.7610 | $1,460.11 | ..... | $292.02 |
| 0224 .... | Implantation of Reservoir/Pump/Shunt ..... | T ..... | 34.1770 | $1,864.73 | $453.41 | $372.95 |
| 0225 .... | Level I Implementation of Neurostimulator Electrodes ..... | S ..... | 206.0034 | $11,239.75 | ..... | $2,247.95 |
| 0226 .... | Implantation of Drug Infusion Reservoir ..... | T ..... | 136.2989 | $7,436.60 | ..... | $1,487.32 |
| 0227 .... | Implantation of Drug Infusion Device ..... | T ..... | 160.8363 | $8,775.39 | ..... | $1,755.08 |
| 0228 .... | Creation of Lumbar Subarachnoid Shunt ..... | T ..... | 52.2880 | $2,852.89 | $639.03 | $570.58 |
| 0229 .... | Transcatherter Placement of Intravascular Shunts ..... | T ..... | 61.9895 | $3,382.21 | $771.23 | $676.44 |
| 0230 .... | Level I Eye Tests & Treatments ..... | S ..... | 0.7619 | $41.57 | $14.97 | $8.31 |
| 0231 .... | Level III Eye Tests & Treatments ..... | S ..... | 2.1883 | $119.40 | $50.94 | $23.88 |

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 0232 | Level I Anterior Segment Eye Procedures | T | 4.9206 | $268.47 | $103.17 | $53.69 |
| 0233 | Level II Anterior Segment Eye Procedures | T | 14.4205 | $786.80 | $266.33 | $157.36 |
| 0234 | Level III Anterior Segment Eye Procedures | T | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 0235 | Level I Posterior Segment Eye Procedures | T | 5.0749 | $276.89 | $72.04 | $55.38 |
| 0236 | Level II Posterior Segment Eye Procedures | T | 18.6701 | $1,018.66 | ..... | $203.73 |
| 0237 | Level III Posterior Segment Eye Procedures | T | 34.1784 | $1,864.81 | $818.54 | $372.96 |
| 0238 | Level I Repair and Plastic Eye Procedures | T | 3.1954 | $174.34 | $58.96 | $34.87 |
| 0239 | Level II Repair and Plastic Eye Procedures | T | 6.1331 | $334.63 | ..... | $66.93 |
| 0240 | Level III Repair and Plastic Eye Procedures | T | 17.4535 | $952.28 | $315.31 | $190.46 |
| 0241 | Level IV Repair and Plastic Eye Procedures | T | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 0242 | Level V Repair and Plastic Eye Procedures | T | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 0243 | Strabismus/Muscle Procedures | T | 21.7323 | $1,185.74 | $431.39 | $237.15 |
| 0244 | Corneal Transplant | T | 37.6284 | $2,053.04 | $803.26 | $410.61 |
| 0245 | Level I Cataract Procedures without IOL Insert | T | 12.2973 | $670.95 | $222.22 | $134.19 |
| 0246 | Cataract Procedures with IOL Insert | T | 22.9755 | $1,253.57 | $495.96 | $250.71 |
| 0247 | Laser Eye Procedures Except Retinal | T | 4.9482 | $269.98 | $104.31 | $54.00 |
| 0248 | Laser Retinal Procedures | T | 4.8223 | $263.11 | $95.08 | $52.62 |
| 0249 | Level II Cataract Procedures without IOL Insert | T | 27.7406 | $1,513.55 | $524.67 | $302.71 |
| 0250 | Nasal Cauterization/Packing | T | 1.4697 | $80.19 | $28.07 | $16.04 |
| 0251 | Level I ENT Procedures | T | 1.7880 | $97.56 | ..... | $19.51 |
| 0252 | Level II ENT Procedures | T | 6.4469 | $351.75 | $113.41 | $70.35 |
| 0253 | Level III ENT Procedures | T | 15.2249 | $830.69 | $282.29 | $166.14 |
| 0254 | Level IV ENT Procedures | T | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 0256 | Level V ENT Procedures | T | 35.1548 | $1,918.08 | ..... | $383.62 |
| 0258 | Tonsil and Adenoid Procedures | T | 20.6265 | $1,125.40 | $437.25 | $225.08 |
| 0259 | Level VI ENT Procedures | T | 392.8622 | $21,434.95 | $9,394.83 | $4,286.99 |
| 0260 | Level I Plain Film Except Teeth | X | 0.7802 | $42.57 | $21.28 | $8.51 |
| 0261 | Level II Plain Film Except Teeth Including Bone Density Measurement. | X | 1.3176 | $71.89 | ..... | $14.38 |
| 0262 | Plain Film of Teeth | X | 0.7540 | $41.14 | $9.82 | $8.23 |
| 0263 | Level I Miscellaneous Radiology Procedures | X | 2.1883 | $119.40 | $43.58 | $23.88 |
| 0264 | Level II Miscellaneous Radiology Procedures | X | 3.0287 | $165.25 | $79.41 | $33.05 |
| 0265 | Level I Diagnostic Ultrasound Except Vascular | S | 1.0289 | $56.14 | $28.07 | $11.23 |
| 0266 | Level II Diagnostic Ultrasound Except Vascular | S | 1.6117 | $87.94 | $43.97 | $17.59 |
| 0267 | Level III Diagnostic Ultrasound Except Vascular | S | 2.4586 | $134.14 | $65.52 | $26.83 |
| 0268 | Ultrasound Guidance Procedures | S | 1.3081 | $71.37 | ..... | $14.27 |
| 0269 | Level III Echocardiogram Except Transesophageal | S | 3.2309 | $176.28 | $87.24 | $35.26 |
| 0270 | Transesophageal Echocardiogram | S | 5.8546 | $319.43 | $146.79 | $63.89 |
| 0271 | Mammography | S | 0.6499 | $35.46 | $16.80 | $7.09 |
| 0272 | Level I Fluoroscopy | X | 1.4166 | $77.29 | $38.36 | $15.46 |
| 0274 | Myelography | S | 3.5931 | $196.04 | $93.63 | $39.21 |
| 0275 | Arthrography | S | 3.2775 | $178.82 | $69.09 | $35.76 |
| 0276 | Level I Digestive Radiology | S | 1.5906 | $86.78 | $41.72 | $17.36 |
| 0277 | Level II Digestive Radiology | S | 2.4444 | $133.37 | $60.47 | $26.67 |
| 0278 | Diagnostic Urography | S | 2.7012 | $147.38 | $66.07 | $29.48 |
| 0279 | Level II Angiography and Venography except Extremity | S | 10.7073 | $584.20 | $174.57 | $116.84 |
| 0280 | Level III Angiography and Venography except Extremity | S | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 0281 | Venography of Extremity | S | 6.6031 | $360.27 | $115.16 | $72.05 |
| 0282 | Miscellaneous Computerized Axial Tomography | S | 1.6834 | $91.85 | $44.51 | $18.37 |
| 0283 | Computerized Axial Tomography with Contrast Material | S | 4.6543 | $253.94 | $126.27 | $50.79 |
| 0284 | Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contras. | S | 7.1165 | $388.28 | $194.13 | $77.66 |
| 0285 | Myocardial Positron Emission Tomography (PET) | S | 14.1508 | $772.08 | $334.45 | $154.42 |
| 0287 | Complex Venography | S | 6.4923 | $354.23 | $111.33 | $70.85 |
| 0288 | Bone Density:Axial Skeleton | S | 1.2726 | $69.43 | ..... | $13.89 |
| 0289 | Needle Localization for Breast Biopsy | X | 3.4900 | $190.42 | $44.80 | $38.08 |
| 0296 | Level I Therapeutic Radiologic Procedures | S | 2.8635 | $156.24 | $69.20 | $31.25 |
| 0297 | Level II Therapeutic Radiologic Procedures | S | 7.7145 | $420.91 | $172.51 | $84.18 |
| 0299 | Miscellaneous Radiation Treatment | S | 5.7618 | $314.37 | ..... | $62.87 |
| 0300 | Level I Radiation Therapy | S | 1.4912 | $81.36 | ..... | $16.27 |
| 0301 | Level II Radiation Therapy | S | 2.1340 | $116.43 | ..... | $23.29 |
| 0302 | Level III Radiation Therapy | S | 6.3268 | $345.20 | $130.77 | $69.04 |
| 0303 | Treatment Device Construction | X | 2.8835 | $157.33 | $66.95 | $31.47 |
| 0304 | Level I Therapeutic Radiation Treatment Preparation | X | 1.6742 | $91.35 | $41.52 | $18.27 |
| 0305 | Level II Therapeutic Radiation Treatment Preparation | X | 3.6767 | $200.60 | $91.38 | $40.12 |
| 0310 | Level III Therapeutic Radiation Treatment Preparation | X | 13.7165 | $748.39 | $325.27 | $149.68 |
| 0312 | Radioelement Applications | S | 3.6637 | $199.90 | ..... | $39.98 |
| 0313 | Brachytherapy | S | 16.2481 | $886.51 | ..... | $177.30 |
| 0314 | Hyperthermic Therapies | S | 4.6041 | $251.20 | $101.77 | $50.24 |

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 0320 | Electroconvulsive Therapy | S | 5.3785 | $293.46 | $80.06 | $58.69 |
| 0321 | Biofeedback and Other Training | S | 1.2387 | $67.58 | $21.78 | $13.52 |
| 0322 | Brief Individual Psychotherapy | S | 1.2802 | $69.85 | ..... | $13.97 |
| 0323 | Extended Individual Psychotherapy | S | 1.8689 | $101.97 | $21.26 | $20.39 |
| 0324 | Family Psychotherapy | S | 2.4473 | $133.53 | ..... | $26.71 |
| 0325 | Group Psychotherapy | S | 1.4865 | $81.10 | $18.27 | $16.22 |
| 0330 | Dental Procedures | S | 0.5745 | $31.35 | ..... | $6.27 |
| 0332 | Computerized Axial Tomography and Computerized Angiography without Contras. | S | 3.3936 | $185.16 | $91.27 | $37.03 |
| 0333 | Computerized Axial Tomography and Computerized Angio w/o Contrast Material. | S | 5.4241 | $295.94 | $146.98 | $59.19 |
| 0335 | Magnetic Resonance Imaging, Miscellaneous | S | 6.3499 | $346.46 | $151.46 | $69.29 |
| 0336 | Magnetic Resonance Imaging and Magnetic Resonance Angiography without Cont. | S | 6.3897 | $348.63 | $174.31 | $69.73 |
| 0337 | MRI and Magnetic Resonance Angiography without Contrast Material followed. | S | 9.2075 | $502.37 | $240.77 | $100.47 |
| 0339 | Observation | S | 3.8356 | $209.27 | ..... | $41.85 |
| 0340 | Minor Ancillary Procedures | X | 0.6314 | $34.45 | ..... | $6.89 |
| 0341 | Skin Tests | X | 0.1365 | $7.45 | $3.03 | $1.49 |
| 0342 | Level I Pathology | X | 0.2162 | $11.80 | $5.88 | $2.36 |
| 0343 | Level II Pathology | X | 0.4617 | $25.19 | $12.55 | $5.04 |
| 0344 | Level III Pathology | X | 0.6291 | $34.32 | $17.16 | $6.86 |
| 0345 | Level I Transfusion Laboratory Procedures | X | 0.2550 | $13.91 | $3.10 | $2.78 |
| 0346 | Level II Transfusion Laboratory Procedures | X | 0.3866 | $21.09 | $5.32 | $4.22 |
| 0347 | Level III Transfusion Laboratory Procedures | X | 0.9610 | $52.43 | $13.20 | $10.49 |
| 0348 | Fertility Laboratory Procedures | X | 0.8194 | $44.71 | ..... | $8.94 |
| 0352 | Level I Injections | X | 0.1230 | $6.71 | ..... | $1.34 |
| 0353 | Level II Allergy Injections | X | 0.3982 | $21.73 | ..... | $4.35 |
| 0355 | Level III Immunizations | K | 0.2749 | $15.00 | ..... | $3.00 |
| 0356 | Level IV Immunizations | K | 0.7698 | $42.00 | ..... | $8.40 |
| 0359 | Level II Injections | X | 0.8000 | $43.65 | ..... | $8.73 |
| 0360 | Level I Alimentary Tests | X | 1.7313 | $94.46 | $42.45 | $18.89 |
| 0361 | Level II Alimentary Tests | X | 3.5510 | $193.75 | $83.23 | $38.75 |
| 0362 | Level III Otorhinolaryngologic Function Tests | X | 2.6984 | $147.23 | ..... | $29.45 |
| 0363 | Level I Otorhinolaryngologic Function Tests | X | 0.8641 | $47.15 | $17.44 | $9.43 |
| 0364 | Level I Audiometry | X | 0.4459 | $24.33 | $9.06 | $4.87 |
| 0365 | Level II Audiometry | X | 1.2132 | $66.19 | $18.95 | $13.24 |
| 0367 | Level I Pulmonary Test | X | 0.5887 | $32.12 | $15.16 | $6.42 |
| 0368 | Level II Pulmonary Tests | X | 0.9319 | $50.85 | $25.42 | $10.17 |
| 0369 | Level III Pulmonary Tests | X | 2.4984 | $136.32 | $44.18 | $27.26 |
| 0370 | Allergy Tests | X | 0.9185 | $50.11 | $11.58 | $10.02 |
| 0371 | Level I Allergy Injections | X | 0.4105 | $22.40 | ..... | $4.48 |
| 0372 | Therapeutic Phlebotomy | X | 0.5607 | $30.59 | $10.09 | $6.12 |
| 0373 | Neuropsychological Testing | X | 2.0899 | $114.03 | ..... | $22.81 |
| 0374 | Monitoring Psychiatric Drugs | X | 1.1252 | $61.39 | ..... | $12.28 |
| 0375 | Ancillary Outpatient Services When Patient Expires | T | ..... | $1,150.00 | ..... | $230.00 |
| 0376 | Level II Cardiac Imaging | S | 4.4510 | $242.85 | $121.42 | $48.57 |
| 0377 | Level III Cardiac Imaging | S | 6.8830 | $375.54 | $187.76 | $75.11 |
| 0378 | Level II Pulmonary Imaging | S | 5.4852 | $299.28 | $149.63 | $59.86 |
| 0379 | Injection adenosine 6 MG | K | 0.2078 | $11.34 | ..... | $2.27 |
| 0380 | Dipyridamole injection | K | 0.2525 | $13.78 | ..... | $2.76 |
| 0384 | GI Procedures with Stents | T | 20.6602 | $1,127.24 | $244.83 | $225.45 |
| 0385 | Level I Prosthetic Urological Procedures | S | 67.1530 | $3,663.93 | ..... | $732.79 |
| 0386 | Level II Prosthetic Urological Procedures | S | 116.2382 | $6,342.07 | ..... | $1,268.41 |
| 0387 | Level II Hysteroscopy | T | 28.1480 | $1,535.78 | $655.55 | $307.16 |
| 0388 | Discography | S | 11.6347 | $634.80 | $303.19 | $126.96 |
| 0389 | Non-imaging Nuclear Medicine | S | 1.6328 | $89.09 | $44.54 | $17.82 |
| 0390 | Level I Endocrine Imaging | S | 2.7907 | $152.26 | $76.13 | $30.45 |
| 0391 | Level II Endocrine Imaging | S | 3.1956 | $174.36 | $87.18 | $34.87 |
| 0393 | Red Cell/Plasma Studies | S | 4.4354 | $242.00 | $121.00 | $48.40 |
| 0394 | Hepatobiliary Imaging | S | 4.3714 | $238.51 | $119.25 | $47.70 |
| 0395 | GI Tract Imaging | S | 3.9536 | $215.71 | $107.85 | $43.14 |
| 0396 | Bone Imaging | S | 4.1883 | $228.52 | $114.26 | $45.70 |
| 0397 | Vascular Imaging | S | 2.2183 | $121.03 | $60.51 | $24.21 |
| 0398 | Level I Cardiac Imaging | S | 4.5091 | $246.02 | $123.01 | $49.20 |
| 0399 | Nuclear Medicine Add-on Imaging | S | 1.5273 | $83.33 | $41.66 | $16.67 |
| 0400 | Hematopoietic Imaging | S | 3.8242 | $208.65 | $104.32 | $41.73 |
| 0401 | Level I Pulmonary Imaging | S | 3.3736 | $184.07 | $92.03 | $36.81 |
| 0402 | Brain Imaging | S | 5.4063 | $294.97 | $147.48 | $58.99 |

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 0403 | CSF Imaging | S | 3.8402 | $209.53 | $104.76 | $41.91 |
| 0404 | Renal and Genitourinary Studies Level I | S | 3.7303 | $203.53 | $101.76 | $40.71 |
| 0405 | Renal and Genitourinary Studies Level II | S | 4.3432 | $236.97 | $118.48 | $47.39 |
| 0406 | Tumor/Infection Imaging | S | 4.3955 | $239.82 | $119.91 | $47.96 W≤ |
| 0407 | Radionuclide Therapy | S | 3.5841 | $195.55 | $97.77 | $39.11 |
| 0409 | Red Blood Cell Tests | X | 0.1390 | $7.58 | $2.32 | $1.52 |
| 0410 | Mammogram Add On | S | 0.1523 | $8.31 | | $1.66 |
| 0411 | Respiratory Procedures | S | 0.4367 | $23.83 | | $4.77 |
| 0412 | IMRT Treatment Delivery | S | 5.3904 | $294.11 | | $58.82 |
| 0413 | IMRT Treatment Plan | S | 7.4469 | $406.31 | | $81.26 |
| 0415 | Level II Endoscopy Lower Airway | T | 20.7348 | $1,131.31 | $459.92 | $226.26 |
| 0600 | Low Level Clinic Visits | V | 0.9278 | $50.62 | | $10.12 |
| 0601 | Mid Level Clinic Visits | V | 0.9816 | $53.56 | | $10.71 |
| 0602 | High Level Clinic Visits | V | 1.5041 | $82.07 | | $16.41 |
| 0610 | Low Level Emergency Visits | V | 1.3691 | $74.70 | $19.57 | $14.94 |
| 0611 | Mid Level Emergency Visits | V | 2.3967 | $130.77 | $36.16 | $26.15 |
| 0612 | High Level Emergency Visits | V | 4.1476 | $226.30 | $54.12 | $45.26 |
| 0620 | Critical Care | S | 8.9992 | $491.01 | $142.30 | $98.20 |
| 0648 | Breast Reconstruction with Prosthesis | T | 54.0165 | $2,947.19 | | $589.44 |
| 0651 | Complex Interstitial Radiation Source Application | S | 10.2314 | $558.24 | | $111.65 |
| 0652 | Insertion of Intraperitoneal Catheters | T | 27.0364 | $1,475.13 | | $295.03 |
| 0653 | Vascular Reconstruction/Fistula Repair with Device | T | 30.0334 | $1,638.65 | | $327.73 |
| 0654 | Insertion/Replacement of a permanent dual chamber pacemaker. | T | 112.6957 | $6,148.79 | | $1,229.76 |
| 0655 | Insertion/Replacement/Conversion of a permanent dual chamber pacemaker. | T | 142.7039 | $7,786.07 | | $1,557.21 |
| 0656 | Transcatheter Placement of Intracoronary Drug-Eluting Stents. | T | 103.4907 | $5,646.56 | | $1,129.31 |
| 0657 | Placement of Tissue Clips | S | 1.5102 | $82.40 | | $16.48 |
| 0658 | Percutaneous Breast Biopsies | T | 5.5779 | $304.34 | | $60.87 |
| 0659 | Hyperbaric Oxygen | S | 3.0228 | $164.93 | | $32.99 |
| 0660 | Level II Otorhinolaryngologic Function Tests | X | 1.7353 | $94.68 | $30.66 | $18.94 |
| 0661 | Level IV Pathology | X | 3.2576 | $177.74 | $88.87 | $35.55 |
| 0662 | CT Angiography | S | 5.8775 | $320.68 | $156.47 | $64.14 |
| 0664 | Proton Beam Radiation Therapy | S | 9.7295 | $530.85 | | $106.17 |
| 0665 | Bone Density:AppendicularSkeleton | S | 0.7257 | $39.59 | | $7.92 |
| 0668 | Level I Angiography and Venography except Extremity | S | 10.2660 | $560.12 | $237.76 | $112.02 |
| 0669 | Digital Mammography | S | 0.9009 | $49.15 | | $9.83 |
| 0670 | Intravenous and Intracardiac Ultrasound | S | 27.4483 | $1,497.61 | $542.37 | $299.52 |
| 0671 | Level II Echocardiogram Except Transesophageal | S | 1.6384 | $89.39 | $44.69 | $17.88 |
| 0672 | Level IV Posterior Segment Procedures | T | 38.9476 | $2,125.02 | $988.43 | $425.00 |
| 0673 | Level IV Anterior Segment Eye Procedures | T | 26.8390 | $1,464.36 | $649.56 | $292.87 |
| 0674 | Prostate Cryoablation | T | 119.9733 | $6,545.86 | | $1,309.17 |
| 0675 | Prostatic Thermotherapy | T | 49.3452 | $2,692.32 | | $538.46 |
| 0676 | Level II Transcatheter Thrombolysis | T | 2.7315 | $149.03 | $40.30 | $29.81 |
| 0677 | Level I Transcatheter Thrombolysis | T | 2.1805 | $118.97 | | $23.79 |
| 0678 | External Counterpulsation | T | 2.0659 | $112.72 | | $22.54 |
| 0679 | Level II Resuscitation and Cardioversion | S | 5.4887 | $299.47 | $95.30 | $59.89 |
| 0680 | Insertion of Patient Activated Event Recorders | S | 62.8252 | $3,427.81 | | $685.56 |
| 0681 | Knee Arthroplasty | T | 98.1613 | $5,355.78 | $2,131.36 | $1,071.16 |
| 0682 | Level V Debridement & Destruction | T | 8.0790 | $440.80 | $174.57 | $88.16 |
| 0683 | Level II Photochemotherapy | S | 1.5489 | $84.51 | $30.42 | $16.90 |
| 0685 | Level III Needle Biopsy/Aspiration Except Bone Marrow | T | 4.8100 | $262.44 | $115.47 | $52.49 |
| 0686 | Level III Skin Repair | T | 7.9247 | $432.38 | $198.89 | $86.48 |
| 0687 | Revision/Removal of Neurostimulator Electrodes | T | 20.4416 | $1,115.31 | $513.05 | $223.06 |
| 0688 | Revision/Removal of Neurostimulator Pulse Generator Receiver. | T | 46.7347 | $2,549.89 | $1,249.45 | $509.98 |
| 0689 | Electronic Analysis of Cardioverter-defibrillators | S | 0.5533 | $30.19 | | $6.04 |
| 0690 | Electronic Analysis of Pacemakers and other Cardiac Devices. | S | 0.4074 | $22.23 | $10.63 | $4.45 |
| 0691 | Electronic Analysis of Programmable Shunts/Pumps | S | 2.8066 | $153.13 | $76.56 | $30.63 |
| 0692 | Electronic Analysis of Neurostimulator Pulse Generators | S | 1.1057 | $60.33 | $30.16 | $12.07 |
| 0693 | Level II Breast Reconstruction | T | 39.0111 | $2,128.48 | $798.17 | $425.70 |
| 0694 | Mohs Surgery | T | 2.9752 | $162.33 | $64.93 | $32.47 |
| 0695 | Level VII Debridement & Destruction | T | 19.1849 | $1,046.75 | $266.59 | $209.35 |
| 0697 | Level I Echocardiogram Except Transesophageal | S | 1.4415 | $78.65 | $39.32 | $15.73 |
| 0698 | Level II Eye Tests & Treatments | S | 0.9599 | $52.37 | $18.72 | $10.47 |
| 0699 | Level IV Eye Tests & Treatments | T | 2.2303 | $121.69 | $47.46 | $24.34 |
| 0700 | Antepartum Manipulation | T | 2.4306 | $132.62 | $37.13 | $26.52 |

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| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 0701 | SR 89 chloride, per mCi | K | 7.3835 | $402.85 | | $80.57 |
| 0702 | SM 153 lexidronam, 50 mCi | K | 16.0268 | $874.44 | | $174.89 |
| 0704 | IN 111 Satumomab pendetide per dose | K | 2.2811 | $124.46 | | $24.89 |
| 0705 | Technetium TC99M tetrofosmin | K | 1.0642 | $58.06 | | $11.61 |
| 0726 | Dexrazoxane hcl injection, 250 mg | K | 2.0616 | $112.48 | | $22.50 |
| 0728 | Filgrastim 300 mcg injection | K | 2.2631 | $123.48 | | $24.70 |
| 0730 | Pamidronate disodium , 30 mg | K | 3.1949 | $174.32 | | $34.86 |
| 0731 | Sargramostim injection | K | 0.2991 | $16.32 | | $3.26 |
| 0732 | Mesna injection 200 mg | K | 0.5211 | $28.43 | | $5.69 |
| 0733 | Non esrd epoetin alpha inj, 1000 u | K | 0.1802 | $9.83 | | $1.97 |
| 0734 | Injection, darbepoetin alfa (for non-ESRD), per 1 mcg | K | | $3.24 | | $0.65 |
| 0763 | Dolasetron mesylate oral | K | 0.7514 | $41.00 | | $8.20 |
| 0764 | Granisetron HCl injection | K | 0.1044 | $5.70 | | $1.14 |
| 0765 | Granisetron HCl 1 mg oral | K | 0.6322 | $34.49 | | $6.90 |
| 0800 | Leuprolide acetate, 3.75 mg | K | 3.3525 | $182.92 | | $36.58 |
| 0802 | Etoposide oral 50 mg | K | 0.5016 | $27.37 | | $5.47 |
| 0807 | Aldesleukin/single use vial | K | | $680.35 | | $136.07 |
| 0809 | Bcg live intravesical vac | K | 1.9015 | $103.75 | | $20.75 |
| 0810 | Goserelin acetate implant 3.6 mg | K | 5.2265 | $285.16 | | $57.03 |
| 0811 | Carboplatin injection 50 mg | K | 1.5849 | $86.47 | | $17.29 |
| 0813 | Cisplatin 10 mg injection | K | 0.3985 | $21.74 | | $4.35 |
| 0814 | Asparaginase injection | K | 0.2957 | $16.13 | | $3.23 |
| 0815 | Cyclophosphamide 100 MG inj | K | 0.0868 | $4.74 | | $0.95 |
| 0816 | Cyclophosphamide lyophilized | K | 0.0825 | $4.50 | | $0.90 |
| 0817 | Cytarabine hcl 100 MG inj | K | 0.0930 | $5.07 | | $1.01 |
| 0819 | Dacarbazine 100 mg inj | K | 0.0974 | $5.31 | | $1.06 |
| 0820 | Daunorubicin 10 mg | K | 1.3557 | $73.97 | | $14.79 |
| 0821 | Daunorubicin citrate liposom 10 mg | K | 2.9976 | $163.55 | | $32.71 |
| 0823 | Docetaxel, 20 mg | K | 4.0499 | $220.97 | | $44.19 |
| 0824 | Etoposide 10 MG inj | K | 0.0836 | $4.56 | | $0.91 |
| 0827 | Floxuridine injection 500 mg | K | 2.0928 | $114.19 | | $22.84 |
| 0828 | Gemcitabine HCL 200 mg | K | 1.4742 | $80.43 | | $16.09 |
| 0830 | Irinotecan injection 20 mg | K | 1.8428 | $100.55 | | $20.11 |
| 0831 | Ifosfomide injection 1 gm | K | 1.9435 | $106.04 | | $21.21 |
| 0832 | Idarubicin hcl injection 5 mg | K | 3.2663 | $178.21 | | $35.64 |
| 0834 | Interferon alfa-2a inj | K | 0.3777 | $20.61 | | $4.12 |
| 0836 | Interferon alfa-2b inj recombinant, 1 million | K | 0.2003 | $10.93 | | $2.19 |
| 0838 | Interferon gamma 1-b inj, 3 million u | K | | $180.15 | | $36.03 |
| 0840 | Melphalan hydrochl 50 mg | K | 4.6719 | $254.90 | | $50.98 |
| 0842 | Fludarabine phosphate inj 50 mg | K | 3.7708 | $205.74 | | $41.15 |
| 0844 | Pentostatin injection, 10 mg | K | 17.7045 | $965.98 | | $193.20 |
| 0847 | Doxorubic hcl 10 MG vl chemo | K | 0.1212 | $6.61 | | $1.32 |
| 0849 | Rituximab, 100 mg | K | 5.6158 | $306.40 | | $61.28 |
| 0850 | Streptozocin injection, 1 gm | K | 1.1948 | $65.19 | | $13.04 |
| 0851 | Thiotepa injection | K | 1.0984 | $59.93 | | $11.99 |
| 0852 | Topotecan, 4 mg | K | 7.9435 | $433.41 | | $86.68 |
| 0855 | Vinorelbine tartrate, 10 mg | K | 1.1874 | $64.79 | | $12.96 |
| 0856 | Porfimer sodium, 75 mg | K | 29.2205 | $1,594.30 | | $318.86 |
| 0857 | Bleomycin sulfate injection 15 u | K | 2.9427 | $160.56 | | $32.11 |
| 0858 | Cladribine, 1mg | K | 0.6931 | $37.82 | | $7.56 |
| 0860 | Plicamycin (mithramycin) inj | K | 0.2826 | $15.42 | | $3.08 |
| 0861 | Leuprolide acetate injection 1 mg | K | 0.7991 | $43.60 | | $8.72 |
| 0862 | Mitomycin 5 mg inj | K | 0.9719 | $53.03 | | $10.61 |
| 0863 | Paclitaxel injection, 30 mg | K | 2.0553 | $112.14 | | $22.43 |
| 0864 | Mitoxantrone hcl, 5 mg | K | 3.1832 | $173.68 | | $34.74 |
| 0865 | Interferon alfa-n3 inj, human leukocyte derived, 2 | K | 1.4598 | $79.65 | | $15.93 |
| 0884 | Rho d immune globulin inj, 1 dose pkg | K | 0.1863 | $10.16 | | $2.03 |
| 0888 | Cyclosporine oral 100 mg | K | 0.0470 | $2.56 | | $0.51 |
| 0890 | Lymphocyte immune globulin 250 mg | K | 2.3439 | $127.89 | | $25.58 |
| 0891 | Tacrolimus oral per 1 mg | K | 0.0246 | $1.34 | | $0.27 |
| 0900 | Alglucerase injection, per 10 u | K | | $37.13 | | $7.43 |
| 0901 | Alpha 1 proteinase inhibitor, 10 mg | K | | $3.43 | | $0.69 |
| 0902 | Botulinum toxin a, per unit | K | 0.0588 | $3.21 | | $0.64 |
| 0903 | Cytomegalovirus imm IV/vial | K | 5.3368 | $291.18 | | $58.24 |
| 0905 | Immune globulin, 1g | K | 0.8057 | $43.96 | | $8.79 |
| 0906 | RSV-ivig, 50 mg | K | 0.8910 | $48.61 | | $9.72 |
| 0907 | Ganciclovir sodium injection | K | 0.5918 | $32.29 | | $6.46 |
| 0909 | Interferon beta-1a, 33 mcg | K | 3.3868 | $184.79 | | $36.96 |
| 0910 | Interferon beta-1b /0.25 mg | K | 1.8421 | $100.51 | | $20.10 |

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| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 0911 | Streptokinase per 250,000 iu | K | 1.5733 | $85.84 | | $17.17 |
| 0913 | Ganciclovir long act implant | K | 1.5861 | $86.54 | | $17.31 |
| 0916 | Imiglucerase injection/unit | K | | $3.71 | | $0.74 |
| 0917 | Adenosine injection | K | 1.0393 | $56.71 | | $11.34 |
| 0925 | Factor viii per iu | K | | $0.51 | | $0.10 |
| 0926 | Factor VIII (porcine) per iu | K | | $1.52 | | $0.30 |
| 0927 | Factor viii recombinant per iu | K | | $1.01 | | $0.20 |
| 0928 | Factor ix complex per iu | K | | $0.51 | | $0.10 |
| 0929 | Anti-inhibitor per iu | K | | $1.01 | | $0.20 |
| 0931 | Factor IX non-recombinant, per iu | K | | $0.51 | | $0.10 |
| 0932 | Factor IX recombinant, per iu | K | | $1.01 | | $0.20 |
| 0949 | Plasma, Pooled Multiple Donor, Solvent/Detergent T | K | | $124.31 | | $24.86 |
| 0950 | Blood (Whole) For Transfusion | K | | $87.93 | | $17.59 |
| 0952 | Cryoprecipitate | K | | $29.31 | | $5.86 |
| 0954 | RBC leukocytes reduced | K | | $119.26 | | $23.85 |
| 0955 | Plasma, Fresh Frozen | K | | $95.00 | | $19.00 |
| 0956 | Plasma Protein Fraction | K | | $92.98 | | $18.60 |
| 0957 | Platelet Concentrate | K | | $41.44 | | $8.29 |
| 0958 | Platelet Rich Plasma | K | | $53.56 | | $10.71 |
| 0959 | Red Blood Cells | K | | $86.41 | | $17.28 |
| 0960 | Washed Red Blood Cells | K | | $160.69 | | $32.14 |
| 0961 | Infusion, Albumin (Human) 5%, 50 ml | K | 0.2802 | $15.29 | | $3.06 |
| 0963 | Albumin (human), 5%, 250 ml | K | 1.0901 | $59.48 | | $11.90 |
| 0964 | Albumin (human), 25%, 20 ml | K | 0.3741 | $20.41 | | $4.08 |
| 0965 | Albumin (human), 25%, 50ml | K | 0.8869 | $48.39 | | $9.68 |
| 0966 | Plasmaprotein fract,5%,250ml | K | | $464.90 | | $92.98 |
| 1009 | Cryoprecip reduced plasma | K | | $37.39 | | $7.48 |
| 1010 | Blood, L/R, CMV-neg | K | | $121.78 | | $24.36 |
| 1011 | Platelets, HLA-m, L/R, unit | K | | $499.77 | | $99.95 |
| 1013 | Platelet concentrate, L/R, unit | K | | $49.52 | | $9.90 |
| 1016 | Blood, L/R, froz/deglycerol/washed | K | | $301.68 | | $60.34 |
| 1017 | Platelets, aph/pher, L/R, CMV-neg, unit | K | | $393.15 | | $78.63 |
| 1018 | Blood, L/R, irradiated | K | | $132.40 | | $26.48 |
| 1019 | Platelets, aph/pher, L/R, irradiated, unit | K | | $406.28 | | $81.26 |
| 1020 | Pit, pher,L/R,CMV,irrad | K | | $495.22 | | $99.04 |
| 1021 | RBC, frz/deg/wsh, L/R, irrad | K | | $336.04 | | $67.21 |
| 1022 | RBC, L/R, CMV neg, irrad | K | | $201.12 | | $40.22 |
| 1045 | Iobenguane sulfate I-131per 0.5 mCi | K | 3.0392 | $165.82 | | $33.16 |
| 1064 | I-131 sodium iodide capsule | K | 0.1004 | $5.48 | | $1.10 |
| 1065 | I-131 sodium iodide solution | K | 0.1189 | $6.49 | | $1.30 |
| 1079 | CO 57/58 per 0.5 uCi | K | 1.2556 | $68.51 | | $13.70 |
| 1080 | I-131 tositumomab, dx | K | | $2,260.00 | | $452.00 |
| 1081 | I-131 tositumomab, tx | K | | $19,565.00 | | $3,913.00 |
| 1084 | Denileukin diftitox, 300 MCG | K | | $1,232.88 | | $246.58 |
| 1086 | Temozolomide,oral 5 mg | K | 0.0690 | $3.76 | | $0.75 |
| 1089 | Cyanocobalamin cobalt co57 | K | 1.0460 | $57.07 | | $11.41 |
| 1091 | IN 111 Oxyquinoline, per .5 mCi | K | 4.1151 | $224.52 | | $44.90 |
| 1092 | IN 111 Pentetate, per 0.5 mCi | K | 3.9855 | $217.45 | | $43.49 |
| 1095 | Technetium TC 99M Depreotide | K | 0.6940 | $37.87 | | $7.57 |
| 1096 | TC 99M Exametazime, per dose | K | 3.8609 | $210.65 | | $42.13 |
| 1122 | TC 99M arcitumomab, per vial | K | 9.8014 | $534.77 | | $106.95 |
| 1166 | Cytarabine liposome | K | 5.1134 | $278.99 | | $55.80 |
| 1167 | Epirubicin hcl, 2 mg | K | 0.3744 | $20.43 | | $4.09 |
| 1178 | Busulfan IV, 6 mg | K | 5.4930 | $299.70 | | $59.94 |
| 1200 | TC 99M Sodium Glucoheptonat | K | 0.5550 | $30.28 | | $6.06 |
| 1201 | TC 99M SUCCIMER, PER Vial | K | 1.4706 | $80.24 | | $16.05 |
| 1203 | Verteporfin for injection | K | 16.4439 | $897.20 | | $179.44 |
| 1207 | Octreotide injection, depot | K | 1.2049 | $65.74 | | $13.15 |
| 1305 | Apligraf | K | 15.0691 | $822.19 | | $164.44 |
| 1409 | Factor viia recombinant, per 1.2 mg | K | | $1,083.93 | | $216.79 |
| 1501 | New Technology—Level I ($0–$50) | S | | $25.00 | | $5.00 |
| 1502 | New Technology—Level II ($50–$100) | S | | $75.00 | | $15.00 |
| 1503 | New Technology—Level III ($100–$200) | S | | $150.00 | | $30.00 |
| 1504 | New Technology—Level IV ($200–$300) | S | | $250.00 | | $50.00 |
| 1505 | New Technology—Level V ($300–$400) | S | | $350.00 | | $70.00 |
| 1506 | New Technology—Level VI ($400–$500) | S | | $450.00 | | $90.00 |
| 1507 | New Technology—Level VII ($500–$600) | S | | $550.00 | | $110.00 |
| 1508 | New Technology—Level VIII ($600–$700) | S | | $650.00 | | $130.00 |
| 1509 | New Technology—Level IX ($700–$800) | S | | $750.00 | | $150.00 |

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 1510 .... | New Technology—Level X ($800–$900) ..... | S ..... | ..... | $850.00 | ..... | $170.00 |
| 1511 .... | New Technology—Level XI ($900–$1000) ..... | S ..... | ..... | $950.00 | ..... | $190.00 |
| 1512 .... | New Technology—Level XII ($1000–$1100) ..... | S ..... | ..... | $1,050.00 | ..... | $210.00 |
| 1513 .... | New Technology—Level XIII ($1100–$1200) ..... | S ..... | ..... | $1,150.00 | ..... | $230.00 |
| 1514 .... | New Technology-Level XIV ($1200- $1300) ..... | S ..... | ..... | $1,250.00 | ..... | $250.00 |
| 1515 .... | New Technology—Level XV ($1300–$1400) ..... | S ..... | ..... | $1,350.00 | ..... | $270.00 |
| 1516 .... | New Technology—Level XVI ($1400–$1500) ..... | S ..... | ..... | $1,450.00 | ..... | $290.00 |
| 1517 .... | New Technology—Level XVII ($1500-$1600) ..... | S ..... | ..... | $1,550.00 | ..... | $310.00 |
| 1518 .... | New Technology—Level XVIII ($1600-$1700) ..... | S ..... | ..... | $1,650.00 | ..... | $330.00 |
| 1519 .... | New Technology—Level IXX ($1700-$1800) ..... | S ..... | ..... | $1,750.00 | ..... | $350.00 |
| 1520 .... | New Technology—Level XX ($1800-$1900) ..... | S ..... | ..... | $1,850.00 | ..... | $370.00 |
| 1521 .... | New Technology—Level XXI ($1900-$2000) ..... | S ..... | ..... | $1,950.00 | ..... | $390.00 |
| 1522 .... | New Technology—Level XXII ($2000-$2500) ..... | S ..... | ..... | $2,250.00 | ..... | $450.00 |
| 1523 .... | New Technology—Level XXIII ($2500-$3000) ..... | S ..... | ..... | $2,750.00 | ..... | $550.00 |
| 1524 .... | New Technology—Level XIV ($3000-$3500) ..... | S ..... | ..... | $3,250.00 | ..... | $650.00 |
| 1525 .... | New Technology—Level XXV ($3500-$4000) ..... | S ..... | ..... | $3,750.00 | ..... | $750.00 |
| 1526 .... | New Technology—Level XXVI ($4000-$4500) ..... | S ..... | ..... | $4,250.00 | ..... | $850.00 |
| 1527 .... | New Technology—Level XXVII ($4500-$5000) ..... | S ..... | ..... | $4,750.00 | ..... | $950.00 |
| 1528 .... | New Technology—Level XXVIII ($5000-$5500) ..... | S ..... | ..... | $5,250.00 | ..... | $1,050.00 |
| 1529 .... | New Technology—Level XXIX ($5500-$6000) ..... | S ..... | ..... | $5,750.00 | ..... | $1,150.00 |
| 1530 .... | New Technology—Level XXX ($6000-$6500) ..... | S ..... | ..... | $6,250.00 | ..... | $1,250.00 |
| 1531 .... | New Technology—Level XXXI ($6500-$7000) ..... | S ..... | ..... | $6,750.00 | ..... | $1,350.00 |
| 1532 .... | New Technology—Level XXXII ($7000-$7500) ..... | S ..... | ..... | $7,250.00 | ..... | $1,450.00 |
| 1533 .... | New Technology—Level XXXIII ($7500-$8000) ..... | S ..... | ..... | $7,750.00 | ..... | $1,550.00 |
| 1534 .... | New Technology—Level XXXIV ($8000-$8500) ..... | S ..... | ..... | $8,250.00 | ..... | $1,650.00 |
| 1535 .... | New Technology—Level XXXV ($8500-$9000) ..... | S ..... | ..... | $8,750.00 | ..... | $1,750.00 |
| 1536 .... | New Technology—Level XXXVI ($9000-$9500) ..... | S ..... | ..... | $9,250.00 | ..... | $1,850.00 |
| 1537 .... | New Technology—Level XXXVII ($9500-$10000) ..... | S ..... | ..... | $9,750.00 | ..... | $1,950.00 |
| 1538 .... | New Technology—Level I ($0–$50) ..... | T ..... | ..... | $25.00 | ..... | $5.00 |
| 1539 .... | New Technology—Level II ($50–$100) ..... | T ..... | ..... | $75.00 | ..... | $15.00 |
| 1540 .... | New Technology—Level III ($100–$200) ..... | T ..... | ..... | $150.00 | ..... | $30.00 |
| 1541 .... | New Technology—Level IV ($200–$300) ..... | T ..... | ..... | $250.00 | ..... | $50.00 |
| 1542 .... | New Technology—Level V ($300–$400) ..... | T ..... | ..... | $350.00 | ..... | $70.00 |
| 1543 .... | New Technology—Level VI ($400–$500) ..... | T ..... | ..... | $450.00 | ..... | $90.00 |
| 1544 .... | New Technology—Level VII ($500–$600) ..... | T ..... | ..... | $550.00 | ..... | $110.00 |
| 1545 .... | New Technology—Level VIII ($600–$700) ..... | T ..... | ..... | $650.00 | ..... | $130.00 |
| 1546 .... | New Technology—Level IX ($700–$800) ..... | T ..... | ..... | $750.00 | ..... | $150.00 |
| 1547 .... | New Technology—Level X ($800–$900) ..... | T ..... | ..... | $850.00 | ..... | $170.00 |
| 1548 .... | New Technology—Level XI ($900–$1000) ..... | T ..... | ..... | $950.00 | ..... | $190.00 |
| 1549 .... | New Technology—Level XII ($1000–$1100) ..... | T ..... | ..... | $1,050.00 | ..... | $210.00 |
| 1550 .... | New Technology—Level XIII ($1100–$1200) ..... | T ..... | ..... | $1,150.00 | ..... | $230.00 |
| 1551 .... | New Technology-Level XIV ($1200- $1300) ..... | T ..... | ..... | $1,250.00 | ..... | $250.00 |
| 1552 .... | New Technology—Level XV ($1300–$1400) ..... | T ..... | ..... | $1,350.00 | ..... | $270.00 |
| 1553 .... | New Technology—Level XVI ($1400–$1500) ..... | T ..... | ..... | $1,450.00 | ..... | $290.00 |
| 1554 .... | New Technology—Level XVII ($1500-$1600) ..... | T ..... | ..... | $1,550.00 | ..... | $310.00 |
| 1555 .... | New Technology—Level XVIII ($1600-$1700) ..... | T ..... | ..... | $1,650.00 | ..... | $330.00 |
| 1556 .... | New Technology—Level XIX ($1700-$1800) ..... | T ..... | ..... | $1,750.00 | ..... | $350.00 |
| 1557 .... | New Technology—Level XX ($1800-$1900) ..... | T ..... | ..... | $1,850.00 | ..... | $370.00 |
| 1558 .... | New Technology—Level XXI ($1900-$2000) ..... | T ..... | ..... | $1,950.00 | ..... | $390.00 |
| 1559 .... | New Technology—Level XXII ($2000-$2500) ..... | T ..... | ..... | $2,250.00 | ..... | $450.00 |
| 1560 .... | New Technology—Level XXIII ($2500-$3000) ..... | T ..... | ..... | $2,750.00 | ..... | $550.00 |
| 1561 .... | New Technology—Level XXIV ($3000-$3500) ..... | T ..... | ..... | $3,250.00 | ..... | $650.00 |
| 1562 .... | New Technology—Level XXV ($3500-$4000) ..... | T ..... | ..... | $3,750.00 | ..... | $750.00 |
| 1563 .... | New Technology—Level XXVI ($4000-$4500) ..... | T ..... | ..... | $4,250.00 | ..... | $850.00 |
| 1564 .... | New Technology—Level XXVII ($4500-$5000) ..... | T ..... | ..... | $4,750.00 | ..... | $950.00 |
| 1565 .... | New Technology—Level XXVIII ($5000-$5500) ..... | T ..... | ..... | $5,250.00 | ..... | $1,050.00 |
| 1566 .... | New Technology—Level XXIX ($5500-$6000) ..... | T ..... | ..... | $5,750.00 | ..... | $1,150.00 |
| 1567 .... | New Technology—Level XXX ($6000-$6500) ..... | T ..... | ..... | $6,250.00 | ..... | $1,250.00 |
| 1568 .... | New Technology—Level XXXI ($6500-$7000) ..... | T ..... | ..... | $6,750.00 | ..... | $1,350.00 |
| 1569 .... | New Technology—Level XXXII ($7000-$7500) ..... | T ..... | ..... | $7,250.00 | ..... | $1,450.00 |
| 1570 .... | New Technology—Level XXXIII ($7500-$8000) ..... | T ..... | ..... | $7,750.00 | ..... | $1,550.00 |
| 1571 .... | New Technology—Level XXXIV ($8000-$8500) ..... | T ..... | ..... | $8,250.00 | ..... | $1,650.00 |
| 1572 .... | New Technology—Level XXXV ($8500-$9000) ..... | T ..... | ..... | $8,750.00 | ..... | $1,750.00 |
| 1573 .... | New Technology—Level XXXVI ($9000-$9500) ..... | T ..... | ..... | $9,250.00 | ..... | $1,850.00 |
| 1574 .... | New Technology—Level XXXVII ($9500-$10000) ..... | T ..... | ..... | $9,750.00 | ..... | $1,950.00 |
| 1600 .... | Technetium TC 99m sestamibi ..... | K ..... | 1.1782 | $64.28 | ..... | $12.86 |
| 1603 .... | Thallous chloride TL 201/mci ..... | K ..... | 0.3645 | $19.89 | ..... | $3.98 |
| 1604 .... | IN 111 capromab pendetide, per dose ..... | K ..... | 12.6045 | $687.71 | ..... | $137.54 |
| 1605 .... | Abciximab injection, 10 mg ..... | K ..... | 5.3048 | $289.44 | ..... | $57.89 |

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 1606 | Anistreplase, 30 u | K | 27.7939 | $1,516.46 | | $303.29 |
| 1607 | Eptifibatide injection, 5mg | K | 0.1465 | $7.99 | | $1.60 |
| 1608 | Etanercept injection | K | 1.8762 | $102.37 | | $20.47 |
| 1609 | Rho(D) immune globulin h, sd, 100 iu | K | 0.1789 | $9.76 | | $1.95 |
| 1611 | Hylan G-F 20 injection, 16 mg | K | 2.2628 | $123.46 | | $24.69 |
| 1612 | Daclizumab, parenteral, 25 mg | K | | $393.78 | | $78.76 |
| 1613 | Trastuzumab, 10 mg | K | 0.7434 | $40.56 | | $8.11 |
| 1614 | Valrubicin, 200 mg | K | 8.4635 | $461.78 | | $92.36 |
| 1615 | Basiliximab, 20 mg | K | | $1,425.06 | | $285.01 |
| 1618 | Vonwillebrandfactrcmplx, per iu | K | | $1.01 | | $0.20 |
| 1619 | Gallium ga 67 | K | 0.2056 | $11.22 | | $2.24 |
| 1620 | Technetium tc99m bicisate | K | 3.3666 | $183.69 | | $36.74 |
| 1622 | Technetium tc99m mertiatide | K | 0.3782 | $20.63 | | $4.13 |
| 1624 | Sodium phosphate p32 | K | 1.2941 | $70.61 | | $14.12 |
| 1625 | Indium 111-in pentetreotide | K | 8.2447 | $449.84 | | $89.97 |
| 1628 | Chromic phosphate p32 | K | 1.8057 | $98.52 | | $19.70 |
| 1716 | Brachytx source, Gold 198 | K | 1.3811 | $75.35 | | $15.07 |
| 1718 | Brachytx source, Iodine 125 | K | 0.6843 | $37.34 | | $7.47 |
| 1719 | Brachytx source,Non-HDR Ir-192 | K | 0.3187 | $17.39 | | $3.48 |
| 1720 | Brachytx source, Palladium 103 | K | 0.8187 | $44.67 | | $8.93 |
| 1775 | FDG, per dose (4-40 mCi/ml) | K | 5.9471 | $324.48 | | $64.90 |
| 1783 | Ocular implant, aqueous drain device | H | | | | $0.00 |
| 1814 | Retinal Tamp, silicone oil | H | | | | $-.00 |
| 1818 | Integrated keratoprosthesis | H | | | | $0.00 |
| 1819 | Tissue localization-excision dev | H | | | | $0.00 |
| 1884 | Embolization Protect syst | H | | | | $0.00 |
| 1888 | Catheter, ablation, non-cardiac, endovascular (implantable) | H | | | | $0.00 |
| 1900 | Lead coronary venous | H | | | | $0.00 |
| 2614 | Probe, percutaneous lumbar disc | H | | | | $0.00 |
| 2616 | Brachytx source, Yttrium-90 | K | 176.2339 | $9,615.50 | | $1,923.10 |
| 2632 | Brachytx sol, I-125, per mCi | H | | | | $0.00 |
| 2633 | Brachytx source, Cesium-131 | K | 0.8187 | $44.67 | | $8.93 |
| 7000 | Amifostine, 500 mg | K | 5.3041 | $289.40 | | $57.88 |
| 7007 | Inj milrinone lactate, per 5 mg | K | 0.2129 | $11.62 | | $2.32 |
| 7011 | Oprelvekin injection, 5 mg | K | | $248.16 | | $49.63 |
| 7015 | Busulfan, oral, 2 mg | K | 0.0288 | $1.57 | | $0.31 |
| 7019 | Aprotinin, 10,000 kiu | K | 0.0215 | $1.17 | | $0.23 |
| 7024 | Corticorelin ovine triflutat | K | 4.1221 | $224.91 | | $44.98 |
| 7025 | Digoxin immune FAB (ovine) | K | 4.9694 | $271.14 | | $54.23 |
| 7026 | Ethanolamine oleate 100 mg | K | 0.5099 | $27.82 | | $5.56 |
| 7027 | Fomepizole, 15mg | K | 0.1325 | $7.23 | | $1.45 |
| 7028 | Fosphenytoin, 50 mg | K | 0.0895 | $4.88 | | $0.98 |
| 7030 | Hemin, per 1 mg | K | 0.0118 | $0.64 | | $0.13 |
| 7031 | Octreotide acetate injection | K | 0.0264 | $1.44 | | $0.29 |
| 7034 | Somatropin injection | K | 0.7547 | $41.18 | | $8.24 |
| 7035 | Teniposide, 50 mg | K | 2.5185 | $137.41 | | $27.48 |
| 7036 | Urokinase 250,000 iu inj | K | 3.7855 | $206.54 | | $41.31 |
| 7037 | Urofollitropin, 75 iu | K | 1.1634 | $63.48 | | $12.70 |
| 7038 | Muromonab-CD3, 5 mg | K | 5.8803 | $320.84 | | $64.17 |
| 7040 | Pentastarch 10% solution | K | 0.4838 | $26.40 | | $5.28 |
| 7041 | Tirofiban hydrochloride 12.5 mg | K | 4.176 | $227.85 | | $45.57 |
| 7042 | Capecitabine, oral, 150 mg | K | 0.0302 | $1.65 | | $0.33 |
| 7043 | Infliximab injection 10 mg | K | 0.7122 | $38.86 | | $7.77 |
| 7045 | Trimetrexate glucoronate | K | 1.1246 | $61.36 | | $12.27 |
| 7046 | Doxorubicin hcl liposome inj 10 mg | K | 4.6982 | $256.34 | | $51.27 |
| 7048 | Alteplase recombinant | K | 0.2856 | $15.58 | | $3.12 |
| 7049 | Filgrastim 480 mcg injection | K | 3.2251 | $175.96 | | $35.19 |
| 7051 | Leuprolide acetate implant, 65 mg | K | 67.2039 | $3,666.71 | | $733.34 |
| 7316 | Sodium hyaluronate injection | K | 2.5436 | $138.78 | | $27.76 |
| 9001 | Linezolid injection | K | 0.2771 | $15.12 | | $3.02 |
| 9002 | Tenecteplase, 50mg/vial | K | 23.7669 | $1,296.75 | | $259.35 |
| 9003 | Palivizumab, per 50mg | K | 6.3077 | $344.15 | | $68.83 |
| 9004 | Gemtuzumab ozogamicin inj,5mg | K | | $2,022.90 | | $404.58 |
| 9005 | Reteplase injection | K | 10.4165 | $568.33 | | $113.67 |
| 9006 | Tacrolimus injection | K | 0.1048 | $5.72 | | $1.14 |
| 9008 | Baclofen Refill Kit-500mcg | K | 0.1264 | $6.90 | | $1.38 |
| 9009 | Baclofen refill kit—per 2000 mcg | K | 0.7499 | $40.92 | | $8.18 |
| 9010 | Baclofen refill kit—per 4000 mcg | K | 0.7739 | $42.22 | | $8.44 |
| 9012 | Arsenic Trioxide | K | 0.4933 | $26.91 | | $5.38 |

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 9013 | Co 57 cobaltous chloride | K | 1.0386 | $56.67 | | $11.33 |
| 9015 | Mycophenolate mofetil oral 250 mg | K | 0.0374 | $2.04 | | $0.41 |
| 9018 | Botulinum toxin B, per 100 u | K | 0.1279 | $6.98 | | $1.40 |
| 9019 | Caspofungin acetate, 5 mg | K | 0.5432 | $29.64 | | $5.93 |
| 9020 | Sirolimus tablet, 1 mg | K | 0.0529 | $2.89 | | $0.58 |
| 9021 | Immune globulin 10 mg | K | 0.0080 | $0.44 | | $0.09 |
| 9022 | IM inj interferon beta 1-a | K | 1.1290 | $61.60 | | $12.32 |
| 9023 | Rho d immune globulin 50 mcg | K | 0.0310 | $1.69 | | $0.34 |
| 9024 | Amphotericin B, lipid formulation | K | 0.3823 | $20.86 | | $4.17 |
| 9025 | Radiopharms Used to Image Perfusion of Heart | K | 2.6372 | $143.89 | | $28.78 |
| 9100 | Iodinated I-131albumin, per 5 uci | K | 0.0066 | $0.36 | | $0.07 |
| 9104 | Anti-thymocyte globulin rabbit | K | 2.9978 | $163.56 | | $32.71 |
| 9105 | Hep B imm glob, per 1 ml | K | 1.3074 | $71.33 | | $14.27 |
| 9108 | Thyrotropin alfa, per 1.1 mg | K | | $572.00 | | $114.40 |
| 9109 | Tirofliban hcl, per 6.25 mg | K | 2.1737 | $118.60 | | $23.72 |
| 9110 | Alemtuzumab, per 10 mg | K | 7.7873 | $424.88 | | $84.98 |
| 9111 | Inj, bivalirudin, per 250 mg vial | G | | $1.60 | | $0.24 |
| 9112 | Perflutren lipid micro, per 2ml | G | | $148.20 | | $22.15 |
| 9113 | Inj, pantoprazole sodium, vial | G | | $25.08 | | $3.75 |
| 9114 | Nesiritide, per 0.5 mg vial | G | | $151.62 | | $22.66 |
| 9115 | Inj, zoledronic acid, per 1 mg | G | | $217.43 | | $32.50 |
| 9116 | Inj, Ertapenem sodium, per 1 gm vial | G | | $23.74 | | $3.55 |
| 9117 | Yttrium 90 ibritumomab tiuxetan | K | | $19,565.00 | | $3,913.00 |
| 9118 | In-111 ibritumomab tiuxetan | K | | $2,260.00 | | $452.00 |
| 9119 | Pegfilgrastim, per 1 mg | G | | $2,802.50 | | $418.90 |
| 9120 | Inj, Fulvestrant, per 50 mg | G | | $87.58 | | $13.09 |
| 9121 | Inj, Argatroban, per 5 mg | G | | $16.35 | | $2.44 |
| 9122 | Inj, Triptorelin pamoate, per 3.75 mg | G | | $398.62 | | $59.58 |
| 9123 | Transcyte, per 247 sq cm | G | | $770.93 | | $115.23 |
| 9200 | Orcel, per 36 cm2 | G | | $1,135.25 | | $169.69 |
| 9201 | Dermagraft, per 37.5 sq cm | G | | $577.60 | | $86.34 |
| 9202 | Octafluoropropane | K | 2.1737 | $118.60 | | $23.72 |
| 9203 | Perflexane lipid micro | G | | $142.50 | | $21.30 |
| 9204 | Ziprasidone mesylate | G | | $20.79 | | $3.11 |
| 9205 | Oxaliplatin | G | | $94.46 | | $14.12 |
| 9207 | Injection, bortezomib | G | | $1,039.68 | | $155.40 |
| 9208 | Injection, agalsidase beta | G | | $123.78 | | $18.50 |
| 9209 | Injection, laronidase | G | | $644.10 | | $96.28 |
| 9210 | Injection, palonosetron HCL | G | | $307.80 | | $46.01 |
| 9211 | Inj, alefacept, IV | G | | $665.00 | | $99.40 |
| 9212 | Inj, alefacept, IM | G | | $472.63 | | $70.65 |
| 9217 | Leuprolide acetate suspnsion, 7.5 mg | K | 5.7252 | $312.37 | | $62.47 |
| 9500 | Platelets, irradiated | K | | $74.79 | | $14.96 |
| 9501 | Platelets, pheresis | K | | $408.81 | | $81.76 |
| 9502 | Platelet pheresis irradiated | K | | $443.68 | | $88.74 |
| 9503 | Fresh frozen plasma, ea unit | K | | $69.74 | | $13.95 |
| 9504 | RBC deglycerolized | K | | $183.44 | | $36.69 |
| 9505 | RBC irradiated | K | | $108.65 | | $21.73 |
| 9506 | Granulocytes, pheresis | K | | $1,248.66 | | $249.73 |

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 0001F | E | NI | Blood pressure, measured | | | | | |
| 0001T | C | | Endovas repr abdo ao aneurys | | | | | |
| 0002F | E | NI | Tobacco use, smoking, assess | | | | | |
| 0002T | C | DG | Endovas repr abdo ao aneurys | | | | | |
| 0003F | E | NI | Tobacco use, non-smoking | | | | | |
| 0003T | S | | Cervicography | 1501 | | $25.00 | | $5.00 |
| 0004F | E | NI | Tobacco use txmnt counseling | | | | | |
| 0005F | E | NI | Tobacco use txmnt, pharmacol | | | | | |
| 0005T | C | | Perc cath stent/brain cv art | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 0006F | E | NI | Statin therapy, prescribed | | | | | |
| 0006T | C | | Perc cath stent/brain cv art | | | | | |
| 0007F | E | NI | Beta-blocker thx prescribed | | | | | |
| 0007T | C | | Perc cath stent/brain cv art | | | | | |
| 0008F | E | NI | Ace inhibitor thx prescribed | | | | | |
| 0008T | E | | Upper gi endoscopy w/suture | | | | | |
| 0009F | E | NI | Assess anginal symptom/level | | | | | |
| 0009T | T | | Endometrial cryoablation | 1557 | | $1,850.00 | | $370.00 |
| 00100 | N | | Anesth, salivary gland | | | | | |
| 00102 | N | | Anesth, repair of cleft lip | | | | | |
| 00103 | N | | Anesth, blepharoplasty | | | | | |
| 00104 | N | | Anesth, electroshock | | | | | |
| 0010F | E | NI | Assess anginal symptom/level | | | | | |
| 0010T | A | | Tb test, gamma interferon | | | | | |
| 0011F | E | NI | Oral antiplat thx prescribed | | | | | |
| 00120 | N | | Anesth, ear surgery | | | | | |
| 00124 | N | | Anesth, ear exam | | | | | |
| 00126 | N | | Anesth, tympanotomy | | | | | |
| 0012T | T | | Osteochondral knee autograft | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 0013T | T | | Osteochondral knee allograft | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 00140 | N | | Anesth, procedures on eye | | | | | |
| 00142 | N | | Anesth, lens surgery | | | | | |
| 00144 | N | | Anesth, corneal transplant | | | | | |
| 00145 | N | | Anesth, vitreoretinal surg | | | | | |
| 00147 | N | | Anesth, iridectomy | | | | | |
| 00148 | N | | Anesth, eye exam | | | | | |
| 0014T | T | | Meniscal transplant, knee | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 00160 | N | | Anesth, nose/sinus surgery | | | | | |
| 00162 | N | | Anesth, nose/sinus surgery | | | | | |
| 00164 | N | | Anesth, biopsy of nose | | | | | |
| 0016T | T | | Thermotx choroid vasc lesion | 0235 | 5.0749 | $276.89 | $72.04 | $55.38 |
| 00170 | N | | Anesth, procedure on mouth | | | | | |
| 00172 | N | | Anesth, cleft palate repair | | | | | |
| 00174 | C | | Anesth, pharyngeal surgery | | | | | |
| 00176 | C | | Anesth, pharyngeal surgery | | | | | |
| 0017T | E | | Photocoagulat macular drusen | | | | | |
| 0018T | S | | Transcranial magnetic stimul | 0215 | 0.6457 | $35.23 | $15.76 | $7.05 |
| 00190 | N | | Anesth, face/skull bone surg | | | | | |
| 00192 | C | | Anesth, facial bone surgery | | | | | |
| 0019T | E | | Extracorp shock wave tx, ms | | | | | |
| 0020T | A | | Extracorp shock wave tx, ft | | | | | |
| 00210 | N | | Anesth, open head surgery | | | | | |
| 00212 | N | | Anesth, skull drainage | | | | | |
| 00214 | C | | Anesth, skull drainage | | | | | |
| 00215 | C | | Anesth, skull repair/fract | | | | | |
| 00216 | N | | Anesth, head vessel surgery | | | | | |
| 00218 | N | | Anesth, special head surgery | | | | | |
| 0021T | C | | Fetal oximetry, trnsvag/cerv | | | | | |
| 00220 | N | | Anesth, intrcrn nerve | | | | | |
| 00222 | N | | Anesth, head nerve surgery | | | | | |
| 0023T | A | | Phenotype drug test, hiv 1 | | | | | |
| 0024T | C | | Transcath cardiac reduction | | | | | |
| 0025T | S | DG | Ultrasonic pachymetry | 0230 | 0.7619 | $41.57 | $14.97 | $8.31 |
| 0026T | A | | Measure remnant lipoproteins | | | | | |
| 0027T | T | | Endoscopic epidural lysis | 1547 | | $850.00 | | $170.00 |
| 0028T | N | | Dexa body composition study | | | | | |
| 0029T | A | | Magnetic tx for incontinence | | | | | |
| 00300 | N | | Anesth, head/neck/ptrunk | | | | | |
| 0030T | A | | Antiprothrombin antibody | | | | | |
| 0031T | N | | Speculoscopy | | | | | |
| 00320 | N | | Anesth, neck organ, 1 & over | | | | | |
| 00322 | N | | Anesth, biopsy of thyroid | | | | | |
| 00326 | N | | Anesth, larynx/trach, < 1 yr | | | | | |
| 0032T | N | | Speculoscopy w/direct sample | | | | | |
| 0033T | C | | Endovasc taa repr incl subcl | | | | | |
| 0034T | C | | Endovasc taa repr w/o subcl | | | | | |
| 00350 | N | | Anesth, neck vessel surgery | | | | | |
| 00352 | N | | Anesth, neck vessel surgery | | | | | |
| 0035T | C | | Insert endovasc prosth, taa | | | | | |
| 0036T | C | | Endovasc prosth, taa, add-on | | | | | |
| 0037T | C | | Artery transpose/endovas taa | | | | | |
| 0038T | C | | Rad endovasc taa rpr w/cover | | | | | |
| 0039T | C | | Rad s/i, endovasc taa repair | | | | | |
| 00400 | N | | Anesth, skin, ext/per/atrunk | | | | | |
| 00402 | N | | Anesth, surgery of breast | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 00404 | C | | Anesth, surgery of breast | | | | | |
| 00406 | C | | Anesth, surgery of breast | | | | | |
| 0040T | C | | Rad s/i, endovasc taa prosth | | | | | |
| 00410 | N | | Anesth, correct heart rhythm | | | | | |
| 0041T | A | | Detect ur infect agnt w/cpas | | | | | |
| 0042T | N | | Ct perfusion w/contrast, cbf | | | | | |
| 0043T | A | | Co expired gas analysis | | | | | |
| 0044T | N | | Whole body photography | | | | | |
| 00450 | N | | Anesth, surgery of shoulder | | | | | |
| 00452 | C | | Anesth, surgery of shoulder | | | | | |
| 00454 | N | | Anesth, collar bone biopsy | | | | | |
| 0045T | N | NI | Whole body photography | | | | | |
| 0046T | T | NI | Cath lavage, mammary duct(s) | 0018 | 0.9178 | $50.08 | $16.04 | $10.02 |
| 00470 | N | | Anesth, removal of rib | | | | | |
| 00472 | N | | Anesth, chest wall repair | | | | | |
| 00474 | C | | Anesth, surgery of rib(s) | | | | | |
| 0047T | T | NI | Cath lavage, mammary duct(s) | 0018 | 0.9178 | $50.08 | $16.04 | $10.02 |
| 0048T | C | NI | Implant ventricular device | | | | | |
| 0049T | C | NI | External circulation assist | | | | | |
| 00500 | N | | Anesth, esophageal surgery | | | | | |
| 0050T | C | NI | Removal circulation assist | | | | | |
| 0051T | C | NI | Implant total heart system | | | | | |
| 00520 | N | | Anesth, chest procedure | | | | | |
| 00522 | N | | Anesth, chest lining biopsy | | | | | |
| 00524 | C | | Anesth, chest drainage | | | | | |
| 00528 | N | | Anesth, chest partition view | | | | | |
| 00529 | N | NI | Anesth, chest partition view | | | | | |
| 0052T | C | NI | Replace component heart syst | | | | | |
| 00530 | N | | Anesth, pacemaker insertion | | | | | |
| 00532 | N | | Anesth, vascular access | | | | | |
| 00534 | N | | Anesth, cardioverter/defib | | | | | |
| 00537 | N | | Anesth, cardiac electrophys | | | | | |
| 00539 | N | | Anesth, trach-bronch reconst | | | | | |
| 0053T | C | NI | Replace component heart syst | | | | | |
| 00540 | C | | Anesth, chest surgery | | | | | |
| 00541 | N | | Anesth, one lung ventilation | | | | | |
| 00542 | C | | Anesth, release of lung | | | | | |
| 00544 | C | DG | Anesth, chest lining removal | | | | | |
| 00546 | C | DG | Anesth, lung,chest wall surg | | | | | |
| 00548 | N | DG | Anesth, trachea,bronchi surg | | | | | |
| 0054T | E | NI | Bone surgery using computer | | | | | |
| 00550 | N | DG | Anesth, sternal debridement | | | | | |
| 0055T | E | NI | Bone surgery using computer | | | | | |
| 00560 | C | DG | Anesth, open heart surgery | | | | | |
| 00562 | C | DG | Anesth, open heart surgery | | | | | |
| 00563 | N | DG | Anesth, heart proc w/pump | | | | | |
| 00566 | N | DG | Anesth, cabg w/o pump | | | | | |
| 0056T | E | NI | Bone surgery using computer | | | | | |
| 0057T | E | NI | Uppr gi scope w/ thrml txmnt | | | | | |
| 00580 | C | | Anesth, heart/lung transplnt | | | | | |
| 0058T | X | NI | Cryopreservation, ovary tiss | 0348 | 0.8194 | $44.71 | | $8.94 |
| 0059T | X | NI | Cryopreservation, oocyte | 0348 | 0.8194 | $44.71 | | $8.94 |
| 00600 | N | | Anesth, spine, cord surgery | | | | | |
| 00604 | C | | Anesth, sitting procedure | | | | | |
| 0060T | E | NI | Electrical impedance scan | | | | | |
| 0061T | E | NI | Destruction of tumor, breast | | | | | |
| 00620 | N | | Anesth, spine, cord surgery | | | | | |
| 00622 | C | | Anesth, removal of nerves | | | | | |
| 00630 | N | | Anesth, spine, cord surgery | | | | | |
| 00632 | C | | Anesth, removal of nerves | | | | | |
| 00634 | C | | Anesth for chemonucleolysis | | | | | |
| 00635 | N | | Anesth, lumbar puncture | | | | | |
| 00640 | N | | Anesth, spine manipulation | | | | | |
| 00670 | C | | Anesth, spine, cord surgery | | | | | |
| 00700 | N | | Anesth, abdominal wall surg | | | | | |
| 00702 | N | | Anesth, for liver biopsy | | | | | |
| 00730 | N | | Anesth, abdominal wall surg | | | | | |
| 00740 | N | | Anesth, upper gi visualize | | | | | |
| 00750 | N | | Anesth, repair of hernia | | | | | |
| 00752 | N | | Anesth, repair of hernia | | | | | |
| 00754 | N | | Anesth, repair of hernia | | | | | |
| 00756 | N | | Anesth, repair of hernia | | | | | |
| 00770 | N | | Anesth, blood vessel repair | | | | | |
| 00790 | N | | Anesth, surg upper abdomen | | | | | |
| 00792 | C | | Anesth, hemorr/excise liver | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 00794 | C | | Anesth, pancreas removal | | | | | |
| 00796 | C | | Anesth, for liver transplant | | | | | |
| 00797 | N | | Anesth, surgery for obesity | | | | | |
| 00800 | N | | Anesth, abdominal wall surg | | | | | |
| 00802 | C | | Anesth, fat layer removal | | | | | |
| 00810 | N | | Anesth, low intestine scope | | | | | |
| 00820 | N | | Anesth, abdominal wall surg | | | | | |
| 00830 | N | | Anesth, repair of hernia | | | | | |
| 00832 | N | | Anesth, repair of hernia | | | | | |
| 00834 | N | | Anesth, hernia repair< 1 yr | | | | | |
| 00836 | N | | Anesth hernia repair preemie | | | | | |
| 00840 | N | | Anesth, surg lower abdomen | | | | | |
| 00842 | N | | Anesth, amniocentesis | | | | | |
| 00844 | C | | Anesth, pelvis surgery | | | | | |
| 00846 | C | | Anesth, hysterectomy | | | | | |
| 00848 | C | | Anesth, pelvic organ surg | | | | | |
| 00851 | N | | Anesth, tubal ligation | | | | | |
| 00860 | N | | Anesth, surgery of abdomen | | | | | |
| 00862 | N | | Anesth, kidney/ureter surg | | | | | |
| 00864 | C | | Anesth, removal of bladder | | | | | |
| 00865 | C | | Anesth, removal of prostate | | | | | |
| 00866 | C | | Anesth, removal of adrenal | | | | | |
| 00868 | C | | Anesth, kidney transplant | | | | | |
| 00870 | N | | Anesth, bladder stone surg | | | | | |
| 00872 | N | | Anesth kidney stone destruct | | | | | |
| 00873 | N | | Anesth kidney stone destruct | | | | | |
| 00880 | N | | Anesth, abdomen vessel surg | | | | | |
| 00882 | C | | Anesth, major vein ligation | | | | | |
| 00902 | N | | Anesth, anorectal surgery | | | | | |
| 00904 | C | | Anesth, perineal surgery | | | | | |
| 00906 | N | | Anesth, removal of vulva | | | | | |
| 00908 | C | | Anesth, removal of prostate | | | | | |
| 00910 | N | | Anesth, bladder surgery | | | | | |
| 00912 | N | | Anesth, bladder tumor surg | | | | | |
| 00914 | N | | Anesth, removal of prostate | | | | | |
| 00916 | N | | Anesth, bleeding control | | | | | |
| 00918 | N | | Anesth, stone removal | | | | | |
| 00920 | N | | Anesth, genitalia surgery | | | | | |
| 00921 | N | | Anesth, vasectomy | | | | | |
| 00922 | N | | Anesth, sperm duct surgery | | | | | |
| 00924 | N | | Anesth, testis exploration | | | | | |
| 00926 | N | | Anesth, removal of testis | | | | | |
| 00928 | C | | Anesth, removal of testis | | | | | |
| 00930 | N | | Anesth, testis suspension | | | | | |
| 00932 | C | | Anesth, amputation of penis | | | | | |
| 00934 | C | | Anesth, penis, nodes removal | | | | | |
| 00936 | C | | Anesth, penis, nodes removal | | | | | |
| 00938 | N | | Anesth, insert penis device | | | | | |
| 00940 | N | | Anesth, vaginal procedures | | | | | |
| 00942 | N | | Anesth, surg on vag/urethral | | | | | |
| 00944 | C | | Anesth, vaginal hysterectomy | | | | | |
| 00948 | N | | Anesth, repair of cervix | | | | | |
| 00950 | N | | Anesth, vaginal endoscopy | | | | | |
| 00952 | N | | Anesth, hysteroscope/graph | | | | | |
| 01112 | N | | Anesth, bone aspirate/bx | | | | | |
| 01120 | N | | Anesth, pelvis surgery | | | | | |
| 01130 | N | | Anesth, body cast procedure | | | | | |
| 01140 | C | | Anesth, amputation at pelvis | | | | | |
| 01150 | C | | Anesth, pelvic tumor surgery | | | | | |
| 01160 | N | | Anesth, pelvis procedure | | | | | |
| 01170 | N | | Anesth, pelvis surgery | | | | | |
| 01173 | N | NI | Anesth, fx repair, pelvis | | | | | |
| 01180 | N | | Anesth, pelvis nerve removal | | | | | |
| 01190 | C | | Anesth, pelvis nerve removal | | | | | |
| 01200 | N | | Anesth, hip joint procedure | | | | | |
| 01202 | N | | Anesth, arthroscopy of hip | | | | | |
| 01210 | N | | Anesth, hip joint surgery | | | | | |
| 01212 | C | | Anesth, hip disarticulation | | | | | |
| 01214 | C | | Anesth, hip arthroplasty | | | | | |
| 01215 | N | | Anesth, revise hip repair | | | | | |
| 01220 | N | | Anesth, procedure on femur | | | | | |
| 01230 | N | | Anesth, surgery of femur | | | | | |
| 01232 | C | | Anesth, amputation of femur | | | | | |
| 01234 | C | | Anesth, radical femur surg | | | | | |
| 01250 | N | | Anesth, upper leg surgery | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 01260 | N | | Anesth, upper leg veins surg | | | | | |
| 01270 | N | | Anesth, thigh arteries surg | | | | | |
| 01272 | C | | Anesth, femoral artery surg | | | | | |
| 01274 | C | | Anesth, femoral embolectomy | | | | | |
| 01320 | N | | Anesth, knee area surgery | | | | | |
| 01340 | N | | Anesth, knee area procedure | | | | | |
| 01360 | N | | Anesth, knee area surgery | | | | | |
| 01380 | N | | Anesth, knee joint procedure | | | | | |
| 01382 | N | | Anesth, dx knee arthroscopy | | | | | |
| 01390 | N | | Anesth, knee area procedure | | | | | |
| 01392 | N | | Anesth, knee area surgery | | | | | |
| 01400 | N | | Anesth, knee joint surgery | | | | | |
| 01402 | C | | Anesth, knee arthroplasty | | | | | |
| 01404 | C | | Anesth, amputation at knee | | | | | |
| 01420 | N | | Anesth, knee joint casting | | | | | |
| 01430 | N | | Anesth, knee veins surgery | | | | | |
| 01432 | N | | Anesth, knee vessel surg | | | | | |
| 01440 | N | | Anesth, knee arteries surg | | | | | |
| 01442 | C | | Anesth, knee artery surg | | | | | |
| 01444 | C | | Anesth, knee artery repair | | | | | |
| 01462 | N | | Anesth, lower leg procedure | | | | | |
| 01464 | N | | Anesth, ankle/ft arthroscopy | | | | | |
| 01470 | N | | Anesth, lower leg surgery | | | | | |
| 01472 | N | | Anesth, achilles tendon surg | | | | | |
| 01474 | N | | Anesth, lower leg surgery | | | | | |
| 01480 | N | | Anesth, lower leg bone surg | | | | | |
| 01482 | N | | Anesth, radical leg surgery | | | | | |
| 01484 | N | | Anesth, lower leg revision | | | | | |
| 01486 | C | | Anesth, ankle replacement | | | | | |
| 01490 | N | | Anesth, lower leg casting | | | | | |
| 01500 | N | | Anesth, leg arteries surg | | | | | |
| 01502 | C | | Anesth, lwr leg embolectomy | | | | | |
| 01520 | N | | Anesth, lower leg vein surg | | | | | |
| 01522 | N | | Anesth, lower leg vein surg | | | | | |
| 01610 | N | | Anesth, surgery of shoulder | | | | | |
| 01620 | N | | Anesth, shoulder procedure | | | | | |
| 01622 | N | | Anes dx shoulder arthroscopy | | | | | |
| 01630 | N | | Anesth, surgery of shoulder | | | | | |
| 01632 | C | | Anesth, surgery of shoulder | | | | | |
| 01634 | C | | Anesth, shoulder joint amput | | | | | |
| 01636 | C | | Anesth, forequarter amput | | | | | |
| 01638 | C | | Anesth, shoulder replacement | | | | | |
| 01650 | N | | Anesth, shoulder artery surg | | | | | |
| 01652 | C | | Anesth, shoulder vessel surg | | | | | |
| 01654 | C | | Anesth, shoulder vessel surg | | | | | |
| 01656 | C | | Anesth, arm-leg vessel surg | | | | | |
| 01670 | N | | Anesth, shoulder vein surg | | | | | |
| 01680 | N | | Anesth, shoulder casting | | | | | |
| 01682 | N | | Anesth, airplane cast | | | | | |
| 01710 | N | | Anesth, elbow area surgery | | | | | |
| 01712 | N | | Anesth, uppr arm tendon surg | | | | | |
| 01714 | N | | Anesth, uppr arm tendon surg | | | | | |
| 01716 | N | | Anesth, biceps tendon repair | | | | | |
| 01730 | N | | Anesth, uppr arm procedure | | | | | |
| 01732 | N | | Anesth, dx elbow arthroscopy | | | | | |
| 01740 | N | | Anesth, upper arm surgery | | | | | |
| 01742 | N | | Anesth, humerus surgery | | | | | |
| 01744 | N | | Anesth, humerus repair | | | | | |
| 01756 | C | | Anesth, radical humerus surg | | | | | |
| 01758 | N | | Anesth, humeral lesion surg | | | | | |
| 01760 | N | | Anesth, elbow replacement | | | | | |
| 01770 | N | | Anesth, uppr arm artery surg | | | | | |
| 01772 | N | | Anesth, uppr arm embolectomy | | | | | |
| 01780 | N | | Anesth, upper arm vein surg | | | | | |
| 01782 | N | | Anesth, uppr arm vein repair | | | | | |
| 01810 | N | | Anesth, lower arm surgery | | | | | |
| 01820 | N | | Anesth, lower arm procedure | | | | | |
| 01829 | N | | Anesth, dx wrist arthroscopy | | | | | |
| 01830 | N | | Anesth, lower arm surgery | | | | | |
| 01832 | N | | Anesth, wrist replacement | | | | | |
| 01840 | N | | Anesth, lwr arm artery surg | | | | | |
| 01842 | N | | Anesth, lwr arm embolectomy | | | | | |
| 01844 | N | | Anesth, vascular shunt surg | | | | | |
| 01850 | N | | Anesth, lower arm vein surg | | | | | |
| 01852 | N | | Anesth, lwr arm vein repair | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 01860 | N | | Anesth, lower arm casting | | | | | |
| 01905 | N | | Anes, spine inject, x-ray/re | | | | | |
| 01916 | N | | Anesth, dx arteriography | | | | | |
| 01920 | N | | Anesth, catheterize heart | | | | | |
| 01922 | N | | Anesth, cat or MRI scan | | | | | |
| 01924 | N | | Anes, ther interven rad, art | | | | | |
| 01925 | N | | Anes, ther interven rad, car | | | | | |
| 01926 | N | | Anes, tx interv rad hrt/cran | | | | | |
| 01930 | N | | Anes, ther interven rad, vei | | | | | |
| 01931 | N | | Anes, ther interven rad, tip | | | | | |
| 01932 | N | | Anes, tx interv rad, th vein | | | | | |
| 01933 | N | | Anes, tx interv rad, cran v | | | | | |
| 01951 | N | | Anesth, burn, less 4 percent | | | | | |
| 01952 | N | | Anesth, burn, 4-9 percent | | | | | |
| 01953 | N | | Anesth, burn, each 9 percent | | | | | |
| 01958 | N | NI | Anesth, antepartum manipul | | | | | |
| 01960 | N | | Anesth, vaginal delivery | | | | | |
| 01961 | N | | Anesth, cs delivery | | | | | |
| 01962 | N | | Anesth, emer hysterectomy | | | | | |
| 01963 | N | | Anesth, cs hysterectomy | | | | | |
| 01964 | N | | Anesth, abortion procedures | | | | | |
| 01967 | N | | Anesth/analg, vag delivery | | | | | |
| 01968 | N | | Anes/analg cs deliver add-on | | | | | |
| 01969 | N | | Anesth/analg cs hyst add-on | | | | | |
| 01990 | C | | Support for organ donor | | | | | |
| 01991 | N | | Anesth, nerve block/inj | | | | | |
| 01992 | N | | Anesth, n block/inj, prone | | | | | |
| 01995 | N | | Regional anesthesia limb | | | | | |
| 01996 | N | | Hosp manage cont drug admin | | | | | |
| 01999 | N | | Unlisted anesth procedure | | | | | |
| 10021 | T | | Fna w/o image | 0002 | 0.8083 | $44.10 | | $8.82 |
| 10022 | T | | Fna w/image | 0036 | 1.5170 | $82.77 | | $16.55 |
| 10040 | T | | Acne surgery | 0010 | 0.6480 | $35.36 | $10.08 | $7.07 |
| 10060 | T | | Drainage of skin abscess | 0006 | 1.6527 | $90.17 | $23.26 | $18.03 |
| 10061 | T | | Drainage of skin abscess | 0006 | 1.6527 | $90.17 | $23.26 | $18.03 |
| 10080 | T | | Drainage of pilonidal cyst | 0006 | 1.6527 | $90.17 | $23.26 | $18.03 |
| 10081 | T | | Drainage of pilonidal cyst | 0007 | 11.8633 | $647.27 | | $129.45 |
| 10120 | T | | Remove foreign body | 0006 | 1.6527 | $90.17 | $23.26 | $18.03 |
| 10121 | T | | Remove foreign body | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 10140 | T | | Drainage of hematoma/fluid | 0007 | 11.8633 | $647.27 | | $129.45 |
| 10160 | T | | Puncture drainage of lesion | 0018 | 0.9178 | $50.08 | $16.04 | $10.02 |
| 10180 | T | | Complex drainage, wound | 0007 | 11.8633 | $647.27 | | $129.45 |
| 11000 | T | | Debride infected skin | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 11001 | T | | Debride infected skin add-on | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 11010 | T | | Debride skin, fx | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 11011 | T | | Debride skin/muscle, fx | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 11012 | T | | Debride skin/muscle/bone, fx | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 11040 | T | | Debride skin, partial | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 11041 | T | | Debride skin, full | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 11042 | T | | Debride skin/tissue | 0016 | 2.5724 | $140.35 | $57.31 | $28.07 |
| 11043 | T | | Debride tissue/muscle | 0016 | 2.5724 | $140.35 | $57.31 | $28.07 |
| 11044 | T | | Debride tissue/muscle/bone | 0682 | 8.0790 | $440.80 | $174.57 | $88.16 |
| 11055 | T | | Trim skin lesion | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 11056 | T | | Trim skin lesions, 2 to 4 | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 11057 | T | | Trim skin lesions, over 4 | 0013 | 1.1272 | $61.50 | $14.20 | $12.30 |
| 11100 | T | | Biopsy, skin lesion | 0018 | 0.9178 | $50.08 | $16.04 | $10.02 |
| 11101 | T | | Biopsy, skin add-on | 0018 | 0.9178 | $50.08 | $16.04 | $10.02 |
| 11200 | T | | Removal of skin tags | 0013 | 1.1272 | $61.50 | $14.20 | $12.30 |
| 11201 | T | | Remove skin tags add-on | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 11300 | T | | Shave skin lesion | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 11301 | T | | Shave skin lesion | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 11302 | T | | Shave skin lesion | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 11303 | T | | Shave skin lesion | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 11305 | T | | Shave skin lesion | 0013 | 1.1272 | $61.50 | $14.20 | $12.30 |
| 11306 | T | | Shave skin lesion | 0013 | 1.1272 | $61.50 | $14.20 | $12.30 |
| 11307 | T | | Shave skin lesion | 0013 | 1.1272 | $61.50 | $14.20 | $12.30 |
| 11308 | T | | Shave skin lesion | 0013 | 1.1272 | $61.50 | $14.20 | $12.30 |
| 11310 | T | | Shave skin lesion | 0013 | 1.1272 | $61.50 | $14.20 | $12.30 |
| 11311 | T | | Shave skin lesion | 0013 | 1.1272 | $61.50 | $14.20 | $12.30 |
| 11312 | T | | Shave skin lesion | 0013 | 1.1272 | $61.50 | $14.20 | $12.30 |
| 11313 | T | | Shave skin lesion | 0016 | 2.5724 | $140.35 | $57.31 | $28.07 |
| 11400 | T | | Removal of skin lesion | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 11401 | T | | Removal of skin lesion | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 11402 | T | | Removal of skin lesion | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 11403 | T | | Removal of skin lesion | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 11404 | T | | Removal of skin lesion | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 11406 | T | | Removal of skin lesion | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 11420 | T | | Removal of skin lesion | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 11421 | T | | Removal of skin lesion | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 11422 | T | | Removal of skin lesion | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 11423 | T | | Removal of skin lesion | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 11424 | T | | Removal of skin lesion | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 11426 | T | | Removal of skin lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 11440 | T | | Removal of skin lesion | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 11441 | T | | Removal of skin lesion | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 11442 | T | | Removal of skin lesion | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 11443 | T | | Removal of skin lesion | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 11444 | T | | Removal of skin lesion | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 11446 | T | | Removal of skin lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 11450 | T | | Removal, sweat gland lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 11451 | T | | Removal, sweat gland lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 11462 | T | | Removal, sweat gland lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 11463 | T | | Removal, sweat gland lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 11470 | T | | Removal, sweat gland lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 11471 | T | | Removal, sweat gland lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 11600 | T | | Removal of skin lesion | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 11601 | T | | Removal of skin lesion | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 11602 | T | | Removal of skin lesion | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 11603 | T | | Removal of skin lesion | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 11604 | T | | Removal of skin lesion | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 11606 | T | | Removal of skin lesion | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 11620 | T | | Removal of skin lesion | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 11621 | T | | Removal of skin lesion | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 11622 | T | | Removal of skin lesion | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 11623 | T | | Removal of skin lesion | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 11624 | T | | Removal of skin lesion | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 11626 | T | | Removal of skin lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 11640 | T | | Removal of skin lesion | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 11641 | T | | Removal of skin lesion | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 11642 | T | | Removal of skin lesion | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 11643 | T | | Removal of skin lesion | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 11644 | T | | Removal of skin lesion | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 11646 | T | | Removal of skin lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 11719 | T | | Trim nail(s) | 0009 | 0.6652 | $36.29 | $8.34 | $7.26 |
| 11720 | T | | Debride nail, 1-5 | 0009 | 0.6652 | $36.29 | $8.34 | $7.26 |
| 11721 | T | | Debride nail, 6 or more | 0009 | 0.6652 | $36.29 | $8.34 | $7.26 |
| 11730 | T | | Removal of nail plate | 0013 | 1.1272 | $61.50 | $14.20 | $12.30 |
| 11732 | T | | Remove nail plate, add-on | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 11740 | T | | Drain blood from under nail | 0009 | 0.6652 | $36.29 | $8.34 | $7.26 |
| 11750 | T | | Removal of nail bed | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 11752 | T | | Remove nail bed/finger tip | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 11755 | T | | Biopsy, nail unit | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 11760 | T | | Repair of nail bed | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 11762 | T | | Reconstruction of nail bed | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 11765 | T | | Excision of nail fold, toe | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 11770 | T | | Removal of pilonidal lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 11771 | T | | Removal of pilonidal lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 11772 | T | | Removal of pilonidal lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 11900 | T | | Injection into skin lesions | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 11901 | T | | Added skin lesions injection | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 11920 | T | | Correct skin color defects | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 11921 | T | | Correct skin color defects | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 11922 | T | | Correct skin color defects | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 11950 | T | | Therapy for contour defects | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 11951 | T | | Therapy for contour defects | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 11952 | T | | Therapy for contour defects | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 11954 | T | | Therapy for contour defects | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 11960 | T | | Insert tissue expander(s) | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 11970 | T | | Replace tissue expander | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 11971 | T | | Remove tissue expander(s) | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 11975 | E | | Insert contraceptive cap | | | | | |
| 11976 | T | | Removal of contraceptive cap | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 11977 | E | | Removal/reinsert contra cap | | | | | |
| 11980 | X | | Implant hormone pellet(s) | 0340 | 0.6314 | $34.45 | | $6.89 |
| 11981 | X | | Insert drug implant device | 0340 | 0.6314 | $34.45 | | $6.89 |
| 11982 | X | | Remove drug implant device | 0340 | 0.6314 | $34.45 | | $6.89 |
| 11983 | X | | Remove/insert drug implant | 0340 | 0.6314 | $34.45 | | $6.89 |
| 12001 | T | | Repair superficial wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12002 | T | | Repair superficial wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12004 | T | | Repair superficial wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 12005 | T | | Repair superficial wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12006 | T | | Repair superficial wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12007 | T | | Repair superficial wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12011 | T | | Repair superficial wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12013 | T | | Repair superficial wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12014 | T | | Repair superficial wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12015 | T | | Repair superficial wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12016 | T | | Repair superficial wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12017 | T | | Repair superficial wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12018 | T | | Repair superficial wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12020 | T | | Closure of split wound | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12021 | T | | Closure of split wound | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12031 | T | | Layer closure of wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12032 | T | | Layer closure of wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12034 | T | | Layer closure of wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12035 | T | | Layer closure of wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12036 | T | | Layer closure of wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12037 | T | | Layer closure of wound(s) | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 12041 | T | | Layer closure of wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12042 | T | | Layer closure of wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12044 | T | | Layer closure of wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12045 | T | | Layer closure of wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12046 | T | | Layer closure of wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12047 | T | | Layer closure of wound(s) | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 12051 | T | | Layer closure of wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12052 | T | | Layer closure of wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12053 | T | | Layer closure of wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12054 | T | | Layer closure of wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12055 | T | | Layer closure of wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12056 | T | | Layer closure of wound(s) | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 12057 | T | | Layer closure of wound(s) | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 13100 | T | | Repair of wound or lesion | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 13101 | T | | Repair of wound or lesion | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 13102 | T | | Repair wound/lesion add-on | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 13120 | T | | Repair of wound or lesion | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 13121 | T | | Repair of wound or lesion | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 13122 | T | | Repair wound/lesion add-on | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 13131 | T | | Repair of wound or lesion | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 13132 | T | | Repair of wound or lesion | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 13133 | T | | Repair wound/lesion add-on | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 13150 | T | | Repair of wound or lesion | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 13151 | T | | Repair of wound or lesion | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 13152 | T | | Repair of wound or lesion | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 13153 | T | | Repair wound/lesion add-on | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 13160 | T | | Late closure of wound | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 14000 | T | | Skin tissue rearrangement | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 14001 | T | | Skin tissue rearrangement | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 14020 | T | | Skin tissue rearrangement | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 14021 | T | | Skin tissue rearrangement | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 14040 | T | | Skin tissue rearrangement | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 14041 | T | | Skin tissue rearrangement | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 14060 | T | | Skin tissue rearrangement | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 14061 | T | | Skin tissue rearrangement | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 14300 | T | | Skin tissue rearrangement | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 14350 | T | | Skin tissue rearrangement | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15000 | T | | Skin graft | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 15001 | T | | Skin graft add-on | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 15050 | T | | Skin pinch graft | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 15100 | T | | Skin split graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15101 | T | | Skin split graft add-on | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15120 | T | | Skin split graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15121 | T | | Skin split graft add-on | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15200 | T | | Skin full graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15201 | T | | Skin full graft add-on | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 15220 | T | | Skin full graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15221 | T | | Skin full graft add-on | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 15240 | T | | Skin full graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15241 | T | | Skin full graft add-on | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 15260 | T | | Skin full graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15261 | T | | Skin full graft add-on | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 15342 | T | | Cultured skin graft, 25 cm | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 15343 | T | | Culture skn graft addl 25 cm | 0024 | 1.6850 | $91.94 | $33.10 | $18.39 |
| 15350 | T | | Skin homograft | 0686 | 7.9247 | $432.38 | $198.89 | $86.48 |
| 15351 | T | | Skin homograft add-on | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15400 | T | | Skin heterograft | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 15401 | T | | Skin heterograft add-on | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 15570 | T | | Form skin pedicle flap | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15572 | T | | Form skin pedicle flap | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15574 | T | | Form skin pedicle flap | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15576 | T | | Form skin pedicle flap | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15600 | T | | Skin graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15610 | T | | Skin graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15620 | T | | Skin graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15630 | T | | Skin graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15650 | T | | Transfer skin pedicle flap | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15732 | T | | Muscle-skin graft, head/neck | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15734 | T | | Muscle-skin graft, trunk | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15736 | T | | Muscle-skin graft, arm | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15738 | T | | Muscle-skin graft, leg | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15740 | T | | Island pedicle flap graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15750 | T | | Neurovascular pedicle graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15756 | C | | Free muscle flap, microvasc | | | | | |
| 15757 | C | | Free skin flap, microvasc | | | | | |
| 15758 | C | | Free fascial flap, microvasc | | | | | |
| 15760 | T | | Composite skin graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15770 | T | | Derma-fat-fascia graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15775 | T | | Hair transplant punch grafts | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 15776 | T | | Hair transplant punch grafts | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 15780 | T | | Abrasion treatment of skin | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 15781 | T | | Abrasion treatment of skin | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 15782 | T | | Dressing change not for burn | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 15783 | T | | Abrasion treatment of skin | 0016 | 2.5724 | $140.35 | $57.31 | $28.07 |
| 15786 | T | | Abrasion, lesion, single | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 15787 | T | | Abrasion, lesions, add-on | 0013 | 1.1272 | $61.50 | $14.20 | $12.30 |
| 15788 | T | | Chemical peel, face, epiderm | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 15789 | T | | Chemical peel, face, dermal | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 15792 | T | | Chemical peel, nonfacial | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 15793 | T | | Chemical peel, nonfacial | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 15810 | T | | Salabrasion | 0016 | 2.5724 | $140.35 | $57.31 | $28.07 |
| 15811 | T | | Salabrasion | 0016 | 2.5724 | $140.35 | $57.31 | $28.07 |
| 15819 | T | | Plastic surgery, neck | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 15820 | T | | Revision of lower eyelid | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15821 | T | | Revision of lower eyelid | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15822 | T | | Revision of upper eyelid | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15823 | T | | Revision of upper eyelid | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15824 | T | | Removal of forehead wrinkles | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15825 | T | | Removal of neck wrinkles | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15826 | T | | Removal of brow wrinkles | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15828 | T | | Removal of face wrinkles | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15829 | T | | Removal of skin wrinkles | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15831 | T | | Excise excessive skin tissue | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 15832 | T | | Excise excessive skin tissue | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 15833 | T | | Excise excessive skin tissue | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 15834 | T | | Excise excessive skin tissue | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 15835 | T | | Excise excessive skin tissue | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 15836 | T | | Excise excessive skin tissue | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 15837 | T | | Excise excessive skin tissue | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 15838 | T | | Excise excessive skin tissue | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 15839 | T | | Excise excessive skin tissue | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 15840 | T | | Graft for face nerve palsy | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15841 | T | | Graft for face nerve palsy | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15842 | T | | Flap for face nerve palsy | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15845 | T | | Skin and muscle repair, face | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15850 | T | | Removal of sutures | 0016 | 2.5724 | $140.35 | $57.31 | $28.07 |
| 15851 | T | | Removal of sutures | 0016 | 2.5724 | $140.35 | $57.31 | $28.07 |
| 15852 | X | | Dressing change,not for burn | 0340 | 0.6314 | $34.45 | | $6.89 |
| 15860 | S | | Test for blood flow in graft | 1501 | | $25.00 | | $5.00 |
| 15876 | T | | Suction assisted lipectomy | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15877 | T | | Suction assisted lipectomy | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15878 | T | | Suction assisted lipectomy | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15879 | T | | Suction assisted lipectomy | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15920 | T | | Removal of tail bone ulcer | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 15922 | T | | Removal of tail bone ulcer | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15931 | T | | Remove sacrum pressure sore | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 15933 | T | | Remove sacrum pressure sore | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 15934 | T | | Remove sacrum pressure sore | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15935 | T | | Remove sacrum pressure sore | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15936 | T | | Remove sacrum pressure sore | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15937 | T | | Remove sacrum pressure sore | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15940 | T | | Remove hip pressure sore | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 15941 | T | | Remove hip pressure sore | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 15944 | T | | Remove hip pressure sore | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15945 | T | | Remove hip pressure sore | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15946 | T | | Remove hip pressure sore | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15950 | T | | Remove thigh pressure sore | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 15951 | T | | Remove thigh pressure sore | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 15952 | T | | Remove thigh pressure sore | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15953 | T | | Remove thigh pressure sore | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15956 | T | | Remove thigh pressure sore | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15958 | T | | Remove thigh pressure sore | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 15999 | T | | Removal of pressure sore | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 16000 | T | | Initial treatment of burn(s) | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 16010 | T | | Treatment of burn(s) | 0016 | 2.5724 | $140.35 | $57.31 | $28.07 |
| 16015 | T | | Treatment of burn(s) | 0017 | 16.3697 | $893.15 | $227.84 | $178.63 |
| 16020 | T | | Treatment of burn(s) | 0013 | 1.1272 | $61.50 | $14.20 | $12.30 |
| 16025 | T | | Treatment of burn(s) | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 16030 | T | | Treatment of burn(s) | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 16035 | C | | Incision of burn scab, initi | | | | | |
| 16036 | C | | Escharotomy; add'l incision | | | | | |
| 17000 | T | | Destroy benign/premlg lesion | 0010 | 0.6480 | $35.36 | $10.08 | $7.07 |
| 17003 | T | | Destroy lesions, 2-14 | 0010 | 0.6480 | $35.36 | $10.08 | $7.07 |
| 17004 | T | | Destroy lesions, 15 or more | 0011 | 2.2217 | $121.22 | $27.88 | $24.24 |
| 17106 | T | | Destruction of skin lesions | 0011 | 2.2217 | $121.22 | $27.88 | $24.24 |
| 17107 | T | | Destruction of skin lesions | 0011 | 2.2217 | $121.22 | $27.88 | $24.24 |
| 17108 | T | | Destruction of skin lesions | 0011 | 2.2217 | $121.22 | $27.88 | $24.24 |
| 17110 | T | | Destruct lesion, 1-14 | 0010 | 0.6480 | $35.36 | $10.08 | $7.07 |
| 17111 | T | | Destruct lesion, 15 or more | 0010 | 0.6480 | $35.36 | $10.08 | $7.07 |
| 17250 | T | | Chemical cautery, tissue | 0013 | 1.1272 | $61.50 | $14.20 | $12.30 |
| 17260 | T | | Destruction of skin lesions | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 17261 | T | | Destruction of skin lesions | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 17262 | T | | Destruction of skin lesions | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 17263 | T | | Destruction of skin lesions | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 17264 | T | | Destruction of skin lesions | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 17266 | T | | Destruction of skin lesions | 0016 | 2.5724 | $140.35 | $57.31 | $28.07 |
| 17270 | T | | Destruction of skin lesions | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 17271 | T | | Destruction of skin lesions | 0013 | 1.1272 | $61.50 | $14.20 | $12.30 |
| 17272 | T | | Destruction of skin lesions | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 17273 | T | | Destruction of skin lesions | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 17274 | T | | Destruction of skin lesions | 0016 | 2.5724 | $140.35 | $57.31 | $28.07 |
| 17276 | T | | Destruction of skin lesions | 0016 | 2.5724 | $140.35 | $57.31 | $28.07 |
| 17280 | T | | Destruction of skin lesions | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 17281 | T | | Destruction of skin lesions | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 17282 | T | | Destruction of skin lesions | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 17283 | T | | Destruction of skin lesions | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 17284 | T | | Destruction of skin lesions | 0016 | 2.5724 | $140.35 | $57.31 | $28.07 |
| 17286 | T | | Destruction of skin lesions | 0015 | 1.5968 | $87.12 | $20.35 | $17.42 |
| 17304 | T | | Chemosurgery of skin lesion | 0694 | 2.9752 | $162.33 | $64.93 | $32.47 |
| 17305 | T | | 2 stage mohs, up to 5 spec | 0694 | 2.9752 | $162.33 | $64.93 | $32.47 |
| 17306 | T | | 3 stage mohs, up to 5 spec | 0694 | 2.9752 | $162.33 | $64.93 | $32.47 |
| 17307 | T | | Mohs addl stage up to 5 spec | 0694 | 2.9752 | $162.33 | $64.93 | $32.47 |
| 17310 | T | | Extensive skin chemosurgery | 0694 | 2.9752 | $162.33 | $64.93 | $32.47 |
| 17340 | T | | Cryotherapy of skin | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 17360 | T | | Skin peel therapy | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 17380 | T | | Hair removal by electrolysis | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 17999 | T | | Skin tissue procedure | 0006 | 1.6527 | $90.17 | $23.26 | $18.03 |
| 19000 | T | | Drainage of breast lesion | 0004 | 1.5882 | $86.65 | $22.36 | $17.33 |
| 19001 | T | | Drain breast lesion add-on | 0004 | 1.5882 | $86.65 | $22.36 | $17.33 |
| 19020 | T | | Incision of breast lesion | 0007 | 11.8633 | $647.27 | | $129.45 |
| 19030 | N | | Injection for breast x-ray | | | | | |
| 19100 | T | | Bx breast percut w/o image | 0005 | 3.2698 | $178.40 | $71.59 | $35.68 |
| 19101 | T | | Biopsy of breast, open | 0028 | 17.6584 | $963.46 | $303.74 | $192.69 |
| 19102 | T | | Bx breast percut w/image | 0005 | 3.2698 | $178.40 | $71.59 | $35.68 |
| 19103 | T | | Bx breast percut w/device | 0658 | 5.5779 | $304.34 | | $60.87 |
| 19110 | T | | nipple exploration | 0028 | 17.6584 | $963.46 | $303.74 | $192.69 |
| 19112 | T | | Excise breast duct fistula | 0028 | 17.6584 | $963.46 | $303.74 | $192.69 |
| 19120 | T | | Removal of breast lesion | 0028 | 17.6584 | $963.46 | $303.74 | $192.69 |
| 19125 | T | | Excision, breast lesion | 0028 | 17.6584 | $963.46 | $303.74 | $192.69 |
| 19126 | T | | Excision, addl breast lesion | 0028 | 17.6584 | $963.46 | $303.74 | $192.69 |
| 19140 | T | | Removal of breast tissue | 0028 | 17.6584 | $963.46 | $303.74 | $192.69 |
| 19160 | T | | Removal of breast tissue | 0028 | 17.6584 | $963.46 | $303.74 | $192.69 |
| 19162 | T | | Remove breast tissue, nodes | 0693 | 39.0111 | $2,128.48 | $798.17 | $425.70 |
| 19180 | T | | Removal of breast | 0029 | 30.1167 | $1,643.20 | $632.64 | $328.64 |
| 19182 | T | | Removal of breast | 0029 | 30.1167 | $1,643.20 | $632.64 | $328.64 |
| 19200 | C | | Removal of breast | | | | | |
| 19220 | C | | Removal of breast | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 19240 | T | | Removal of breast | 0030 | 37.3083 | $2,035.58 | $763.55 | $407.12 |
| 19260 | T | | Removal of chest wall lesion | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 19271 | C | | Revision of chest wall | | | | | |
| 19272 | C | | Extensive chest wall surgery | | | | | |
| 19290 | N | | Place needle wire, breast | | | | | |
| 19291 | N | | Place needle wire, breast | | | | | |
| 19295 | S | | Place breast clip, percut | 0657 | 1.5102 | $82.40 | | $16.48 |
| 19316 | T | | Suspension of breast | 0029 | 30.1167 | $1,643.20 | $632.64 | $328.64 |
| 19318 | T | | Reduction of large breast | 0693 | 39.0111 | $2,128.48 | $798.17 | $425.70 |
| 19324 | T | | Enlarge breast | 0693 | 39.0111 | $2,128.48 | $798.17 | $425.70 |
| 19325 | T | | Enlarge breast with implant | 0648 | 54.0165 | $2,947.19 | | $589.44 |
| 19328 | T | | Removal of breast implant | 0029 | 30.1167 | $1,643.20 | $632.64 | $328.64 |
| 19330 | T | | Removal of implant material | 0029 | 30.1167 | $1,643.20 | $632.64 | $328.64 |
| 19340 | T | | Immediate breast prosthesis | 0030 | 37.3083 | $2,035.58 | $763.55 | $407.12 |
| 19342 | T | | Delayed breast prosthesis | 0648 | 54.0165 | $2,947.19 | | $589.44 |
| 19350 | T | | Breast reconstruction | 0028 | 17.6584 | $963.46 | $303.74 | $192.69 |
| 19355 | T | | Correct inverted nipple(s) | 0029 | 30.1167 | $1,643.20 | $632.64 | $328.64 |
| 19357 | T | | Breast reconstruction | 0648 | 54.0165 | $2,947.19 | | $589.44 |
| 19361 | C | | Breast reconstruction | | | | | |
| 19364 | C | | Breast reconstruction | | | | | |
| 19366 | T | | Breast reconstruction | 0029 | 30.1167 | $1,643.20 | $632.64 | $328.64 |
| 19367 | C | | Breast reconstruction | | | | | |
| 19368 | C | | Breast reconstruction | | | | | |
| 19369 | C | | Breast reconstruction | | | | | |
| 19370 | T | | Surgery of breast capsule | 0029 | 30.1167 | $1,643.20 | $632.64 | $328.64 |
| 19371 | T | | Removal of breast capsule | 0029 | 30.1167 | $1,643.20 | $632.64 | $328.64 |
| 19380 | T | | Revise breast reconstruction | 0030 | 37.3083 | $2,035.58 | $763.55 | $407.12 |
| 19396 | T | | Design custom breast implant | 0029 | 30.1167 | $1,643.20 | $632.64 | $328.64 |
| 19499 | T | | Breast surgery procedure | 0028 | 17.6584 | $963.46 | $303.74 | $192.69 |
| 20000 | T | | Incision of abscess | 0006 | 1.6527 | $90.17 | $23.26 | $18.03 |
| 20005 | T | | Incision of deep abscess | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 20100 | T | | Explore wound, neck | 0023 | 2.8141 | $153.54 | $40.37 | $30.71 |
| 20101 | T | | Explore wound, chest | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 20102 | T | | Explore wound, abdomen | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 20103 | T | | Explore wound, extremity | 0023 | 2.8141 | $153.54 | $40.37 | $30.71 |
| 20150 | T | | Excise epiphyseal bar | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 20200 | T | | Muscle biopsy | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 20205 | T | | Deep muscle biopsy | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 20206 | T | | Needle biopsy, muscle | 0005 | 3.2698 | $178.40 | $71.59 | $35.68 |
| 20220 | T | | Bone biopsy, trocar/needle | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 20225 | T | | Bone biopsy, trocar/needle | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 20240 | T | | Bone biopsy, excisional | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 20245 | T | | Bone biopsy, excisional | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 20250 | T | | Open bone biopsy | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 20251 | T | | Open bone biopsy | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 20500 | T | | Injection of sinus tract | 0251 | 1.7880 | $97.56 | | $19.51 |
| 20501 | N | | Inject sinus tract for x-ray | | | | | |
| 20520 | T | | Removal of foreign body | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 20525 | T | | Removal of foreign body | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 20526 | T | | Ther injection, carp tunnel | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 20550 | T | | Inject tendon/ligament/cyst | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 20551 | T | | Inj tendon origin/insertion | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 20552 | T | | Inj trigger point, 1/2 muscl | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 20553 | T | | Inject trigger points, > 3 | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 20600 | T | | Drain/inject, joint/bursa | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 20605 | T | | Drain/inject, joint/bursa | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 20610 | T | | Drain/inject, joint/bursa | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 20612 | T | | Aspirate/inj ganglion cyst | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 20615 | T | | Treatment of bone cyst | 0004 | 1.5882 | $86.65 | $22.36 | $17.33 |
| 20650 | T | | Insert and remove bone pin | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 20660 | C | | Apply, rem fixation device | | | | | |
| 20661 | C | | Application of head brace | | | | | |
| 20662 | C | | Application of pelvis brace | | | | | |
| 20663 | C | | Application of thigh brace | | | | | |
| 20664 | C | | Halo brace application | | | | | |
| 20665 | X | | Removal of fixation device | 0340 | 0.6314 | $34.45 | | $6.89 |
| 20670 | T | | Removal of support implant | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 20680 | T | | Removal of support implant | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 20690 | T | | Apply bone fixation device | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 20692 | T | | Apply bone fixation device | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 20693 | T | | Adjust bone fixation device | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 20694 | T | | Remove bone fixation device | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 20802 | C | | Replantation, arm, complete | | | | | |
| 20805 | C | | Replant forearm, complete | | | | | |
| 20808 | C | | Replantation hand, complete | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 20816 | C | | Replantation digit, complete | | | | | |
| 20822 | C | | Replantation digit, complete | | | | | |
| 20824 | C | | Replantation thumb, complete | | | | | |
| 20827 | C | | Replantation thumb, complete | | | | | |
| 20838 | C | | Replantation foot, complete | | | | | |
| 20900 | T | | Removal of bone for graft | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 20902 | T | | Removal of bone for graft | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 20910 | T | | Remove cartilage for graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 20912 | T | | Remove cartilage for graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 20920 | T | | Removal of fascia for graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 20922 | T | | Removal of fascia for graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 20924 | T | | Removal of tendon for graft | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 20926 | T | | Removal of tissue for graft | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 20930 | C | | Spinal bone allograft | | | | | |
| 20931 | C | | Spinal bone allograft | | | | | |
| 20936 | C | | Spinal bone autograft | | | | | |
| 20937 | C | | Spinal bone autograft | | | | | |
| 20938 | C | | Spinal bone autograft | | | | | |
| 20950 | T | | Fluid pressure, muscle | 0006 | 1.6527 | $90.17 | $23.26 | $18.03 |
| 20955 | C | | Fibula bone graft, microvasc | | | | | |
| 20956 | C | | Iliac bone graft, microvasc | | | | | |
| 20957 | C | | Mt bone graft, microvasc | | | | | |
| 20962 | C | | Other bone graft, microvasc | | | | | |
| 20969 | C | | Bone/skin graft, microvasc | | | | | |
| 20970 | C | | Bone/skin graft, iliac crest | | | | | |
| 20972 | C | | Bone/skin graft, metatarsal | | | | | |
| 20973 | C | | Bone/skin graft, great toe | | | | | |
| 20974 | A | | Electrical bone stimulation | | | | | |
| 20975 | T | | Electrical bone stimulation | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 20979 | A | | Us bone stimulation | | | | | |
| 20982 | T | NI | Ablate, bone tumor(s) perq | 1557 | | $1,850.00 | | $370.00 |
| 20999 | T | | Musculoskeletal surgery | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 21010 | T | | Incision of jaw joint | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21015 | T | | Resection of facial tumor | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 21025 | T | | Excision of bone, lower jaw | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21026 | T | | Excision of facial bone(s) | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21029 | T | | Contour of face bone lesion | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21030 | T | | Removal of face bone lesion | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21031 | T | | Remove exostosis, mandible | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21032 | T | | Remove exostosis, maxilla | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21034 | T | | Removal of face bone lesion | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21040 | T | | Removal of jaw bone lesion | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21044 | T | | Removal of jaw bone lesion | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21045 | C | | Extensive jaw surgery | | | | | |
| 21046 | T | | Remove mandible cyst complex | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21047 | T | | Excise lwr jaw cyst w/repair | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21048 | T | | Remove maxilla cyst complex | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21049 | T | | Excis uppr jaw cyst w/repair | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21050 | T | | Removal of jaw joint | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21060 | T | | Remove jaw joint cartilage | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21070 | T | | Remove coronoid process | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21076 | T | | Prepare face/oral prosthesis | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21077 | T | | Prepare face/oral prosthesis | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21079 | T | | Prepare face/oral prosthesis | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21080 | T | | Prepare face/oral prosthesis | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21081 | T | | Prepare face/oral prosthesis | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21082 | T | | Prepare face/oral prosthesis | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21083 | T | | Prepare face/oral prosthesis | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21084 | T | | Prepare face/oral prosthesis | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21085 | T | | Prepare face/oral prosthesis | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 21086 | T | | Prepare face/oral prosthesis | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21087 | T | | Prepare face/oral prosthesis | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21088 | T | | Prepare face/oral prosthesis | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21089 | T | | Prepare face/oral prosthesis | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 21100 | T | | Maxillofacial fixation | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21110 | T | | Interdental fixation | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 21116 | N | | Injection, jaw joint x-ray | | | | | |
| 21120 | T | | Reconstruction of chin | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21121 | T | | Reconstruction of chin | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21122 | T | | Reconstruction of chin | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21123 | T | | Reconstruction of chin | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21125 | T | | Augmentation, lower jaw bone | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21127 | T | | Augmentation, lower jaw bone | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21137 | T | | Reduction of forehead | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21138 | T | | Reduction of forehead | 0256 | 35.1548 | $1,918.08 | | $383.62 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 21139 | T | | Reduction of forehead | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21141 | C | | Reconstruct midface, lefort | | | | | |
| 21142 | C | | Reconstruct midface, lefort | | | | | |
| 21143 | C | | Reconstruct midface, lefort | | | | | |
| 21145 | C | | Reconstruct midface, lefort | | | | | |
| 21146 | C | | Reconstruct midface, lefort | | | | | |
| 21147 | C | | Reconstruct midface, lefort | | | | | |
| 21150 | C | | Reconstruct midface, lefort | | | | | |
| 21151 | C | | Reconstruct midface, lefort | | | | | |
| 21154 | C | | Reconstruct midface, lefort | | | | | |
| 21155 | C | | Reconstruct midface, lefort | | | | | |
| 21159 | C | | Reconstruct midface, lefort | | | | | |
| 21160 | C | | Reconstruct midface, lefort | | | | | |
| 21172 | C | | Reconstruct orbit/forehead | | | | | |
| 21175 | C | | Reconstruct orbit/forehead | | | | | |
| 21179 | C | | Reconstruct entire forehead | | | | | |
| 21180 | C | | Reconstruct entire forehead | | | | | |
| 21181 | T | | Contour cranial bone lesion | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21182 | C | | Reconstruct cranial bone | | | | | |
| 21183 | C | | Reconstruct cranial bone | | | | | |
| 21184 | C | | Reconstruct cranial bone | | | | | |
| 21188 | C | | Reconstruction of midface | | | | | |
| 21193 | C | | Reconst lwr jaw w/o graft | | | | | |
| 21194 | C | | Reconst lwr jaw w/graft | | | | | |
| 21195 | C | | Reconst lwr jaw w/o fixation | | | | | |
| 21196 | C | | Reconst lwr jaw w/fixation | | | | | |
| 21198 | T | | Reconstr lwr jaw segment | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21199 | T | | Reconstr lwr jaw w/advance | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21206 | T | | Reconstruct upper jaw bone | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21208 | T | | Augmentation of facial bones | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21209 | T | | Reduction of facial bones | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21210 | T | | Face bone graft | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21215 | T | | Lower jaw bone graft | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21230 | T | | Rib cartilage graft | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21235 | T | | Ear cartilage graft | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21240 | T | | Reconstruction of jaw joint | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21242 | T | | Reconstruction of jaw joint | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21243 | T | | Reconstruction of jaw joint | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21244 | T | | Reconstruction of lower jaw | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21245 | T | | Reconstruction of jaw | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21246 | T | | Reconstruction of jaw | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21247 | C | | Reconstruct lower jaw bone | | | | | |
| 21248 | T | | Reconstruction of jaw | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21249 | T | | Reconstruction of jaw | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21255 | C | | Reconstruct lower jaw bone | | | | | |
| 21256 | C | | Reconstruction of orbit | | | | | |
| 21260 | T | | Revise eye sockets | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21261 | T | | Revise eye sockets | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21263 | T | | Revise eye sockets | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21267 | T | | Revise eye sockets | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21268 | C | | Revise eye sockets | | | | | |
| 21270 | T | | Augmentation, cheek bone | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21275 | T | | Revision, orbitofacial bones | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21280 | T | | Revision of eyelid | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21282 | T | | Revision of eyelid | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 21295 | T | | Revision of jaw muscle/bone | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 21296 | T | | Revision of jaw muscle/bone | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21299 | T | | Cranio/maxillofacial surgery | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 21300 | T | | Treatment of skull fracture | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 21310 | X | | Treatment of nose fracture | 0340 | 0.6314 | $34.45 | | $6.89 |
| 21315 | X | | Treatment of nose fracture | 0340 | 0.6314 | $34.45 | | $6.89 |
| 21320 | X | | Treatment of nose fracture | 0340 | 0.6314 | $34.45 | | $6.89 |
| 21325 | T | | Treatment of nose fracture | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21330 | T | | Treatment of nose fracture | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21335 | T | | Treatment of nose fracture | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21336 | T | | Treat nasal septal fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 21337 | T | | Treat nasal septal fracture | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 21338 | T | | Treat nasoethmoid fracture | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21339 | T | | Treat nasoethmoid fracture | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21340 | T | | Treatment of nose fracture | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21343 | C | | Treatment of sinus fracture | | | | | |
| 21344 | C | | Treatment of sinus fracture | | | | | |
| 21345 | T | | Treat nose/jaw fracture | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21346 | C | | Treat nose/jaw fracture | | | | | |
| 21347 | C | | Treat nose/jaw fracture | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 21348 | C | | Treat nose/jaw fracture | | | | | |
| 21355 | T | | Treat cheek bone fracture | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21356 | C | | Treat cheek bone fracture | | | | | |
| 21360 | C | | Treat cheek bone fracture | | | | | |
| 21365 | C | | Treat cheek bone fracture | | | | | |
| 21366 | C | | Treat cheek bone fracture | | | | | |
| 21385 | C | | Treat eye socket fracture | | | | | |
| 21386 | C | | Treat eye socket fracture | | | | | |
| 21387 | C | | Treat eye socket fracture | | | | | |
| 21390 | T | | Treat eye socket fracture | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21395 | C | | Treat eye socket fracture | | | | | |
| 21400 | T | | Treat eye socket fracture | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 21401 | T | | Treat eye socket fracture | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 21406 | T | | Treat eye socket fracture | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21407 | T | | Treat eye socket fracture | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21408 | C | | Treat eye socket fracture | | | | | |
| 21421 | T | | Treat mouth roof fracture | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21422 | C | | Treat mouth roof fracture | | | | | |
| 21423 | C | | Treat mouth roof fracture | | | | | |
| 21431 | C | | Treat craniofacial fracture | | | | | |
| 21432 | C | | Treat craniofacial fracture | | | | | |
| 21433 | C | | Treat craniofacial fracture | | | | | |
| 21435 | C | | Treat craniofacial fracture | | | | | |
| 21436 | C | | Treat craniofacial fracture | | | | | |
| 21440 | T | | Treat dental ridge fracture | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21445 | T | | Treat dental ridge fracture | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21450 | T | | Treat lower jaw fracture | 0251 | 1.7880 | $97.56 | | $19.51 |
| 21451 | T | | Treat lower jaw fracture | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 21452 | T | | Treat lower jaw fracture | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 21453 | T | | Treat lower jaw fracture | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21454 | T | | Treat lower jaw fracture | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 21461 | T | | Treat lower jaw fracture | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21462 | T | | Treat lower jaw fracture | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21465 | T | | Treat lower jaw fracture | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21470 | T | | Treat lower jaw fracture | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21480 | T | | Reset dislocated jaw | 0251 | 1.7880 | $97.56 | | $19.51 |
| 21485 | T | | Reset dislocated jaw | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 21490 | T | | Repair dislocated jaw | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 21493 | T | | Treat hyoid bone fracture | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 21494 | T | | Treat hyoid bone fracture | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 21495 | C | | Treat hyoid bone fracture | | | | | |
| 21497 | T | | Interdental wiring | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 21499 | T | | Head surgery procedure | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 21501 | T | | Drain neck/chest lesion | 0008 | 19.4831 | $1,063.02 | | $212.60 |
| 21502 | T | | Drain chest lesion | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 21510 | C | | Drainage of bone lesion | | | | | |
| 21550 | T | | Biopsy of neck/chest | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 21555 | T | | Remove lesion, neck/chest | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 21556 | T | | Remove lesion, neck/chest | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 21557 | C | | Remove tumor, neck/chest | | | | | |
| 21600 | T | | Partial removal of rib | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 21610 | T | | Partial removal of rib | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 21615 | C | | Removal of rib | | | | | |
| 21616 | C | | Removal of rib and nerves | | | | | |
| 21620 | C | | Partial removal of sternum | | | | | |
| 21627 | C | | Sternal debridement | | | | | |
| 21630 | C | | Extensive sternum surgery | | | | | |
| 21632 | C | | Extensive sternum surgery | | | | | |
| 21685 | T | NI | Hyoid myotomy & suspension | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 21700 | T | | Revision of neck muscle | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 21705 | C | | Revision of neck muscle/rib | | | | | |
| 21720 | T | | Revision of neck muscle | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 21725 | T | | Revision of neck muscle | 0006 | 1.6527 | $90.17 | $23.26 | $18.03 |
| 21740 | C | | Reconstruction of sternum | | | | | |
| 21742 | T | | Repair stern/nuss w/o scope | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 21743 | T | | Repair sternum/nuss w/scope | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 21750 | C | | Repair of sternum separation | | | | | |
| 21800 | T | | Treatment of rib fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 21805 | T | | Treatment of rib fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 21810 | C | | Treatment of rib fracture(s) | | | | | |
| 21820 | T | | Treat sternum fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 21825 | C | | Treat sternum fracture | | | | | |
| 21899 | T | | Neck/chest surgery procedure | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 21920 | T | | Biopsy soft tissue of back | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 21925 | T | | Biopsy soft tissue of back | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 21930 | T | | Remove lesion, back or flank | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 21935 | T | | Remove tumor, back | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 22100 | T | | Remove part of neck vertebra | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 22101 | T | | Remove part, thorax vertebra | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 22102 | T | | Remove part, lumbar vertebra | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 22103 | T | | Remove extra spine segment | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 22110 | C | | Remove part of neck vertebra | | | | | |
| 22112 | C | | Remove part, thorax vertebra | | | | | |
| 22114 | C | | Remove part, lumbar vertebra | | | | | |
| 22116 | C | | Remove extra spine segment | | | | | |
| 22210 | C | | Revision of neck spine | | | | | |
| 22212 | C | | Revision of thorax spine | | | | | |
| 22214 | C | | Revision of lumbar spine | | | | | |
| 22216 | C | | Revise, extra spine segment | | | | | |
| 22220 | C | | Revision of neck spine | | | | | |
| 22222 | C | | Revision of thorax spine | | | | | |
| 22224 | C | | Revision of lumbar spine | | | | | |
| 22226 | C | | Revise, extra spine segment | | | | | |
| 22305 | T | | Treat spine process fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 22310 | T | | Treat spine fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 22315 | T | | Treat spine fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 22318 | C | | Treat odontoid fx w/o graft | | | | | |
| 22319 | C | | Treat odontoid fx w/graft | | | | | |
| 22325 | C | | Treat spine fracture | | | | | |
| 22326 | C | | Treat neck spine fracture | | | | | |
| 22327 | C | | Treat thorax spine fracture | | | | | |
| 22328 | C | | Treat each add spine fx | | | | | |
| 22505 | T | | Manipulation of spine | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 22520 | T | | Percut vertebroplasty thor | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 22521 | T | | Percut vertebroplasty lumb | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 22522 | T | | Percut vertebroplasty add'l | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 22532 | C | NI | Lat thorax spine fusion | | | | | |
| 22533 | C | NI | Lat lumbar spine fusion | | | | | |
| 22534 | C | NI | Lat thor/lumb, add'l seg | | | | | |
| 22548 | C | | Neck spine fusion | | | | | |
| 22554 | C | | Neck spine fusion | | | | | |
| 22556 | C | | Thorax spine fusion | | | | | |
| 22558 | C | | Lumbar spine fusion | | | | | |
| 22585 | C | | Additional spinal fusion | | | | | |
| 22590 | C | | Spine & skull spinal fusion | | | | | |
| 22595 | C | | Neck spinal fusion | | | | | |
| 22600 | C | | Neck spine fusion | | | | | |
| 22610 | C | | Thorax spine fusion | | | | | |
| 22612 | T | | Lumbar spine fusion | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 22614 | T | | Spine fusion, extra segment | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 22630 | C | | Lumbar spine fusion | | | | | |
| 22632 | C | | Spine fusion, extra segment | | | | | |
| 22800 | C | | Fusion of spine | | | | | |
| 22802 | C | | Fusion of spine | | | | | |
| 22804 | C | | Fusion of spine | | | | | |
| 22808 | C | | Fusion of spine | | | | | |
| 22810 | C | | Fusion of spine | | | | | |
| 22812 | C | | Fusion of spine | | | | | |
| 22818 | C | | Kyphectomy, 1-2 segments | | | | | |
| 22819 | C | | Kyphectomy, 3 or more | | | | | |
| 22830 | C | | Exploration of spinal fusion | | | | | |
| 22840 | C | | Insert spine fixation device | | | | | |
| 22841 | C | | Insert spine fixation device | | | | | |
| 22842 | C | | Insert spine fixation device | | | | | |
| 22843 | C | | Insert spine fixation device | | | | | |
| 22844 | C | | Insert spine fixation device | | | | | |
| 22845 | C | | Insert spine fixation device | | | | | |
| 22846 | C | | Insert spine fixation device | | | | | |
| 22847 | C | | Insert spine fixation device | | | | | |
| 22848 | C | | Insert pelv fixation device | | | | | |
| 22849 | C | | Reinsert spinal fixation | | | | | |
| 22850 | C | | Remove spine fixation device | | | | | |
| 22851 | C | | Apply spine prosth device | | | | | |
| 22852 | C | | Remove spine fixation device | | | | | |
| 22855 | C | | Remove spine fixation device | | | | | |
| 22899 | T | | Spine surgery procedure | 0043 | 1.9074 | $104.07 | | $20.81 |
| 22900 | T | | Remove abdominal wall lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 22999 | T | | Abdomen surgery procedure | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 23000 | T | | Removal of calcium deposits | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 23020 | T | | Release shoulder joint | 0051 | 34.5144 | $1,883.14 | | $376.63 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 23030 | T | | Drain shoulder lesion | 0008 | 19.4831 | $1,063.02 | | $212.60 |
| 23031 | T | | Drain shoulder bursa | 0008 | 19.4831 | $1,063.02 | | $212.60 |
| 23035 | T | | Drain shoulder bone lesion | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 23040 | T | | Exploratory shoulder surgery | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23044 | T | | Exploratory shoulder surgery | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23065 | T | | Biopsy shoulder tissues | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 23066 | T | | Biopsy shoulder tissues | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 23075 | T | | Removal of shoulder lesion | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 23076 | T | | Removal of shoulder lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 23077 | T | | Remove tumor of shoulder | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 23100 | T | | Biopsy of shoulder joint | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 23101 | T | | Shoulder joint surgery | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23105 | T | | Remove shoulder joint lining | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23106 | T | | Incision of collarbone joint | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23107 | T | | Explore treat shoulder joint | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23120 | T | | Partial removal, collar bone | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 23125 | T | | Removal of collar bone | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 23130 | T | | Remove shoulder bone, part | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 23140 | T | | Removal of bone lesion | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 23145 | T | | Removal of bone lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23146 | T | | Removal of bone lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23150 | T | | Removal of humerus lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23155 | T | | Removal of humerus lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23156 | T | | Removal of humerus lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23170 | T | | Remove collar bone lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23172 | T | | Remove shoulder blade lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23174 | T | | Remove humerus lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23180 | T | | Remove collar bone lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23182 | T | | Remove shoulder blade lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23184 | T | | Remove humerus lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23190 | T | | Partial removal of scapula | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23195 | T | | Removal of head of humerus | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23200 | C | | Removal of collar bone | | | | | |
| 23210 | C | | Removal of shoulder blade | | | | | |
| 23220 | C | | Partial removal of humerus | | | | | |
| 23221 | C | | Partial removal of humerus | | | | | |
| 23222 | C | | Partial removal of humerus | | | | | |
| 23330 | T | | Remove shoulder foreign body | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 23331 | T | | Remove shoulder foreign body | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 23332 | C | | Remove shoulder foreign body | | | | | |
| 23350 | N | | Injection for shoulder x-ray | | | | | |
| 23395 | T | | Muscle transfer,shoulder/arm | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 23397 | T | | Muscle transfers | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 23400 | T | | Fixation of shoulder blade | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23405 | T | | Incision of tendon & muscle | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23406 | T | | Incise tendon(s) & muscle(s) | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 23410 | T | | Repair of tendon(s) | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 23412 | T | | Repair rotator cuff, chronic | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 23415 | T | | Release of shoulder ligament | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 23420 | T | | Repair of shoulder | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 23430 | T | | Repair biceps tendon | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 23440 | T | | Remove/transplant tendon | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 23450 | T | | Repair shoulder capsule | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 23455 | T | | Repair shoulder capsule | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 23460 | T | | Repair shoulder capsule | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 23462 | T | | Repair shoulder capsule | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 23465 | T | | Repair shoulder capsule | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 23466 | T | | Repair shoulder capsule | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 23470 | T | | Reconstruct shoulder joint | 0048 | 51.4609 | $2,807.76 | $695.60 | $561.55 |
| 23472 | C | | Reconstruct shoulder joint | | | | | |
| 23480 | T | | Revision of collar bone | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 23485 | T | | Revision of collar bone | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 23490 | T | | Reinforce clavicle | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 23491 | T | | Reinforce shoulder bones | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 23500 | T | | Treat clavicle fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 23505 | T | | Treat clavicle fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 23515 | T | | Treat clavicle fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 23520 | T | | Treat clavicle dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 23525 | T | | Treat clavicle dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 23530 | T | | Treat clavicle dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 23532 | T | | Treat clavicle dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 23540 | T | | Treat clavicle dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 23545 | T | | Treat clavicle dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 23550 | T | | Treat clavicle dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 23552 | T | | Treat clavicle dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 23570 | T | | Treat shoulder blade fx | 0043 | 1.9074 | $104.07 | | $20.81 |
| 23575 | T | | Treat shoulder blade fx | 0043 | 1.9074 | $104.07 | | $20.81 |
| 23585 | T | | Treat scapula fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 23600 | T | | Treat humerus fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 23605 | T | | Treat humerus fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 23615 | T | | Treat humerus fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 23616 | T | | Treat humerus fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 23620 | T | | Treat humerus fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 23625 | T | | Treat humerus fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 23630 | T | | Treat humerus fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 23650 | T | | Treat shoulder dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 23655 | T | | Treat shoulder dislocation | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 23660 | T | | Treat shoulder dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 23665 | T | | Treat dislocation/fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 23670 | T | | Treat dislocation/fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 23675 | T | | Treat dislocation/fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 23680 | T | | Treat dislocation/fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 23700 | T | | Fixation of shoulder | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 23800 | T | | Fusion of shoulder joint | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 23802 | T | | Fusion of shoulder joint | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 23900 | C | | Amputation of arm & girdle | | | | | |
| 23920 | C | | Amputation at shoulder joint | | | | | |
| 23921 | T | | Amputation follow-up surgery | 0025 | 5.1912 | $283.24 | $107.00 | $56.65 |
| 23929 | T | | Shoulder surgery procedure | 0043 | 1.9074 | $104.07 | | $20.81 |
| 23930 | T | | Drainage of arm lesion | 0008 | 19.4831 | $1,063.02 | | $212.60 |
| 23931 | T | | Drainage of arm bursa | 0007 | 11.8633 | $647.27 | | $129.45 |
| 23935 | T | | Drain arm/elbow bone lesion | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 24000 | T | | Exploratory elbow surgery | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24006 | T | | Release elbow joint | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24065 | T | | Biopsy arm/elbow soft tissue | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 24066 | T | | Biopsy arm/elbow soft tissue | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 24075 | T | | Remove arm/elbow lesion | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 24076 | T | | Remove arm/elbow lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 24077 | T | | Remove tumor of arm/elbow | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 24100 | T | | Biopsy elbow joint lining | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 24101 | T | | Explore/treat elbow joint | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24102 | T | | Remove elbow joint lining | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24105 | T | | Removal of elbow bursa | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 24110 | T | | Remove humerus lesion | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 24115 | T | | Remove/graft bone lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24116 | T | | Remove/graft bone lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24120 | T | | Remove elbow lesion | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 24125 | T | | Remove/graft bone lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24126 | T | | Remove/graft bone lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24130 | T | | Removal of head of radius | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24134 | T | | Removal of arm bone lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24136 | T | | Remove radius bone lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24138 | T | | Remove elbow bone lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24140 | T | | Partial removal of arm bone | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24145 | T | | Partial removal of radius | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24147 | T | | Partial removal of elbow | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24149 | C | | Radical resection of elbow | | | | | |
| 24150 | T | | Extensive humerus surgery | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 24151 | T | | Extensive humerus surgery | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 24152 | T | | Extensive radius surgery | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 24153 | T | | Extensive radius surgery | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 24155 | T | | Removal of elbow joint | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 24160 | T | | Remove elbow joint implant | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24164 | T | | Remove radius head implant | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24200 | T | | Removal of arm foreign body | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 24201 | T | | Removal of arm foreign body | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 24220 | N | | Injection for elbow x-ray | | | | | |
| 24300 | T | | Manipulate elbow w/anesth | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 24301 | T | | Muscle/tendon transfer | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24305 | T | | Arm tendon lengthening | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24310 | T | | Revision of arm tendon | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 24320 | T | | Repair of arm tendon | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 24330 | T | | Revision of arm muscles | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 24331 | T | | Revision of arm muscles | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 24332 | T | | Tenolysis, triceps | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 24340 | T | | Repair of biceps tendon | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 24341 | T | | Repair arm tendon/muscle | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 24342 | T | | Repair of ruptured tendon | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 24343 | T | | Repr elbow lat ligmnt w/tiss | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24344 | T | | Reconstruct elbow lat ligmnt | 0051 | 34.5144 | $1,883.14 | | $376.63 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 24345 | T | | Repr elbw med ligmnt w/tissu | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24346 | T | | Reconstruct elbow med ligmnt | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 24350 | T | | Repair of tennis elbow | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24351 | T | | Repair of tennis elbow | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24352 | T | | Repair of tennis elbow | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24354 | T | | Repair of tennis elbow | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24356 | T | | Revision of tennis elbow | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24360 | T | | Reconstruct elbow joint | 0047 | 29.9582 | $1,634.55 | $537.03 | $326.91 |
| 24361 | T | | Reconstruct elbow joint | 0048 | 51.4609 | $2,807.76 | $695.60 | $561.55 |
| 24362 | T | | Reconstruct elbow joint | 0048 | 51.4609 | $2,807.76 | $695.60 | $561.55 |
| 24363 | T | | Replace elbow joint | 0048 | 51.4609 | $2,807.76 | $695.60 | $561.55 |
| 24365 | T | | Reconstruct head of radius | 0047 | 29.9582 | $1,634.55 | $537.03 | $326.91 |
| 24366 | T | | Reconstruct head of radius | 0048 | 51.4609 | $2,807.76 | $695.60 | $561.55 |
| 24400 | T | | Revision of humerus | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24410 | T | | Revision of humerus | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24420 | T | | Revision of humerus | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 24430 | T | | Repair of humerus | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 24435 | T | | Repair humerus with graft | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 24470 | T | | Revision of elbow joint | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 24495 | T | | Decompression of forearm | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 24498 | T | | Reinforce humerus | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 24500 | T | | Treat humerus fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 24505 | T | | Treat humerus fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 24515 | T | | Treat humerus fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 24516 | T | | Treat humerus fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 24530 | T | | Treat humerus fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 24535 | T | | Treat humerus fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 24538 | T | | Treat humerus fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 24545 | T | | Treat humerus fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 24546 | T | | Treat humerus fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 24560 | T | | Treat humerus fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 24565 | T | | Treat humerus fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 24566 | T | | Treat humerus fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 24575 | T | | Treat humerus fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 24576 | T | | Treat humerus fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 24577 | T | | Treat humerus fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 24579 | T | | Treat humerus fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 24582 | T | | Treat humerus fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 24586 | T | | Treat elbow fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 24587 | T | | Treat elbow fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 24600 | T | | Treat elbow dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 24605 | T | | Treat elbow dislocation | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 24615 | T | | Treat elbow dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 24620 | T | | Treat elbow fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 24635 | T | | Treat elbow fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 24640 | T | | Treat elbow dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 24650 | T | | Treat radius fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 24655 | T | | Treat radius fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 24665 | T | | Treat radius fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 24666 | T | | Treat radius fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 24670 | T | | Treat ulnar fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 24675 | T | | Treat ulnar fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 24685 | T | | Treat ulnar fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 24800 | T | | Fusion of elbow joint | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 24802 | T | | Fusion/graft of elbow joint | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 24900 | C | | Amputation of upper arm | | | | | |
| 24920 | C | | Amputation of upper arm | | | | | |
| 24925 | T | | Amputation follow-up surgery | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 24930 | C | | Amputation follow-up surgery | | | | | |
| 24931 | C | | Amputate upper arm & implant | | | | | |
| 24935 | T | | Revision of amputation | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 24940 | C | | Revision of upper arm | | | | | |
| 24999 | T | | Upper arm/elbow surgery | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25000 | T | | Incision of tendon sheath | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 25001 | T | | Incise flexor carpi radialis | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 25020 | T | | Decompress forearm 1 space | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 25023 | T | | Decompress forearm 1 space | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25024 | T | | Decompress forearm 2 spaces | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25025 | T | | Decompress forearm 2 spaces | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25028 | T | | Drainage of forearm lesion | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 25031 | T | | Drainage of forearm bursa | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 25035 | T | | Treat forearm bone lesion | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 25040 | T | | Explore/treat wrist joint | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25065 | T | | Biopsy forearm soft tissues | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 25066 | T | | Biopsy forearm soft tissues | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 25075 | T | | Removel forearm lesion subcu | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 25076 | T | | Removel forearm lesion deep | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 25077 | T | | Remove tumor, forearm/wrist | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 25085 | T | | Incision of wrist capsule | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 25100 | T | | Biopsy of wrist joint | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 25101 | T | | Explore/treat wrist joint | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25105 | T | | Remove wrist joint lining | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25107 | T | | Remove wrist joint cartilage | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25110 | T | | Remove wrist tendon lesion | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 25111 | T | | Remove wrist tendon lesion | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 25112 | T | | Reremove wrist tendon lesion | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 25115 | T | | Remove wrist/forearm lesion | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 25116 | T | | Remove wrist/forearm lesion | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 25118 | T | | Excise wrist tendon sheath | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25119 | T | | Partial removal of ulna | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25120 | T | | Removal of forearm lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25125 | T | | Remove/graft forearm lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25126 | T | | Remove/graft forearm lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25130 | T | | Removal of wrist lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25135 | T | | Remove & graft wrist lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25136 | T | | Remove & graft wrist lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25145 | T | | Remove forearm bone lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25150 | T | | Partial removal of ulna | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25151 | T | | Partial removal of radius | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25170 | T | | Extensive forearm surgery | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 25210 | T | | Removal of wrist bone | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 25215 | T | | Removal of wrist bones | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 25230 | T | | Partial removal of radius | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25240 | T | | Partial removal of ulna | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25246 | N | | Injection for wrist x-ray | | | | | |
| 25248 | T | | Remove forearm foreign body | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 25250 | T | | Removal of wrist prosthesis | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25251 | T | | Removal of wrist prosthesis | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25259 | T | | Manipulate wrist w/anesthes | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25260 | T | | Repair forearm tendon/muscle | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25263 | T | | Repair forearm tendon/muscle | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25265 | T | | Repair forearm tendon/muscle | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25270 | T | | Repair forearm tendon/muscle | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25272 | T | | Repair forearm tendon/muscle | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25274 | T | | Repair forearm tendon/muscle | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25275 | T | | Repair forearm tendon sheath | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25280 | T | | Revise wrist/forearm tendon | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25290 | T | | Incise wrist/forearm tendon | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25295 | T | | Release wrist/forearm tendon | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 25300 | T | | Fusion of tendons at wrist | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25301 | T | | Fusion of tendons at wrist | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25310 | T | | Transplant forearm tendon | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25312 | T | | Transplant forearm tendon | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25315 | T | | Revise palsy hand tendon(s) | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25316 | T | | Revise palsy hand tendon(s) | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25320 | T | | Repair/revise wrist joint | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25332 | T | | Revise wrist joint | 0047 | 29.9582 | $1,634.55 | $537.03 | $326.91 |
| 25335 | T | | Realignment of hand | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25337 | T | | Reconstruct ulna/radioulnar | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25350 | T | | Revision of radius | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25355 | T | | Revision of radius | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25360 | T | | Revision of ulna | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25365 | T | | Revise radius & ulna | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25370 | T | | Revise radius or ulna | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25375 | T | | Revise radius & ulna | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25390 | T | | Shorten radius or ulna | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25391 | T | | Lengthen radius or ulna | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25392 | T | | Shorten radius & ulna | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25393 | T | | Lengthen radius & ulna | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25394 | T | | Repair carpal bone, shorten | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 25400 | T | | Repair radius or ulna | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25405 | T | | Repair/graft radius or ulna | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25415 | T | | Repair radius & ulna | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 25420 | T | | Repair/graft radius & ulna | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25425 | T | | Repair/graft radius or ulna | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25426 | T | | Repair/graft radius & ulna | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25430 | T | | Vasc graft into carpal bone | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 25431 | T | | Repair nonunion carpal bone | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 25440 | T | | Repair/graft wrist bone | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25441 | T | | Reconstruct wrist joint | 0048 | 51.4609 | $2,807.76 | $695.60 | $561.55 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 25442 | T | | Reconstruct wrist joint | 0048 | 51.4609 | $2,807.76 | $695.60 | $561.55 |
| 25443 | T | | Reconstruct wrist joint | 0048 | 51.4609 | $2,807.76 | $695.60 | $561.55 |
| 25444 | T | | Reconstruct wrist joint | 0048 | 51.4609 | $2,807.76 | $695.60 | $561.55 |
| 25445 | T | | Reconstruct wrist joint | 0048 | 51.4609 | $2,807.76 | $695.60 | $561.55 |
| 25446 | T | | Wrist replacement | 0048 | 51.4609 | $2,807.76 | $695.60 | $561.55 |
| 25447 | T | | Repair wrist joint(s) | 0047 | 29.9582 | $1,634.55 | $537.03 | $326.91 |
| 25449 | T | | Remove wrist joint implant | 0047 | 29.9582 | $1,634.55 | $537.03 | $326.91 |
| 25450 | T | | Revision of wrist joint | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25455 | T | | Revision of wrist joint | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25490 | T | | Reinforce radius | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25491 | T | | Reinforce ulna | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25492 | T | | Reinforce radius and ulna | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25500 | T | | Treat fracture of radius | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25505 | T | | Treat fracture of radius | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25515 | T | | Treat fracture of radius | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 25520 | T | | Treat fracture of radius | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25525 | T | | Treat fracture of radius | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 25526 | T | | Treat fracture of radius | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 25530 | T | | Treat fracture of ulna | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25535 | T | | Treat fracture of ulna | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25545 | T | | Treat fracture of ulna | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 25560 | T | | Treat fracture radius & ulna | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25565 | T | | Treat fracture radius & ulna | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25574 | T | | Treat fracture radius & ulna | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 25575 | T | | Treat fracture radius/ulna | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 25600 | T | | Treat fracture radius/ulna | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25605 | T | | Treat fracture radius/ulna | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25611 | T | | Treat fracture radius/ulna | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 25620 | T | | Treat fracture radius/ulna | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 25622 | T | | Treat wrist bone fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25624 | T | | Treat wrist bone fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25628 | T | | Treat wrist bone fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 25630 | T | | Treat wrist bone fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25635 | T | | Treat wrist bone fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25645 | T | | Treat wrist bone fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 25650 | T | | Treat wrist bone fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25651 | T | | Pin ulnar styloid fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 25652 | T | | Treat fracture ulnar styloid | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 25660 | T | | Treat wrist dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25670 | T | | Treat wrist dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 25671 | T | | Pin radioulnar dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 25675 | T | | Treat wrist dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25676 | T | | Treat wrist dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 25680 | T | | Treat wrist fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25685 | T | | Treat wrist fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 25690 | T | | Treat wrist dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 25695 | T | | Treat wrist dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 25800 | T | | Fusion of wrist joint | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25805 | T | | Fusion/graft of wrist joint | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25810 | T | | Fusion/graft of wrist joint | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25820 | T | | Fusion of hand bones | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 25825 | T | | Fuse hand bones with graft | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 25830 | T | | Fusion, radioulnar jnt/ulna | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 25900 | C | | Amputation of forearm | | | | | |
| 25905 | C | | Amputation of forearm | | | | | |
| 25907 | T | | Amputation follow-up surgery | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 25909 | C | | Amputation follow-up surgery | | | | | |
| 25915 | C | | Amputation of forearm | | | | | |
| 25920 | C | | Amputate hand at wrist | | | | | |
| 25922 | T | | Amputate hand at wrist | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 25924 | C | | Amputation follow-up surgery | | | | | |
| 25927 | C | | Amputation of hand | | | | | |
| 25929 | T | | Amputation follow-up surgery | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 25931 | C | | Amputation follow-up surgery | | | | | |
| 25999 | T | | Forearm or wrist surgery | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26010 | T | | Drainage of finger abscess | 0006 | 1.6527 | $90.17 | $23.26 | $18.03 |
| 26011 | T | | Drainage of finger abscess | 0007 | 11.8633 | $647.27 | | $129.45 |
| 26020 | T | | Drain hand tendon sheath | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26025 | T | | Drainage of palm bursa | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26030 | T | | Drainage of palm bursa(s) | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26034 | T | | Treat hand bone lesion | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26035 | T | | Decompress fingers/hand | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26037 | T | | Decompress fingers/hand | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26040 | T | | Release palm contracture | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26045 | T | | Release palm contracture | 0054 | 24.2456 | $1,322.86 | | $264.57 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 26055 | T | | Incise finger tendon sheath | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26060 | T | | Incision of finger tendon | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26070 | T | | Explore/treat hand joint | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26075 | T | | Explore/treat finger joint | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26080 | T | | Explore/treat finger joint | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26100 | T | | Biopsy hand joint lining | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26105 | T | | Biopsy finger joint lining | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26110 | T | | Biopsy finger joint lining | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26115 | T | | Removel hand lesion subcut | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 26116 | T | | Removel hand lesion, deep | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 26117 | T | | Remove tumor, hand/finger | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 26121 | T | | Release palm contracture | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26123 | T | | Release palm contracture | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26125 | T | | Release palm contracture | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26130 | T | | Remove wrist joint lining | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26135 | T | | Revise finger joint, each | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26140 | T | | Revise finger joint, each | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26145 | T | | Tendon excision, palm/finger | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26160 | T | | Remove tendon sheath lesion | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26170 | T | | Removal of palm tendon, each | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26180 | T | | Removal of finger tendon | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26185 | T | | Remove finger bone | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26200 | T | | Remove hand bone lesion | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26205 | T | | Remove/graft bone lesion | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26210 | T | | Removal of finger lesion | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26215 | T | | Remove/graft finger lesion | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26230 | T | | Partial removal of hand bone | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26235 | T | | Partial removal, finger bone | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26236 | T | | Partial removal, finger bone | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26250 | T | | Extensive hand surgery | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26255 | T | | Extensive hand surgery | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26260 | T | | Extensive finger surgery | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26261 | T | | Extensive finger surgery | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26262 | T | | Partial removal of finger | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26320 | T | | Removal of implant from hand | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 26340 | T | | Manipulate finger w/anesth | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26350 | T | | Repair finger/hand tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26352 | T | | Repair/graft hand tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26356 | T | | Repair finger/hand tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26357 | T | | Repair finger/hand tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26358 | T | | Repair/graft hand tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26370 | T | | Repair finger/hand tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26372 | T | | Repair/graft hand tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26373 | T | | Repair finger/hand tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26390 | T | | Revise hand/finger tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26392 | T | | Repair/graft hand tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26410 | T | | Repair hand tendon | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26412 | T | | Repair/graft hand tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26415 | T | | Excision, hand/finger tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26416 | T | | Graft hand or finger tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26418 | T | | Repair finger tendon | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26420 | T | | Repair/graft finger tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26426 | T | | Repair finger/hand tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26428 | T | | Repair/graft finger tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26432 | T | | Repair finger tendon | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26433 | T | | Repair finger tendon | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26434 | T | | Repair/graft finger tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26437 | T | | Realignment of tendons | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26440 | T | | Release palm/finger tendon | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26442 | T | | Release palm & finger tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26445 | T | | Release hand/finger tendon | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26449 | T | | Release forearm/hand tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26450 | T | | Incision of palm tendon | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26455 | T | | Incision of finger tendon | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26460 | T | | Incise hand/finger tendon | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26471 | T | | Fusion of finger tendons | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26474 | T | | Fusion of finger tendons | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26476 | T | | Tendon lengthening | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26477 | T | | Tendon shortening | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26478 | T | | Lengthening of hand tendon | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26479 | T | | Shortening of hand tendon | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26480 | T | | Transplant hand tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26483 | T | | Transplant/graft hand tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26485 | T | | Transplant palm tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26489 | T | | Transplant/graft palm tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 26490 | T | | Revise thumb tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26492 | T | | Tendon transfer with graft | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26494 | T | | Hand tendon/muscle transfer | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26496 | T | | Revise thumb tendon | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26497 | T | | Finger tendon transfer | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26498 | T | | Finger tendon transfer | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26499 | T | | Revision of finger | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26500 | T | | Hand tendon reconstruction | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26502 | T | | Hand tendon reconstruction | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26504 | T | | Hand tendon reconstruction | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26508 | T | | Release thumb contracture | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26510 | T | | Thumb tendon transfer | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26516 | T | | Fusion of knuckle joint | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26517 | T | | Fusion of knuckle joints | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26518 | T | | Fusion of knuckle joints | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26520 | T | | Release knuckle contracture | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26525 | T | | Release finger contracture | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26530 | T | | Revise knuckle joint | 0047 | 29.9582 | $1,634.55 | $537.03 | $326.91 |
| 26531 | T | | Revise knuckle with implant | 0048 | 51.4609 | $2,807.76 | $695.60 | $561.55 |
| 26535 | T | | Revise finger joint | 0047 | 29.9582 | $1,634.55 | $537.03 | $326.91 |
| 26536 | T | | Revise/implant finger joint | 0048 | 51.4609 | $2,807.76 | $695.60 | $561.55 |
| 26540 | T | | Repair hand joint | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26541 | T | | Repair hand joint with graft | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26542 | T | | Repair hand joint with graft | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26545 | T | | Reconstruct finger joint | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26546 | T | | Repair nonunion hand | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26548 | T | | Reconstruct finger joint | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26550 | T | | Construct thumb replacement | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26551 | C | | Great toe-hand transfer | | | | | |
| 26553 | C | | Single transfer, toe-hand | | | | | |
| 26554 | C | | Double transfer, toe-hand | | | | | |
| 26555 | T | | Positional change of finger | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26556 | C | | Toe joint transfer | | | | | |
| 26560 | T | | Repair of web finger | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26561 | T | | Repair of web finger | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26562 | T | | Repair of web finger | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26565 | T | | Correct metacarpal flaw | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26567 | T | | Correct finger deformity | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26568 | T | | Lengthen metacarpal/finger | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26580 | T | | Repair hand deformity | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26587 | T | | Reconstruct extra finger | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26590 | T | | Repair finger deformity | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26591 | T | | Repair muscles of hand | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26593 | T | | Release muscles of hand | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26596 | T | | Excision constricting tissue | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26600 | T | | Treat metacarpal fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26605 | T | | Treat metacarpal fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26607 | T | | Treat metacarpal fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26608 | T | | Treat metacarpal fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 26615 | T | | Treat metacarpal fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 26641 | T | | Treat thumb dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26645 | T | | Treat thumb fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26650 | T | | Treat thumb fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 26665 | T | | Treat thumb fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 26670 | T | | Treat hand dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26675 | T | | Treat hand dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26676 | T | | Pin hand dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 26685 | T | | Treat hand dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 26686 | T | | Treat hand dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 26700 | T | | Treat knuckle dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26705 | T | | Treat knuckle dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26706 | T | | Pin knuckle dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26715 | T | | Treat knuckle dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 26720 | T | | Treat finger fracture, each | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26725 | T | | Treat finger fracture, each | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26727 | T | | Treat finger fracture, each | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 26735 | T | | Treat finger fracture, each | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 26740 | T | | Treat finger fracture, each | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26742 | T | | Treat finger fracture, each | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26746 | T | | Treat finger fracture, each | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 26750 | T | | Treat finger fracture, each | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26755 | T | | Treat finger fracture, each | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26756 | T | | Pin finger fracture, each | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 26765 | T | | Treat finger fracture, each | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 26770 | T | | Treat finger dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 26775 | T | | Treat finger dislocation | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 26776 | T | | Pin finger dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 26785 | T | | Treat finger dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 26820 | T | | Thumb fusion with graft | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26841 | T | | Fusion of thumb | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26842 | T | | Thumb fusion with graft | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26843 | T | | Fusion of hand joint | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26844 | T | | Fusion/graft of hand joint | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26850 | T | | Fusion of knuckle | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26852 | T | | Fusion of knuckle with graft | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26860 | T | | Fusion of finger joint | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26861 | T | | Fusion of finger jnt, add-on | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26862 | T | | Fusion/graft of finger joint | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26863 | T | | Fuse/graft added joint | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26910 | T | | Amputate metacarpal bone | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 26951 | T | | Amputation of finger/thumb | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26952 | T | | Amputation of finger/thumb | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 26989 | T | | Hand/finger surgery | 0043 | 1.9074 | $104.07 | | $20.81 |
| 26990 | T | | Drainage of pelvis lesion | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 26991 | T | | Drainage of pelvis bursa | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 26992 | C | | Drainage of bone lesion | | | | | |
| 27000 | T | | Incision of hip tendon | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27001 | T | | Incision of hip tendon | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27003 | T | | Incision of hip tendon | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27005 | C | | Incision of hip tendon | | | | | |
| 27006 | C | | Incision of hip tendons | | | | | |
| 27025 | C | | Incision of hip/thigh fascia | | | | | |
| 27030 | C | | Drainage of hip joint | | | | | |
| 27033 | T | | Exploration of hip joint | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27035 | T | | Denervation of hip joint | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 27036 | C | | Excision of hip joint/muscle | | | | | |
| 27040 | T | | Biopsy of soft tissues | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 27041 | T | | Biopsy of soft tissues | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 27047 | T | | Remove hip/pelvis lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 27048 | T | | Remove hip/pelvis lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 27049 | T | | Remove tumor, hip/pelvis | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 27050 | T | | Biopsy of sacroiliac joint | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27052 | T | | Biopsy of hip joint | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27054 | C | | Removal of hip joint lining | | | | | |
| 27060 | T | | Removal of ischial bursa | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27062 | T | | Remove femur lesion/bursa | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27065 | T | | Removal of hip bone lesion | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27066 | T | | Removal of hip bone lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27067 | T | | Remove/graft hip bone lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27070 | C | | Partial removal of hip bone | | | | | |
| 27071 | C | | Partial removal of hip bone | | | | | |
| 27075 | C | | Extensive hip surgery | | | | | |
| 27076 | C | | Extensive hip surgery | | | | | |
| 27077 | C | | Extensive hip surgery | | | | | |
| 27078 | C | | Extensive hip surgery | | | | | |
| 27079 | C | | Extensive hip surgery | | | | | |
| 27080 | T | | Removal of tail bone | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27086 | T | | Remove hip foreign body | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 27087 | T | | Remove hip foreign body | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27090 | C | | Removal of hip prosthesis | | | | | |
| 27091 | C | | Removal of hip prosthesis | | | | | |
| 27093 | N | | Injection for hip x-ray | | | | | |
| 27095 | N | | Injection for hip x-ray | | | | | |
| 27096 | B | | Inject sacroiliac joint | | | | | |
| 27097 | T | | Revision of hip tendon | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27098 | T | | Transfer tendon to pelvis | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27100 | T | | Transfer of abdominal muscle | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27105 | T | | Transfer of spinal muscle | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27110 | T | | Transfer of iliopsoas muscle | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27111 | T | | Transfer of iliopsoas muscle | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27120 | C | | Reconstruction of hip socket | | | | | |
| 27122 | C | | Reconstruction of hip socket | | | | | |
| 27125 | C | | Partial hip replacement | | | | | |
| 27130 | C | | Total hip arthroplasty | | | | | |
| 27132 | C | | Total hip arthroplasty | | | | | |
| 27134 | C | | Revise hip joint replacement | | | | | |
| 27137 | C | | Revise hip joint replacement | | | | | |
| 27138 | C | | Revise hip joint replacement | | | | | |
| 27140 | C | | Transplant femur ridge | | | | | |
| 27146 | C | | Incision of hip bone | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 27147 | C | | Revision of hip bone | | | | | |
| 27151 | C | | Incision of hip bones | | | | | |
| 27156 | C | | Revision of hip bones | | | | | |
| 27158 | C | | Revision of pelvis | | | | | |
| 27161 | C | | Incision of neck of femur | | | | | |
| 27165 | C | | Incision/fixation of femur | | | | | |
| 27170 | C | | Repair/graft femur head/neck | | | | | |
| 27175 | C | | Treat slipped epiphysis | | | | | |
| 27176 | C | | Treat slipped epiphysis | | | | | |
| 27177 | C | | Treat slipped epiphysis | | | | | |
| 27178 | C | | Treat slipped epiphysis | | | | | |
| 27179 | C | | Revise head/neck of femur | | | | | |
| 27181 | C | | Treat slipped epiphysis | | | | | |
| 27185 | C | | Revision of femur epiphysis | | | | | |
| 27187 | C | | Reinforce hip bones | | | | | |
| 27193 | T | | Treat pelvic ring fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27194 | T | | Treat pelvic ring fracture | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 27200 | T | | Treat tail bone fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27202 | T | | Treat tail bone fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27215 | C | | Treat pelvic fracture(s) | | | | | |
| 27216 | T | | Treat pelvic ring fracture | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27217 | C | | Treat pelvic ring fracture | | | | | |
| 27218 | C | | Treat pelvic ring fracture | | | | | |
| 27220 | T | | Treat hip socket fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27222 | C | | Treat hip socket fracture | | | | | |
| 27226 | C | | Treat hip wall fracture | | | | | |
| 27227 | C | | Treat hip fracture(s) | | | | | |
| 27228 | C | | Treat hip fracture(s) | | | | | |
| 27230 | T | | Treat thigh fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27232 | C | | Treat thigh fracture | | | | | |
| 27235 | T | | Treat thigh fracture | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27236 | C | | Treat thigh fracture | | | | | |
| 27238 | T | | Treat thigh fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27240 | C | | Treat thigh fracture | | | | | |
| 27244 | C | | Treat thigh fracture | | | | | |
| 27245 | C | | Treat thigh fracture | | | | | |
| 27246 | T | | Treat thigh fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27248 | C | | Treat thigh fracture | | | | | |
| 27250 | T | | Treat hip dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27252 | T | | Treat hip dislocation | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 27253 | C | | Treat hip dislocation | | | | | |
| 27254 | C | | Treat hip dislocation | | | | | |
| 27256 | T | | Treat hip dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27257 | T | | Treat hip dislocation | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 27258 | C | | Treat hip dislocation | | | | | |
| 27259 | C | | Treat hip dislocation | | | | | |
| 27265 | T | | Treat hip dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27266 | T | | Treat hip dislocation | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 27275 | T | | Manipulation of hip joint | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 27280 | C | | Fusion of sacroiliac joint | | | | | |
| 27282 | C | | Fusion of pubic bones | | | | | |
| 27284 | C | | Fusion of hip joint | | | | | |
| 27286 | C | | Fusion of hip joint | | | | | |
| 27290 | C | | Amputation of leg at hip | | | | | |
| 27295 | C | | Amputation of leg at hip | | | | | |
| 27299 | T | | Pelvis/hip joint surgery | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27301 | T | | Drain thigh/knee lesion | 0008 | 19.4831 | $1,063.02 | | $212.60 |
| 27303 | C | | Drainage of bone lesion | | | | | |
| 27305 | T | | Incise thigh tendon & fascia | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27306 | T | | Incision of thigh tendon | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27307 | T | | Incision of thigh tendons | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27310 | T | | Exploration of knee joint | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27315 | T | | Partial removal, thigh nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 27320 | T | | Partial removal, thigh nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 27323 | T | | Biopsy, thigh soft tissues | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 27324 | T | | Biopsy, thigh soft tissues | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 27327 | T | | Removal of thigh lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 27328 | T | | Removal of thigh lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 27329 | T | | Remove tumor, thigh/knee | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 27330 | T | | Biopsy, knee joint lining | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27331 | T | | Explore/treat knee joint | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27332 | T | | Removal of knee cartilage | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27333 | T | | Removal of knee cartilage | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27334 | T | | Remove knee joint lining | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27335 | T | | Remove knee joint lining | 0050 | 24.8651 | $1,356.66 | | $271.33 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 27340 | T | | Removal of kneecap bursa | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27345 | T | | Removal of knee cyst | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27347 | T | | Remove knee cyst | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27350 | T | | Removal of kneecap | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27355 | T | | Remove femur lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27356 | T | | Remove femur lesion/graft | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27357 | T | | Remove femur lesion/graft | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27358 | T | | Remove femur lesion/fixation | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27360 | T | | Partial removal, leg bone(s) | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27365 | C | | Extensive leg surgery | | | | | |
| 27370 | N | | Injection for knee x-ray | | | | | |
| 27372 | T | | Removal of foreign body | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 27380 | T | | Repair of kneecap tendon | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27381 | T | | Repair/graft kneecap tendon | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27385 | T | | Repair of thigh muscle | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27386 | T | | Repair/graft of thigh muscle | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27390 | T | | Incision of thigh tendon | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27391 | T | | Incision of thigh tendons | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27392 | T | | Incision of thigh tendons | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27393 | T | | Lengthening of thigh tendon | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27394 | T | | Lengthening of thigh tendons | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27395 | T | | Lengthening of thigh tendons | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27396 | T | | Transplant of thigh tendon | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27397 | T | | Transplants of thigh tendons | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27400 | T | | Revise thigh muscles/tendons | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27403 | T | | Repair of knee cartilage | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27405 | T | | Repair of knee ligament | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27407 | T | | Repair of knee ligament | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27409 | T | | Repair of knee ligaments | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27418 | T | | Repair degenerated kneecap | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27420 | T | | Revision of unstable kneecap | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27422 | T | | Revision of unstable kneecap | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27424 | T | | Revision/removal of kneecap | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27425 | T | | Lateral retinacular release | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27427 | T | | Reconstruction, knee | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 27428 | T | | Reconstruction, knee | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 27429 | T | | Reconstruction, knee | 0052 | 42.7126 | $2,330.44 | | $466.09 |
| 27430 | T | | Revision of thigh muscles | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27435 | T | | Incision of knee joint | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27437 | T | | Revise kneecap | 0047 | 29.9582 | $1,634.55 | $537.03 | $326.91 |
| 27438 | T | | Revise kneecap with implant | 0048 | 51.4609 | $2,807.76 | $695.60 | $561.55 |
| 27440 | T | | Revision of knee joint | 0047 | 29.9582 | $1,634.55 | $537.03 | $326.91 |
| 27441 | T | | Revision of knee joint | 0047 | 29.9582 | $1,634.55 | $537.03 | $326.91 |
| 27442 | T | | Revision of knee joint | 0047 | 29.9582 | $1,634.55 | $537.03 | $326.91 |
| 27443 | T | | Revision of knee joint | 0047 | 29.9582 | $1,634.55 | $537.03 | $326.91 |
| 27445 | C | | Revision of knee joint | | | | | |
| 27446 | T | | Revision of knee joint | 0681 | 98.1613 | $5,355.78 | $2,131.36 | $1,071.16 |
| 27447 | C | | Total knee arthroplasty | | | | | |
| 27448 | C | | Incision of thigh | | | | | |
| 27450 | C | | Incision of thigh | | | | | |
| 27454 | C | | Realignment of thigh bone | | | | | |
| 27455 | C | | Realignment of knee | | | | | |
| 27457 | C | | Realignment of knee | | | | | |
| 27465 | C | | Shortening of thigh bone | | | | | |
| 27466 | C | | Lengthening of thigh bone | | | | | |
| 27468 | C | | Shorten/lengthen thighs | | | | | |
| 27470 | C | | Repair of thigh | | | | | |
| 27472 | C | | Repair/graft of thigh | | | | | |
| 27475 | C | | Surgery to stop leg growth | | | | | |
| 27477 | C | | Surgery to stop leg growth | | | | | |
| 27479 | C | | Surgery to stop leg growth | | | | | |
| 27485 | C | | Surgery to stop leg growth | | | | | |
| 27486 | C | | Revise/replace knee joint | | | | | |
| 27487 | C | | Revise/replace knee joint | | | | | |
| 27488 | C | | Removal of knee prosthesis | | | | | |
| 27495 | C | | Reinforce thigh | | | | | |
| 27496 | T | | Decompression of thigh/knee | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27497 | T | | Decompression of thigh/knee | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27498 | T | | Decompression of thigh/knee | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27499 | T | | Decompression of thigh/knee | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27500 | T | | Treatment of thigh fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27501 | T | | Treatment of thigh fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27502 | T | | Treatment of thigh fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27503 | T | | Treatment of thigh fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27506 | C | | Treatment of thigh fracture | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 27507 | C | | Treatment of thigh fracture | | | | | |
| 27508 | T | | Treatment of thigh fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27509 | T | | Treatment of thigh fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27510 | T | | Treatment of thigh fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27511 | C | | Treatment of thigh fracture | | | | | |
| 27513 | C | | Treatment of thigh fracture | | | | | |
| 27514 | C | | Treatment of thigh fracture | | | | | |
| 27516 | T | | Treat thigh fx growth plate | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27517 | T | | Treat thigh fx growth plate | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27519 | C | | Treat thigh fx growth plate | | | | | |
| 27520 | T | | Treat kneecap fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27524 | T | | Treat kneecap fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27530 | T | | Treat knee fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27532 | T | | Treat knee fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27535 | C | | Treat knee fracture | | | | | |
| 27536 | C | | Treat knee fracture | | | | | |
| 27538 | T | | Treat knee fracture(s) | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27540 | C | | Treat knee fracture | | | | | |
| 27550 | T | | Treat knee dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27552 | T | | Treat knee dislocation | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 27556 | C | | Treat knee dislocation | | | | | |
| 27557 | C | | Treat knee dislocation | | | | | |
| 27558 | C | | Treat knee dislocation | | | | | |
| 27560 | T | | Treat kneecap dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27562 | T | | Treat kneecap dislocation | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 27566 | T | | Treat kneecap dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27570 | T | | Fixation of knee joint | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 27580 | C | | Fusion of knee | | | | | |
| 27590 | C | | Amputate leg at thigh | | | | | |
| 27591 | C | | Amputate leg at thigh | | | | | |
| 27592 | C | | Amputate leg at thigh | | | | | |
| 27594 | T | | Amputation follow-up surgery | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27596 | C | | Amputation follow-up surgery | | | | | |
| 27598 | C | | Amputate lower leg at knee | | | | | |
| 27599 | T | | Leg surgery procedure | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27600 | T | | Decompression of lower leg | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27601 | T | | Decompression of lower leg | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27602 | T | | Decompression of lower leg | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27603 | T | | Drain lower leg lesion | 0007 | 11.8633 | $647.27 | | $129.45 |
| 27604 | T | | Drain lower leg bursa | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27605 | T | | Incision of achilles tendon | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 27606 | T | | Incision of achilles tendon | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27607 | T | | Treat lower leg bone lesion | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27610 | T | | Explore/treat ankle joint | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27612 | T | | Exploration of ankle joint | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27613 | T | | Biopsy lower leg soft tissue | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 27614 | T | | Biopsy lower leg soft tissue | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 27615 | T | | Remove tumor, lower leg | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27618 | T | | Remove lower leg lesion | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 27619 | T | | Remove lower leg lesion | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 27620 | T | | Explore/treat ankle joint | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27625 | T | | Remove ankle joint lining | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27626 | T | | Remove ankle joint lining | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27630 | T | | Removal of tendon lesion | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27635 | T | | Remove lower leg bone lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27637 | T | | Remove/graft leg bone lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27638 | T | | Remove/graft leg bone lesion | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27640 | T | | Partial removal of tibia | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27641 | T | | Partial removal of fibula | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27645 | C | | Extensive lower leg surgery | | | | | |
| 27646 | C | | Extensive lower leg surgery | | | | | |
| 27647 | T | | Extensive ankle/heel surgery | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27648 | N | | Injection for ankle x-ray | | | | | |
| 27650 | T | | Repair achilles tendon | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27652 | T | | Repair/graft achilles tendon | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27654 | T | | Repair of achilles tendon | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27656 | T | | Repair leg fascia defect | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27658 | T | | Repair of leg tendon, each | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27659 | T | | Repair of leg tendon, each | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27664 | T | | Repair of leg tendon, each | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27665 | T | | Repair of leg tendon, each | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27675 | T | | Repair lower leg tendons | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27676 | T | | Repair lower leg tendons | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27680 | T | | Release of lower leg tendon | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27681 | T | | Release of lower leg tendons | 0050 | 24.8651 | $1,356.66 | | $271.33 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 27685 | T | | Revision of lower leg tendon | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27686 | T | | Revise lower leg tendons | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27687 | T | | Revision of calf tendon | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27690 | T | | Revise lower leg tendon | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27691 | T | | Revise lower leg tendon | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27692 | T | | Revise additional leg tendon | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27695 | T | | Repair of ankle ligament | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27696 | T | | Repair of ankle ligaments | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27698 | T | | Repair of ankle ligament | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27700 | T | | Revision of ankle joint | 0047 | 29.9582 | $1,634.55 | $537.03 | $326.91 |
| 27702 | C | | Reconstruct ankle joint | | | | | |
| 27703 | C | | Reconstruction, ankle joint | | | | | |
| 27704 | T | | Removal of ankle implant | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27705 | T | | Incision of tibia | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27707 | T | | Incision of fibula | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27709 | T | | Incision of tibia & fibula | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27712 | C | | Realignment of lower leg | | | | | |
| 27715 | C | | Revision of lower leg | | | | | |
| 27720 | C | | Repair of tibia | | | | | |
| 27722 | C | | Repair/graft of tibia | | | | | |
| 27724 | C | | Repair/graft of tibia | | | | | |
| 27725 | C | | Repair of lower leg | | | | | |
| 27727 | C | | Repair of lower leg | | | | | |
| 27730 | T | | Repair of tibia epiphysis | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27732 | T | | Repair of fibula epiphysis | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27734 | T | | Repair lower leg epiphyses | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27740 | T | | Repair of leg epiphyses | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27742 | T | | Repair of leg epiphyses | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27745 | T | | Reinforce tibia | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27750 | T | | Treatment of tibia fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27752 | T | | Treatment of tibia fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27756 | T | | Treatment of tibia fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27758 | T | | Treatment of tibia fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27759 | T | | Treatment of tibia fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27760 | T | | Treatment of ankle fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27762 | T | | Treatment of ankle fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27766 | T | | Treatment of ankle fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27780 | T | | Treatment of fibula fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27781 | T | | Treatment of fibula fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27784 | T | | Treatment of fibula fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27786 | T | | Treatment of ankle fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27788 | T | | Treatment of ankle fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27792 | T | | Treatment of ankle fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27808 | T | | Treatment of ankle fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27810 | T | | Treatment of ankle fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27814 | T | | Treatment of ankle fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27816 | T | | Treatment of ankle fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27818 | T | | Treatment of ankle fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27822 | T | | Treatment of ankle fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27823 | T | | Treatment of ankle fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27824 | T | | Treat lower leg fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27825 | T | | Treat lower leg fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27826 | T | | Treat lower leg fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27827 | T | | Treat lower leg fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27828 | T | | Treat lower leg fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27829 | T | | Treat lower leg joint | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27830 | T | | Treat lower leg dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27831 | T | | Treat lower leg dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27832 | T | | Treat lower leg dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27840 | T | | Treat ankle dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 27842 | T | | Treat ankle dislocation | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 27846 | T | | Treat ankle dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27848 | T | | Treat ankle dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 27860 | T | | Fixation of ankle joint | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 27870 | T | | Fusion of ankle joint | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27871 | T | | Fusion of tibiofibular joint | 0051 | 34.5144 | $1,883.14 | | $376.63 |
| 27880 | C | | Amputation of lower leg | | | | | |
| 27881 | C | | Amputation of lower leg | | | | | |
| 27882 | C | | Amputation of lower leg | | | | | |
| 27884 | T | | Amputation follow-up surgery | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27886 | C | | Amputation follow-up surgery | | | | | |
| 27888 | C | | Amputation of foot at ankle | | | | | |
| 27889 | T | | Amputation of foot at ankle | 0050 | 24.8651 | $1,356.66 | | $271.33 |
| 27892 | T | | Decompression of leg | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27893 | T | | Decompression of leg | 0049 | 19.6046 | $1,069.65 | | $213.93 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 27894 | T | | Decompression of leg | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 27899 | T | | Leg/ankle surgery procedure | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28001 | T | | Drainage of bursa of foot | 0007 | 11.8633 | $647.27 | | $129.45 |
| 28002 | T | | Treatment of foot infection | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 28003 | T | | Treatment of foot infection | 0049 | 19.6046 | $1,069.65 | | $213.93 |
| 28005 | T | | Treat foot bone lesion | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28008 | T | | Incision of foot fascia | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28010 | T | | Incision of toe tendon | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28011 | T | | Incision of toe tendons | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28020 | T | | Exploration of foot joint | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28022 | T | | Exploration of foot joint | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28024 | T | | Exploration of toe joint | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28030 | T | | Removal of foot nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 28035 | T | | Decompression of tibia nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 28043 | T | | Excision of foot lesion | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 28045 | T | | Excision of foot lesion | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28046 | T | | Resection of tumor, foot | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28050 | T | | Biopsy of foot joint lining | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28052 | T | | Biopsy of foot joint lining | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28054 | T | | Biopsy of toe joint lining | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28060 | T | | Partial removal, foot fascia | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28062 | T | | Removal of foot fascia | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28070 | T | | Removal of foot joint lining | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28072 | T | | Removal of foot joint lining | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28080 | T | | Removal of foot lesion | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28086 | T | | Excise foot tendon sheath | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28088 | T | | Excise foot tendon sheath | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28090 | T | | Removal of foot lesion | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28092 | T | | Removal of toe lesions | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28100 | T | | Removal of ankle/heel lesion | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28102 | T | | Remove/graft foot lesion | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28103 | T | | Remove/graft foot lesion | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28104 | T | | Removal of foot lesion | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28106 | T | | Remove/graft foot lesion | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28107 | T | | Remove/graft foot lesion | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28108 | T | | Removal of toe lesions | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28110 | T | | Part removal of metatarsal | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28111 | T | | Part removal of metatarsal | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28112 | T | | Part removal of metatarsal | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28113 | T | | Part removal of metatarsal | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28114 | T | | Removal of metatarsal heads | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28116 | T | | Revision of foot | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28118 | T | | Removal of heel bone | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28119 | T | | Removal of heel spur | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28120 | T | | Part removal of ankle/heel | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28122 | T | | Partial removal of foot bone | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28124 | T | | Partial removal of toe | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28126 | T | | Partial removal of toe | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28130 | T | | Removal of ankle bone | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28140 | T | | Removal of metatarsal | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28150 | T | | Removal of toe | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28153 | T | | Partial removal of toe | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28160 | T | | Partial removal of toe | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28171 | T | | Extensive foot surgery | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28173 | T | | Extensive foot surgery | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28175 | T | | Extensive foot surgery | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28190 | T | | Removal of foot foreign body | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 28192 | T | | Removal of foot foreign body | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 28193 | T | | Removal of foot foreign body | 0020 | 7.0842 | $386.52 | $113.25 | $77.30 |
| 28200 | T | | Repair of foot tendon | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28202 | T | | Repair/graft of foot tendon | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28208 | T | | Repair of foot tendon | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28210 | T | | Repair/graft of foot tendon | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28220 | T | | Release of foot tendon | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28222 | T | | Release of foot tendons | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28225 | T | | Release of foot tendon | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28226 | T | | Release of foot tendons | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28230 | T | | Incision of foot tendon(s) | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28232 | T | | Incision of toe tendon | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28234 | T | | Incision of foot tendon | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28238 | T | | Revision of foot tendon | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28240 | T | | Release of big toe | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28250 | T | | Revision of foot fascia | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28260 | T | | Release of midfoot joint | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28261 | T | | Revision of foot tendon | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 28262 | T | | Revision of foot and ankle | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28264 | T | | Release of midfoot joint | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28270 | T | | Release of foot contracture | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28272 | T | | Release of toe joint, each | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28280 | T | | Fusion of toes | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28285 | T | | Repair of hammertoe | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28286 | T | | Repair of hammertoe | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28288 | T | | Partial removal of foot bone | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28289 | T | | Repair hallux rigidus | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28290 | T | | Correction of bunion | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28292 | T | | Correction of bunion | 0057 | 25.5035 | $1,391.50 | $475.91 | $278.30 |
| 28293 | T | | Correction of bunion | 0057 | 25.5035 | $1,391.50 | $475.91 | $278.30 |
| 28294 | T | | Correction of bunion | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28296 | T | | Correction of bunion | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28297 | T | | Correction of bunion | 0057 | 25.5035 | $1,391.50 | $475.91 | $278.30 |
| 28298 | T | | Correction of bunion | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28299 | T | | Correction of bunion | 0057 | 25.5035 | $1,391.50 | $475.91 | $278.30 |
| 28300 | T | | Incision of heel bone | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28302 | T | | Incision of ankle bone | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28304 | T | | Incision of midfoot bones | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28305 | T | | Incise/graft midfoot bones | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28306 | T | | Incision of metatarsal | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28307 | T | | Incision of metatarsal | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28308 | T | | Incision of metatarsal | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28309 | T | | Incision of metatarsals | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28310 | T | | Revision of big toe | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28312 | T | | Revision of toe | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28313 | T | | Repair deformity of toe | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28315 | T | | Removal of sesamoid bone | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28320 | T | | Repair of foot bones | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28322 | T | | Repair of metatarsals | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28340 | T | | Resect enlarged toe tissue | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28341 | T | | Resect enlarged toe | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28344 | T | | Repair extra toe(s) | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28345 | T | | Repair webbed toe(s) | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28360 | T | | Reconstruct cleft foot | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28400 | T | | Treatment of heel fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28405 | T | | Treatment of heel fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28406 | T | | Treatment of heel fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28415 | T | | Treat heel fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28420 | T | | Treat/graft heel fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28430 | T | | Treatment of ankle fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28435 | T | | Treatment of ankle fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28436 | T | | Treatment of ankle fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28445 | T | | Treat ankle fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28450 | T | | Treat midfoot fracture, each | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28455 | T | | Treat midfoot fracture, each | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28456 | T | | Treat midfoot fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28465 | T | | Treat midfoot fracture, each | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28470 | T | | Treat metatarsal fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28475 | T | | Treat metatarsal fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28476 | T | | Treat metatarsal fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28485 | T | | Treat metatarsal fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28490 | T | | Treat big toe fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28495 | T | | Treat big toe fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28496 | T | | Treat big toe fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28505 | T | | Treat big toe fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28510 | T | | Treatment of toe fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28515 | T | | Treatment of toe fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28525 | T | | Treat toe fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28530 | T | | Treat sesamoid bone fracture | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28531 | T | | Treat sesamoid bone fracture | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28540 | T | | Treat foot dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28545 | T | | Treat foot dislocation | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 28546 | T | | Treat foot dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28555 | T | | Repair foot dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28570 | T | | Treat foot dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28575 | T | | Treat foot dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28576 | T | | Treat foot dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28585 | T | | Repair foot dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28600 | T | | Treat foot dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28605 | T | | Treat foot dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28606 | T | | Treat foot dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28615 | T | | Repair foot dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28630 | T | | Treat toe dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 28635 | T | | Treat toe dislocation | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 28636 | T | | Treat toe dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28645 | T | | Repair toe dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28660 | T | | Treat toe dislocation | 0043 | 1.9074 | $104.07 | | $20.81 |
| 28665 | T | | Treat toe dislocation | 0045 | 13.5889 | $741.42 | $268.47 | $148.28 |
| 28666 | T | | Treat toe dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28675 | T | | Repair of toe dislocation | 0046 | 32.5581 | $1,776.40 | $535.76 | $355.28 |
| 28705 | T | | Fusion of foot bones | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28715 | T | | Fusion of foot bones | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28725 | T | | Fusion of foot bones | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28730 | T | | Fusion of foot bones | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28735 | T | | Fusion of foot bones | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28737 | T | | Revision of foot bones | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28740 | T | | Fusion of foot bones | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28750 | T | | Fusion of big toe joint | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28755 | T | | Fusion of big toe joint | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28760 | T | | Fusion of big toe joint | 0056 | 25.3930 | $1,385.47 | $405.81 | $277.09 |
| 28800 | C | | Amputation of midfoot | | | | | |
| 28805 | C | | Amputation thru metatarsal | | | | | |
| 28810 | T | | Amputation toe & metatarsal | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28820 | T | | Amputation of toe | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28825 | T | | Partial amputation of toe | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 28899 | T | | Foot/toes surgery procedure | 0043 | 1.9074 | $104.07 | | $20.81 |
| 29000 | S | | Application of body cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29010 | S | | Application of body cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29015 | S | | Application of body cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29020 | S | | Application of body cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29025 | S | | Application of body cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29035 | S | | Application of body cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29040 | S | | Application of body cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29044 | S | | Application of body cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29046 | S | | Application of body cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29049 | S | | Application of figure eight | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29055 | S | | Application of shoulder cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29058 | S | | Application of shoulder cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29065 | S | | Application of long arm cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29075 | S | | Application of forearm cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29085 | S | | Apply hand/wrist cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29086 | S | | Apply finger cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29105 | S | | Apply long arm splint | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29125 | S | | Apply forearm splint | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29126 | S | | Apply forearm splint | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29130 | S | | Application of finger splint | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29131 | S | | Application of finger splint | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29200 | S | | Strapping of chest | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29220 | S | | Strapping of low back | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29240 | S | | Strapping of shoulder | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29260 | S | | Strapping of elbow or wrist | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29280 | S | | Strapping of hand or finger | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29305 | S | | Application of hip cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29325 | S | | Application of hip casts | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29345 | S | | Application of long leg cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29355 | S | | Application of long leg cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29358 | S | | Apply long leg cast brace | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29365 | S | | Application of long leg cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29405 | S | | Apply short leg cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29425 | S | | Apply short leg cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29435 | S | | Apply short leg cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29440 | S | | Addition of walker to cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29445 | S | | Apply rigid leg cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29450 | S | | Application of leg cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29505 | S | | Application, long leg splint | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29515 | S | | Application lower leg splint | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29520 | S | | Strapping of hip | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29530 | S | | Strapping of knee | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29540 | S | | Strapping of ankle | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29550 | S | | Strapping of toes | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29580 | S | | Application of paste boot | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29590 | S | | Application of foot splint | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29700 | S | | Removal/revision of cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29705 | S | | Removal/revision of cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29710 | S | | Removal/revision of cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29715 | S | | Removal/revision of cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29720 | S | | Repair of body cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29730 | S | | Windowing of cast | 0058 | 1.0931 | $59.64 | | $11.93 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 29740 | S | | Wedging of cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29750 | S | | Wedging of clubfoot cast | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29799 | S | | Casting/strapping procedure | 0058 | 1.0931 | $59.64 | | $11.93 |
| 29800 | T | | Jaw arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29804 | T | | Jaw arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29805 | T | | Shoulder arthroscopy, dx | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29806 | T | | Shoulder arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29807 | T | | Shoulder arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29819 | T | | Shoulder arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29820 | T | | Shoulder arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29821 | T | | Shoulder arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29822 | T | | Shoulder arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29823 | T | | Shoulder arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29824 | T | | Shoulder arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29825 | T | | Shoulder arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29826 | T | | Shoulder arthroscopy/surgery | 0042 | 43.0808 | $2,350.53 | $804.74 | $470.11 |
| 29827 | T | | Arthroscop rotator cuff repr | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29830 | T | | Elbow arthroscopy | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29834 | T | | Elbow arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29835 | T | | Elbow arthroscopy/surgery | 0042 | 43.0808 | $2,350.53 | $804.74 | $470.11 |
| 29836 | T | | Elbow arthroscopy/surgery | 0042 | 43.0808 | $2,350.53 | $804.74 | $470.11 |
| 29837 | T | | Elbow arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29838 | T | | Elbow arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29840 | T | | Wrist arthroscopy | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29843 | T | | Wrist arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29844 | T | | Wrist arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29845 | T | | Wrist arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29846 | T | | Wrist arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29847 | T | | Wrist arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29848 | T | | Wrist endoscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29850 | T | | Knee arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29851 | T | | Knee arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29855 | T | | Tibial arthroscopy/surgery | 0042 | 43.0808 | $2,350.53 | $804.74 | $470.11 |
| 29856 | T | | Tibial arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29860 | T | | Hip arthroscopy, dx | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29861 | T | | Hip arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29862 | T | | Hip arthroscopy/surgery | 0042 | 43.0808 | $2,350.53 | $804.74 | $470.11 |
| 29863 | T | | Hip arthroscopy/surgery | 0042 | 43.0808 | $2,350.53 | $804.74 | $470.11 |
| 29870 | T | | Knee arthroscopy, dx | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29871 | T | | Knee arthroscopy/drainage | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29873 | T | | Knee arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29874 | T | | Knee arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29875 | T | | Knee arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29876 | T | | Knee arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29877 | T | | Knee arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29879 | T | | Knee arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29880 | T | | Knee arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29881 | T | | Knee arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29882 | T | | Knee arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29883 | T | | Knee arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29884 | T | | Knee arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29885 | T | | Knee arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29886 | T | | Knee arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29887 | T | | Knee arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29888 | T | | Knee arthroscopy/surgery | 0042 | 43.0808 | $2,350.53 | $804.74 | $470.11 |
| 29889 | T | | Knee arthroscopy/surgery | 0042 | 43.0808 | $2,350.53 | $804.74 | $470.11 |
| 29891 | T | | Ankle arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29892 | T | | Ankle arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29893 | T | | Scope, plantar fasciotomy | 0055 | 18.7205 | $1,021.41 | $355.34 | $204.28 |
| 29894 | T | | Ankle arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29895 | T | | Ankle arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29897 | T | | Ankle arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29898 | T | | Ankle arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29899 | T | | Ankle arthroscopy/surgery | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 29900 | T | | Mcp joint arthroscopy, dx | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 29901 | T | | Mcp joint arthroscopy, surg | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 29902 | T | | Mcp joint arthroscopy, surg | 0053 | 14.8831 | $812.04 | $253.49 | $162.41 |
| 29999 | T | | Arthroscopy of joint | 0041 | 27.3819 | $1,493.98 | | $298.80 |
| 30000 | T | | Drainage of nose lesion | 0251 | 1.7880 | $97.56 | | $19.51 |
| 30020 | T | | Drainage of nose lesion | 0251 | 1.7880 | $97.56 | | $19.51 |
| 30100 | T | | Intranasal biopsy | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 30110 | T | | Removal of nose polyp(s) | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 30115 | T | | Removal of nose polyp(s) | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 30117 | T | | Removal of intranasal lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 30118 | T | | Removal of intranasal lesion | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 30120 | T | | Revision of nose | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 30124 | T | | Removal of nose lesion | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 30125 | T | | Removal of nose lesion | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 30130 | T | | Removal of turbinate bones | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 30140 | T | | Removal of turbinate bones | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 30150 | T | | Partial removal of nose | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 30160 | T | | Removal of nose | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 30200 | T | | Injection treatment of nose | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 30210 | T | | Nasal sinus therapy | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 30220 | T | | Insert nasal septal button | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 30300 | X | | Remove nasal foreign body | 0340 | 0.6314 | $34.45 | | $6.89 |
| 30310 | T | | Remove nasal foreign body | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 30320 | T | | Remove nasal foreign body | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 30400 | T | | Reconstruction of nose | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 30410 | T | | Reconstruction of nose | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 30420 | T | | Reconstruction of nose | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 30430 | T | | Revision of nose | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 30435 | T | | Revision of nose | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 30450 | T | | Revision of nose | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 30460 | T | | Revision of nose | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 30462 | T | | Revision of nose | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 30465 | T | | Repair nasal stenosis | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 30520 | T | | Repair of nasal septum | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 30540 | T | | Repair nasal defect | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 30545 | T | | Repair nasal defect | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 30560 | T | | Release of nasal adhesions | 0251 | 1.7880 | $97.56 | | $19.51 |
| 30580 | T | | Repair upper jaw fistula | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 30600 | T | | Repair mouth/nose fistula | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 30620 | T | | Intranasal reconstruction | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 30630 | T | | Repair nasal septum defect | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 30801 | T | | Cauterization, inner nose | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 30802 | T | | Cauterization, inner nose | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 30901 | T | | Control of nosebleed | 0250 | 1.4697 | $80.19 | $28.07 | $16.04 |
| 30903 | T | | Control of nosebleed | 0250 | 1.4697 | $80.19 | $28.07 | $16.04 |
| 30905 | T | | Control of nosebleed | 0250 | 1.4697 | $80.19 | $28.07 | $16.04 |
| 30906 | T | | Repeat control of nosebleed | 0250 | 1.4697 | $80.19 | $28.07 | $16.04 |
| 30915 | T | | Ligation, nasal sinus artery | 0091 | 28.8326 | $1,573.14 | $348.23 | $314.63 |
| 30920 | T | | Ligation, upper jaw artery | 0092 | 25.0959 | $1,369.26 | $505.37 | $273.85 |
| 30930 | T | | Therapy, fracture of nose | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 30999 | T | | Nasal surgery procedure | 0251 | 1.7880 | $97.56 | | $19.51 |
| 31000 | T | | Irrigation, maxillary sinus | 0251 | 1.7880 | $97.56 | | $19.51 |
| 31002 | T | | Irrigation, sphenoid sinus | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 31020 | T | | Exploration, maxillary sinus | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 31030 | T | | Exploration, maxillary sinus | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31032 | T | | Explore sinus, remove polyps | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31040 | T | | Exploration behind upper jaw | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 31050 | T | | Exploration, sphenoid sinus | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31051 | T | | Sphenoid sinus surgery | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31070 | T | | Exploration of frontal sinus | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 31075 | T | | Exploration of frontal sinus | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31080 | T | | Removal of frontal sinus | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31081 | T | | Removal of frontal sinus | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31084 | T | | Removal of frontal sinus | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31085 | T | | Removal of frontal sinus | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31086 | T | | Removal of frontal sinus | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31087 | T | | Removal of frontal sinus | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31090 | T | | Exploration of sinuses | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31200 | T | | Removal of ethmoid sinus | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31201 | T | | Removal of ethmoid sinus | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31205 | T | | Removal of ethmoid sinus | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31225 | C | | Removal of upper jaw | | | | | |
| 31230 | C | | Removal of upper jaw | | | | | |
| 31231 | T | | Nasal endoscopy, dx | 0071 | 0.8799 | $48.01 | $12.89 | $9.60 |
| 31233 | T | | Nasal/sinus endoscopy, dx | 0072 | 1.7613 | $96.10 | $26.68 | $19.22 |
| 31235 | T | | Nasal/sinus endoscopy, dx | 0074 | 13.9480 | $761.02 | $295.70 | $152.20 |
| 31237 | T | | Nasal/sinus endoscopy, surg | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31238 | T | | Nasal/sinus endoscopy, surg | 0074 | 13.9480 | $761.02 | $295.70 | $152.20 |
| 31239 | T | | Nasal/sinus endoscopy, surg | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31240 | T | | Nasal/sinus endoscopy, surg | 0074 | 13.9480 | $761.02 | $295.70 | $152.20 |
| 31254 | T | | Revision of ethmoid sinus | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31255 | T | | Removal of ethmoid sinus | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31256 | T | | Exploration maxillary sinus | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31267 | T | | Endoscopy, maxillary sinus | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31276 | T | | Sinus endoscopy, surgical | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31287 | T | | Nasal/sinus endoscopy, surg | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 31288 | T | | Nasal/sinus endoscopy, surg | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31290 | C | | Nasal/sinus endoscopy, surg | | | | | |
| 31291 | C | | Nasal/sinus endoscopy, surg | | | | | |
| 31292 | C | | Nasal/sinus endoscopy, surg | | | | | |
| 31293 | C | | Nasal/sinus endoscopy, surg | | | | | |
| 31294 | C | | Nasal/sinus endoscopy, surg | | | | | |
| 31299 | T | | Sinus surgery procedure | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 31300 | T | | Removal of larynx lesion | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 31320 | T | | Diagnostic incision, larynx | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31360 | C | | Removal of larynx | | | | | |
| 31365 | C | | Removal of larynx | | | | | |
| 31367 | C | | Partial removal of larynx | | | | | |
| 31368 | C | | Partial removal of larynx | | | | | |
| 31370 | C | | Partial removal of larynx | | | | | |
| 31375 | C | | Partial removal of larynx | | | | | |
| 31380 | C | | Partial removal of larynx | | | | | |
| 31382 | C | | Partial removal of larynx | | | | | |
| 31390 | C | | Removal of larynx & pharynx | | | | | |
| 31395 | C | | Reconstruct larynx & pharynx | | | | | |
| 31400 | T | | Revision of larynx | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31420 | T | | Removal of epiglottis | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31500 | S | | Insert emergency airway | 0094 | 2.6345 | $143.74 | $48.58 | $28.75 |
| 31502 | T | | Change of windpipe airway | 0121 | 2.1189 | $115.61 | $43.80 | $23.12 |
| 31505 | T | | Diagnostic laryngoscopy | 0071 | 0.8799 | $48.01 | $12.89 | $9.60 |
| 31510 | T | | Laryngoscopy with biopsy | 0074 | 13.9480 | $761.02 | $295.70 | $152.20 |
| 31511 | T | | Remove foreign body, larynx | 0072 | 1.7613 | $96.10 | $26.68 | $19.22 |
| 31512 | T | | Removal of larynx lesion | 0074 | 13.9480 | $761.02 | $295.70 | $152.20 |
| 31513 | T | | Injection into vocal cord | 0072 | 1.7613 | $96.10 | $26.68 | $19.22 |
| 31515 | T | | Laryngoscopy for aspiration | 0074 | 13.9480 | $761.02 | $295.70 | $152.20 |
| 31520 | T | | Diagnostic laryngoscopy | 0072 | 1.7613 | $96.10 | $26.68 | $19.22 |
| 31525 | T | | Diagnostic laryngoscopy | 0074 | 13.9480 | $761.02 | $295.70 | $152.20 |
| 31526 | T | | Diagnostic laryngoscopy | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31527 | T | | Laryngoscopy for treatment | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31528 | T | | Laryngoscopy and dilation | 0074 | 13.9480 | $761.02 | $295.70 | $152.20 |
| 31529 | T | | Laryngoscopy and dilation | 0074 | 13.9480 | $761.02 | $295.70 | $152.20 |
| 31530 | T | | Operative laryngoscopy | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31531 | T | | Operative laryngoscopy | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31535 | T | | Operative laryngoscopy | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31536 | T | | Operative laryngoscopy | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31540 | T | | Operative laryngoscopy | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31541 | T | | Operative laryngoscopy | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31560 | T | | Operative laryngoscopy | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31561 | T | | Operative laryngoscopy | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31570 | T | | Laryngoscopy with injection | 0074 | 13.9480 | $761.02 | $295.70 | $152.20 |
| 31571 | T | | Laryngoscopy with injection | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31575 | T | | Diagnostic laryngoscopy | 0072 | 1.7613 | $96.10 | $26.68 | $19.22 |
| 31576 | T | | Laryngoscopy with biopsy | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31577 | T | | Remove foreign body, larynx | 0073 | 3.4541 | $188.46 | $73.38 | $37.69 |
| 31578 | T | | Removal of larynx lesion | 0075 | 20.3815 | $1,112.04 | $445.92 | $222.41 |
| 31579 | T | | Diagnostic laryngoscopy | 0073 | 3.4541 | $188.46 | $73.38 | $37.69 |
| 31580 | T | | Revision of larynx | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31582 | T | | Revision of larynx | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31584 | C | | Treat larynx fracture | | | | | |
| 31585 | T | | Treat larynx fracture | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 31586 | T | | Treat larynx fracture | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31587 | C | | Revision of larynx | | | | | |
| 31588 | T | | Revision of larynx | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31590 | T | | Reinnervate larynx | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31595 | T | | Larynx nerve surgery | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31599 | T | | Larynx surgery procedure | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 31600 | T | | Incision of windpipe | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 31601 | T | | Incision of windpipe | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 31603 | T | | Incision of windpipe | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 31605 | T | | Incision of windpipe | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 31610 | T | | Incision of windpipe | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 31611 | T | | Surgery/speech prosthesis | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 31612 | T | | Puncture/clear windpipe | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 31613 | T | | Repair windpipe opening | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 31614 | T | | Repair windpipe opening | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31615 | T | | Visualization of windpipe | 0076 | 9.2346 | $503.85 | $189.82 | $100.77 |
| 31622 | T | | Dx bronchoscope/wash | 0076 | 9.2346 | $503.85 | $189.82 | $100.77 |
| 31623 | T | | Dx bronchoscope/brush | 0076 | 9.2346 | $503.85 | $189.82 | $100.77 |
| 31624 | T | | Dx bronchoscope/lavage | 0076 | 9.2346 | $503.85 | $189.82 | $100.77 |
| 31625 | T | | Bronchoscopy w/biopsy(s) | 0076 | 9.2346 | $503.85 | $189.82 | $100.77 |
| 31628 | T | | Bronchoscopy/lung bx, each | 0076 | 9.2346 | $503.85 | $189.82 | $100.77 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 31629 | T | | Bronchoscopy/needle bx, each | 0076 | 9.2346 | $503.85 | $189.82 | $100.77 |
| 31630 | T | | Bronchoscopy dilate/fx repr | 0415 | 20.7348 | $1,131.31 | $459.92 | $226.26 |
| 31631 | T | | Bronchoscopy, dilate w/stent | 0415 | 20.7348 | $1,131.31 | $459.92 | $226.26 |
| 31632 | T | NI | Bronchoscopy/lung bx, add'l | 0076 | 9.2346 | $503.85 | $189.82 | $100.77 |
| 31633 | T | NI | Bronchoscopy/needle bx add'l | 0076 | 9.2346 | $503.85 | $189.82 | $100.77 |
| 31635 | T | | Bronchoscopy w/fb removal | 0076 | 9.2346 | $503.85 | $189.82 | $100.77 |
| 31640 | T | | Bronchoscopy w/tumor excise | 0415 | 20.7348 | $1,131.31 | $459.92 | $226.26 |
| 31641 | T | | Bronchoscopy, treat blockage | 0415 | 20.7348 | $1,131.31 | $459.92 | $226.26 |
| 31643 | T | | Diag bronchoscope/catheter | 0076 | 9.2346 | $503.85 | $189.82 | $100.77 |
| 31645 | T | | Bronchoscopy, clear airways | 0076 | 9.2346 | $503.85 | $189.82 | $100.77 |
| 31646 | T | | Bronchoscopy, reclear airway | 0076 | 9.2346 | $503.85 | $189.82 | $100.77 |
| 31656 | T | | Bronchoscopy, inj for x-ray | 0076 | 9.2346 | $503.85 | $189.82 | $100.77 |
| 31700 | T | | Insertion of airway catheter | 0072 | 1.7613 | $96.10 | $26.68 | $19.22 |
| 31708 | N | | Instill airway contrast dye | | | | | |
| 31710 | N | | Insertion of airway catheter | | | | | |
| 31715 | N | | Injection for bronchus x-ray | | | | | |
| 31717 | T | | Bronchial brush biopsy | 0073 | 3.4541 | $188.46 | $73.38 | $37.69 |
| 31720 | T | | Clearance of airways | 0071 | 0.8799 | $48.01 | $12.89 | $9.60 |
| 31725 | C | | Clearance of airways | | | | | |
| 31730 | T | | Intro, windpipe wire/tube | 0073 | 3.4541 | $188.46 | $73.38 | $37.69 |
| 31750 | T | | Repair of windpipe | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31755 | T | | Repair of windpipe | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 31760 | C | | Repair of windpipe | | | | | |
| 31766 | C | | Reconstruction of windpipe | | | | | |
| 31770 | C | | Repair/graft of bronchus | | | | | |
| 31775 | C | | Reconstruct bronchus | | | | | |
| 31780 | C | | Reconstruct windpipe | | | | | |
| 31781 | C | | Reconstruct windpipe | | | | | |
| 31785 | T | | Remove windpipe lesion | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 31786 | C | | Remove windpipe lesion | | | | | |
| 31800 | C | | Repair of windpipe injury | | | | | |
| 31805 | C | | Repair of windpipe injury | | | | | |
| 31820 | T | | Closure of windpipe lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 31825 | T | | Repair of windpipe defect | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 31830 | T | | Revise windpipe scar | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 31899 | T | | Airways surgical procedure | 0076 | 9.2346 | $503.85 | $189.82 | $100.77 |
| 32000 | T | | Drainage of chest | 0070 | 3.0717 | $167.60 | | $33.52 |
| 32002 | T | | Treatment of collapsed lung | 0070 | 3.0717 | $167.60 | | $33.52 |
| 32005 | T | | Treat lung lining chemically | 0070 | 3.0717 | $167.60 | | $33.52 |
| 32020 | T | | Insertion of chest tube | 0070 | 3.0717 | $167.60 | | $33.52 |
| 32035 | C | | Exploration of chest | | | | | |
| 32036 | C | | Exploration of chest | | | | | |
| 32095 | C | | Biopsy through chest wall | | | | | |
| 32100 | C | | Exploration/biopsy of chest | | | | | |
| 32110 | C | | Explore/repair chest | | | | | |
| 32120 | C | | Re-exploration of chest | | | | | |
| 32124 | C | | Explore chest free adhesions | | | | | |
| 32140 | C | | Removal of lung lesion(s) | | | | | |
| 32141 | C | | Remove/treat lung lesions | | | | | |
| 32150 | C | | Removal of lung lesion(s) | | | | | |
| 32151 | C | | Remove lung foreign body | | | | | |
| 32160 | C | | Open chest heart massage | | | | | |
| 32200 | C | | Drain, open, lung lesion | | | | | |
| 32201 | T | | Drain, percut, lung lesion | 0070 | 3.0717 | $167.60 | | $33.52 |
| 32215 | C | | Treat chest lining | | | | | |
| 32220 | C | | Release of lung | | | | | |
| 32225 | C | | Partial release of lung | | | | | |
| 32310 | C | | Removal of chest lining | | | | | |
| 32320 | C | | Free/remove chest lining | | | | | |
| 32400 | T | | Needle biopsy chest lining | 0005 | 3.2698 | $178.40 | $71.59 | $35.68 |
| 32402 | C | | Open biopsy chest lining | | | | | |
| 32405 | T | | Biopsy, lung or mediastinum | 0685 | 4.8100 | $262.44 | $115.47 | $52.49 |
| 32420 | T | | Puncture/clear lung | 0070 | 3.0717 | $167.60 | | $33.52 |
| 32440 | C | | Removal of lung | | | | | |
| 32442 | C | | Sleeve pneumonectomy | | | | | |
| 32445 | C | | Removal of lung | | | | | |
| 32480 | C | | Partial removal of lung | | | | | |
| 32482 | C | | Bilobectomy | | | | | |
| 32484 | C | | Segmentectomy | | | | | |
| 32486 | C | | Sleeve lobectomy | | | | | |
| 32488 | C | | Completion pneumonectomy | | | | | |
| 32491 | C | | Lung volume reduction | | | | | |
| 32500 | C | | Partial removal of lung | | | | | |
| 32501 | C | | Repair bronchus add-on | | | | | |
| 32520 | C | | Remove lung & revise chest | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 32522 | C | | Remove lung & revise chest | | | | | |
| 32525 | C | | Remove lung & revise chest | | | | | |
| 32540 | C | | Removal of lung lesion | | | | | |
| 32601 | T | | Thoracoscopy, diagnostic | 0069 | 28.9392 | $1,578.95 | $591.64 | $315.79 |
| 32602 | T | | Thoracoscopy, diagnostic | 0069 | 28.9392 | $1,578.95 | $591.64 | $315.79 |
| 32603 | T | | Thoracoscopy, diagnostic | 0069 | 28.9392 | $1,578.95 | $591.64 | $315.79 |
| 32604 | T | | Thoracoscopy, diagnostic | 0069 | 28.9392 | $1,578.95 | $591.64 | $315.79 |
| 32605 | T | | Thoracoscopy, diagnostic | 0069 | 28.9392 | $1,578.95 | $591.64 | $315.79 |
| 32606 | T | | Thoracoscopy, diagnostic | 0069 | 28.9392 | $1,578.95 | $591.64 | $315.79 |
| 32650 | C | | Thoracoscopy, surgical | | | | | |
| 32651 | C | | Thoracoscopy, surgical | | | | | |
| 32652 | C | | Thoracoscopy, surgical | | | | | |
| 32653 | C | | Thoracoscopy, surgical | | | | | |
| 32654 | C | | Thoracoscopy, surgical | | | | | |
| 32655 | C | | Thoracoscopy, surgical | | | | | |
| 32656 | C | | Thoracoscopy, surgical | | | | | |
| 32657 | C | | Thoracoscopy, surgical | | | | | |
| 32658 | C | | Thoracoscopy, surgical | | | | | |
| 32659 | C | | Thoracoscopy, surgical | | | | | |
| 32660 | C | | Thoracoscopy, surgical | | | | | |
| 32661 | C | | Thoracoscopy, surgical | | | | | |
| 32662 | C | | Thoracoscopy, surgical | | | | | |
| 32663 | C | | Thoracoscopy, surgical | | | | | |
| 32664 | C | | Thoracoscopy, surgical | | | | | |
| 32665 | C | | Thoracoscopy, surgical | | | | | |
| 32800 | C | | Repair lung hernia | | | | | |
| 32810 | C | | Close chest after drainage | | | | | |
| 32815 | C | | Close bronchial fistula | | | | | |
| 32820 | C | | Reconstruct injured chest | | | | | |
| 32850 | C | | Donor pneumonectomy | | | | | |
| 32851 | C | | Lung transplant, single | | | | | |
| 32852 | C | | Lung transplant with bypass | | | | | |
| 32853 | C | | Lung transplant, double | | | | | |
| 32854 | C | | Lung transplant with bypass | | | | | |
| 32900 | C | | Removal of rib(s) | | | | | |
| 32905 | C | | Revise & repair chest wall | | | | | |
| 32906 | C | | Revise & repair chest wall | | | | | |
| 32940 | C | | Revision of lung | | | | | |
| 32960 | T | | Therapeutic pneumothorax | 0070 | 3.0717 | $167.60 | | $33.52 |
| 32997 | C | | Total lung lavage | | | | | |
| 32999 | T | | Chest surgery procedure | 0070 | 3.0717 | $167.60 | | $33.52 |
| 33010 | T | | Drainage of heart sac | 0070 | 3.0717 | $167.60 | | $33.52 |
| 33011 | T | | Repeat drainage of heart sac | 0070 | 3.0717 | $167.60 | | $33.52 |
| 33015 | C | | Incision of heart sac | | | | | |
| 33020 | C | | Incision of heart sac | | | | | |
| 33025 | C | | Incision of heart sac | | | | | |
| 33030 | C | | Partial removal of heart sac | | | | | |
| 33031 | C | | Partial removal of heart sac | | | | | |
| 33050 | C | | Removal of heart sac lesion | | | | | |
| 33120 | C | | Removal of heart lesion | | | | | |
| 33130 | C | | Removal of heart lesion | | | | | |
| 33140 | C | | Heart revascularize (tmr) | | | | | |
| 33141 | C | | Heart tmr w/other procedure | | | | | |
| 33200 | C | | Insertion of heart pacemaker | | | | | |
| 33201 | C | | Insertion of heart pacemaker | | | | | |
| 33206 | T | | Insertion of heart pacemaker | 0089 | 117.1896 | $6,393.98 | $1,722.59 | $1,278.80 |
| 33207 | T | | Insertion of heart pacemaker | 0089 | 117.1896 | $6,393.98 | $1,722.59 | $1,278.80 |
| 33208 | T | | Insertion of heart pacemaker | 0655 | 142.7039 | $7,786.07 | | $1,557.21 |
| 33210 | T | | Insertion of heart electrode | 0106 | 58.9719 | $3,217.57 | | $643.51 |
| 33211 | T | | Insertion of heart electrode | 0106 | 58.9719 | $3,217.57 | | $643.51 |
| 33212 | T | | Insertion of pulse generator | 0090 | 96.8284 | $5,283.05 | $1,651.45 | $1,056.61 |
| 33213 | T | | Insertion of pulse generator | 0654 | 112.6957 | $6,148.79 | | $1,229.76 |
| 33214 | T | | Upgrade of pacemaker system | 0655 | 142.7039 | $7,786.07 | | $1,557.21 |
| 33215 | T | | Reposition pacing-defib lead | 0105 | 19.1898 | $1,047.01 | $370.40 | $209.40 |
| 33216 | T | | Revise eltrd pacing-defib | 0106 | 58.9719 | $3,217.57 | | $643.51 |
| 33217 | T | | Insert lead pace-defib, dual | 0106 | 58.9719 | $3,217.57 | | $643.51 |
| 33218 | T | | Repair lead pace-defib, one | 0106 | 58.9719 | $3,217.57 | | $643.51 |
| 33220 | T | | Repair lead pace-defib, dual | 0106 | 58.9719 | $3,217.57 | | $643.51 |
| 33222 | T | | Revise pocket, pacemaker | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 33223 | T | | Revise pocket, pacing-defib | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 33224 | T | | Insert pacing lead & connect | 1547 | | $850.00 | | $170.00 |
| 33225 | T | | L ventric pacing lead add-on | 1550 | | $1,150.00 | | $230.00 |
| 33226 | T | | Reposition l ventric lead | 0105 | 19.1898 | $1,047.01 | $370.40 | $209.40 |
| 33233 | T | | Removal of pacemaker system | 0105 | 19.1898 | $1,047.01 | $370.40 | $209.40 |
| 33234 | T | | Removal of pacemaker system | 0105 | 19.1898 | $1,047.01 | $370.40 | $209.40 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 33235 | T | | Removal pacemaker electrode | 0105 | 19.1898 | $1,047.01 | $370.40 | $209.40 |
| 33236 | C | | Remove electrode/thoracotomy | | | | | |
| 33237 | C | | Remove electrode/thoracotomy | | | | | |
| 33238 | C | | Remove electrode/thoracotomy | | | | | |
| 33240 | B | | Insert pulse generator | | | | | |
| 33241 | T | | Remove pulse generator | 0105 | 19.1898 | $1,047.01 | $370.40 | $209.40 |
| 33243 | C | | Remove eltrd/thoracotomy | | | | | |
| 33244 | T | | Remove eltrd, transven | 0105 | 19.1898 | $1,047.01 | $370.40 | $209.40 |
| 33245 | C | | Insert epic eltrd pace-defib | | | | | |
| 33246 | C | | Insert epic eltrd/generator | | | | | |
| 33249 | B | | Eltrd/insert pace-defib | | | | | |
| 33250 | C | | Ablate heart dysrhythm focus | | | | | |
| 33251 | C | | Ablate heart dysrhythm focus | | | | | |
| 33253 | C | | Reconstruct atria | | | | | |
| 33261 | C | | Ablate heart dysrhythm focus | | | | | |
| 33282 | S | | Implant pat-active ht record | 0680 | 62.8252 | $3,427.81 | | $685.56 |
| 33284 | T | | Remove pat-active ht record | 0109 | 7.4705 | $407.60 | $131.49 | $81.52 |
| 33300 | C | | Repair of heart wound | | | | | |
| 33305 | C | | Repair of heart wound | | | | | |
| 33310 | C | | Exploratory heart surgery | | | | | |
| 33315 | C | | Exploratory heart surgery | | | | | |
| 33320 | C | | Repair major blood vessel(s) | | | | | |
| 33321 | C | | Repair major vessel | | | | | |
| 33322 | C | | Repair major blood vessel(s) | | | | | |
| 33330 | C | | Insert major vessel graft | | | | | |
| 33332 | C | | Insert major vessel graft | | | | | |
| 33335 | C | | Insert major vessel graft | | | | | |
| 33400 | C | | Repair of aortic valve | | | | | |
| 33401 | C | | Valvuloplasty, open | | | | | |
| 33403 | C | | Valvuloplasty, w/cp bypass | | | | | |
| 33404 | C | | Prepare heart-aorta conduit | | | | | |
| 33405 | C | | Replacement of aortic valve | | | | | |
| 33406 | C | | Replacement of aortic valve | | | | | |
| 33410 | C | | Replacement of aortic valve | | | | | |
| 33411 | C | | Replacement of aortic valve | | | | | |
| 33412 | C | | Replacement of aortic valve | | | | | |
| 33413 | C | | Replacement of aortic valve | | | | | |
| 33414 | C | | Repair of aortic valve | | | | | |
| 33415 | C | | Revision, subvalvular tissue | | | | | |
| 33416 | C | | Revise ventricle muscle | | | | | |
| 33417 | C | | Repair of aortic valve | | | | | |
| 33420 | C | | Revision of mitral valve | | | | | |
| 33422 | C | | Revision of mitral valve | | | | | |
| 33425 | C | | Repair of mitral valve | | | | | |
| 33426 | C | | Repair of mitral valve | | | | | |
| 33427 | C | | Repair of mitral valve | | | | | |
| 33430 | C | | Replacement of mitral valve | | | | | |
| 33460 | C | | Revision of tricuspid valve | | | | | |
| 33463 | C | | Valvuloplasty, tricuspid | | | | | |
| 33464 | C | | Valvuloplasty, tricuspid | | | | | |
| 33465 | C | | Replace tricuspid valve | | | | | |
| 33468 | C | | Revision of tricuspid valve | | | | | |
| 33470 | C | | Revision of pulmonary valve | | | | | |
| 33471 | C | | Valvotomy, pulmonary valve | | | | | |
| 33472 | C | | Revision of pulmonary valve | | | | | |
| 33474 | C | | Revision of pulmonary valve | | | | | |
| 33475 | C | | Replacement, pulmonary valve | | | | | |
| 33476 | C | | Revision of heart chamber | | | | | |
| 33478 | C | | Revision of heart chamber | | | | | |
| 33496 | C | | Repair, prosth valve clot | | | | | |
| 33500 | C | | Repair heart vessel fistula | | | | | |
| 33501 | C | | Repair heart vessel fistula | | | | | |
| 33502 | C | | Coronary artery correction | | | | | |
| 33503 | C | | Coronary artery graft | | | | | |
| 33504 | C | | Coronary artery graft | | | | | |
| 33505 | C | | Repair artery w/tunnel | | | | | |
| 33506 | C | | Repair artery, translocation | | | | | |
| 33508 | N | | Endoscopic vein harvest | | | | | |
| 33510 | C | | CABG, vein, single | | | | | |
| 33511 | C | | CABG, vein, two | | | | | |
| 33512 | C | | CABG, vein, three | | | | | |
| 33513 | C | | CABG, vein, four | | | | | |
| 33514 | C | | CABG, vein, five | | | | | |
| 33516 | C | | Cabg, vein, six or more | | | | | |
| 33517 | C | | CABG, artery-vein, single | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 33518 | C | | CABG, artery-vein, two | | | | | |
| 33519 | C | | CABG, artery-vein, three | | | | | |
| 33521 | C | | CABG, artery-vein, four | | | | | |
| 33522 | C | | CABG, artery-vein, five | | | | | |
| 33523 | C | | Cabg, art-vein, six or more | | | | | |
| 33530 | C | | Coronary artery, bypass/reop | | | | | |
| 33533 | C | | CABG, arterial, single | | | | | |
| 33534 | C | | CABG, arterial, two | | | | | |
| 33535 | C | | CABG, arterial, three | | | | | |
| 33536 | C | | Cabg, arterial, four or more | | | | | |
| 33542 | C | | Removal of heart lesion | | | | | |
| 33545 | C | | Repair of heart damage | | | | | |
| 33572 | C | | Open coronary endarterectomy | | | | | |
| 33600 | C | | Closure of valve | | | | | |
| 33602 | C | | Closure of valve | | | | | |
| 33606 | C | | Anastomosis/artery-aorta | | | | | |
| 33608 | C | | Repair anomaly w/conduit | | | | | |
| 33610 | C | | Repair by enlargement | | | | | |
| 33611 | C | | Repair double ventricle | | | | | |
| 33612 | C | | Repair double ventricle | | | | | |
| 33615 | C | | Repair, modified fontan | | | | | |
| 33617 | C | | Repair single ventricle | | | | | |
| 33619 | C | | Repair single ventricle | | | | | |
| 33641 | C | | Repair heart septum defect | | | | | |
| 33645 | C | | Revision of heart veins | | | | | |
| 33647 | C | | Repair heart septum defects | | | | | |
| 33660 | C | | Repair of heart defects | | | | | |
| 33665 | C | | Repair of heart defects | | | | | |
| 33670 | C | | Repair of heart chambers | | | | | |
| 33681 | C | | Repair heart septum defect | | | | | |
| 33684 | C | | Repair heart septum defect | | | | | |
| 33688 | C | | Repair heart septum defect | | | | | |
| 33690 | C | | Reinforce pulmonary artery | | | | | |
| 33692 | C | | Repair of heart defects | | | | | |
| 33694 | C | | Repair of heart defects | | | | | |
| 33697 | C | | Repair of heart defects | | | | | |
| 33702 | C | | Repair of heart defects | | | | | |
| 33710 | C | | Repair of heart defects | | | | | |
| 33720 | C | | Repair of heart defect | | | | | |
| 33722 | C | | Repair of heart defect | | | | | |
| 33730 | C | | Repair heart-vein defect(s) | | | | | |
| 33732 | C | | Repair heart-vein defect | | | | | |
| 33735 | C | | Revision of heart chamber | | | | | |
| 33736 | C | | Revision of heart chamber | | | | | |
| 33737 | C | | Revision of heart chamber | | | | | |
| 33750 | C | | Major vessel shunt | | | | | |
| 33755 | C | | Major vessel shunt | | | | | |
| 33762 | C | | Major vessel shunt | | | | | |
| 33764 | C | | Major vessel shunt & graft | | | | | |
| 33766 | C | | Major vessel shunt | | | | | |
| 33767 | C | | Major vessel shunt | | | | | |
| 33770 | C | | Repair great vessels defect | | | | | |
| 33771 | C | | Repair great vessels defect | | | | | |
| 33774 | C | | Repair great vessels defect | | | | | |
| 33775 | C | | Repair great vessels defect | | | | | |
| 33776 | C | | Repair great vessels defect | | | | | |
| 33777 | C | | Repair great vessels defect | | | | | |
| 33778 | C | | Repair great vessels defect | | | | | |
| 33779 | C | | Repair great vessels defect | | | | | |
| 33780 | C | | Repair great vessels defect | | | | | |
| 33781 | C | | Repair great vessels defect | | | | | |
| 33786 | C | | Repair arterial trunk | | | | | |
| 33788 | C | | Revision of pulmonary artery | | | | | |
| 33800 | C | | Aortic suspension | | | | | |
| 33802 | C | | Repair vessel defect | | | | | |
| 33803 | C | | Repair vessel defect | | | | | |
| 33813 | C | | Repair septal defect | | | | | |
| 33814 | C | | Repair septal defect | | | | | |
| 33820 | C | | Revise major vessel | | | | | |
| 33822 | C | | Revise major vessel | | | | | |
| 33824 | C | | Revise major vessel | | | | | |
| 33840 | C | | Remove aorta constriction | | | | | |
| 33845 | C | | Remove aorta constriction | | | | | |
| 33851 | C | | Remove aorta constriction | | | | | |
| 33852 | C | | Repair septal defect | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 33853 | C | | Repair septal defect | | | | | |
| 33860 | C | | Ascending aortic graft | | | | | |
| 33861 | C | | Ascending aortic graft | | | | | |
| 33863 | C | | Ascending aortic graft | | | | | |
| 33870 | C | | Transverse aortic arch graft | | | | | |
| 33875 | C | | Thoracic aortic graft | | | | | |
| 33877 | C | | Thoracoabdominal graft | | | | | |
| 33910 | C | | Remove lung artery emboli | | | | | |
| 33915 | C | | Remove lung artery emboli | | | | | |
| 33916 | C | | Surgery of great vessel | | | | | |
| 33917 | C | | Repair pulmonary artery | | | | | |
| 33918 | C | | Repair pulmonary atresia | | | | | |
| 33919 | C | | Repair pulmonary atresia | | | | | |
| 33920 | C | | Repair pulmonary atresia | | | | | |
| 33922 | C | | Transect pulmonary artery | | | | | |
| 33924 | C | | Remove pulmonary shunt | | | | | |
| 33930 | C | | Removal of donor heart/lung | | | | | |
| 33935 | C | | Transplantation, heart/lung | | | | | |
| 33940 | C | | Removal of donor heart | | | | | |
| 33945 | C | | Transplantation of heart | | | | | |
| 33960 | C | | External circulation assist | | | | | |
| 33961 | C | | External circulation assist | | | | | |
| 33967 | C | | Insert ia percut device | | | | | |
| 33968 | C | | Remove aortic assist device | | | | | |
| 33970 | C | | Aortic circulation assist | | | | | |
| 33971 | C | | Aortic circulation assist | | | | | |
| 33973 | C | | Insert balloon device | | | | | |
| 33974 | C | | Remove intra-aortic balloon | | | | | |
| 33975 | C | | Implant ventricular device | | | | | |
| 33976 | C | | Implant ventricular device | | | | | |
| 33977 | C | | Remove ventricular device | | | | | |
| 33978 | C | | Remove ventricular device | | | | | |
| 33979 | C | | Insert intracorporeal device | | | | | |
| 33980 | C | | Remove intracorporeal device | | | | | |
| 33999 | T | | Cardiac surgery procedure | 0070 | 3.0717 | $167.60 | | $33.52 |
| 34001 | C | | Removal of artery clot | | | | | |
| 34051 | C | | Removal of artery clot | | | | | |
| 34101 | T | | Removal of artery clot | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 34111 | T | | Removal of arm artery clot | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 34151 | C | | Removal of artery clot | | | | | |
| 34201 | T | | Removal of artery clot | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 34203 | T | | Removal of leg artery clot | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 34401 | C | | Removal of vein clot | | | | | |
| 34421 | T | | Removal of vein clot | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 34451 | C | | Removal of vein clot | | | | | |
| 34471 | T | | Removal of vein clot | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 34490 | T | | Removal of vein clot | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 34501 | T | | Repair valve, femoral vein | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 34502 | C | | Reconstruct vena cava | | | | | |
| 34510 | T | | Transposition of vein valve | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 34520 | T | | Cross-over vein graft | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 34530 | T | | Leg vein fusion | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 34800 | C | | Endovasc abdo repair w/tube | | | | | |
| 34802 | C | | Endovasc abdo repr w/device | | | | | |
| 34804 | C | | Endovasc abdo repr w/device | | | | | |
| 34805 | C | NI | Endovasc abdo repair w/pros | | | | | |
| 34808 | C | | Endovasc abdo occlud device | | | | | |
| 34812 | C | | Xpose for endoprosth, aortic | | | | | |
| 34813 | C | | Femoral endovas graft add-on | | | | | |
| 34820 | C | | Xpose for endoprosth, iliac | | | | | |
| 34825 | C | | Endovasc extend prosth, init | | | | | |
| 34826 | C | | Endovasc exten prosth, add'l | | | | | |
| 34830 | C | | Open aortic tube prosth repr | | | | | |
| 34831 | C | | Open aortoiliac prosth repr | | | | | |
| 34832 | C | | Open aortofemor prosth repr | | | | | |
| 34833 | C | | Xpose for endoprosth, iliac | | | | | |
| 34834 | C | | Xpose, endoprosth, brachial | | | | | |
| 34900 | C | | Endovasc iliac repr w/graft | | | | | |
| 35001 | C | | Repair defect of artery | | | | | |
| 35002 | C | | Repair artery rupture, neck | | | | | |
| 35005 | C | | Repair defect of artery | | | | | |
| 35011 | T | | Repair defect of artery | 0653 | 30.0334 | $1,638.65 | | $327.73 |
| 35013 | C | | Repair artery rupture, arm | | | | | |
| 35021 | C | | Repair defect of artery | | | | | |
| 35022 | C | | Repair artery rupture, chest | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 35045 | C | | Repair defect of arm artery | | | | | |
| 35081 | C | | Repair defect of artery | | | | | |
| 35082 | C | | Repair artery rupture, aorta | | | | | |
| 35091 | C | | Repair defect of artery | | | | | |
| 35092 | C | | Repair artery rupture, aorta | | | | | |
| 35102 | C | | Repair defect of artery | | | | | |
| 35103 | C | | Repair artery rupture, groin | | | | | |
| 35111 | C | | Repair defect of artery | | | | | |
| 35112 | C | | Repair artery rupture,spleen | | | | | |
| 35121 | C | | Repair defect of artery | | | | | |
| 35122 | C | | Repair artery rupture, belly | | | | | |
| 35131 | C | | Repair defect of artery | | | | | |
| 35132 | C | | Repair artery rupture, groin | | | | | |
| 35141 | C | | Repair defect of artery | | | | | |
| 35142 | C | | Repair artery rupture, thigh | | | | | |
| 35151 | C | | Repair defect of artery | | | | | |
| 35152 | C | | Repair artery rupture, knee | | | | | |
| 35161 | C | | Repair defect of artery | | | | | |
| 35162 | C | | Repair artery rupture | | | | | |
| 35180 | T | | Repair blood vessel lesion | 0093 | 21.3104 | $1,162.72 | $277.34 | $232.54 |
| 35182 | C | | Repair blood vessel lesion | | | | | |
| 35184 | T | | Repair blood vessel lesion | 0093 | 21.3104 | $1,162.72 | $277.34 | $232.54 |
| 35188 | T | | Repair blood vessel lesion | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 35189 | C | | Repair blood vessel lesion | | | | | |
| 35190 | T | | Repair blood vessel lesion | 0093 | 21.3104 | $1,162.72 | $277.34 | $232.54 |
| 35201 | T | | Repair blood vessel lesion | 0093 | 21.3104 | $1,162.72 | $277.34 | $232.54 |
| 35206 | T | | Repair blood vessel lesion | 0093 | 21.3104 | $1,162.72 | $277.34 | $232.54 |
| 35207 | T | | Repair blood vessel lesion | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 35211 | C | | Repair blood vessel lesion | | | | | |
| 35216 | C | | Repair blood vessel lesion | | | | | |
| 35221 | C | | Repair blood vessel lesion | | | | | |
| 35226 | T | | Repair blood vessel lesion | 0093 | 21.3104 | $1,162.72 | $277.34 | $232.54 |
| 35231 | T | | Repair blood vessel lesion | 0093 | 21.3104 | $1,162.72 | $277.34 | $232.54 |
| 35236 | T | | Repair blood vessel lesion | 0093 | 21.3104 | $1,162.72 | $277.34 | $232.54 |
| 35241 | C | | Repair blood vessel lesion | | | | | |
| 35246 | C | | Repair blood vessel lesion | | | | | |
| 35251 | C | | Repair blood vessel lesion | | | | | |
| 35256 | T | | Repair blood vessel lesion | 0093 | 21.3104 | $1,162.72 | $277.34 | $232.54 |
| 35261 | T | | Repair blood vessel lesion | 0653 | 30.0334 | $1,638.65 | | $327.73 |
| 35266 | T | | Repair blood vessel lesion | 0653 | 30.0334 | $1,638.65 | | $327.73 |
| 35271 | C | | Repair blood vessel lesion | | | | | |
| 35276 | C | | Repair blood vessel lesion | | | | | |
| 35281 | C | | Repair blood vessel lesion | | | | | |
| 35286 | T | | Repair blood vessel lesion | 0653 | 30.0334 | $1,638.65 | | $327.73 |
| 35301 | C | | Rechanneling of artery | | | | | |
| 35311 | C | | Rechanneling of artery | | | | | |
| 35321 | T | | Rechanneling of artery | 0093 | 21.3104 | $1,162.72 | $277.34 | $232.54 |
| 35331 | C | | Rechanneling of artery | | | | | |
| 35341 | C | | Rechanneling of artery | | | | | |
| 35351 | C | | Rechanneling of artery | | | | | |
| 35355 | C | | Rechanneling of artery | | | | | |
| 35361 | C | | Rechanneling of artery | | | | | |
| 35363 | C | | Rechanneling of artery | | | | | |
| 35371 | C | | Rechanneling of artery | | | | | |
| 35372 | C | | Rechanneling of artery | | | | | |
| 35381 | C | | Rechanneling of artery | | | | | |
| 35390 | C | | Reoperation, carotid add-on | | | | | |
| 35400 | C | | Angioscopy | | | | | |
| 35450 | C | | Repair arterial blockage | | | | | |
| 35452 | C | | Repair arterial blockage | | | | | |
| 35454 | C | | Repair arterial blockage | | | | | |
| 35456 | C | | Repair arterial blockage | | | | | |
| 35458 | T | | Repair arterial blockage | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35459 | T | | Repair arterial blockage | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35460 | T | | Repair venous blockage | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35470 | T | | Repair arterial blockage | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35471 | T | | Repair arterial blockage | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35472 | T | | Repair arterial blockage | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35473 | T | | Repair arterial blockage | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35474 | T | | Repair arterial blockage | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35475 | T | | Repair arterial blockage | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35476 | T | | Repair venous blockage | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35480 | C | | Atherectomy, open | | | | | |
| 35481 | C | | Atherectomy, open | | | | | |
| 35482 | C | | Atherectomy, open | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 35483 | C | | Atherectomy, open | | | | | |
| 35484 | T | | Atherectomy, open | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35485 | T | | Atherectomy, open | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35490 | T | | Atherectomy, percutaneous | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35491 | T | | Atherectomy, percutaneous | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35492 | T | | Atherectomy, percutaneous | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35493 | T | | Atherectomy, percutaneous | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35494 | T | | Atherectomy, percutaneous | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35495 | T | | Atherectomy, percutaneous | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35500 | T | | Harvest vein for bypass | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 35501 | C | | Artery bypass graft | | | | | |
| 35506 | C | | Artery bypass graft | | | | | |
| 35507 | C | | Artery bypass graft | | | | | |
| 35508 | C | | Artery bypass graft | | | | | |
| 35509 | C | | Artery bypass graft | | | | | |
| 35510 | C | NI | Artery bypass graft | | | | | |
| 35511 | C | | Artery bypass graft | | | | | |
| 35512 | C | NI | Artery bypass graft | | | | | |
| 35515 | C | | Artery bypass graft | | | | | |
| 35516 | C | | Artery bypass graft | | | | | |
| 35518 | C | | Artery bypass graft | | | | | |
| 35521 | C | | Artery bypass graft | | | | | |
| 35522 | C | NI | Artery bypass graft | | | | | |
| 35525 | C | NI | Artery bypass graft | | | | | |
| 35526 | C | | Artery bypass graft | | | | | |
| 35531 | C | | Artery bypass graft | | | | | |
| 35533 | C | | Artery bypass graft | | | | | |
| 35536 | C | | Artery bypass graft | | | | | |
| 35541 | C | | Artery bypass graft | | | | | |
| 35546 | C | | Artery bypass graft | | | | | |
| 35548 | C | | Artery bypass graft | | | | | |
| 35549 | C | | Artery bypass graft | | | | | |
| 35551 | C | | Artery bypass graft | | | | | |
| 35556 | C | | Artery bypass graft | | | | | |
| 35558 | C | | Artery bypass graft | | | | | |
| 35560 | C | | Artery bypass graft | | | | | |
| 35563 | C | | Artery bypass graft | | | | | |
| 35565 | C | | Artery bypass graft | | | | | |
| 35566 | C | | Artery bypass graft | | | | | |
| 35571 | C | | Artery bypass graft | | | | | |
| 35572 | N | | Harvest femoropopliteal vein | | | | | |
| 35582 | C | | Vein bypass graft | | | | | |
| 35583 | C | | Vein bypass graft | | | | | |
| 35585 | C | | Vein bypass graft | | | | | |
| 35587 | C | | Vein bypass graft | | | | | |
| 35600 | C | | Harvest artery for cabg | | | | | |
| 35601 | C | | Artery bypass graft | | | | | |
| 35606 | C | | Artery bypass graft | | | | | |
| 35612 | C | | Artery bypass graft | | | | | |
| 35616 | C | | Artery bypass graft | | | | | |
| 35621 | C | | Artery bypass graft | | | | | |
| 35623 | C | | Bypass graft, not vein | | | | | |
| 35626 | C | | Artery bypass graft | | | | | |
| 35631 | C | | Artery bypass graft | | | | | |
| 35636 | C | | Artery bypass graft | | | | | |
| 35641 | C | | Artery bypass graft | | | | | |
| 35642 | C | | Artery bypass graft | | | | | |
| 35645 | C | | Artery bypass graft | | | | | |
| 35646 | C | | Artery bypass graft | | | | | |
| 35647 | C | | Artery bypass graft | | | | | |
| 35650 | C | | Artery bypass graft | | | | | |
| 35651 | C | | Artery bypass graft | | | | | |
| 35654 | C | | Artery bypass graft | | | | | |
| 35656 | C | | Artery bypass graft | | | | | |
| 35661 | C | | Artery bypass graft | | | | | |
| 35663 | C | | Artery bypass graft | | | | | |
| 35665 | C | | Artery bypass graft | | | | | |
| 35666 | C | | Artery bypass graft | | | | | |
| 35671 | C | | Artery bypass graft | | | | | |
| 35681 | C | | Composite bypass graft | | | | | |
| 35682 | C | | Composite bypass graft | | | | | |
| 35683 | C | | Composite bypass graft | | | | | |
| 35685 | T | | Bypass graft patency/patch | 0093 | 21.3104 | $1,162.72 | $277.34 | $232.54 |
| 35686 | T | | Bypass graft/av fist patency | 0093 | 21.3104 | $1,162.72 | $277.34 | $232.54 |
| 35691 | C | | Arterial transposition | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 35693 | C | | Arterial transposition | | | | | |
| 35694 | C | | Arterial transposition | | | | | |
| 35695 | C | | Arterial transposition | | | | | |
| 35697 | C | NI | Reimplant artery each | | | | | |
| 35700 | C | | Reoperation, bypass graft | | | | | |
| 35701 | C | | Exploration, carotid artery | | | | | |
| 35721 | C | | Exploration, femoral artery | | | | | |
| 35741 | C | | Exploration popliteal artery | | | | | |
| 35761 | T | | Exploration of artery/vein | 0115 | 25.6437 | $1,399.15 | $459.35 | $279.83 |
| 35800 | C | | Explore neck vessels | | | | | |
| 35820 | C | | Explore chest vessels | | | | | |
| 35840 | C | | Explore abdominal vessels | | | | | |
| 35860 | T | | Explore limb vessels | 0093 | 21.3104 | $1,162.72 | $277.34 | $232.54 |
| 35870 | C | | Repair vessel graft defect | | | | | |
| 35875 | T | | Removal of clot in graft | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 35876 | T | | Removal of clot in graft | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 35879 | T | | Revise graft w/vein | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 35881 | T | | Revise graft w/vein | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 35901 | C | | Excision, graft, neck | | | | | |
| 35903 | T | | Excision, graft, extremity | 0115 | 25.6437 | $1,399.15 | $459.35 | $279.83 |
| 35905 | C | | Excision, graft, thorax | | | | | |
| 35907 | C | | Excision, graft, abdomen | | | | | |
| 36000 | N | | Place needle in vein | | | | | |
| 36002 | S | | Pseudoaneurysm injection trt | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 36005 | N | | Injection ext venography | | | | | |
| 36010 | N | | Place catheter in vein | | | | | |
| 36011 | N | | Place catheter in vein | | | | | |
| 36012 | N | | Place catheter in vein | | | | | |
| 36013 | N | | Place catheter in artery | | | | | |
| 36014 | N | | Place catheter in artery | | | | | |
| 36015 | N | | Place catheter in artery | | | | | |
| 36100 | N | | Establish access to artery | | | | | |
| 36120 | N | | Establish access to artery | | | | | |
| 36140 | N | | Establish access to artery | | | | | |
| 36145 | N | | Artery to vein shunt | | | | | |
| 36160 | N | | Establish access to aorta | | | | | |
| 36200 | N | | Place catheter in aorta | | | | | |
| 36215 | N | | Place catheter in artery | | | | | |
| 36216 | N | | Place catheter in artery | | | | | |
| 36217 | N | | Place catheter in artery | | | | | |
| 36218 | N | | Place catheter in artery | | | | | |
| 36245 | N | | Place catheter in artery | | | | | |
| 36246 | N | | Place catheter in artery | | | | | |
| 36247 | N | | Place catheter in artery | | | | | |
| 36248 | N | | Place catheter in artery | | | | | |
| 36260 | T | | Insertion of infusion pump | 0119 | 134.7194 | $7,350.43 | | $1,470.09 |
| 36261 | T | | Revision of infusion pump | 0124 | 23.8050 | $1,298.82 | | $259.76 |
| 36262 | T | | Removal of infusion pump | 0124 | 23.8050 | $1,298.82 | | $259.76 |
| 36299 | N | | Vessel injection procedure | | | | | |
| 36400 | N | | Bl draw < 3 yrs fem/jugular | | | | | |
| 36405 | N | | Bl draw < 3 yrs scalp vein | | | | | |
| 36406 | N | | Bl draw < 3 yrs other vein | | | | | |
| 36410 | N | | Non-routine bl draw > 3 yrs | | | | | |
| 36415 | E | | Drawing blood | | | | | |
| 36416 | E | | Capillary blood draw | | | | | |
| 36420 | T | | Vein access cutdown < 1 yr | 0035 | 0.1691 | $9.23 | $2.79 | $1.85 |
| 36425 | T | | Vein access cutdown > 1 yr | 0035 | 0.1691 | $9.23 | $2.79 | $1.85 |
| 36430 | S | | Blood transfusion service | 0110 | 3.6718 | $200.34 | | $40.07 |
| 36440 | S | | Bl push transfuse, 2 yr or < | 0110 | 3.6718 | $200.34 | | $40.07 |
| 36450 | S | | Bl exchange/transfuse, nb | 0110 | 3.6718 | $200.34 | | $40.07 |
| 36455 | S | | Bl exchange/transfuse non-nb | 0110 | 3.6718 | $200.34 | | $40.07 |
| 36460 | S | | Transfusion service, fetal | 0110 | 3.6718 | $200.34 | | $40.07 |
| 36468 | T | | Injection(s), spider veins | 0098 | 1.0729 | $58.54 | $14.06 | $11.71 |
| 36469 | T | | Injection(s), spider veins | 0098 | 1.0729 | $58.54 | $14.06 | $11.71 |
| 36470 | T | | Injection therapy of vein | 0098 | 1.0729 | $58.54 | $14.06 | $11.71 |
| 36471 | T | | Injection therapy of veins | 0098 | 1.0729 | $58.54 | $14.06 | $11.71 |
| 36481 | N | | Insertion of catheter, vein | | | | | |
| 36488 | T | DG | Insertion of catheter, vein | 0032 | 11.4907 | $626.94 | | $125.39 |
| 36489 | T | DG | Insertion of catheter, vein | 0032 | 11.4907 | $626.94 | | $125.39 |
| 36490 | T | DG | Insertion of catheter, vein | 0032 | 11.4907 | $626.94 | | $125.39 |
| 36491 | T | DG | Insertion of catheter, vein | 0032 | 11.4907 | $626.94 | | $125.39 |
| 36493 | X | DG | Repositioning of cvc | 0187 | 4.4288 | $241.64 | $90.71 | $48.33 |
| 36500 | N | | Insertion of catheter, vein | | | | | |
| 36510 | C | | Insertion of catheter, vein | | | | | |
| 36511 | S | | Apheresis wbc | 0111 | 13.1719 | $718.67 | $200.18 | $143.73 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 36512 | S | | Apheresis rbc | 0111 | 13.1719 | $718.67 | $200.18 | $143.73 |
| 36513 | S | | Apheresis platelets | 0111 | 13.1719 | $718.67 | $200.18 | $143.73 |
| 36514 | S | | Apheresis plasma | 0111 | 13.1719 | $718.67 | $200.18 | $143.73 |
| 36515 | S | | Apheresis, adsorp/reinfuse | 0112 | 37.5832 | $2,050.58 | $612.47 | $410.12 |
| 36516 | S | | Apheresis, selective | 0112 | 37.5832 | $2,050.58 | $612.47 | $410.12 |
| 36522 | S | | Photopheresis | 0112 | 37.5832 | $2,050.58 | $612.47 | $410.12 |
| 36530 | T | DG | Insertion of infusion pump | 0119 | 134.7194 | $7,350.43 | | $1,470.09 |
| 36531 | T | DG | Revision of infusion pump | 0124 | 23.8050 | $1,298.82 | | $259.76 |
| 36532 | T | DG | Removal of infusion pump | 0109 | 7.4705 | $407.60 | $131.49 | $81.52 |
| 36533 | T | DG | Insertion of access device | 0115 | 25.6437 | $1,399.15 | $459.35 | $279.83 |
| 36534 | T | DG | Revision of access device | 0109 | 7.4705 | $407.60 | $131.49 | $81.52 |
| 36535 | T | DG | Removal of access device | 0109 | 7.4705 | $407.60 | $131.49 | $81.52 |
| 36536 | T | DG | Remove cva device obstruct | 1541 | | $250.00 | | $50.00 |
| 36537 | T | DG | Remove cva lumen obstruct | 1541 | | $250.00 | | $50.00 |
| 36540 | N | | Collect blood venous device | | | | | |
| 36550 | T | | Declot vascular device | 0677 | 2.1805 | $118.97 | | $23.79 |
| 36555 | T | NI | Insert non-tunnel cv cath | 0032 | 11.4907 | $626.94 | | $125.39 |
| 36556 | T | NI | Insert non-tunnel cv cath | 0032 | 11.4907 | $626.94 | | $125.39 |
| 36557 | T | NI | Insert tunneled cv cath | 0032 | 11.4907 | $626.94 | | $125.39 |
| 36558 | T | NI | Insert tunneled cv cath | 0032 | 11.4907 | $626.94 | | $125.39 |
| 36560 | T | NI | Insert tunneled cv cath | 0115 | 25.6437 | $1,399.15 | $459.35 | $279.83 |
| 36561 | T | NI | Insert tunneled cv cath | 0115 | 25.6437 | $1,399.15 | $459.35 | $279.83 |
| 36563 | T | NI | Insert tunneled cv cath | 0115 | 25.6437 | $1,399.15 | $459.35 | $279.83 |
| 36565 | T | NI | Insert tunneled cv cath | 0115 | 25.6437 | $1,399.15 | $459.35 | $279.83 |
| 36566 | T | NI | Insert tunneled cv cath | 1564 | | $4,750.00 | | $950.00 |
| 36568 | T | NI | Insert tunneled cv cath | 0032 | 11.4907 | $626.94 | | $125.39 |
| 36569 | T | NI | Insert tunneled cv cath | 0032 | 11.4907 | $626.94 | | $125.39 |
| 36570 | T | NI | Insert tunneled cv cath | 0032 | 11.4907 | $626.94 | | $125.39 |
| 36571 | T | NI | Insert tunneled cv cath | 0032 | 11.4907 | $626.94 | | $125.39 |
| 36575 | X | NI | Repair tunneled cv cath | 0187 | 4.4288 | $241.64 | $90.71 | $48.33 |
| 36576 | X | NI | Repair tunneled cv cath | 0187 | 4.4288 | $241.64 | $90.71 | $48.33 |
| 36578 | X | NI | Replace tunneled cv cath | 0187 | 4.4288 | $241.64 | $90.71 | $48.33 |
| 36580 | T | NI | Replace tunneled cv cath | 0032 | 11.4907 | $626.94 | | $125.39 |
| 36581 | T | NI | Replace tunneled cv cath | 0032 | 11.4907 | $626.94 | | $125.39 |
| 36582 | T | NI | Replace tunneled cv cath | 0115 | 25.6437 | $1,399.15 | $459.35 | $279.83 |
| 36583 | T | NI | Replace tunneled cv cath | 0115 | 25.6437 | $1,399.15 | $459.35 | $279.83 |
| 36584 | T | NI | Replace tunneled cv cath | 0032 | 11.4907 | $626.94 | | $125.39 |
| 36585 | T | NI | Replace tunneled cv cath | 0032 | 11.4907 | $626.94 | | $125.39 |
| 36589 | X | NI | Removal tunneled cv cath | 0187 | 4.4288 | $241.64 | $90.71 | $48.33 |
| 36590 | T | NI | Removal tunneled cv cath | 0109 | 7.4705 | $407.60 | $131.49 | $81.52 |
| 36595 | T | NI | Mech remov tunneled cv cath | 1541 | | $250.00 | | $50.00 |
| 36596 | T | NI | Mech remov tunneled cv cath | 1541 | | $250.00 | | $50.00 |
| 36597 | X | NI | Reposition venous catheter | 0187 | 4.4288 | $241.64 | $90.71 | $48.33 |
| 36600 | N | | Withdrawal of arterial blood | | | | | |
| 36620 | N | | Insertion catheter, artery | | | | | |
| 36625 | N | | Insertion catheter, artery | | | | | |
| 36640 | T | | Insertion catheter, artery | 0032 | 11.4907 | $626.94 | | $125.39 |
| 36660 | C | | Insertion catheter, artery | | | | | |
| 36680 | T | | Insert needle, bone cavity | 0120 | 1.9114 | $104.29 | $28.21 | $20.86 |
| 36800 | T | | Insertion of cannula | 0115 | 25.6437 | $1,399.15 | $459.35 | $279.83 |
| 36810 | T | | Insertion of cannula | 0115 | 25.6437 | $1,399.15 | $459.35 | $279.83 |
| 36815 | T | | Insertion of cannula | 0115 | 25.6437 | $1,399.15 | $459.35 | $279.83 |
| 36819 | T | | Av fusion/uppr arm vein | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 36820 | T | | Av fusion/forearm vein | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 36821 | T | | Av fusion direct any site | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 36822 | C | | Insertion of cannula(s) | | | | | |
| 36823 | C | | Insertion of cannula(s) | | | | | |
| 36825 | T | | Artery-vein autograft | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 36830 | T | | Artery-vein graft | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 36831 | T | | Open thrombect av fistula | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 36832 | T | | Av fistula revision, open | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 36833 | T | | Av fistula revision | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 36834 | T | | Repair A-V aneurysm | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 36835 | T | | Artery to vein shunt | 0115 | 25.6437 | $1,399.15 | $459.35 | $279.83 |
| 36838 | T | NI | Dist revas ligation, hemo | 0088 | 34.6942 | $1,892.95 | $655.22 | $378.59 |
| 36860 | T | | External cannula declotting | 0103 | 11.6202 | $634.01 | $223.63 | $126.80 |
| 36861 | T | | Cannula declotting | 0115 | 25.6437 | $1,399.15 | $459.35 | $279.83 |
| 36870 | T | | Percut thrombect av fistula | 0653 | 30.0334 | $1,638.65 | | $327.73 |
| 37140 | C | | Revision of circulation | | | | | |
| 37145 | C | | Revision of circulation | | | | | |
| 37160 | C | | Revision of circulation | | | | | |
| 37180 | C | | Revision of circulation | | | | | |
| 37181 | C | | Splice spleen/kidney veins | | | | | |
| 37182 | C | | Insert hepatic shunt (tips) | | | | | |
| 37183 | C | | Remove hepatic shunt (tips) | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 37195 | C | | Thrombolytic therapy, stroke | | | | | |
| 37200 | T | | Transcatheter biopsy | 0685 | 4.8100 | $262.44 | $115.47 | $52.49 |
| 37201 | T | | Transcatheter therapy infuse | 0676 | 2.7315 | $149.03 | $40.30 | $29.81 |
| 37202 | T | | Transcatheter therapy infuse | 0677 | 2.1805 | $118.97 | | $23.79 |
| 37203 | T | | Transcatheter retrieval | 0103 | 11.6202 | $634.01 | $223.63 | $126.80 |
| 37204 | T | | Transcatheter occlusion | 0115 | 25.6437 | $1,399.15 | $459.35 | $279.83 |
| 37205 | T | | Transcatheter stent | 0229 | 61.9895 | $3,382.21 | $771.23 | $676.44 |
| 37206 | T | | Transcatheter stent add-on | 0229 | 61.9895 | $3,382.21 | $771.23 | $676.44 |
| 37207 | T | | Transcatheter stent | 0229 | 61.9895 | $3,382.21 | $771.23 | $676.44 |
| 37208 | T | | Transcatheter stent add-on | 0229 | 61.9895 | $3,382.21 | $771.23 | $676.44 |
| 37209 | T | | Exchange arterial catheter | 0103 | 11.6202 | $634.01 | $223.63 | $126.80 |
| 37250 | S | | Iv us first vessel add-on | 0670 | 27.4483 | $1,497.61 | $542.37 | $299.52 |
| 37251 | S | | Iv us each add vessel add-on | 0670 | 27.4483 | $1,497.61 | $542.37 | $299.52 |
| 37500 | T | | Endoscopy ligate perf veins | 0092 | 25.0959 | $1,369.26 | $505.37 | $273.85 |
| 37501 | T | | Vascular endoscopy procedure | 0092 | 25.0959 | $1,369.26 | $505.37 | $273.85 |
| 37565 | T | | Ligation of neck vein | 0093 | 21.3104 | $1,162.72 | $277.34 | $232.54 |
| 37600 | T | | Ligation of neck artery | 0093 | 21.3104 | $1,162.72 | $277.34 | $232.54 |
| 37605 | T | | Ligation of neck artery | 0091 | 28.8326 | $1,573.14 | $348.23 | $314.63 |
| 37606 | T | | Ligation of neck artery | 0091 | 28.8326 | $1,573.14 | $348.23 | $314.63 |
| 37607 | T | | Ligation of a-v fistula | 0092 | 25.0959 | $1,369.26 | $505.37 | $273.85 |
| 37609 | T | | Temporal artery procedure | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 37615 | T | | Ligation of neck artery | 0091 | 28.8326 | $1,573.14 | $348.23 | $314.63 |
| 37616 | C | | Ligation of chest artery | | | | | |
| 37617 | C | | Ligation of abdomen artery | | | | | |
| 37618 | C | | Ligation of extremity artery | | | | | |
| 37620 | T | | Revision of major vein | 0091 | 28.8326 | $1,573.14 | $348.23 | $314.63 |
| 37650 | T | | Revision of major vein | 0091 | 28.8326 | $1,573.14 | $348.23 | $314.63 |
| 37660 | C | | Revision of major vein | | | | | |
| 37700 | T | | Revise leg vein | 0091 | 28.8326 | $1,573.14 | $348.23 | $314.63 |
| 37720 | T | | Removal of leg vein | 0092 | 25.0959 | $1,369.26 | $505.37 | $273.85 |
| 37730 | T | | Removal of leg veins | 0092 | 25.0959 | $1,369.26 | $505.37 | $273.85 |
| 37735 | T | | Removal of leg veins/lesion | 0092 | 25.0959 | $1,369.26 | $505.37 | $273.85 |
| 37760 | T | | Revision of leg veins | 0091 | 28.8326 | $1,573.14 | $348.23 | $314.63 |
| 37765 | T | NI | Phleb veins - extrem - to 20 | 0091 | 28.8326 | $1,573.14 | $348.23 | $314.63 |
| 37766 | T | NI | Phleb veins - extrem 20+ | 0091 | 28.8326 | $1,573.14 | $348.23 | $314.63 |
| 37780 | T | | Revision of leg vein | 0091 | 28.8326 | $1,573.14 | $348.23 | $314.63 |
| 37785 | T | | Ligate/divide/excise vein | 0091 | 28.8326 | $1,573.14 | $348.23 | $314.63 |
| 37788 | C | | Revascularization, penis | | | | | |
| 37790 | T | | Penile venous occlusion | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 37799 | T | | Vascular surgery procedure | 0035 | 0.1691 | $9.23 | $2.79 | $1.85 |
| 38100 | C | | Removal of spleen, total | | | | | |
| 38101 | C | | Removal of spleen, partial | | | | | |
| 38102 | C | | Removal of spleen, total | | | | | |
| 38115 | C | | Repair of ruptured spleen | | | | | |
| 38120 | T | | Laparoscopy, splenectomy | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 38129 | T | | Laparoscope proc, spleen | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 38200 | N | | Injection for spleen x-ray | | | | | |
| 38204 | E | | Bl donor search management | | | | | |
| 38205 | S | | Harvest allogenic stem cells | 0111 | 13.1719 | $718.67 | $200.18 | $143.73 |
| 38206 | S | | Harvest auto stem cells | 0111 | 13.1719 | $718.67 | $200.18 | $143.73 |
| 38207 | E | | Cryopreserve stem cells | | | | | |
| 38208 | E | | Thaw preserved stem cells | | | | | |
| 38209 | E | | Wash harvest stem cells | | | | | |
| 38210 | E | | T-cell depletion of harvest | | | | | |
| 38211 | E | | Tumor cell deplete of harvst | | | | | |
| 38212 | E | | Rbc depletion of harvest | | | | | |
| 38213 | E | | Platelet deplete of harvest | | | | | |
| 38214 | E | | Volume deplete of harvest | | | | | |
| 38215 | E | | Harvest stem cell concentrte | | | | | |
| 38220 | T | | Bone marrow aspiration | 0003 | 2.3229 | $126.74 | | $25.35 |
| 38221 | T | | Bone marrow biopsy | 0003 | 2.3229 | $126.74 | | $25.35 |
| 38230 | S | | Bone marrow collection | 0123 | 5.2882 | $288.53 | | $57.71 |
| 38240 | S | | Bone marrow/stem transplant | 0123 | 5.2882 | $288.53 | | $57.71 |
| 38241 | S | | Bone marrow/stem transplant | 0123 | 5.2882 | $288.53 | | $57.71 |
| 38242 | S | | Lymphocyte infuse transplant | 0111 | 13.1719 | $718.67 | $200.18 | $143.73 |
| 38300 | T | | Drainage, lymph node lesion | 0008 | 19.4831 | $1,063.02 | | $212.60 |
| 38305 | T | | Drainage, lymph node lesion | 0008 | 19.4831 | $1,063.02 | | $212.60 |
| 38308 | T | | Incision of lymph channels | 0113 | 19.9322 | $1,087.52 | | $217.50 |
| 38380 | C | | Thoracic duct procedure | | | | | |
| 38381 | C | | Thoracic duct procedure | | | | | |
| 38382 | C | | Thoracic duct procedure | | | | | |
| 38500 | T | | Biopsy/removal, lymph nodes | 0113 | 19.9322 | $1,087.52 | | $217.50 |
| 38505 | T | | Needle biopsy, lymph nodes | 0005 | 3.2698 | $178.40 | $71.59 | $35.68 |
| 38510 | T | | Biopsy/removal, lymph nodes | 0113 | 19.9322 | $1,087.52 | | $217.50 |
| 38520 | T | | Biopsy/removal, lymph nodes | 0113 | 19.9322 | $1,087.52 | | $217.50 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 38525 | T | | Biopsy/removal, lymph nodes | 0113 | 19.9322 | $1,087.52 | | $217.50 |
| 38530 | T | | Biopsy/removal, lymph nodes | 0113 | 19.9322 | $1,087.52 | | $217.50 |
| 38542 | T | | Explore deep node(s), neck | 0114 | 37.5963 | $2,051.29 | $485.91 | $410.26 |
| 38550 | T | | Removal, neck/armpit lesion | 0113 | 19.9322 | $1,087.52 | | $217.50 |
| 38555 | T | | Removal, neck/armpit lesion | 0113 | 19.9322 | $1,087.52 | | $217.50 |
| 38562 | C | | Removal, pelvic lymph nodes | | | | | |
| 38564 | C | | Removal, abdomen lymph nodes | | | | | |
| 38570 | T | | Laparoscopy, lymph node biop | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 38571 | T | | Laparoscopy, lymphadenectomy | 0132 | 57.2045 | $3,121.13 | $1,239.22 | $624.23 |
| 38572 | T | | Laparoscopy, lymphadenectomy | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 38589 | T | | Laparoscope proc, lymphatic | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 38700 | T | | Removal of lymph nodes, neck | 0113 | 19.9322 | $1,087.52 | | $217.50 |
| 38720 | T | | Removal of lymph nodes, neck | 0113 | 19.9322 | $1,087.52 | | $217.50 |
| 38724 | C | | Removal of lymph nodes, neck | | | | | |
| 38740 | T | | Remove armpit lymph nodes | 0114 | 37.5963 | $2,051.29 | $485.91 | $410.26 |
| 38745 | T | | Remove armpit lymph nodes | 0114 | 37.5963 | $2,051.29 | $485.91 | $410.26 |
| 38746 | C | | Remove thoracic lymph nodes | | | | | |
| 38747 | C | | Remove abdominal lymph nodes | | | | | |
| 38760 | T | | Remove groin lymph nodes | 0113 | 19.9322 | $1,087.52 | | $217.50 |
| 38765 | C | | Remove groin lymph nodes | | | | | |
| 38770 | C | | Remove pelvis lymph nodes | | | | | |
| 38780 | C | | Remove abdomen lymph nodes | | | | | |
| 38790 | N | | Inject for lymphatic x-ray | | | | | |
| 38792 | N | | Identify sentinel node | | | | | |
| 38794 | N | | Access thoracic lymph duct | | | | | |
| 38999 | S | | Blood/lymph system procedure | 0110 | 3.6718 | $200.34 | | $40.07 |
| 39000 | C | | Exploration of chest | | | | | |
| 39010 | C | | Exploration of chest | | | | | |
| 39200 | C | | Removal chest lesion | | | | | |
| 39220 | C | | Removal chest lesion | | | | | |
| 39400 | T | | Visualization of chest | 0069 | 28.9392 | $1,578.95 | $591.64 | $315.79 |
| 39499 | C | | Chest procedure | | | | | |
| 39501 | C | | Repair diaphragm laceration | | | | | |
| 39502 | C | | Repair paraesophageal hernia | | | | | |
| 39503 | C | | Repair of diaphragm hernia | | | | | |
| 39520 | C | | Repair of diaphragm hernia | | | | | |
| 39530 | C | | Repair of diaphragm hernia | | | | | |
| 39531 | C | | Repair of diaphragm hernia | | | | | |
| 39540 | C | | Repair of diaphragm hernia | | | | | |
| 39541 | C | | Repair of diaphragm hernia | | | | | |
| 39545 | C | | Revision of diaphragm | | | | | |
| 39560 | C | | Resect diaphragm, simple | | | | | |
| 39561 | C | | Resect diaphragm, complex | | | | | |
| 39599 | C | | Diaphragm surgery procedure | | | | | |
| 40490 | T | | Biopsy of lip | 0251 | 1.7880 | $97.56 | | $19.51 |
| 40500 | T | | Partial excision of lip | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 40510 | T | | Partial excision of lip | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 40520 | T | | Partial excision of lip | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 40525 | T | | Reconstruct lip with flap | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 40527 | T | | Reconstruct lip with flap | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 40530 | T | | Partial removal of lip | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 40650 | T | | Repair lip | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 40652 | T | | Repair lip | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 40654 | T | | Repair lip | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 40700 | T | | Repair cleft lip/nasal | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 40701 | T | | Repair cleft lip/nasal | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 40702 | T | | Repair cleft lip/nasal | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 40720 | T | | Repair cleft lip/nasal | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 40761 | T | | Repair cleft lip/nasal | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 40799 | T | | Lip surgery procedure | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 40800 | T | | Drainage of mouth lesion | 0251 | 1.7880 | $97.56 | | $19.51 |
| 40801 | T | | Drainage of mouth lesion | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 40804 | X | | Removal, foreign body, mouth | 0340 | 0.6314 | $34.45 | | $6.89 |
| 40805 | T | | Removal, foreign body, mouth | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 40806 | T | | Incision of lip fold | 0251 | 1.7880 | $97.56 | | $19.51 |
| 40808 | T | | Biopsy of mouth lesion | 0251 | 1.7880 | $97.56 | | $19.51 |
| 40810 | T | | Excision of mouth lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 40812 | T | | Excise/repair mouth lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 40814 | T | | Excise/repair mouth lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 40816 | T | | Excision of mouth lesion | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 40818 | T | | Excise oral mucosa for graft | 0251 | 1.7880 | $97.56 | | $19.51 |
| 40819 | T | | Excise lip or cheek fold | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 40820 | T | | Treatment of mouth lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 40830 | T | | Repair mouth laceration | 0251 | 1.7880 | $97.56 | | $19.51 |
| 40831 | T | | Repair mouth laceration | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 40840 | T | | Reconstruction of mouth | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 40842 | T | | Reconstruction of mouth | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 40843 | T | | Reconstruction of mouth | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 40844 | T | | Reconstruction of mouth | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 40845 | T | | Reconstruction of mouth | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 40899 | T | | Mouth surgery procedure | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 41000 | T | | Drainage of mouth lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41005 | T | | Drainage of mouth lesion | 0251 | 1.7880 | $97.56 | | $19.51 |
| 41006 | T | | Drainage of mouth lesion | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 41007 | T | | Drainage of mouth lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41008 | T | | Drainage of mouth lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41009 | T | | Drainage of mouth lesion | 0251 | 1.7880 | $97.56 | | $19.51 |
| 41010 | T | | Incision of tongue fold | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41015 | T | | Drainage of mouth lesion | 0251 | 1.7880 | $97.56 | | $19.51 |
| 41016 | T | | Drainage of mouth lesion | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 41017 | T | | Drainage of mouth lesion | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 41018 | T | | Drainage of mouth lesion | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 41100 | T | | Biopsy of tongue | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 41105 | T | | Biopsy of tongue | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41108 | T | | Biopsy of floor of mouth | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 41110 | T | | Excision of tongue lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41112 | T | | Excision of tongue lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41113 | T | | Excision of tongue lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41114 | T | | Excision of tongue lesion | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 41115 | T | | Excision of tongue fold | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 41116 | T | | Excision of mouth lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41120 | T | | Partial removal of tongue | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 41130 | C | | Partial removal of tongue | | | | | |
| 41135 | C | | Tongue and neck surgery | | | | | |
| 41140 | C | | Removal of tongue | | | | | |
| 41145 | C | | Tongue removal, neck surgery | | | | | |
| 41150 | C | | Tongue, mouth, jaw surgery | | | | | |
| 41153 | C | | Tongue, mouth, neck surgery | | | | | |
| 41155 | C | | Tongue, jaw, & neck surgery | | | | | |
| 41250 | T | | Repair tongue laceration | 0251 | 1.7880 | $97.56 | | $19.51 |
| 41251 | T | | Repair tongue laceration | 0251 | 1.7880 | $97.56 | | $19.51 |
| 41252 | T | | Repair tongue laceration | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 41500 | T | | Fixation of tongue | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 41510 | T | | Tongue to lip surgery | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41520 | T | | Reconstruction, tongue fold | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 41599 | T | | Tongue and mouth surgery | 0251 | 1.7880 | $97.56 | | $19.51 |
| 41800 | T | | Drainage of gum lesion | 0251 | 1.7880 | $97.56 | | $19.51 |
| 41805 | T | | Removal foreign body, gum | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 41806 | T | | Removal foreign body,jawbone | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41820 | T | | Excision, gum, each quadrant | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 41821 | T | | Excision of gum flap | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 41822 | T | | Excision of gum lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41823 | T | | Excision of gum lesion | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 41825 | T | | Excision of gum lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41826 | T | | Excision of gum lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41827 | T | | Excision of gum lesion | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 41828 | T | | Excision of gum lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41830 | T | | Removal of gum tissue | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41850 | T | | Treatment of gum lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41870 | T | | Gum graft | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 41872 | T | | Repair gum | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 41874 | T | | Repair tooth socket | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 41899 | T | | Dental surgery procedure | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42000 | T | | Drainage mouth roof lesion | 0251 | 1.7880 | $97.56 | | $19.51 |
| 42100 | T | | Biopsy roof of mouth | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 42104 | T | | Excision lesion, mouth roof | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42106 | T | | Excision lesion, mouth roof | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42107 | T | | Excision lesion, mouth roof | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 42120 | T | | Remove palate/lesion | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42140 | T | | Excision of uvula | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 42145 | T | | Repair palate, pharynx/uvula | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 42160 | T | | Treatment mouth roof lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42180 | T | | Repair palate | 0251 | 1.7880 | $97.56 | | $19.51 |
| 42182 | T | | Repair palate | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42200 | T | | Reconstruct cleft palate | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42205 | T | | Reconstruct cleft palate | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42210 | T | | Reconstruct cleft palate | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42215 | T | | Reconstruct cleft palate | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42220 | T | | Reconstruct cleft palate | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42225 | T | | Reconstruct cleft palate | 0256 | 35.1548 | $1,918.08 | | $383.62 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 42226 | T | | Lengthening of palate | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42227 | T | | Lengthening of palate | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42235 | T | | Repair palate | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42260 | T | | Repair nose to lip fistula | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 42280 | T | | Preparation, palate mold | 0251 | 1.7880 | $97.56 | | $19.51 |
| 42281 | T | | Insertion, palate prosthesis | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42299 | T | | Palate/uvula surgery | 0251 | 1.7880 | $97.56 | | $19.51 |
| 42300 | T | | Drainage of salivary gland | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42305 | T | | Drainage of salivary gland | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42310 | T | | Drainage of salivary gland | 0251 | 1.7880 | $97.56 | | $19.51 |
| 42320 | T | | Drainage of salivary gland | 0251 | 1.7880 | $97.56 | | $19.51 |
| 42325 | T | | Create salivary cyst drain | 0251 | 1.7880 | $97.56 | | $19.51 |
| 42326 | T | | Create salivary cyst drain | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 42330 | T | | Removal of salivary stone | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42335 | T | | Removal of salivary stone | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42340 | T | | Removal of salivary stone | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42400 | T | | Biopsy of salivary gland | 0005 | 3.2698 | $178.40 | $71.59 | $35.68 |
| 42405 | T | | Biopsy of salivary gland | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42408 | T | | Excision of salivary cyst | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42409 | T | | Drainage of salivary cyst | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42410 | T | | Excise parotid gland/lesion | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42415 | T | | Excise parotid gland/lesion | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42420 | T | | Excise parotid gland/lesion | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42425 | T | | Excise parotid gland/lesion | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42426 | C | | Excise parotid gland/lesion | | | | | |
| 42440 | T | | Excise submaxillary gland | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42450 | T | | Excise sublingual gland | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 42500 | T | | Repair salivary duct | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 42505 | T | | Repair salivary duct | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42507 | T | | Parotid duct diversion | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42508 | T | | Parotid duct diversion | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42509 | T | | Parotid duct diversion | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42510 | T | | Parotid duct diversion | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42550 | N | | Injection for salivary x-ray | | | | | |
| 42600 | T | | Closure of salivary fistula | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42650 | T | | Dilation of salivary duct | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 42660 | T | | Dilation of salivary duct | 0251 | 1.7880 | $97.56 | | $19.51 |
| 42665 | T | | Ligation of salivary duct | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 42699 | T | | Salivary surgery procedure | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42700 | T | | Drainage of tonsil abscess | 0251 | 1.7880 | $97.56 | | $19.51 |
| 42720 | T | | Drainage of throat abscess | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42725 | T | | Drainage of throat abscess | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42800 | T | | Biopsy of throat | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42802 | T | | Biopsy of throat | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42804 | T | | Biopsy of upper nose/throat | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42806 | T | | Biopsy of upper nose/throat | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 42808 | T | | Excise pharynx lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42809 | X | | Remove pharynx foreign body | 0340 | 0.6314 | $34.45 | | $6.89 |
| 42810 | T | | Excision of neck cyst | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 42815 | T | | Excision of neck cyst | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42820 | T | | Remove tonsils and adenoids | 0258 | 20.6265 | $1,125.40 | $437.25 | $225.08 |
| 42821 | T | | Remove tonsils and adenoids | 0258 | 20.6265 | $1,125.40 | $437.25 | $225.08 |
| 42825 | T | | Removal of tonsils | 0258 | 20.6265 | $1,125.40 | $437.25 | $225.08 |
| 42826 | T | | Removal of tonsils | 0258 | 20.6265 | $1,125.40 | $437.25 | $225.08 |
| 42830 | T | | Removal of adenoids | 0258 | 20.6265 | $1,125.40 | $437.25 | $225.08 |
| 42831 | T | | Removal of adenoids | 0258 | 20.6265 | $1,125.40 | $437.25 | $225.08 |
| 42835 | T | | Removal of adenoids | 0258 | 20.6265 | $1,125.40 | $437.25 | $225.08 |
| 42836 | T | | Removal of adenoids | 0258 | 20.6265 | $1,125.40 | $437.25 | $225.08 |
| 42842 | T | | Extensive surgery of throat | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 42844 | T | | Extensive surgery of throat | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42845 | C | | Extensive surgery of throat | | | | | |
| 42860 | T | | Excision of tonsil tags | 0258 | 20.6265 | $1,125.40 | $437.25 | $225.08 |
| 42870 | T | | Excision of lingual tonsil | 0258 | 20.6265 | $1,125.40 | $437.25 | $225.08 |
| 42890 | T | | Partial removal of pharynx | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42892 | T | | Revision of pharyngeal walls | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42894 | C | | Revision of pharyngeal walls | | | | | |
| 42900 | T | | Repair throat wound | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 42950 | T | | Reconstruction of throat | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 42953 | C | | Repair throat, esophagus | | | | | |
| 42955 | T | | Surgical opening of throat | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 42960 | T | | Control throat bleeding | 0250 | 1.4697 | $80.19 | $28.07 | $16.04 |
| 42961 | C | | Control throat bleeding | | | | | |
| 42962 | T | | Control throat bleeding | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 42970 | T | | Control nose/throat bleeding | 0250 | 1.4697 | $80.19 | $28.07 | $16.04 |
| 42971 | C | | Control nose/throat bleeding | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 42972 | T | | Control nose/throat bleeding | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 42999 | T | | Throat surgery procedure | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 43020 | T | | Incision of esophagus | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 43030 | T | | Throat muscle surgery | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 43045 | C | | Incision of esophagus | | | | | |
| 43100 | C | | Excision of esophagus lesion | | | | | |
| 43101 | C | | Excision of esophagus lesion | | | | | |
| 43107 | C | | Removal of esophagus | | | | | |
| 43108 | C | | Removal of esophagus | | | | | |
| 43112 | C | | Removal of esophagus | | | | | |
| 43113 | C | | Removal of esophagus | | | | | |
| 43116 | C | | Partial removal of esophagus | | | | | |
| 43117 | C | | Partial removal of esophagus | | | | | |
| 43118 | C | | Partial removal of esophagus | | | | | |
| 43121 | C | | Partial removal of esophagus | | | | | |
| 43122 | C | | Partial removal of esophagus | | | | | |
| 43123 | C | | Partial removal of esophagus | | | | | |
| 43124 | C | | Removal of esophagus | | | | | |
| 43130 | T | | Removal of esophagus pouch | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 43135 | C | | Removal of esophagus pouch | | | | | |
| 43200 | T | | Esophagus endoscopy | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43201 | T | | Esoph scope w/submucous inj | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43202 | T | | Esophagus endoscopy, biopsy | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43204 | T | | Esoph scope w/sclerosis inj | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43205 | T | | Esophagus endoscopy/ligation | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43215 | T | | Esophagus endoscopy | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43216 | T | | Esophagus endoscopy/lesion | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43217 | T | | Esophagus endoscopy | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43219 | T | | Esophagus endoscopy | 0384 | 20.6602 | $1,127.24 | $244.83 | $225.45 |
| 43220 | T | | Esoph endoscopy, dilation | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43226 | T | | Esoph endoscopy, dilation | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43227 | T | | Esoph endoscopy, repair | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43228 | T | | Esoph endoscopy, ablation | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43231 | T | | Esoph endoscopy w/us exam | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43232 | T | | Esoph endoscopy w/us fn bx | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43234 | T | | Upper GI endoscopy, exam | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43235 | T | | Uppr gi endoscopy, diagnosis | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43236 | T | | Uppr gi scope w/submuc inj | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43237 | T | NI | Endoscopic us exam, esoph | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43238 | T | NI | Uppr gi endoscopy w/us fn bx | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43239 | T | | Upper GI endoscopy, biopsy | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43240 | T | | Esoph endoscope w/drain cyst | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43241 | T | | Upper GI endoscopy with tube | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43242 | T | | Uppr gi endoscopy w/us fn bx | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43243 | T | | Upper gi endoscopy & inject | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43244 | T | | Upper GI endoscopy/ligation | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43245 | T | | Uppr gi scope dilate strictr | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43246 | T | | Place gastrostomy tube | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43247 | T | | Operative upper GI endoscopy | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43248 | T | | Uppr gi endoscopy/guide wire | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43249 | T | | Esoph endoscopy, dilation | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43250 | T | | Upper GI endoscopy/tumor | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43251 | T | | Operative upper GI endoscopy | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43255 | T | | Operative upper GI endoscopy | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43256 | T | | Uppr gi endoscopy w stent | 0384 | 20.6602 | $1,127.24 | $244.83 | $225.45 |
| 43258 | T | | Operative upper GI endoscopy | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43259 | T | | Endoscopic ultrasound exam | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43260 | T | | Endo cholangiopancreatograph | 0151 | 17.9462 | $979.16 | $245.46 | $195.83 |
| 43261 | T | | Endo cholangiopancreatograph | 0151 | 17.9462 | $979.16 | $245.46 | $195.83 |
| 43262 | T | | Endo cholangiopancreatograph | 0151 | 17.9462 | $979.16 | $245.46 | $195.83 |
| 43263 | T | | Endo cholangiopancreatograph | 0151 | 17.9462 | $979.16 | $245.46 | $195.83 |
| 43264 | T | | Endo cholangiopancreatograph | 0151 | 17.9462 | $979.16 | $245.46 | $195.83 |
| 43265 | T | | Endo cholangiopancreatograph | 0151 | 17.9462 | $979.16 | $245.46 | $195.83 |
| 43267 | T | | Endo cholangiopancreatograph | 0151 | 17.9462 | $979.16 | $245.46 | $195.83 |
| 43268 | T | | Endo cholangiopancreatograph | 0384 | 20.6602 | $1,127.24 | $244.83 | $225.45 |
| 43269 | T | | Endo cholangiopancreatograph | 0384 | 20.6602 | $1,127.24 | $244.83 | $225.45 |
| 43271 | T | | Endo cholangiopancreatograph | 0151 | 17.9462 | $979.16 | $245.46 | $195.83 |
| 43272 | T | | Endo cholangiopancreatograph | 0151 | 17.9462 | $979.16 | $245.46 | $195.83 |
| 43280 | T | | Laparoscopy, fundoplasty | 0132 | 57.2045 | $3,121.13 | $1,239.22 | $624.23 |
| 43289 | T | | Laparoscope proc, esoph | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 43300 | C | | Repair of esophagus | | | | | |
| 43305 | C | | Repair esophagus and fistula | | | | | |
| 43310 | C | | Repair of esophagus | | | | | |
| 43312 | C | | Repair esophagus and fistula | | | | | |
| 43313 | C | | Esophagoplasty congenital | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 43314 | C | | Tracheo-esophagoplasty cong | | | | | |
| 43320 | C | | Fuse esophagus & stomach | | | | | |
| 43324 | C | | Revise esophagus & stomach | | | | | |
| 43325 | C | | Revise esophagus & stomach | | | | | |
| 43326 | C | | Revise esophagus & stomach | | | | | |
| 43330 | C | | Repair of esophagus | | | | | |
| 43331 | C | | Repair of esophagus | | | | | |
| 43340 | C | | Fuse esophagus & intestine | | | | | |
| 43341 | C | | Fuse esophagus & intestine | | | | | |
| 43350 | C | | Surgical opening, esophagus | | | | | |
| 43351 | C | | Surgical opening, esophagus | | | | | |
| 43352 | C | | Surgical opening, esophagus | | | | | |
| 43360 | C | | Gastrointestinal repair | | | | | |
| 43361 | C | | Gastrointestinal repair | | | | | |
| 43400 | C | | Ligate esophagus veins | | | | | |
| 43401 | C | | Esophagus surgery for veins | | | | | |
| 43405 | C | | Ligate/staple esophagus | | | | | |
| 43410 | C | | Repair esophagus wound | | | | | |
| 43415 | C | | Repair esophagus wound | | | | | |
| 43420 | C | | Repair esophagus opening | | | | | |
| 43425 | C | | Repair esophagus opening | | | | | |
| 43450 | T | | Dilate esophagus | 0140 | 6.4525 | $352.05 | $107.24 | $70.41 |
| 43453 | T | | Dilate esophagus | 0140 | 6.4525 | $352.05 | $107.24 | $70.41 |
| 43456 | T | | Dilate esophagus | 0140 | 6.4525 | $352.05 | $107.24 | $70.41 |
| 43458 | T | | Dilate esophagus | 0140 | 6.4525 | $352.05 | $107.24 | $70.41 |
| 43460 | C | | Pressure treatment esophagus | | | | | |
| 43496 | C | | Free jejunum flap, microvasc | | | | | |
| 43499 | T | | Esophagus surgery procedure | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43500 | C | | Surgical opening of stomach | | | | | |
| 43501 | C | | Surgical repair of stomach | | | | | |
| 43502 | C | | Surgical repair of stomach | | | | | |
| 43510 | C | | Surgical opening of stomach | | | | | |
| 43520 | C | | Incision of pyloric muscle | | | | | |
| 43600 | T | | Biopsy of stomach | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43605 | C | | Biopsy of stomach | | | | | |
| 43610 | C | | Excision of stomach lesion | | | | | |
| 43611 | C | | Excision of stomach lesion | | | | | |
| 43620 | C | | Removal of stomach | | | | | |
| 43621 | C | | Removal of stomach | | | | | |
| 43622 | C | | Removal of stomach | | | | | |
| 43631 | C | | Removal of stomach, partial | | | | | |
| 43632 | C | | Removal of stomach, partial | | | | | |
| 43633 | C | | Removal of stomach, partial | | | | | |
| 43634 | C | | Removal of stomach, partial | | | | | |
| 43635 | C | | Removal of stomach, partial | | | | | |
| 43638 | C | | Removal of stomach, partial | | | | | |
| 43639 | C | | Removal of stomach, partial | | | | | |
| 43640 | C | | Vagotomy & pylorus repair | | | | | |
| 43641 | C | | Vagotomy & pylorus repair | | | | | |
| 43651 | T | | Laparoscopy, vagus nerve | 0132 | 57.2045 | $3,121.13 | $1,239.22 | $624.23 |
| 43652 | T | | Laparoscopy, vagus nerve | 0132 | 57.2045 | $3,121.13 | $1,239.22 | $624.23 |
| 43653 | T | | Laparoscopy, gastrostomy | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 43659 | T | | Laparoscope proc, stom | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 43750 | T | | Place gastrostomy tube | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43752 | T | | Nasal/orogastric w/stent | 0121 | 2.1189 | $115.61 | $43.80 | $23.12 |
| 43760 | T | | Change gastrostomy tube | 0121 | 2.1189 | $115.61 | $43.80 | $23.12 |
| 43761 | T | | Reposition gastrostomy tube | 0121 | 2.1189 | $115.61 | $43.80 | $23.12 |
| 43800 | C | | Reconstruction of pylorus | | | | | |
| 43810 | C | | Fusion of stomach and bowel | | | | | |
| 43820 | C | | Fusion of stomach and bowel | | | | | |
| 43825 | C | | Fusion of stomach and bowel | | | | | |
| 43830 | T | | Place gastrostomy tube | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43831 | T | | Place gastrostomy tube | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 43832 | C | | Place gastrostomy tube | | | | | |
| 43840 | C | | Repair of stomach lesion | | | | | |
| 43842 | C | | Gastroplasty for obesity | | | | | |
| 43843 | C | | Gastroplasty for obesity | | | | | |
| 43846 | C | | Gastric bypass for obesity | | | | | |
| 43847 | C | | Gastric bypass for obesity | | | | | |
| 43848 | C | | Revision gastroplasty | | | | | |
| 43850 | C | | Revise stomach-bowel fusion | | | | | |
| 43855 | C | | Revise stomach-bowel fusion | | | | | |
| 43860 | C | | Revise stomach-bowel fusion | | | | | |
| 43865 | C | | Revise stomach-bowel fusion | | | | | |
| 43870 | T | | Repair stomach opening | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 43880 | C | | Repair stomach-bowel fistula | | | | | |
| 43999 | T | | Stomach surgery procedure | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 44005 | C | | Freeing of bowel adhesion | | | | | |
| 44010 | C | | Incision of small bowel | | | | | |
| 44015 | C | | Insert needle cath bowel | | | | | |
| 44020 | C | | Explore small intestine | | | | | |
| 44021 | C | | Decompress small bowel | | | | | |
| 44025 | C | | Incision of large bowel | | | | | |
| 44050 | C | | Reduce bowel obstruction | | | | | |
| 44055 | C | | Correct malrotation of bowel | | | | | |
| 44100 | T | | Biopsy of bowel | 0141 | 7.8206 | $426.70 | $143.38 | $85.34 |
| 44110 | C | | Excise intestine lesion(s) | | | | | |
| 44111 | C | | Excision of bowel lesion(s) | | | | | |
| 44120 | C | | Removal of small intestine | | | | | |
| 44121 | C | | Removal of small intestine | | | | | |
| 44125 | C | | Removal of small intestine | | | | | |
| 44126 | C | | Enterectomy w/o taper, cong | | | | | |
| 44127 | C | | Enterectomy w/taper, cong | | | | | |
| 44128 | C | | Enterectomy cong, add-on | | | | | |
| 44130 | C | | Bowel to bowel fusion | | | | | |
| 44132 | C | | Enterectomy, cadaver donor | | | | | |
| 44133 | C | | Enterectomy, live donor | | | | | |
| 44135 | C | | Intestine transplnt, cadaver | | | | | |
| 44136 | C | | Intestine transplant, live | | | | | |
| 44139 | C | | Mobilization of colon | | | | | |
| 44140 | C | | Partial removal of colon | | | | | |
| 44141 | C | | Partial removal of colon | | | | | |
| 44143 | C | | Partial removal of colon | | | | | |
| 44144 | C | | Partial removal of colon | | | | | |
| 44145 | C | | Partial removal of colon | | | | | |
| 44146 | C | | Partial removal of colon | | | | | |
| 44147 | C | | Partial removal of colon | | | | | |
| 44150 | C | | Removal of colon | | | | | |
| 44151 | C | | Removal of colon/ileostomy | | | | | |
| 44152 | C | | Removal of colon/ileostomy | | | | | |
| 44153 | C | | Removal of colon/ileostomy | | | | | |
| 44155 | C | | Removal of colon/ileostomy | | | | | |
| 44156 | C | | Removal of colon/ileostomy | | | | | |
| 44160 | C | | Removal of colon | | | | | |
| 44200 | T | | Laparoscopy, enterolysis | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 44201 | T | | Laparoscopy, jejunostomy | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 44202 | C | | Lap resect s/intestine singl | | | | | |
| 44203 | C | | Lap resect s/intestine, addl | | | | | |
| 44204 | C | | Laparo partial colectomy | | | | | |
| 44205 | C | | Lap colectomy part w/ileum | | | | | |
| 44206 | T | | Lap part colectomy w/stoma | 0132 | 57.2045 | $3,121.13 | $1,239.22 | $624.23 |
| 44207 | T | | L colectomy/coloproctostomy | 0132 | 57.2045 | $3,121.13 | $1,239.22 | $624.23 |
| 44208 | T | | L colectomy/coloproctostomy | 0132 | 57.2045 | $3,121.13 | $1,239.22 | $624.23 |
| 44210 | C | | Laparo total proctocolectomy | | | | | |
| 44211 | C | | Laparo total proctocolectomy | | | | | |
| 44212 | C | | Laparo total proctocolectomy | | | | | |
| 44238 | T | | Laparoscope proc, intestine | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 44239 | T | | Laparoscope proc, rectum | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 44300 | C | | Open bowel to skin | | | | | |
| 44310 | C | | Ileostomy/jejunostomy | | | | | |
| 44312 | T | | Revision of ileostomy | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 44314 | C | | Revision of ileostomy | | | | | |
| 44316 | C | | Devise bowel pouch | | | | | |
| 44320 | C | | Colostomy | | | | | |
| 44322 | C | | Colostomy with biopsies | | | | | |
| 44340 | T | | Revision of colostomy | 0027 | 15.8990 | $867.47 | $329.72 | $173.49 |
| 44345 | C | | Revision of colostomy | | | | | |
| 44346 | C | | Revision of colostomy | | | | | |
| 44360 | T | | Small bowel endoscopy | 0142 | 8.7959 | $479.91 | $152.78 | $95.98 |
| 44361 | T | | Small bowel endoscopy/biopsy | 0142 | 8.7959 | $479.91 | $152.78 | $95.98 |
| 44363 | T | | Small bowel endoscopy | 0142 | 8.7959 | $479.91 | $152.78 | $95.98 |
| 44364 | T | | Small bowel endoscopy | 0142 | 8.7959 | $479.91 | $152.78 | $95.98 |
| 44365 | T | | Small bowel endoscopy | 0142 | 8.7959 | $479.91 | $152.78 | $95.98 |
| 44366 | T | | Small bowel endoscopy | 0142 | 8.7959 | $479.91 | $152.78 | $95.98 |
| 44369 | T | | Small bowel endoscopy | 0142 | 8.7959 | $479.91 | $152.78 | $95.98 |
| 44370 | T | | Small bowel endoscopy/stent | 0384 | 20.6602 | $1,127.24 | $244.83 | $225.45 |
| 44372 | T | | Small bowel endoscopy | 0142 | 8.7959 | $479.91 | $152.78 | $95.98 |
| 44373 | T | | Small bowel endoscopy | 0142 | 8.7959 | $479.91 | $152.78 | $95.98 |
| 44376 | T | | Small bowel endoscopy | 0142 | 8.7959 | $479.91 | $152.78 | $95.98 |
| 44377 | T | | Small bowel endoscopy/biopsy | 0142 | 8.7959 | $479.91 | $152.78 | $95.98 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 44378 | T | | Small bowel endoscopy | 0142 | 8.7959 | $479.91 | $152.78 | $95.98 |
| 44379 | T | | S bowel endoscope w/stent | 0384 | 20.6602 | $1,127.24 | $244.83 | $225.45 |
| 44380 | T | | Small bowel endoscopy | 0142 | 8.7959 | $479.91 | $152.78 | $95.98 |
| 44382 | T | | Small bowel endoscopy | 0142 | 8.7959 | $479.91 | $152.78 | $95.98 |
| 44383 | T | | Ileoscopy w/stent | 0384 | 20.6602 | $1,127.24 | $244.83 | $225.45 |
| 44385 | T | | Endoscopy of bowel pouch | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 44386 | T | | Endoscopy, bowel pouch/biop | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 44388 | T | | Colonoscopy | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 44389 | T | | Colonoscopy with biopsy | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 44390 | T | | Colonoscopy for foreign body | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 44391 | T | | Colonoscopy for bleeding | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 44392 | T | | Colonoscopy & polypectomy | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 44393 | T | | Colonoscopy, lesion removal | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 44394 | T | | Colonoscopy w/snare | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 44397 | T | | Colonoscopy w/stent | 0384 | 20.6602 | $1,127.24 | $244.83 | $225.45 |
| 44500 | T | | Intro, gastrointestinal tube | 0121 | 2.1189 | $115.61 | $43.80 | $23.12 |
| 44602 | C | | Suture, small intestine | | | | | |
| 44603 | C | | Suture, small intestine | | | | | |
| 44604 | C | | Suture, large intestine | | | | | |
| 44605 | C | | Repair of bowel lesion | | | | | |
| 44615 | C | | Intestinal stricturoplasty | | | | | |
| 44620 | C | | Repair bowel opening | | | | | |
| 44625 | C | | Repair bowel opening | | | | | |
| 44626 | C | | Repair bowel opening | | | | | |
| 44640 | C | | Repair bowel-skin fistula | | | | | |
| 44650 | C | | Repair bowel fistula | | | | | |
| 44660 | C | | Repair bowel-bladder fistula | | | | | |
| 44661 | C | | Repair bowel-bladder fistula | | | | | |
| 44680 | C | | Surgical revision, intestine | | | | | |
| 44700 | C | | Suspend bowel w/prosthesis | | | | | |
| 44701 | N | | Intraop colon lavage add-on | | | | | |
| 44799 | T | | Unlisted procedure intestine | 0142 | 8.7959 | $479.91 | $152.78 | $95.98 |
| 44800 | C | | Excision of bowel pouch | | | | | |
| 44820 | C | | Excision of mesentery lesion | | | | | |
| 44850 | C | | Repair of mesentery | | | | | |
| 44899 | C | | Bowel surgery procedure | | | | | |
| 44900 | C | | Drain app abscess, open | | | | | |
| 44901 | C | | Drain app abscess, percut | | | | | |
| 44950 | C | | Appendectomy | | | | | |
| 44955 | C | | Appendectomy add-on | | | | | |
| 44960 | C | | Appendectomy | | | | | |
| 44970 | T | | Laparoscopy, appendectomy | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 44979 | T | | Laparoscope proc, app | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 45000 | T | | Drainage of pelvic abscess | 0148 | 3.8320 | $209.08 | $63.38 | $41.82 |
| 45005 | T | | Drainage of rectal abscess | 0148 | 3.8320 | $209.08 | $63.38 | $41.82 |
| 45020 | T | | Drainage of rectal abscess | 0148 | 3.8320 | $209.08 | $63.38 | $41.82 |
| 45100 | T | | Biopsy of rectum | 0149 | 17.1425 | $935.31 | $293.06 | $187.06 |
| 45108 | T | | Removal of anorectal lesion | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 45110 | C | | Removal of rectum | | | | | |
| 45111 | C | | Partial removal of rectum | | | | | |
| 45112 | C | | Removal of rectum | | | | | |
| 45113 | C | | Partial proctectomy | | | | | |
| 45114 | C | | Partial removal of rectum | | | | | |
| 45116 | C | | Partial removal of rectum | | | | | |
| 45119 | C | | Remove rectum w/reservoir | | | | | |
| 45120 | C | | Removal of rectum | | | | | |
| 45121 | C | | Removal of rectum and colon | | | | | |
| 45123 | C | | Partial proctectomy | | | | | |
| 45126 | C | | Pelvic exenteration | | | | | |
| 45130 | C | | Excision of rectal prolapse | | | | | |
| 45135 | C | | Excision of rectal prolapse | | | | | |
| 45136 | C | | Excise ileoanal reservior | | | | | |
| 45150 | T | | Excision of rectal stricture | 0149 | 17.1425 | $935.31 | $293.06 | $187.06 |
| 45160 | T | | Excision of rectal lesion | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 45170 | T | | Excision of rectal lesion | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 45190 | T | | Destruction, rectal tumor | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 45300 | T | | Proctosigmoidoscopy dx | 0146 | 3.9826 | $217.29 | $64.40 | $43.46 |
| 45303 | T | | Proctosigmoidoscopy dilate | 0146 | 3.9826 | $217.29 | $64.40 | $43.46 |
| 45305 | T | | Proctosigmoidoscopy w/bx | 0146 | 3.9826 | $217.29 | $64.40 | $43.46 |
| 45307 | T | | Proctosigmoidoscopy fb | 0146 | 3.9826 | $217.29 | $64.40 | $43.46 |
| 45308 | T | | Proctosigmoidoscopy removal | 0147 | 7.6808 | $419.07 | | $83.81 |
| 45309 | T | | Proctosigmoidoscopy removal | 0147 | 7.6808 | $419.07 | | $83.81 |
| 45315 | T | | Proctosigmoidoscopy removal | 0147 | 7.6808 | $419.07 | | $83.81 |
| 45317 | T | | Proctosigmoidoscopy bleed | 0147 | 7.6808 | $419.07 | | $83.81 |
| 45320 | T | | Proctosigmoidoscopy ablate | 0147 | 7.6808 | $419.07 | | $83.81 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 45321 | T | | Proctosigmoidoscopy volvul | 0147 | 7.6808 | $419.07 | | $83.81 |
| 45327 | T | | Proctosigmoidoscopy w/stent | 0384 | 20.6602 | $1,127.24 | $244.83 | $225.45 |
| 45330 | T | | Diagnostic sigmoidoscopy | 0146 | 3.9826 | $217.29 | $64.40 | $43.46 |
| 45331 | T | | Sigmoidoscopy and biopsy | 0146 | 3.9826 | $217.29 | $64.40 | $43.46 |
| 45332 | T | | Sigmoidoscopy w/fb removal | 0146 | 3.9826 | $217.29 | $64.40 | $43.46 |
| 45333 | T | | Sigmoidoscopy & polypectomy | 0147 | 7.6808 | $419.07 | | $83.81 |
| 45334 | T | | Sigmoidoscopy for bleeding | 0147 | 7.6808 | $419.07 | | $83.81 |
| 45335 | T | | Sigmoidoscopy w/submuc inj | 0147 | 7.6808 | $419.07 | | $83.81 |
| 45337 | T | | Sigmoidoscopy & decompress | 0147 | 7.6808 | $419.07 | | $83.81 |
| 45338 | T | | Sigmoidoscopy w/tumr remove | 0147 | 7.6808 | $419.07 | | $83.81 |
| 45339 | T | | Sigmoidoscopy w/ablate tumr | 0147 | 7.6808 | $419.07 | | $83.81 |
| 45340 | T | | Sig w/balloon dilation | 0147 | 7.6808 | $419.07 | | $83.81 |
| 45341 | T | | Sigmoidoscopy w/ultrasound | 0147 | 7.6808 | $419.07 | | $83.81 |
| 45342 | T | | Sigmoidoscopy w/us guide bx | 0147 | 7.6808 | $419.07 | | $83.81 |
| 45345 | T | | Sigmoidoscopy w/stent | 0384 | 20.6602 | $1,127.24 | $244.83 | $225.45 |
| 45355 | T | | Surgical colonoscopy | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 45378 | T | | Diagnostic colonoscopy | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 45379 | T | | Colonoscopy w/fb removal | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 45380 | T | | Colonoscopy and biopsy | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 45381 | T | | Colonoscopy, submucous inj | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 45382 | T | | Colonoscopy/control bleeding | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 45383 | T | | Lesion removal colonoscopy | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 45384 | T | | Lesion remove colonoscopy | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 45385 | T | | Lesion removal colonoscopy | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 45386 | T | | Colonoscopy dilate stricture | 0143 | 8.2957 | $452.62 | $186.06 | $90.52 |
| 45387 | T | | Colonoscopy w/stent | 0384 | 20.6602 | $1,127.24 | $244.83 | $225.45 |
| 45500 | T | | Repair of rectum | 0149 | 17.1425 | $935.31 | $293.06 | $187.06 |
| 45505 | T | | Repair of rectum | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 45520 | T | | Treatment of rectal prolapse | 0098 | 1.0729 | $58.54 | $14.06 | $11.71 |
| 45540 | C | | Correct rectal prolapse | | | | | |
| 45541 | C | | Correct rectal prolapse | | | | | |
| 45550 | C | | Repair rectum/remove sigmoid | | | | | |
| 45560 | T | | Repair of rectocele | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 45562 | C | | Exploration/repair of rectum | | | | | |
| 45563 | C | | Exploration/repair of rectum | | | | | |
| 45800 | C | | Repair rect/bladder fistula | | | | | |
| 45805 | C | | Repair fistula w/colostomy | | | | | |
| 45820 | C | | Repair rectourethral fistula | | | | | |
| 45825 | C | | Repair fistula w/colostomy | | | | | |
| 45900 | T | | Reduction of rectal prolapse | 0148 | 3.8320 | $209.08 | $63.38 | $41.82 |
| 45905 | T | | Dilation of anal sphincter | 0149 | 17.1425 | $935.31 | $293.06 | $187.06 |
| 45910 | T | | Dilation of rectal narrowing | 0149 | 17.1425 | $935.31 | $293.06 | $187.06 |
| 45915 | T | | Remove rectal obstruction | 0148 | 3.8320 | $209.08 | $63.38 | $41.82 |
| 45999 | T | | Rectum surgery procedure | 0148 | 3.8320 | $209.08 | $63.38 | $41.82 |
| 46020 | T | | Placement of seton | 0148 | 3.8320 | $209.08 | $63.38 | $41.82 |
| 46030 | T | | Removal of rectal marker | 0148 | 3.8320 | $209.08 | $63.38 | $41.82 |
| 46040 | T | | Incision of rectal abscess | 0149 | 17.1425 | $935.31 | $293.06 | $187.06 |
| 46045 | T | | Incision of rectal abscess | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46050 | T | | Incision of anal abscess | 0148 | 3.8320 | $209.08 | $63.38 | $41.82 |
| 46060 | T | | Incision of rectal abscess | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46070 | T | | Incision of anal septum | 0155 | 10.0809 | $550.02 | $188.89 | $110.00 |
| 46080 | T | | Incision of anal sphincter | 0149 | 17.1425 | $935.31 | $293.06 | $187.06 |
| 46083 | T | | Incise external hemorrhoid | 0148 | 3.8320 | $209.08 | $63.38 | $41.82 |
| 46200 | T | | Removal of anal fissure | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46210 | T | | Removal of anal crypt | 0149 | 17.1425 | $935.31 | $293.06 | $187.06 |
| 46211 | T | | Removal of anal crypts | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46220 | T | | Removal of anal tag | 0149 | 17.1425 | $935.31 | $293.06 | $187.06 |
| 46221 | T | | Ligation of hemorrhoid(s) | 0148 | 3.8320 | $209.08 | $63.38 | $41.82 |
| 46230 | T | | Removal of anal tags | 0149 | 17.1425 | $935.31 | $293.06 | $187.06 |
| 46250 | T | | Hemorrhoidectomy | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46255 | T | | Hemorrhoidectomy | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46257 | T | | Remove hemorrhoids & fissure | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46258 | T | | Remove hemorrhoids & fistula | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46260 | T | | Hemorrhoidectomy | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46261 | T | | Remove hemorrhoids & fissure | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46262 | T | | Remove hemorrhoids & fistula | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46270 | T | | Removal of anal fistula | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46275 | T | | Removal of anal fistula | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46280 | T | | Removal of anal fistula | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46285 | T | | Removal of anal fistula | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46288 | T | | Repair anal fistula | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46320 | T | | Removal of hemorrhoid clot | 0148 | 3.8320 | $209.08 | $63.38 | $41.82 |
| 46500 | T | | Injection into hemorrhoid(s) | 0155 | 10.0809 | $550.02 | $188.89 | $110.00 |
| 46600 | X | | Diagnostic anoscopy | 0340 | 0.6314 | $34.45 | | $6.89 |
| 46604 | T | | Anoscopy and dilation | 0147 | 7.6808 | $419.07 | | $83.81 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 46606 | T | | Anoscopy and biopsy | 0147 | 7.6808 | $419.07 | | $83.81 |
| 46608 | T | | Anoscopy, remove for body | 0147 | 7.6808 | $419.07 | | $83.81 |
| 46610 | T | | Anoscopy, remove lesion | 0147 | 7.6808 | $419.07 | | $83.81 |
| 46611 | T | | Anoscopy | 0147 | 7.6808 | $419.07 | | $83.81 |
| 46612 | T | | Anoscopy, remove lesions | 0147 | 7.6808 | $419.07 | | $83.81 |
| 46614 | T | | Anoscopy, control bleeding | 0147 | 7.6808 | $419.07 | | $83.81 |
| 46615 | T | | Anoscopy | 0147 | 7.6808 | $419.07 | | $83.81 |
| 46700 | T | | Repair of anal stricture | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46705 | C | | Repair of anal stricture | | | | | |
| 46706 | T | | Repr of anal fistula w/glue | 0148 | 3.8320 | $209.08 | $63.38 | $41.82 |
| 46715 | C | | Repair of anovaginal fistula | | | | | |
| 46716 | C | | Repair of anovaginal fistula | | | | | |
| 46730 | C | | Construction of absent anus | | | | | |
| 46735 | C | | Construction of absent anus | | | | | |
| 46740 | C | | Construction of absent anus | | | | | |
| 46742 | C | | Repair of imperforated anus | | | | | |
| 46744 | C | | Repair of cloacal anomaly | | | | | |
| 46746 | C | | Repair of cloacal anomaly | | | | | |
| 46748 | C | | Repair of cloacal anomaly | | | | | |
| 46750 | T | | Repair of anal sphincter | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46751 | C | | Repair of anal sphincter | | | | | |
| 46753 | T | | Reconstruction of anus | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46754 | T | | Removal of suture from anus | 0149 | 17.1425 | $935.31 | $293.06 | $187.06 |
| 46760 | T | | Repair of anal sphincter | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46761 | T | | Repair of anal sphincter | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46762 | T | | Implant artificial sphincter | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46900 | T | | Destruction, anal lesion(s) | 0016 | 2.5724 | $140.35 | $57.31 | $28.07 |
| 46910 | T | | Destruction, anal lesion(s) | 0017 | 16.3697 | $893.15 | $227.84 | $178.63 |
| 46916 | T | | Cryosurgery, anal lesion(s) | 0013 | 1.1272 | $61.50 | $14.20 | $12.30 |
| 46917 | T | | Laser surgery, anal lesions | 0695 | 19.1849 | $1,046.75 | $266.59 | $209.35 |
| 46922 | T | | Excision of anal lesion(s) | 0695 | 19.1849 | $1,046.75 | $266.59 | $209.35 |
| 46924 | T | | Destruction, anal lesion(s) | 0695 | 19.1849 | $1,046.75 | $266.59 | $209.35 |
| 46934 | T | | Destruction of hemorrhoids | 0155 | 10.0809 | $550.02 | $188.89 | $110.00 |
| 46935 | T | | Destruction of hemorrhoids | 0155 | 10.0809 | $550.02 | $188.89 | $110.00 |
| 46936 | T | | Destruction of hemorrhoids | 0149 | 17.1425 | $935.31 | $293.06 | $187.06 |
| 46937 | T | | Cryotherapy of rectal lesion | 0149 | 17.1425 | $935.31 | $293.06 | $187.06 |
| 46938 | T | | Cryotherapy of rectal lesion | 0150 | 22.1919 | $1,210.81 | $437.12 | $242.16 |
| 46940 | T | | Treatment of anal fissure | 0149 | 17.1425 | $935.31 | $293.06 | $187.06 |
| 46942 | T | | Treatment of anal fissure | 0148 | 3.8320 | $209.08 | $63.38 | $41.82 |
| 46945 | T | | Ligation of hemorrhoids | 0155 | 10.0809 | $550.02 | $188.89 | $110.00 |
| 46946 | T | | Ligation of hemorrhoids | 0155 | 10.0809 | $550.02 | $188.89 | $110.00 |
| 46999 | T | | Anus surgery procedure | 0148 | 3.8320 | $209.08 | $63.38 | $41.82 |
| 47000 | T | | Needle biopsy of liver | 0685 | 4.8100 | $262.44 | $115.47 | $52.49 |
| 47001 | N | | Needle biopsy, liver add-on | | | | | |
| 47010 | C | | Open drainage, liver lesion | | | | | |
| 47011 | T | | Percut drain, liver lesion | 0037 | 9.8921 | $539.72 | $237.45 | $107.94 |
| 47015 | C | | Inject/aspirate liver cyst | | | | | |
| 47100 | C | | Wedge biopsy of liver | | | | | |
| 47120 | C | | Partial removal of liver | | | | | |
| 47122 | C | | Extensive removal of liver | | | | | |
| 47125 | C | | Partial removal of liver | | | | | |
| 47130 | C | | Partial removal of liver | | | | | |
| 47133 | C | | Removal of donor liver | | | | | |
| 47134 | C | DG | Partial removal, donor liver | | | | | |
| 47135 | C | DG | Transplantation of liver | | | | | |
| 47136 | C | DG | Transplantation of liver | | | | | |
| 47140 | C | NI | Partial removal, donor liver | | | | | |
| 47141 | C | NI | Partial removal, donor liver | | | | | |
| 47142 | C | NI | Partial removal, donor liver | | | | | |
| 47300 | C | DG | Surgery for liver lesion | | | | | |
| 47350 | C | DG | Repair liver wound | | | | | |
| 47360 | C | | Repair liver wound | | | | | |
| 47361 | C | | Repair liver wound | | | | | |
| 47362 | C | | Repair liver wound | | | | | |
| 47370 | T | | Laparo ablate liver tumor rf | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 47371 | T | | Laparo ablate liver cryosurg | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 47379 | T | | Laparoscope procedure, liver | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 47380 | C | | Open ablate liver tumor rf | | | | | |
| 47381 | C | | Open ablate liver tumor cryo | | | | | |
| 47382 | T | | Percut ablate liver rf | 1557 | | $1,850.00 | | $370.00 |
| 47399 | T | | Liver surgery procedure | 0037 | 9.8921 | $539.72 | $237.45 | $107.94 |
| 47400 | C | | Incision of liver duct | | | | | |
| 47420 | C | | Incision of bile duct | | | | | |
| 47425 | C | | Incision of bile duct | | | | | |
| 47460 | C | | Incise bile duct sphincter | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 47480 | C | | Incision of gallbladder | | | | | |
| 47490 | T | | Incision of gallbladder | 0152 | 9.1474 | $499.09 | $125.28 | $99.82 |
| 47500 | N | | Injection for liver x-rays | | | | | |
| 47505 | N | | Injection for liver x-rays | | | | | |
| 47510 | T | | Insert catheter, bile duct | 0152 | 9.1474 | $499.09 | $125.28 | $99.82 |
| 47511 | T | | Insert bile duct drain | 0152 | 9.1474 | $499.09 | $125.28 | $99.82 |
| 47525 | T | | Change bile duct catheter | 0122 | 8.8621 | $483.53 | $99.16 | $96.71 |
| 47530 | T | | Revise/reinsert bile tube | 0122 | 8.8621 | $483.53 | $99.16 | $96.71 |
| 47550 | C | | Bile duct endoscopy add-on | | | | | |
| 47552 | T | | Biliary endoscopy thru skin | 0152 | 9.1474 | $499.09 | $125.28 | $99.82 |
| 47553 | T | | Biliary endoscopy thru skin | 0152 | 9.1474 | $499.09 | $125.28 | $99.82 |
| 47554 | T | | Biliary endoscopy thru skin | 0152 | 9.1474 | $499.09 | $125.28 | $99.82 |
| 47555 | T | | Biliary endoscopy thru skin | 0152 | 9.1474 | $499.09 | $125.28 | $99.82 |
| 47556 | T | | Biliary endoscopy thru skin | 0152 | 9.1474 | $499.09 | $125.28 | $99.82 |
| 47560 | T | | Laparoscopy w/cholangio | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 47561 | T | | Laparo w/cholangio/biopsy | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 47562 | T | | Laparoscopic cholecystectomy | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 47563 | T | | Laparo cholecystectomy/graph | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 47564 | T | | Laparo cholecystectomy/explr | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 47570 | C | | Laparo cholecystoenterostomy | | | | | |
| 47579 | T | | Laparoscope proc, biliary | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 47600 | C | | Removal of gallbladder | | | | | |
| 47605 | C | | Removal of gallbladder | | | | | |
| 47610 | C | | Removal of gallbladder | | | | | |
| 47612 | C | | Removal of gallbladder | | | | | |
| 47620 | C | | Removal of gallbladder | | | | | |
| 47630 | T | | Remove bile duct stone | 0152 | 9.1474 | $499.09 | $125.28 | $99.82 |
| 47700 | C | | Exploration of bile ducts | | | | | |
| 47701 | C | | Bile duct revision | | | | | |
| 47711 | C | | Excision of bile duct tumor | | | | | |
| 47712 | C | | Excision of bile duct tumor | | | | | |
| 47715 | C | | Excision of bile duct cyst | | | | | |
| 47716 | C | | Fusion of bile duct cyst | | | | | |
| 47720 | C | | Fuse gallbladder & bowel | | | | | |
| 47721 | C | | Fuse upper gi structures | | | | | |
| 47740 | C | | Fuse gallbladder & bowel | | | | | |
| 47741 | C | | Fuse gallbladder & bowel | | | | | |
| 47760 | C | | Fuse bile ducts and bowel | | | | | |
| 47765 | C | | Fuse liver ducts & bowel | | | | | |
| 47780 | C | | Fuse bile ducts and bowel | | | | | |
| 47785 | C | | Fuse bile ducts and bowel | | | | | |
| 47800 | C | | Reconstruction of bile ducts | | | | | |
| 47801 | C | | Placement, bile duct support | | | | | |
| 47802 | C | | Fuse liver duct & intestine | | | | | |
| 47900 | C | | Suture bile duct injury | | | | | |
| 47999 | T | | Bile tract surgery procedure | 0152 | 9.1474 | $499.09 | $125.28 | $99.82 |
| 48000 | C | | Drainage of abdomen | | | | | |
| 48001 | C | | Placement of drain, pancreas | | | | | |
| 48005 | C | | Resect/debride pancreas | | | | | |
| 48020 | C | | Removal of pancreatic stone | | | | | |
| 48100 | C | | Biopsy of pancreas, open | | | | | |
| 48102 | T | | Needle biopsy, pancreas | 0685 | 4.8100 | $262.44 | $115.47 | $52.49 |
| 48120 | C | | Removal of pancreas lesion | | | | | |
| 48140 | C | | Partial removal of pancreas | | | | | |
| 48145 | C | | Partial removal of pancreas | | | | | |
| 48146 | C | | Pancreatectomy | | | | | |
| 48148 | C | | Removal of pancreatic duct | | | | | |
| 48150 | C | | Partial removal of pancreas | | | | | |
| 48152 | C | | Pancreatectomy | | | | | |
| 48153 | C | | Pancreatectomy | | | | | |
| 48154 | C | | Pancreatectomy | | | | | |
| 48155 | C | | Removal of pancreas | | | | | |
| 48160 | E | | Pancreas removal/transplant | | | | | |
| 48180 | C | | Fuse pancreas and bowel | | | | | |
| 48400 | C | | Injection, intraop add-on | | | | | |
| 48500 | C | | Surgery of pancreatic cyst | | | | | |
| 48510 | C | | Drain pancreatic pseudocyst | | | | | |
| 48511 | T | | Drain pancreatic pseudocyst | 0037 | 9.8921 | $539.72 | $237.45 | $107.94 |
| 48520 | C | | Fuse pancreas cyst and bowel | | | | | |
| 48540 | C | | Fuse pancreas cyst and bowel | | | | | |
| 48545 | C | | Pancreatorrhaphy | | | | | |
| 48547 | C | | Duodenal exclusion | | | | | |
| 48550 | E | | Donor pancreatectomy | | | | | |
| 48554 | E | | Transpl allograft pancreas | | | | | |
| 48556 | C | | Removal, allograft pancreas | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 48999 | T | | Pancreas surgery procedure | 0005 | 3.2698 | $178.40 | $71.59 | $35.68 |
| 49000 | C | | Exploration of abdomen | | | | | |
| 49002 | C | | Reopening of abdomen | | | | | |
| 49010 | C | | Exploration behind abdomen | | | | | |
| 49020 | C | | Drain abdominal abscess | | | | | |
| 49021 | C | | Drain abdominal abscess | | | | | |
| 49040 | C | | Drain, open, abdom abscess | | | | | |
| 49041 | C | | Drain, percut, abdom abscess | | | | | |
| 49060 | C | | Drain, open, retrop abscess | | | | | |
| 49061 | C | | Drain, percut, retroper absc | | | | | |
| 49062 | C | | Drain to peritoneal cavity | | | | | |
| 49080 | T | | Puncture, peritoneal cavity | 0070 | 3.0717 | $167.60 | | $33.52 |
| 49081 | T | | Removal of abdominal fluid | 0070 | 3.0717 | $167.60 | | $33.52 |
| 49085 | T | | Remove abdomen foreign body | 0153 | 20.8723 | $1,138.81 | $410.87 | $227.76 |
| 49180 | T | | Biopsy, abdominal mass | 0685 | 4.8100 | $262.44 | $115.47 | $52.49 |
| 49200 | T | | Removal of abdominal lesion | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 49201 | C | | Remove abdom lesion, complex | | | | | |
| 49215 | C | | Excise sacral spine tumor | | | | | |
| 49220 | C | | Multiple surgery, abdomen | | | | | |
| 49250 | T | | Excision of umbilicus | 0153 | 20.8723 | $1,138.81 | $410.87 | $227.76 |
| 49255 | C | | Removal of omentum | | | | | |
| 49320 | T | | Diag laparo separate proc | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 49321 | T | | Laparoscopy, biopsy | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 49322 | T | | Laparoscopy, aspiration | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 49323 | T | | Laparo drain lymphocele | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 49329 | T | | Laparo proc, abdm/per/oment | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 49400 | N | | Air injection into abdomen | | | | | |
| 49419 | T | | Insrt abdom cath for chemotx | 0119 | 134.7194 | $7,350.43 | | $1,470.09 |
| 49420 | T | | Insert abdom drain, temp | 0652 | 27.0364 | $1,475.13 | | $295.03 |
| 49421 | T | | Insert abdom drain, perm | 0652 | 27.0364 | $1,475.13 | | $295.03 |
| 49422 | T | | Remove perm cannula/catheter | 0105 | 19.1898 | $1,047.01 | $370.40 | $209.40 |
| 49423 | T | | Exchange drainage catheter | 0152 | 9.1474 | $499.09 | $125.28 | $99.82 |
| 49424 | N | | Assess cyst, contrast inject | | | | | |
| 49425 | C | | Insert abdomen-venous drain | | | | | |
| 49426 | T | | Revise abdomen-venous shunt | 0153 | 20.8723 | $1,138.81 | $410.87 | $227.76 |
| 49427 | N | | Injection, abdominal shunt | | | | | |
| 49428 | C | | Ligation of shunt | | | | | |
| 49429 | T | | Removal of shunt | 0105 | 19.1898 | $1,047.01 | $370.40 | $209.40 |
| 49491 | T | | Rpr hern preemie reduc | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49492 | T | | Rpr ing hern premie, blocked | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49495 | T | | Rpr ing hernia baby, reduc | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49496 | T | | Rpr ing hernia baby, blocked | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49500 | T | | Rpr ing hernia, init, reduce | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49501 | T | | Rpr ing hernia, init blocked | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49505 | T | | Prp i/hern init reduc>5 yr | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49507 | T | | Prp i/hern init block>5 yr | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49520 | T | | Rerepair ing hernia, reduce | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49521 | T | | Rerepair ing hernia, blocked | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49525 | T | | Repair ing hernia, sliding | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49540 | T | | Repair lumbar hernia | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49550 | T | | Rpr rem hernia, init, reduce | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49553 | T | | Rpr fem hernia, init blocked | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49555 | T | | Rerepair fem hernia, reduce | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49557 | T | | Rerepair fem hernia, blocked | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49560 | T | | Rpr ventral hern init, reduc | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49561 | T | | Rpr ventral hern init, block | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49565 | T | | Rerepair ventrl hern, reduce | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49566 | T | | Rerepair ventrl hern, block | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49568 | T | | Hernia repair w/mesh | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49570 | T | | Rpr epigastric hern, reduce | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49572 | T | | Rpr epigastric hern, blocked | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49580 | T | | Rpr umbil hern, reduc < 5 yr | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49582 | T | | Rpr umbil hern, block < 5 yr | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49585 | T | | Rpr umbil hern, reduc > 5 yr | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49587 | T | | Rpr umbil hern, block > 5 yr | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49590 | T | | Repair spigilian hernia | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49600 | T | | Repair umbilical lesion | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 49605 | C | | Repair umbilical lesion | | | | | |
| 49606 | C | | Repair umbilical lesion | | | | | |
| 49610 | C | | Repair umbilical lesion | | | | | |
| 49611 | C | | Repair umbilical lesion | | | | | |
| 49650 | T | | Laparo hernia repair initial | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 49651 | T | | Laparo hernia repair recur | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 49659 | T | | Laparo proc, hernia repair | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 49900 | C | | Repair of abdominal wall | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 49904 | C | | Omental flap, extra-abdom | | | | | |
| 49905 | C | | Omental flap | | | | | |
| 49906 | C | | Free omental flap, microvasc | | | | | |
| 49999 | T | | Abdomen surgery procedure | 0153 | 20.8723 | $1,138.81 | $410.87 | $227.76 |
| 50010 | C | | Exploration of kidney | | | | | |
| 50020 | C | | Renal abscess, open drain | | | | | |
| 50021 | T | | Renal abscess, percut drain | 0037 | 9.8921 | $539.72 | $237.45 | $107.94 |
| 50040 | C | | Drainage of kidney | | | | | |
| 50045 | C | | Exploration of kidney | | | | | |
| 50060 | C | | Removal of kidney stone | | | | | |
| 50065 | C | | Incision of kidney | | | | | |
| 50070 | C | | Incision of kidney | | | | | |
| 50075 | C | | Removal of kidney stone | | | | | |
| 50080 | T | | Removal of kidney stone | 0163 | 33.8805 | $1,848.55 | | $369.71 |
| 50081 | T | | Removal of kidney stone | 0163 | 33.8805 | $1,848.55 | | $369.71 |
| 50100 | C | | Revise kidney blood vessels | | | | | |
| 50120 | C | | Exploration of kidney | | | | | |
| 50125 | C | | Explore and drain kidney | | | | | |
| 50130 | C | | Removal of kidney stone | | | | | |
| 50135 | C | | Exploration of kidney | | | | | |
| 50200 | T | | Biopsy of kidney | 0685 | 4.8100 | $262.44 | $115.47 | $52.49 |
| 50205 | C | | Biopsy of kidney | | | | | |
| 50220 | C | | Remove kidney, open | | | | | |
| 50225 | C | | Removal kidney open, complex | | | | | |
| 50230 | C | | Removal kidney open, radical | | | | | |
| 50234 | C | | Removal of kidney & ureter | | | | | |
| 50236 | C | | Removal of kidney & ureter | | | | | |
| 50240 | C | | Partial removal of kidney | | | | | |
| 50280 | C | | Removal of kidney lesion | | | | | |
| 50290 | C | | Removal of kidney lesion | | | | | |
| 50300 | C | | Removal of donor kidney | | | | | |
| 50320 | C | | Removal of donor kidney | | | | | |
| 50340 | C | | Removal of kidney | | | | | |
| 50360 | C | | Transplantation of kidney | | | | | |
| 50365 | C | | Transplantation of kidney | | | | | |
| 50370 | C | | Remove transplanted kidney | | | | | |
| 50380 | C | | Reimplantation of kidney | | | | | |
| 50390 | T | | Drainage of kidney lesion | 0685 | 4.8100 | $262.44 | $115.47 | $52.49 |
| 50392 | T | | Insert kidney drain | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 50393 | T | | Insert ureteral tube | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 50394 | N | | Injection for kidney x-ray | | | | | |
| 50395 | T | | Create passage to kidney | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 50396 | T | | Measure kidney pressure | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 50398 | T | | Change kidney tube | 0122 | 8.8621 | $483.53 | $99.16 | $96.71 |
| 50400 | C | | Revision of kidney/ureter | | | | | |
| 50405 | C | | Revision of kidney/ureter | | | | | |
| 50500 | C | | Repair of kidney wound | | | | | |
| 50520 | C | | Close kidney-skin fistula | | | | | |
| 50525 | C | | Repair renal-abdomen fistula | | | | | |
| 50526 | C | | Repair renal-abdomen fistula | | | | | |
| 50540 | C | | Revision of horseshoe kidney | | | | | |
| 50541 | T | | Laparo ablate renal cyst | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 50542 | T | | Laparo ablate renal mass | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 50543 | T | | Laparo partial nephrectomy | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 50544 | T | | Laparoscopy, pyeloplasty | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 50545 | C | | Laparo radical nephrectomy | | | | | |
| 50546 | C | | Laparoscopic nephrectomy | | | | | |
| 50547 | C | | Laparo removal donor kidney | | | | | |
| 50548 | C | | Laparo remove w/ ureter | | | | | |
| 50549 | T | | Laparoscope proc, renal | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 50551 | T | | Kidney endoscopy | 0160 | 6.8801 | $375.39 | $105.06 | $75.08 |
| 50553 | T | | Kidney endoscopy | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 50555 | T | | Kidney endoscopy & biopsy | 0160 | 6.8801 | $375.39 | $105.06 | $75.08 |
| 50557 | T | | Kidney endoscopy & treatment | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 50559 | T | | Renal endoscopy/radiotracer | 0160 | 6.8801 | $375.39 | $105.06 | $75.08 |
| 50561 | T | | Kidney endoscopy & treatment | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 50562 | T | | Renal scope w/tumor resect | 0160 | 6.8801 | $375.39 | $105.06 | $75.08 |
| 50570 | C | | Kidney endoscopy | | | | | |
| 50572 | C | | Kidney endoscopy | | | | | |
| 50574 | C | | Kidney endoscopy & biopsy | | | | | |
| 50575 | C | | Kidney endoscopy | | | | | |
| 50576 | C | | Kidney endoscopy & treatment | | | | | |
| 50578 | C | | Renal endoscopy/radiotracer | | | | | |
| 50580 | C | | Kidney endoscopy & treatment | | | | | |
| 50590 | T | | Fragmenting of kidney stone | 0169 | 45.1150 | $2,461.52 | $1,115.69 | $492.30 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 50600 | C | | Exploration of ureter | | | | | |
| 50605 | C | | Insert ureteral support | | | | | |
| 50610 | C | | Removal of ureter stone | | | | | |
| 50620 | C | | Removal of ureter stone | | | | | |
| 50630 | C | | Removal of ureter stone | | | | | |
| 50650 | C | | Removal of ureter | | | | | |
| 50660 | C | | Removal of ureter | | | | | |
| 50684 | N | | Injection for ureter x-ray | | | | | |
| 50686 | T | | Measure ureter pressure | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 50688 | T | | Change of ureter tube | 0122 | 8.8621 | $483.53 | $99.16 | $96.71 |
| 50690 | N | | Injection for ureter x-ray | | | | | |
| 50700 | C | | Revision of ureter | | | | | |
| 50715 | C | | Release of ureter | | | | | |
| 50722 | C | | Release of ureter | | | | | |
| 50725 | C | | Release/revise ureter | | | | | |
| 50727 | C | | Revise ureter | | | | | |
| 50728 | C | | Revise ureter | | | | | |
| 50740 | C | | Fusion of ureter & kidney | | | | | |
| 50750 | C | | Fusion of ureter & kidney | | | | | |
| 50760 | C | | Fusion of ureters | | | | | |
| 50770 | C | | Splicing of ureters | | | | | |
| 50780 | C | | Reimplant ureter in bladder | | | | | |
| 50782 | C | | Reimplant ureter in bladder | | | | | |
| 50783 | C | | Reimplant ureter in bladder | | | | | |
| 50785 | C | | Reimplant ureter in bladder | | | | | |
| 50800 | C | | Implant ureter in bowel | | | | | |
| 50810 | C | | Fusion of ureter & bowel | | | | | |
| 50815 | C | | Urine shunt to intestine | | | | | |
| 50820 | C | | Construct bowel bladder | | | | | |
| 50825 | C | | Construct bowel bladder | | | | | |
| 50830 | C | | Revise urine flow | | | | | |
| 50840 | C | | Replace ureter by bowel | | | | | |
| 50845 | C | | Appendico-vesicostomy | | | | | |
| 50860 | C | | Transplant ureter to skin | | | | | |
| 50900 | C | | Repair of ureter | | | | | |
| 50920 | C | | Closure ureter/skin fistula | | | | | |
| 50930 | C | | Closure ureter/bowel fistula | | | | | |
| 50940 | C | | Release of ureter | | | | | |
| 50945 | T | | Laparoscopy ureterolithotomy | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 50947 | T | | Laparo new ureter/bladder | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 50948 | T | | Laparo new ureter/bladder | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 50949 | T | | Laparoscope proc, ureter | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 50951 | T | | Endoscopy of ureter | 0160 | 6.8801 | $375.39 | $105.06 | $75.08 |
| 50953 | T | | Endoscopy of ureter | 0160 | 6.8801 | $375.39 | $105.06 | $75.08 |
| 50955 | T | | Ureter endoscopy & biopsy | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 50957 | T | | Ureter endoscopy & treatment | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 50959 | T | | Ureter endoscopy & tracer | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 50961 | T | | Ureter endoscopy & treatment | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 50970 | T | | Ureter endoscopy | 0160 | 6.8801 | $375.39 | $105.06 | $75.08 |
| 50972 | T | | Ureter endoscopy & catheter | 0160 | 6.8801 | $375.39 | $105.06 | $75.08 |
| 50974 | T | | Ureter endoscopy & biopsy | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 50976 | T | | Ureter endoscopy & treatment | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 50978 | T | | Ureter endoscopy & tracer | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 50980 | T | | Ureter endoscopy & treatment | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 51000 | T | | Drainage of bladder | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 51005 | T | | Drainage of bladder | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 51010 | T | | Drainage of bladder | 0165 | 14.6838 | $801.16 | | $160.23 |
| 51020 | T | | Incise & treat bladder | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 51030 | T | | Incise & treat bladder | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 51040 | T | | Incise & drain bladder | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 51045 | T | | Incise bladder/drain ureter | 0160 | 6.8801 | $375.39 | $105.06 | $75.08 |
| 51050 | T | | Removal of bladder stone | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 51060 | C | | Removal of ureter stone | | | | | |
| 51065 | T | | Remove ureter calculus | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 51080 | T | | Drainage of bladder abscess | 0007 | 11.8633 | $647.27 | | $129.45 |
| 51500 | T | | Removal of bladder cyst | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 51520 | T | | Removal of bladder lesion | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 51525 | C | | Removal of bladder lesion | | | | | |
| 51530 | C | | Removal of bladder lesion | | | | | |
| 51535 | C | | Repair of ureter lesion | | | | | |
| 51550 | C | | Partial removal of bladder | | | | | |
| 51555 | C | | Partial removal of bladder | | | | | |
| 51565 | C | | Revise bladder & ureter(s) | | | | | |
| 51570 | C | | Removal of bladder | | | | | |
| 51575 | C | | Removal of bladder & nodes | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 51580 | C | | Remove bladder/revise tract | | | | | |
| 51585 | C | | Removal of bladder & nodes | | | | | |
| 51590 | C | | Remove bladder/revise tract | | | | | |
| 51595 | C | | Remove bladder/revise tract | | | | | |
| 51596 | C | | Remove bladder/create pouch | | | | | |
| 51597 | C | | Removal of pelvic structures | | | | | |
| 51600 | N | | Injection for bladder x-ray | | | | | |
| 51605 | N | | Preparation for bladder xray | | | | | |
| 51610 | N | | Injection for bladder x-ray | | | | | |
| 51700 | T | | Irrigation of bladder | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 51701 | N | | Insert bladder catheter | | | | | |
| 51702 | N | | Insert temp bladder cath | | | | | |
| 51703 | N | | Insert bladder cath, complex | | | | | |
| 51705 | T | | Change of bladder tube | 0121 | 2.1189 | $115.61 | $43.80 | $23.12 |
| 51710 | T | | Change of bladder tube | 0122 | 8.8621 | $483.53 | $99.16 | $96.71 |
| 51715 | T | | Endoscopic injection/implant | 0167 | 30.0186 | $1,637.84 | $555.84 | $327.57 |
| 51720 | T | | Treatment of bladder lesion | 0156 | 2.4747 | $135.02 | $40.52 | $27.00 |
| 51725 | T | | Simple cystometrogram | 0156 | 2.4747 | $135.02 | $40.52 | $27.00 |
| 51726 | T | | Complex cystometrogram | 0156 | 2.4747 | $135.02 | $40.52 | $27.00 |
| 51736 | T | | Urine flow measurement | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 51741 | T | | Electro-uroflowmetry, first | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 51772 | T | | Urethra pressure profile | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 51784 | T | | Anal/urinary muscle study | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 51785 | T | | Anal/urinary muscle study | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 51792 | T | | Urinary reflex study | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 51795 | T | | Urine voiding pressure study | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 51797 | T | | Intraabdominal pressure test | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 51798 | X | | Us urine capacity measure | 0340 | 0.6314 | $34.45 | | $6.89 |
| 51800 | C | | Revision of bladder/urethra | | | | | |
| 51820 | C | | Revision of urinary tract | | | | | |
| 51840 | C | | Attach bladder/urethra | | | | | |
| 51841 | C | | Attach bladder/urethra | | | | | |
| 51845 | C | | Repair bladder neck | | | | | |
| 51860 | C | | Repair of bladder wound | | | | | |
| 51865 | C | | Repair of bladder wound | | | | | |
| 51880 | T | | Repair of bladder opening | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 51900 | C | | Repair bladder/vagina lesion | | | | | |
| 51920 | C | | Close bladder-uterus fistula | | | | | |
| 51925 | C | | Hysterectomy/bladder repair | | | | | |
| 51940 | C | | Correction of bladder defect | | | | | |
| 51960 | C | | Revision of bladder & bowel | | | | | |
| 51980 | C | | Construct bladder opening | | | | | |
| 51990 | T | | Laparo urethral suspension | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 51992 | T | | Laparo sling operation | 0132 | 57.2045 | $3,121.13 | $1,239.22 | $624.23 |
| 52000 | T | | Cystoscopy | 0160 | 6.8801 | $375.39 | $105.06 | $75.08 |
| 52001 | T | | Cystoscopy, removal of clots | 0160 | 6.8801 | $375.39 | $105.06 | $75.08 |
| 52005 | T | | Cystoscopy & ureter catheter | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52007 | T | | Cystoscopy and biopsy | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52010 | T | | Cystoscopy & duct catheter | 0160 | 6.8801 | $375.39 | $105.06 | $75.08 |
| 52204 | T | | Cystoscopy | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52214 | T | | Cystoscopy and treatment | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52224 | T | | Cystoscopy and treatment | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52234 | T | | Cystoscopy and treatment | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52235 | T | | Cystoscopy and treatment | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52240 | T | | Cystoscopy and treatment | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52250 | T | | Cystoscopy and radiotracer | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52260 | T | | Cystoscopy and treatment | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52265 | T | | Cystoscopy and treatment | 0160 | 6.8801 | $375.39 | $105.06 | $75.08 |
| 52270 | T | | Cystoscopy & revise urethra | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52275 | T | | Cystoscopy & revise urethra | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52276 | T | | Cystoscopy and treatment | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52277 | T | | Cystoscopy and treatment | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52281 | T | | Cystoscopy and treatment | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52282 | S | | Cystoscopy, implant stent | 0385 | 67.1530 | $3,663.93 | | $732.79 |
| 52283 | T | | Cystoscopy and treatment | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52285 | T | | Cystoscopy and treatment | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52290 | T | | Cystoscopy and treatment | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52300 | T | | Cystoscopy and treatment | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52301 | T | | Cystoscopy and treatment | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52305 | T | | Cystoscopy and treatment | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52310 | T | | Cystoscopy and treatment | 0160 | 6.8801 | $375.39 | $105.06 | $75.08 |
| 52315 | T | | Cystoscopy and treatment | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52317 | T | | Remove bladder stone | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52318 | T | | Remove bladder stone | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52320 | T | | Cystoscopy and treatment | 0162 | 21.9098 | $1,195.42 | | $239.08 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 52325 | T | | Cystoscopy, stone removal | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52327 | T | | Cystoscopy, inject material | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52330 | T | | Cystoscopy and treatment | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52332 | T | | Cystoscopy and treatment | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52334 | T | | Create passage to kidney | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52341 | T | | Cysto w/ureter stricture tx | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52342 | T | | Cysto w/up stricture tx | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52343 | T | | Cysto w/renal stricture tx | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52344 | T | | Cysto/uretero, stone remove | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52345 | T | | Cysto/uretero w/up stricture | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52346 | T | | Cystouretero w/renal strict | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52347 | T | | Cystoscopy, resect ducts | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52351 | T | | Cystouretero & or pyeloscope | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52352 | T | | Cystouretero w/stone remove | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52353 | T | | Cystouretero w/lithotripsy | 0163 | 33.8805 | $1,848.55 | | $369.71 |
| 52354 | T | | Cystouretero w/biopsy | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52355 | T | | Cystouretero w/excise tumor | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52400 | T | | Cystouretero w/congen repr | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52450 | T | | Incision of prostate | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52500 | T | | Revision of bladder neck | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52510 | T | | Dilation prostatic urethra | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 52601 | T | | Prostatectomy (TURP) | 0163 | 33.8805 | $1,848.55 | | $369.71 |
| 52606 | T | | Control postop bleeding | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52612 | T | | Prostatectomy, first stage | 0163 | 33.8805 | $1,848.55 | | $369.71 |
| 52614 | T | | Prostatectomy, second stage | 0163 | 33.8805 | $1,848.55 | | $369.71 |
| 52620 | T | | Remove residual prostate | 0163 | 33.8805 | $1,848.55 | | $369.71 |
| 52630 | T | | Remove prostate regrowth | 0163 | 33.8805 | $1,848.55 | | $369.71 |
| 52640 | T | | Relieve bladder contracture | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 52647 | T | | Laser surgery of prostate | 0163 | 33.8805 | $1,848.55 | | $369.71 |
| 52648 | T | | Laser surgery of prostate | 0163 | 33.8805 | $1,848.55 | | $369.71 |
| 52700 | T | | Drainage of prostate abscess | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 53000 | T | | Incision of urethra | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 53010 | T | | Incision of urethra | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 53020 | T | | Incision of urethra | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 53025 | T | | Incision of urethra | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 53040 | T | | Drainage of urethra abscess | 0167 | 30.0186 | $1,637.84 | $555.84 | $327.57 |
| 53060 | T | | Drainage of urethra abscess | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 53080 | T | | Drainage of urinary leakage | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 53085 | C | | Drainage of urinary leakage | | | | | |
| 53200 | T | | Biopsy of urethra | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 53210 | T | | Removal of urethra | 0168 | 30.0147 | $1,637.63 | $405.60 | $327.53 |
| 53215 | T | | Removal of urethra | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 53220 | T | | Treatment of urethra lesion | 0168 | 30.0147 | $1,637.63 | $405.60 | $327.53 |
| 53230 | T | | Removal of urethra lesion | 0168 | 30.0147 | $1,637.63 | $405.60 | $327.53 |
| 53235 | T | | Removal of urethra lesion | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 53240 | T | | Surgery for urethra pouch | 0168 | 30.0147 | $1,637.63 | $405.60 | $327.53 |
| 53250 | T | | Removal of urethra gland | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 53260 | T | | Treatment of urethra lesion | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 53265 | T | | Treatment of urethra lesion | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 53270 | T | | Removal of urethra gland | 0167 | 30.0186 | $1,637.84 | $555.84 | $327.57 |
| 53275 | T | | Repair of urethra defect | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 53400 | T | | Revise urethra, stage 1 | 0168 | 30.0147 | $1,637.63 | $405.60 | $327.53 |
| 53405 | T | | Revise urethra, stage 2 | 0168 | 30.0147 | $1,637.63 | $405.60 | $327.53 |
| 53410 | T | | Reconstruction of urethra | 0168 | 30.0147 | $1,637.63 | $405.60 | $327.53 |
| 53415 | C | | Reconstruction of urethra | | | | | |
| 53420 | T | | Reconstruct urethra, stage 1 | 0168 | 30.0147 | $1,637.63 | $405.60 | $327.53 |
| 53425 | T | | Reconstruct urethra, stage 2 | 0168 | 30.0147 | $1,637.63 | $405.60 | $327.53 |
| 53430 | T | | Reconstruction of urethra | 0168 | 30.0147 | $1,637.63 | $405.60 | $327.53 |
| 53431 | T | | Reconstruct urethra/bladder | 0168 | 30.0147 | $1,637.63 | $405.60 | $327.53 |
| 53440 | S | | Correct bladder function | 0385 | 67.1530 | $3,663.93 | | $732.79 |
| 53442 | T | | Remove perineal prosthesis | 0167 | 30.0186 | $1,637.84 | $555.84 | $327.57 |
| 53444 | S | | Insert tandem cuff | 0385 | 67.1530 | $3,663.93 | | $732.79 |
| 53445 | S | | Insert uro/ves nck sphincter | 0386 | 116.2382 | $6,342.07 | | $1,268.41 |
| 53446 | T | | Remove uro sphincter | 0168 | 30.0147 | $1,637.63 | $405.60 | $327.53 |
| 53447 | S | | Remove/replace ur sphincter | 0386 | 116.2382 | $6,342.07 | | $1,268.41 |
| 53448 | C | | Remov/replc ur sphinctr comp | | | | | |
| 53449 | T | | Repair uro sphincter | 0168 | 30.0147 | $1,637.63 | $405.60 | $327.53 |
| 53450 | T | | Revision of urethra | 0168 | 30.0147 | $1,637.63 | $405.60 | $327.53 |
| 53460 | T | | Revision of urethra | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 53500 | T | NI | Urethrlys, transvag w/ scope | 0168 | 30.0147 | $1,637.63 | $405.60 | $327.53 |
| 53502 | T | | Repair of urethra injury | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 53505 | T | | Repair of urethra injury | 0167 | 30.0186 | $1,637.84 | $555.84 | $327.57 |
| 53510 | T | | Repair of urethra injury | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 53515 | T | | Repair of urethra injury | 0168 | 30.0147 | $1,637.63 | $405.60 | $327.53 |
| 53520 | T | | Repair of urethra defect | 0168 | 30.0147 | $1,637.63 | $405.60 | $327.53 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 53600 | T | | Dilate urethra stricture | 0156 | 2.4747 | $135.02 | $40.52 | $27.00 |
| 53601 | T | | Dilate urethra stricture | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 53605 | T | | Dilate urethra stricture | 0161 | 16.8407 | $918.85 | $249.36 | $183.77 |
| 53620 | T | | Dilate urethra stricture | 0165 | 14.6838 | $801.16 | | $160.23 |
| 53621 | T | | Dilate urethra stricture | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 53660 | T | | Dilation of urethra | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 53661 | T | | Dilation of urethra | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 53665 | T | | Dilation of urethra | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 53850 | T | | Prostatic microwave thermotx | 0675 | 49.3452 | $2,692.32 | | $538.46 |
| 53852 | T | | Prostatic rf thermotx | 0675 | 49.3452 | $2,692.32 | | $538.46 |
| 53853 | T | | Prostatic water thermother | 1550 | | $1,150.00 | | $230.00 |
| 53899 | T | | Urology surgery procedure | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 54000 | T | | Slitting of prepuce | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 54001 | T | | Slitting of prepuce | 0166 | 16.7918 | $916.18 | $218.73 | $183.24 |
| 54015 | T | | Drain penis lesion | 0007 | 11.8633 | $647.27 | | $129.45 |
| 54050 | T | | Destruction, penis lesion(s) | 0013 | 1.1272 | $61.50 | $14.20 | $12.30 |
| 54055 | T | | Destruction, penis lesion(s) | 0017 | 16.3697 | $893.15 | $227.84 | $178.63 |
| 54056 | T | | Cryosurgery, penis lesion(s) | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 54057 | T | | Laser surg, penis lesion(s) | 0017 | 16.3697 | $893.15 | $227.84 | $178.63 |
| 54060 | T | | Excision of penis lesion(s) | 0017 | 16.3697 | $893.15 | $227.84 | $178.63 |
| 54065 | T | | Destruction, penis lesion(s) | 0695 | 19.1849 | $1,046.75 | $266.59 | $209.35 |
| 54100 | T | | Biopsy of penis | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 54105 | T | | Biopsy of penis | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 54110 | T | | Treatment of penis lesion | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54111 | T | | Treat penis lesion, graft | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54112 | T | | Treat penis lesion, graft | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54115 | T | | Treatment of penis lesion | 0008 | 19.4831 | $1,063.02 | | $212.60 |
| 54120 | T | | Partial removal of penis | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54125 | C | | Removal of penis | | | | | |
| 54130 | C | | Remove penis & nodes | | | | | |
| 54135 | C | | Remove penis & nodes | | | | | |
| 54150 | T | | Circumcision | 0180 | 18.6176 | $1,015.79 | $304.87 | $203.16 |
| 54152 | T | | Circumcision | 0180 | 18.6176 | $1,015.79 | $304.87 | $203.16 |
| 54160 | T | | Circumcision | 0180 | 18.6176 | $1,015.79 | $304.87 | $203.16 |
| 54161 | T | | Circumcision | 0180 | 18.6176 | $1,015.79 | $304.87 | $203.16 |
| 54162 | T | | Lysis penil circumic lesion | 0180 | 18.6176 | $1,015.79 | $304.87 | $203.16 |
| 54163 | T | | Repair of circumcision | 0180 | 18.6176 | $1,015.79 | $304.87 | $203.16 |
| 54164 | T | | Frenulotomy of penis | 0180 | 18.6176 | $1,015.79 | $304.87 | $203.16 |
| 54200 | T | | Treatment of penis lesion | 0156 | 2.4747 | $135.02 | $40.52 | $27.00 |
| 54205 | T | | Treatment of penis lesion | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54220 | T | | Treatment of penis lesion | 0156 | 2.4747 | $135.02 | $40.52 | $27.00 |
| 54230 | N | | Prepare penis study | | | | | |
| 54231 | T | | Dynamic cavernosometry | 0165 | 14.6838 | $801.16 | | $160.23 |
| 54235 | T | | Penile injection | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 54240 | T | | Penis study | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 54250 | T | | Penis study | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 54300 | T | | Revision of penis | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54304 | T | | Revision of penis | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54308 | T | | Reconstruction of urethra | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54312 | T | | Reconstruction of urethra | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54316 | T | | Reconstruction of urethra | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54318 | T | | Reconstruction of urethra | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54322 | T | | Reconstruction of urethra | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54324 | T | | Reconstruction of urethra | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54326 | T | | Reconstruction of urethra | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54328 | T | | Revise penis/urethra | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54332 | C | | Revise penis/urethra | | | | | |
| 54336 | C | | Revise penis/urethra | | | | | |
| 54340 | T | | Secondary urethral surgery | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54344 | T | | Secondary urethral surgery | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54348 | T | | Secondary urethral surgery | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54352 | T | | Reconstruct urethra/penis | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54360 | T | | Penis plastic surgery | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54380 | T | | Repair penis | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54385 | T | | Repair penis | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54390 | C | | Repair penis and bladder | | | | | |
| 54400 | S | | Insert semi-rigid prosthesis | 0385 | 67.1530 | $3,663.93 | | $732.79 |
| 54401 | S | | Insert self-contd prosthesis | 0386 | 116.2382 | $6,342.07 | | $1,268.41 |
| 54405 | S | | Insert multi-comp penis pros | 0386 | 116.2382 | $6,342.07 | | $1,268.41 |
| 54406 | T | | Remove muti-comp penis pros | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54408 | T | | Repair multi-comp penis pros | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54410 | S | | Remove/replace penis prosth | 0386 | 116.2382 | $6,342.07 | | $1,268.41 |
| 54411 | C | | Remov/replc penis pros, comp | | | | | |
| 54415 | T | | Remove self-contd penis pros | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54416 | S | | Remv/repl penis contain pros | 0385 | 67.1530 | $3,663.93 | | $732.79 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 54417 | C | | Remv/replc penis pros, compl | | | | | |
| 54420 | T | | Revision of penis | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54430 | C | | Revision of penis | | | | | |
| 54435 | T | | Revision of penis | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54440 | T | | Repair of penis | 0181 | 29.4217 | $1,605.28 | $621.82 | $321.06 |
| 54450 | T | | Preputial stretching | 0156 | 2.4747 | $135.02 | $40.52 | $27.00 |
| 54500 | T | | Biopsy of testis | 0037 | 9.8921 | $539.72 | $237.45 | $107.94 |
| 54505 | T | | Biopsy of testis | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 54512 | T | | Excise lesion testis | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 54520 | T | | Removal of testis | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 54522 | T | | Orchiectomy, partial | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 54530 | T | | Removal of testis | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 54535 | C | | Extensive testis surgery | | | | | |
| 54550 | T | | Exploration for testis | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 54560 | C | | Exploration for testis | | | | | |
| 54600 | T | | Reduce testis torsion | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 54620 | T | | Suspension of testis | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 54640 | T | | Suspension of testis | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 54650 | C | | Orchiopexy (Fowler-Stephens) | | | | | |
| 54660 | T | | Revision of testis | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 54670 | T | | Repair testis injury | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 54680 | T | | Relocation of testis(es) | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 54690 | T | | Laparoscopy, orchiectomy | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 54692 | T | | Laparoscopy, orchiopexy | 0132 | 57.2045 | $3,121.13 | $1,239.22 | $624.23 |
| 54699 | T | | Laparoscope proc, testis | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 54700 | T | | Drainage of scrotum | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 54800 | T | | Biopsy of epididymis | 0004 | 1.5882 | $86.65 | $22.36 | $17.33 |
| 54820 | T | | Exploration of epididymis | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 54830 | T | | Remove epididymis lesion | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 54840 | T | | Remove epididymis lesion | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 54860 | T | | Removal of epididymis | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 54861 | T | | Removal of epididymis | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 54900 | T | | Fusion of spermatic ducts | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 54901 | T | | Fusion of spermatic ducts | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 55000 | T | | Drainage of hydrocele | 0004 | 1.5882 | $86.65 | $22.36 | $17.33 |
| 55040 | T | | Removal of hydrocele | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 55041 | T | | Removal of hydroceles | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 55060 | T | | Repair of hydrocele | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 55100 | T | | Drainage of scrotum abscess | 0007 | 11.8633 | $647.27 | | $129.45 |
| 55110 | T | | Explore scrotum | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 55120 | T | | Removal of scrotum lesion | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 55150 | T | | Removal of scrotum | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 55175 | T | | Revision of scrotum | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 55180 | T | | Revision of scrotum | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 55200 | T | | Incision of sperm duct | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 55250 | T | | Removal of sperm duct(s) | 0183 | 21.6724 | $1,182.47 | | $236.49 W≤ |
| 55300 | N | | Prepare, sperm duct x-ray | | | | | |
| 55400 | T | | Repair of sperm duct | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 55450 | T | | Ligation of sperm duct | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 55500 | T | | Removal of hydrocele | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 55520 | T | | Removal of sperm cord lesion | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 55530 | T | | Revise spermatic cord veins | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 55535 | T | | Revise spermatic cord veins | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 55540 | T | | Revise hernia & sperm veins | 0154 | 26.9636 | $1,471.16 | $464.85 | $294.23 |
| 55550 | T | | Laparo ligate spermatic vein | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 55559 | T | | Laparo proc, spermatic cord | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 55600 | C | | Incise sperm duct pouch | | | | | |
| 55605 | C | | Incise sperm duct pouch | | | | | |
| 55650 | C | | Remove sperm duct pouch | | | | | |
| 55680 | T | | Remove sperm pouch lesion | 0183 | 21.6724 | $1,182.47 | | $236.49 |
| 55700 | T | | Biopsy of prostate | 0184 | 3.8995 | $212.76 | $96.27 | $42.55 |
| 55705 | T | | Biopsy of prostate | 0184 | 3.8995 | $212.76 | $96.27 | $42.55 |
| 55720 | T | | Drainage of prostate abscess | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 55725 | T | | Drainage of prostate abscess | 0162 | 21.9098 | $1,195.42 | | $239.08 |
| 55801 | C | | Removal of prostate | | | | | |
| 55810 | C | | Extensive prostate surgery | | | | | |
| 55812 | C | | Extensive prostate surgery | | | | | |
| 55815 | C | | Extensive prostate surgery | | | | | |
| 55821 | C | | Removal of prostate | | | | | |
| 55831 | C | | Removal of prostate | | | | | |
| 55840 | C | | Extensive prostate surgery | | | | | |
| 55842 | C | | Extensive prostate surgery | | | | | |
| 55845 | C | | Extensive prostate surgery | | | | | |
| 55859 | T | | Percut/needle insert, pros | 0163 | 33.8805 | $1,848.55 | | $369.71 |
| 55860 | T | | Surgical exposure, prostate | 0165 | 14.6838 | $801.16 | | $160.23 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 55862 | C | | Extensive prostate surgery | | | | | |
| 55865 | C | | Extensive prostate surgery | | | | | |
| 55866 | C | | Laparo radical prostatectomy | | | | | |
| 55870 | T | | Vag hyst w/enterocele repair | 0197 | 4.8280 | $263.42 | | $52.68 |
| 55873 | T | | Cryoablate prostate | 0674 | 119.9733 | $6,545.86 | | $1,309.17 |
| 55899 | T | | Genital surgery procedure | 0164 | 1.2021 | $65.59 | $17.59 | $13.12 |
| 55970 | E | | Sex transformation, M to F | | | | | |
| 55980 | E | | Sex transformation, F to M | | | | | |
| 56405 | T | | I & D of vulva/perineum | 0192 | 2.7121 | $147.97 | $39.11 | $29.59 |
| 56420 | T | | Drainage of gland abscess | 0192 | 2.7121 | $147.97 | $39.11 | $29.59 |
| 56440 | T | | Surgery for vulva lesion | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 56441 | T | | Lysis of labial lesion(s) | 0193 | 15.0453 | $820.89 | $171.13 | $164.18 |
| 56501 | T | | Destroy, vulva lesions, sim | 0017 | 16.3697 | $893.15 | $227.84 | $178.63 |
| 56515 | T | | Destroy vulva lesion/s compl | 0695 | 19.1849 | $1,046.75 | $266.59 | $209.35 |
| 56605 | T | | Biopsy of vulva/perineum | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 56606 | T | | Biopsy of vulva/perineum | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 56620 | T | | Partial removal of vulva | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 56625 | T | | Complete removal of vulva | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 56630 | C | | Extensive vulva surgery | | | | | |
| 56631 | C | | Extensive vulva surgery | | | | | |
| 56632 | C | | Extensive vulva surgery | | | | | |
| 56633 | C | | Extensive vulva surgery | | | | | |
| 56634 | C | | Extensive vulva surgery | | | | | |
| 56637 | C | | Extensive vulva surgery | | | | | |
| 56640 | C | | Extensive vulva surgery | | | | | |
| 56700 | T | | Partial removal of hymen | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 56720 | T | | Incision of hymen | 0193 | 15.0453 | $820.89 | $171.13 | $164.18 |
| 56740 | T | | Remove vagina gland lesion | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 56800 | T | | Repair of vagina | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 56805 | T | | Repair clitoris | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 56810 | T | | Repair of perineum | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 56820 | T | | Exam of vulva w/scope | 0188 | 1.1365 | $62.01 | | $12.40 |
| 56821 | T | | Exam/biopsy of vulva w/scope | 0189 | 1.4232 | $77.65 | $18.09 | $15.53 |
| 57000 | T | | Exploration of vagina | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 57010 | T | | Drainage of pelvic abscess | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 57020 | T | | Drainage of pelvic fluid | 0192 | 2.7121 | $147.97 | $39.11 | $29.59 |
| 57022 | T | | I & d vaginal hematoma, pp | 0007 | 11.8633 | $647.27 | | $129.45 |
| 57023 | T | | I & d vag hematoma, non-ob | 0007 | 11.8633 | $647.27 | | $129.45 |
| 57061 | T | | Destroy vag lesions, simple | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 57065 | T | | Destroy vag lesions, complex | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 57100 | T | | Biopsy of vagina | 0192 | 2.7121 | $147.97 | $39.11 | $29.59 |
| 57105 | T | | Biopsy of vagina | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 57106 | T | | Remove vagina wall, partial | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 57107 | T | | Remove vagina tissue, part | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57109 | T | | Vaginectomy partial w/nodes | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57110 | C | | Remove vagina wall, complete | | | | | |
| 57111 | C | | Remove vagina tissue, compl | | | | | |
| 57112 | C | | Vaginectomy w/nodes, compl | | | | | |
| 57120 | T | | Closure of vagina | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57130 | T | | Remove vagina lesion | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 57135 | T | | Remove vagina lesion | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 57150 | T | | Treat vagina infection | 0191 | 0.1853 | $10.11 | $2.93 | $2.02 |
| 57155 | T | | Insert uteri tandems/ovoids | 0193 | 15.0453 | $820.89 | $171.13 | $164.18 |
| 57160 | T | | Insert pessary/other device | 0188 | 1.1365 | $62.01 | | $12.40 |
| 57170 | T | | Fitting of diaphragm/cap | 0191 | 0.1853 | $10.11 | $2.93 | $2.02 |
| 57180 | T | | Treat vaginal bleeding | 0192 | 2.7121 | $147.97 | $39.11 | $29.59 |
| 57200 | T | | Repair of vagina | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 57210 | T | | Repair vagina/perineum | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 57220 | T | | Revision of urethra | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57230 | T | | Repair of urethral lesion | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57240 | T | | Repair bladder & vagina | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57250 | T | | Repair rectum & vagina | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57260 | T | | Repair of vagina | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57265 | T | | Extensive repair of vagina | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57268 | T | | Repair of bowel bulge | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57270 | C | | Repair of bowel pouch | | | | | |
| 57280 | C | | Suspension of vagina | | | | | |
| 57282 | C | | Repair of vaginal prolapse | | | | | |
| 57284 | T | | Repair paravaginal defect | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57287 | T | | Revise/remove sling repair | 0202 | 38.9821 | $2,126.90 | $1,042.18 | $425.38 |
| 57288 | T | | Repair bladder defect | 0202 | 38.9821 | $2,126.90 | $1,042.18 | $425.38 |
| 57289 | T | | Repair bladder & vagina | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57291 | T | | Construction of vagina | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57292 | C | | Construct vagina with graft | | | | | |
| 57300 | T | | Repair rectum-vagina fistula | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 57305 | C | | Repair rectum-vagina fistula | | | | | |
| 57307 | C | | Fistula repair & colostomy | | | | | |
| 57308 | C | | Fistula repair, transperine | | | | | |
| 57310 | T | | Repair urethrovaginal lesion | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57311 | C | | Repair urethrovaginal lesion | | | | | |
| 57320 | T | | Repair bladder-vagina lesion | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57330 | T | | Repair bladder-vagina lesion | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57335 | C | | Repair vagina | | | | | |
| 57400 | T | | Dilation of vagina | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 57410 | T | | Pelvic examination | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 57415 | T | | Remove vaginal foreign body | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 57420 | T | | Exam of vagina w/scope | 0192 | 2.7121 | $147.97 | $39.11 | $29.59 |
| 57421 | T | | Exam/biopsy of vag w/scope | 0192 | 2.7121 | $147.97 | $39.11 | $29.59 |
| 57425 | T | NI | Laparoscopy, surg, colpopexy | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 57452 | T | | Examination of vagina | 0189 | 1.4232 | $77.65 | $18.09 | $15.53 |
| 57454 | T | | Vagina examination & biopsy | 0192 | 2.7121 | $147.97 | $39.11 | $29.59 |
| 57455 | T | | Biopsy of cervix w/scope | 0192 | 2.7121 | $147.97 | $39.11 | $29.59 |
| 57456 | T | | Endocerv curettage w/scope | 0192 | 2.7121 | $147.97 | $39.11 | $29.59 |
| 57460 | T | | Cervix excision | 0193 | 15.0453 | $820.89 | $171.13 | $164.18 |
| 57461 | T | | Conz of cervix w/scope, leep | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 57500 | T | | Biopsy of cervix | 0192 | 2.7121 | $147.97 | $39.11 | $29.59 |
| 57505 | T | | Endocervical curettage | 0192 | 2.7121 | $147.97 | $39.11 | $29.59 |
| 57510 | T | | Cauterization of cervix | 0193 | 15.0453 | $820.89 | $171.13 | $164.18 |
| 57511 | T | | Cryocautery of cervix | 0189 | 1.4232 | $77.65 | $18.09 | $15.53 |
| 57513 | T | | Laser surgery of cervix | 0193 | 15.0453 | $820.89 | $171.13 | $164.18 |
| 57520 | T | | Conization of cervix | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 57522 | T | | Conization of cervix | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57530 | T | | Removal of cervix | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57531 | C | | Removal of cervix, radical | | | | | |
| 57540 | C | | Removal of residual cervix | | | | | |
| 57545 | C | | Remove cervix/repair pelvis | | | | | |
| 57550 | T | | Removal of residual cervix | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57555 | T | | Remove cervix/repair vagina | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57556 | T | | Remove cervix, repair bowel | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 57700 | T | | Revision of cervix | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 57720 | T | | Revision of cervix | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 57800 | T | | Dilation of cervical canal | 0193 | 15.0453 | $820.89 | $171.13 | $164.18 |
| 57820 | T | | D & c of residual cervix | 0196 | 16.1219 | $879.63 | $338.23 | $175.93 |
| 58100 | T | | Biopsy of uterus lining | 0188 | 1.1365 | $62.01 | | $12.40 |
| 58120 | T | | Dilation and curettage | 0196 | 16.1219 | $879.63 | $338.23 | $175.93 |
| 58140 | C | | Removal of uterus lesion | | | | | |
| 58145 | T | | Myomectomy vag method | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 58146 | C | | Myomectomy abdom complex | | | | | |
| 58150 | C | | Total hysterectomy | | | | | |
| 58152 | C | | Total hysterectomy | | | | | |
| 58180 | C | | Partial hysterectomy | | | | | |
| 58200 | C | | Extensive hysterectomy | | | | | |
| 58210 | C | | Extensive hysterectomy | | | | | |
| 58240 | C | | Removal of pelvis contents | | | | | |
| 58260 | C | | Vaginal hysterectomy | | | | | |
| 58262 | C | | Vag hyst including t/o | | | | | |
| 58263 | C | | Vag hyst w/t/o & vag repair | | | | | |
| 58267 | C | | Vag hyst w/urinary repair | | | | | |
| 58270 | C | | Vag hyst w/enterocele repair | | | | | |
| 58275 | C | | Hysterectomy/revise vagina | | | | | |
| 58280 | C | | Hysterectomy/revise vagina | | | | | |
| 58285 | C | | Extensive hysterectomy | | | | | |
| 58290 | C | | Vag hyst complex | | | | | |
| 58291 | C | | Vag hyst incl t/o, complex | | | | | |
| 58292 | C | | Vag hyst t/o & repair, compl | | | | | |
| 58293 | C | | Vag hyst w/uro repair, compl | | | | | |
| 58294 | C | | Vag hyst w/enterocele, compl | | | | | |
| 58300 | E | | Insert intrauterine device | | | | | |
| 58301 | T | | Remove intrauterine device | 0189 | 1.4232 | $77.65 | $18.09 | $15.53 |
| 58321 | T | | Artificial insemination | 0197 | 4.8280 | $263.42 | | $52.68 |
| 58322 | T | | Artificial insemination | 0197 | 4.8280 | $263.42 | | $52.68 |
| 58323 | T | | Sperm washing | 0197 | 4.8280 | $263.42 | | $52.68 |
| 58340 | N | | Catheter for hysterography | | | | | |
| 58345 | T | | Reopen fallopian tube | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 58346 | T | | Insert heyman uteri capsule | 0193 | 15.0453 | $820.89 | $171.13 | $164.18 |
| 58350 | T | | Reopen fallopian tube | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 58353 | T | | Endometr ablate, thermal | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 58400 | C | | Suspension of uterus | | | | | |
| 58410 | C | | Suspension of uterus | | | | | |
| 58520 | C | | Repair of ruptured uterus | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 58540 | C | | Revision of uterus | | | | | |
| 58545 | T | | Laparoscopic myomectomy | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 58546 | T | | Laparo-myomectomy, complex | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 58550 | T | | Laparo-asst vag hysterectomy | 0132 | 57.2045 | $3,121.13 | $1,239.22 | $624.23 |
| 58552 | T | | Laparo-vag hyst incl t/o | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 58553 | T | | Laparo-vag hyst, complex | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 58554 | T | | Laparo-vag hyst w/t/o, compl | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 58555 | T | | Hysteroscopy, dx, sep proc | 0190 | 19.6922 | $1,074.43 | $424.28 | $214.89 |
| 58558 | T | | Hysteroscopy, biopsy | 0190 | 19.6922 | $1,074.43 | $424.28 | $214.89 |
| 58559 | T | | Hysteroscopy, lysis | 0190 | 19.6922 | $1,074.43 | $424.28 | $214.89 |
| 58560 | T | | Hysteroscopy, resect septum | 0387 | 28.1480 | $1,535.78 | $655.55 | $307.16 |
| 58561 | T | | Hysteroscopy, remove myoma | 0387 | 28.1480 | $1,535.78 | $655.55 | $307.16 |
| 58562 | T | | Hysteroscopy, remove fb | 0190 | 19.6922 | $1,074.43 | $424.28 | $214.89 |
| 58563 | T | | Hysteroscopy, ablation | 0387 | 28.1480 | $1,535.78 | $655.55 | $307.16 |
| 58578 | T | | Laparo proc, uterus | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 58579 | T | | Hysteroscope procedure | 0190 | 19.6922 | $1,074.43 | $424.28 | $214.89 |
| 58600 | T | | Division of fallopian tube | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 58605 | C | | Division of fallopian tube | | | | | |
| 58611 | C | | Ligate oviduct(s) add-on | | | | | |
| 58615 | T | | Occlude fallopian tube(s) | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 58660 | T | | Laparoscopy, lysis | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 58661 | T | | Laparoscopy, remove adnexa | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 58662 | T | | Laparoscopy, excise lesions | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 58670 | T | | Laparoscopy, tubal cautery | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 58671 | T | | Laparoscopy, tubal block | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 58672 | T | | Laparoscopy, fimbrioplasty | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 58673 | T | | Laparoscopy, salpingostomy | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 58679 | T | | Laparo proc, oviduct-ovary | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 58700 | C | | Removal of fallopian tube | | | | | |
| 58720 | C | | Removal of ovary/tube(s) | | | | | |
| 58740 | C | | Revise fallopian tube(s) | | | | | |
| 58750 | C | | Repair oviduct | | | | | |
| 58752 | C | | Revise ovarian tube(s) | | | | | |
| 58760 | C | | Remove tubal obstruction | | | | | |
| 58770 | C | | Create new tubal opening | | | | | |
| 58800 | T | | Drainage of ovarian cyst(s) | 0193 | 15.0453 | $820.89 | $171.13 | $164.18 |
| 58805 | C | | Drainage of ovarian cyst(s) | | | | | |
| 58820 | T | | Drain ovary abscess, open | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 58822 | C | | Drain ovary abscess, percut | | | | | |
| 58823 | T | | Drain pelvic abscess, percut | 0193 | 15.0453 | $820.89 | $171.13 | $164.18 |
| 58825 | C | | Transposition, ovary(s) | | | | | |
| 58900 | T | | Biopsy of ovary(s) | 0193 | 15.0453 | $820.89 | $171.13 | $164.18 |
| 58920 | T | | Partial removal of ovary(s) | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 58925 | T | | Removal of ovarian cyst(s) | 0195 | 25.6950 | $1,401.94 | $483.80 | $280.39 |
| 58940 | C | | Removal of ovary(s) | | | | | |
| 58943 | C | | Removal of ovary(s) | | | | | |
| 58950 | C | | Resect ovarian malignancy | | | | | |
| 58951 | C | | Resect ovarian malignancy | | | | | |
| 58952 | C | | Resect ovarian malignancy | | | | | |
| 58953 | C | | Tah, rad dissect for debulk | | | | | |
| 58954 | C | | Tah rad debulk/lymph remove | | | | | |
| 58960 | C | | Exploration of abdomen | | | | | |
| 58970 | T | | Retrieval of oocyte | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 58974 | T | | Transfer of embryo | 0197 | 4.8280 | $263.42 | | $52.68 |
| 58976 | T | | Transfer of embryo | 0197 | 4.8280 | $263.42 | | $52.68 |
| 58999 | T | | Genital surgery procedure | 0191 | 0.1853 | $10.11 | $2.93 | $2.02 |
| 59000 | T | | Amniocentesis, diagnostic | 0198 | 1.3578 | $74.08 | $32.19 | $14.82 |
| 59001 | T | | Amniocentesis, therapeutic | 0198 | 1.3578 | $74.08 | $32.19 | $14.82 |
| 59012 | T | | Fetal cord puncture,prenatal | 0198 | 1.3578 | $74.08 | $32.19 | $14.82 |
| 59015 | T | | Chorion biopsy | 0198 | 1.3578 | $74.08 | $32.19 | $14.82 |
| 59020 | T | | Fetal contract stress test | 0198 | 1.3578 | $74.08 | $32.19 | $14.82 |
| 59025 | T | | Fetal non-stress test | 0198 | 1.3578 | $74.08 | $32.19 | $14.82 |
| 59030 | T | | Fetal scalp blood sample | 0198 | 1.3578 | $74.08 | $32.19 | $14.82 |
| 59050 | E | | Fetal monitor w/report | | | | | |
| 59051 | B | | Fetal monitor/interpret only | | | | | |
| 59070 | T | NI | Transabdom amnioinfus w/ us | 0198 | 1.3578 | $74.08 | $32.19 | $14.82 |
| 59072 | T | NI | Umbilical cord occlud w/ us | 0198 | 1.3578 | $74.08 | $32.19 | $14.82 |
| 59074 | T | NI | Fetal fluid drainage w/ us | 0198 | 1.3578 | $74.08 | $32.19 | $14.82 |
| 59076 | T | NI | Fetal shunt placement, w/ us | 0198 | 1.3578 | $74.08 | $32.19 | $14.82 |
| 59100 | C | | Remove uterus lesion | | | | | |
| 59120 | C | | Treat ectopic pregnancy | | | | | |
| 59121 | C | | Treat ectopic pregnancy | | | | | |
| 59130 | C | | Treat ectopic pregnancy | | | | | |
| 59135 | C | | Treat ectopic pregnancy | | | | | |
| 59136 | C | | Treat ectopic pregnancy | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 59140 | C | | Treat ectopic pregnancy | | | | | |
| 59150 | T | | Treat ectopic pregnancy | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 59151 | T | | Treat ectopic pregnancy | 0131 | 40.8064 | $2,226.44 | $1,001.89 | $445.29 |
| 59160 | T | | D & c after delivery | 0196 | 16.1219 | $879.63 | $338.23 | $175.93 |
| 59200 | T | | Insert cervical dilator | 0189 | 1.4232 | $77.65 | $18.09 | $15.53 |
| 59300 | T | | Episiotomy or vaginal repair | 0193 | 15.0453 | $820.89 | $171.13 | $164.18 |
| 59320 | T | | Revision of cervix | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 59325 | C | | Revision of cervix | | | | | |
| 59350 | C | | Repair of uterus | | | | | |
| 59400 | B | | Obstetrical care | | | | | |
| 59409 | T | | Obstetrical care | 0199 | 17.2831 | $942.98 | | $188.60 |
| 59410 | B | | Obstetrical care | | | | | |
| 59412 | T | | Antepartum manipulation | 0700 | 2.4306 | $132.62 | $37.13 | $26.52 |
| 59414 | T | | Deliver placenta | 0199 | 17.2831 | $942.98 | | $188.60 |
| 59425 | B | | Antepartum care only | | | | | |
| 59426 | B | | Antepartum care only | | | | | |
| 59430 | B | | Care after delivery | | | | | |
| 59510 | E | | Cesarean delivery | | | | | |
| 59514 | C | | Cesarean delivery only | | | | | |
| 59515 | E | | Cesarean delivery | | | | | |
| 59525 | C | | Remove uterus after cesarean | | | | | |
| 59610 | E | | Vbac delivery | | | | | |
| 59612 | T | | Vbac delivery only | 0199 | 17.2831 | $942.98 | | $188.60 |
| 59614 | E | | Vbac care after delivery | | | | | |
| 59618 | E | | Attempted vbac delivery | | | | | |
| 59620 | C | | Attempted vbac delivery only | | | | | |
| 59622 | E | | Attempted vbac after care | | | | | |
| 59812 | T | | Treatment of miscarriage | 0201 | 16.8660 | $920.23 | $329.65 | $184.05 |
| 59820 | T | | Care of miscarriage | 0201 | 16.8660 | $920.23 | $329.65 | $184.05 |
| 59821 | T | | Treatment of miscarriage | 0201 | 16.8660 | $920.23 | $329.65 | $184.05 |
| 59830 | C | | Treat uterus infection | | | | | |
| 59840 | T | | Abortion | 0200 | 17.9920 | $981.66 | $307.83 | $196.33 |
| 59841 | T | | Abortion | 0200 | 17.9920 | $981.66 | $307.83 | $196.33 |
| 59850 | C | | Abortion | | | | | |
| 59851 | C | | Abortion | | | | | |
| 59852 | C | | Abortion | | | | | |
| 59855 | C | | Abortion | | | | | |
| 59856 | C | | Abortion | | | | | |
| 59857 | C | | Abortion | | | | | |
| 59866 | T | | Abortion (mpr) | 0198 | 1.3578 | $74.08 | $32.19 | $14.82 |
| 59870 | T | | Evacuate mole of uterus | 0201 | 16.8660 | $920.23 | $329.65 | $184.05 |
| 59871 | T | | Remove cerclage suture | 0194 | 18.4286 | $1,005.48 | $397.84 | $201.10 |
| 59897 | T | NI | Fetal invas px w/ us | 0198 | 1.3578 | $74.08 | $32.19 | $14.82 |
| 59898 | T | | Laparo proc, ob care/deliver | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 59899 | T | | Maternity care procedure | 0198 | 1.3578 | $74.08 | $32.19 | $14.82 |
| 60000 | T | | Drain thyroid/tongue cyst | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 60001 | T | | Aspirate/inject thyriod cyst | 0004 | 1.5882 | $86.65 | $22.36 | $17.33 |
| 60100 | T | | Biopsy of thyroid | 0004 | 1.5882 | $86.65 | $22.36 | $17.33 |
| 60200 | T | | Remove thyroid lesion | 0114 | 37.5963 | $2,051.29 | $485.91 | $410.26 |
| 60210 | T | | Partial thyroid excision | 0114 | 37.5963 | $2,051.29 | $485.91 | $410.26 |
| 60212 | T | | Partial thyroid excision | 0114 | 37.5963 | $2,051.29 | $485.91 | $410.26 |
| 60220 | T | | Partial removal of thyroid | 0114 | 37.5963 | $2,051.29 | $485.91 | $410.26 |
| 60225 | T | | Partial removal of thyroid | 0114 | 37.5963 | $2,051.29 | $485.91 | $410.26 |
| 60240 | T | | Removal of thyroid | 0114 | 37.5963 | $2,051.29 | $485.91 | $410.26 |
| 60252 | T | | Removal of thyroid | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 60254 | C | | Extensive thyroid surgery | | | | | |
| 60260 | T | | Repeat thyroid surgery | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 60270 | C | | Removal of thyroid | | | | | |
| 60271 | C | | Removal of thyroid | | | | | |
| 60280 | T | | Remove thyroid duct lesion | 0114 | 37.5963 | $2,051.29 | $485.91 | $410.26 |
| 60281 | T | | Remove thyroid duct lesion | 0114 | 37.5963 | $2,051.29 | $485.91 | $410.26 |
| 60500 | T | | Explore parathyroid glands | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 60502 | C | | Re-explore parathyroids | | | | | |
| 60505 | C | | Explore parathyroid glands | | | | | |
| 60512 | T | | Autotransplant parathyroid | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 60520 | C | | Removal of thymus gland | | | | | |
| 60521 | C | | Removal of thymus gland | | | | | |
| 60522 | C | | Removal of thymus gland | | | | | |
| 60540 | C | | Explore adrenal gland | | | | | |
| 60545 | C | | Explore adrenal gland | | | | | |
| 60600 | C | | Remove carotid body lesion | | | | | |
| 60605 | C | | Remove carotid body lesion | | | | | |
| 60650 | C | | Laparoscopy adrenalectomy | | | | | |
| 60659 | T | | Laparo proc, endocrine | 0130 | 32.7724 | $1,788.09 | $659.53 | $357.62 |
| 60699 | T | | Endocrine surgery procedure | 0114 | 37.5963 | $2,051.29 | $485.91 | $410.26 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 61000 | T | | Remove cranial cavity fluid | 0212 | 2.9739 | $162.26 | $74.67 | $32.45 |
| 61001 | T | | Remove cranial cavity fluid | 0212 | 2.9739 | $162.26 | $74.67 | $32.45 |
| 61020 | T | | Remove brain cavity fluid | 0212 | 2.9739 | $162.26 | $74.67 | $32.45 |
| 61026 | T | | Injection into brain canal | 0212 | 2.9739 | $162.26 | $74.67 | $32.45 |
| 61050 | T | | Remove brain canal fluid | 0212 | 2.9739 | $162.26 | $74.67 | $32.45 |
| 61055 | T | | Injection into brain canal | 0212 | 2.9739 | $162.26 | $74.67 | $32.45 |
| 61070 | T | | Brain canal shunt procedure | 0212 | 2.9739 | $162.26 | $74.67 | $32.45 |
| 61105 | C | | Twist drill hole | | | | | |
| 61107 | C | | Drill skull for implantation | | | | | |
| 61108 | C | | Drill skull for drainage | | | | | |
| 61120 | C | | Burr hole for puncture | | | | | |
| 61140 | C | | Pierce skull for biopsy | | | | | |
| 61150 | C | | Pierce skull for drainage | | | | | |
| 61151 | C | | Pierce skull for drainage | | | | | |
| 61154 | C | | Pierce skull & remove clot | | | | | |
| 61156 | C | | Pierce skull for drainage | | | | | |
| 61210 | C | | Pierce skull, implant device | | | | | |
| 61215 | T | | Insert brain-fluid device | 0224 | 34.1770 | $1,864.73 | $453.41 | $372.95 |
| 61250 | C | | Pierce skull & explore | | | | | |
| 61253 | C | | Pierce skull & explore | | | | | |
| 61304 | C | | Open skull for exploration | | | | | |
| 61305 | C | | Open skull for exploration | | | | | |
| 61312 | C | | Open skull for drainage | | | | | |
| 61313 | C | | Open skull for drainage | | | | | |
| 61314 | C | | Open skull for drainage | | | | | |
| 61315 | C | | Open skull for drainage | | | | | |
| 61316 | C | | Implt cran bone flap to abdo | | | | | |
| 61320 | C | | Open skull for drainage | | | | | |
| 61321 | C | | Open skull for drainage | | | | | |
| 61322 | C | | Decompressive craniotomy | | | | | |
| 61323 | C | | Decompressive lobectomy | | | | | |
| 61330 | T | | Decompress eye socket | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 61332 | C | | Explore/biopsy eye socket | | | | | |
| 61333 | C | | Explore orbit/remove lesion | | | | | |
| 61334 | C | | Explore orbit/remove object | | | | | |
| 61340 | C | | Relieve cranial pressure | | | | | |
| 61343 | C | | Incise skull (press relief) | | | | | |
| 61345 | C | | Relieve cranial pressure | | | | | |
| 61440 | C | | Incise skull for surgery | | | | | |
| 61450 | C | | Incise skull for surgery | | | | | |
| 61458 | C | | Incise skull for brain wound | | | | | |
| 61460 | C | | Incise skull for surgery | | | | | |
| 61470 | C | | Incise skull for surgery | | | | | |
| 61480 | C | | Incise skull for surgery | | | | | |
| 61490 | C | | Incise skull for surgery | | | | | |
| 61500 | C | | Removal of skull lesion | | | | | |
| 61501 | C | | Remove infected skull bone | | | | | |
| 61510 | C | | Removal of brain lesion | | | | | |
| 61512 | C | | Remove brain lining lesion | | | | | |
| 61514 | C | | Removal of brain abscess | | | | | |
| 61516 | C | | Removal of brain lesion | | | | | |
| 61517 | C | | Implt brain chemotx add-on | | | | | |
| 61518 | C | | Removal of brain lesion | | | | | |
| 61519 | C | | Remove brain lining lesion | | | | | |
| 61520 | C | | Removal of brain lesion | | | | | |
| 61521 | C | | Removal of brain lesion | | | | | |
| 61522 | C | | Removal of brain abscess | | | | | |
| 61524 | C | | Removal of brain lesion | | | | | |
| 61526 | C | | Removal of brain lesion | | | | | |
| 61530 | C | | Removal of brain lesion | | | | | |
| 61531 | C | | Implant brain electrodes | | | | | |
| 61533 | C | | Implant brain electrodes | | | | | |
| 61534 | C | | Removal of brain lesion | | | | | |
| 61535 | C | | Remove brain electrodes | | | | | |
| 61536 | C | | Removal of brain lesion | | | | | |
| 61537 | C | NI | Removal of brain tissue | | | | | |
| 61538 | C | | Removal of brain tissue | | | | | |
| 61539 | C | | Removal of brain tissue | | | | | |
| 61540 | C | NI | Removal of brain tissue | | | | | |
| 61541 | C | | Incision of brain tissue | | | | | |
| 61542 | C | | Removal of brain tissue | | | | | |
| 61543 | C | | Removal of brain tissue | | | | | |
| 61544 | C | | Remove & treat brain lesion | | | | | |
| 61545 | C | | Excision of brain tumor | | | | | |
| 61546 | C | | Removal of pituitary gland | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 61548 | C | | Removal of pituitary gland | | | | | |
| 61550 | C | | Release of skull seams | | | | | |
| 61552 | C | | Release of skull seams | | | | | |
| 61556 | C | | Incise skull/sutures | | | | | |
| 61557 | C | | Incise skull/sutures | | | | | |
| 61558 | C | | Excision of skull/sutures | | | | | |
| 61559 | C | | Excision of skull/sutures | | | | | |
| 61563 | C | | Excision of skull tumor | | | | | |
| 61564 | C | | Excision of skull tumor | | | | | |
| 61566 | C | NI | Removal of brain tissue | | | | | |
| 61567 | C | NI | Incision of brain tissue | | | | | |
| 61570 | C | | Remove foreign body, brain | | | | | |
| 61571 | C | | Incise skull for brain wound | | | | | |
| 61575 | C | | Skull base/brainstem surgery | | | | | |
| 61576 | C | | Skull base/brainstem surgery | | | | | |
| 61580 | C | | Craniofacial approach, skull | | | | | |
| 61581 | C | | Craniofacial approach, skull | | | | | |
| 61582 | C | | Craniofacial approach, skull | | | | | |
| 61583 | C | | Craniofacial approach, skull | | | | | |
| 61584 | C | | Orbitocranial approach/skull | | | | | |
| 61585 | C | | Orbitocranial approach/skull | | | | | |
| 61586 | C | | Resect nasopharynx, skull | | | | | |
| 61590 | C | | Infratemporal approach/skull | | | | | |
| 61591 | C | | Infratemporal approach/skull | | | | | |
| 61592 | C | | Orbitocranial approach/skull | | | | | |
| 61595 | C | | Transtemporal approach/skull | | | | | |
| 61596 | C | | Transcochlear approach/skull | | | | | |
| 61597 | C | | Transcondylar approach/skull | | | | | |
| 61598 | C | | Transpetrosal approach/skull | | | | | |
| 61600 | C | | Resect/excise cranial lesion | | | | | |
| 61601 | C | | Resect/excise cranial lesion | | | | | |
| 61605 | C | | Resect/excise cranial lesion | | | | | |
| 61606 | C | | Resect/excise cranial lesion | | | | | |
| 61607 | C | | Resect/excise cranial lesion | | | | | |
| 61608 | C | | Resect/excise cranial lesion | | | | | |
| 61609 | C | | Transect artery, sinus | | | | | |
| 61610 | C | | Transect artery, sinus | | | | | |
| 61611 | C | | Transect artery, sinus | | | | | |
| 61612 | C | | Transect artery, sinus | | | | | |
| 61613 | C | | Remove aneurysm, sinus | | | | | |
| 61615 | C | | Resect/excise lesion, skull | | | | | |
| 61616 | C | | Resect/excise lesion, skull | | | | | |
| 61618 | C | | Repair dura | | | | | |
| 61619 | C | | Repair dura | | | | | |
| 61623 | T | | Endovasc tempory vessel occl | 1555 | | $1,650.00 | | $330.00 |
| 61624 | C | | Occlusion/embolization cath | | | | | |
| 61626 | T | | Transcath occlusion, non-cns | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 61680 | C | | Intracranial vessel surgery | | | | | |
| 61682 | C | | Intracranial vessel surgery | | | | | |
| 61684 | C | | Intracranial vessel surgery | | | | | |
| 61686 | C | | Intracranial vessel surgery | | | | | |
| 61690 | C | | Intracranial vessel surgery | | | | | |
| 61692 | C | | Intracranial vessel surgery | | | | | |
| 61697 | C | | Brain aneurysm repr, complx | | | | | |
| 61698 | C | | Brain aneurysm repr, complx | | | | | |
| 61700 | C | | Brain aneurysm repr, simple | | | | | |
| 61702 | C | | Inner skull vessel surgery | | | | | |
| 61703 | C | | Clamp neck artery | | | | | |
| 61705 | C | | Revise circulation to head | | | | | |
| 61708 | C | | Revise circulation to head | | | | | |
| 61710 | C | | Revise circulation to head | | | | | |
| 61711 | C | | Fusion of skull arteries | | | | | |
| 61720 | C | | Incise skull/brain surgery | | | | | |
| 61735 | C | | Incise skull/brain surgery | | | | | |
| 61750 | C | | Incise skull/brain biopsy | | | | | |
| 61751 | C | | Brain biopsy w/ ct/mr guide | | | | | |
| 61760 | C | | Implant brain electrodes | | | | | |
| 61770 | C | | Incise skull for treatment | | | | | |
| 61790 | T | | Treat trigeminal nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 61791 | T | | Treat trigeminal tract | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 61793 | E | | Focus radiation beam | | | | | |
| 61795 | S | | Brain surgery using computer | 0302 | 6.3268 | $345.20 | $130.77 | $69.04 |
| 61850 | C | | Implant neuroelectrodes | | | | | |
| 61860 | C | | Implant neuroelectrodes | | | | | |
| 61862 | C | DG | Implant neurostimul, subcort | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 61863 | C | NI | Implant neuroelectrode | | | | | |
| 61864 | C | NI | Implant neuroelectrde, add'l | | | | | |
| 61867 | C | NI | Implant neuroelectrode | | | | | |
| 61868 | C | NI | Implant neuroelectrde, add'l | | | | | |
| 61870 | C | | Implant neuroelectrodes | | | | | |
| 61875 | C | | Implant neuroelectrodes | | | | | |
| 61880 | T | | Revise/remove neuroelectrode | 0687 | 20.4416 | $1,115.31 | $513.05 | $223.06 |
| 61885 | S | | Implant neurostim one array | 0039 | 235.1866 | $12,832.02 | | $2,566.40 |
| 61886 | T | | Implant neurostim arrays | 0222 | 232.2024 | $12,669.20 | | $2,533.84 |
| 61888 | T | | Revise/remove neuroreceiver | 0688 | 46.7347 | $2,549.89 | $1,249.45 | $509.98 |
| 62000 | C | | Treat skull fracture | | | | | |
| 62005 | C | | Treat skull fracture | | | | | |
| 62010 | C | | Treatment of head injury | | | | | |
| 62100 | C | | Repair brain fluid leakage | | | | | |
| 62115 | C | | Reduction of skull defect | | | | | |
| 62116 | C | | Reduction of skull defect | | | | | |
| 62117 | C | | Reduction of skull defect | | | | | |
| 62120 | C | | Repair skull cavity lesion | | | | | |
| 62121 | C | | Incise skull repair | | | | | |
| 62140 | C | | Repair of skull defect | | | | | |
| 62141 | C | | Repair of skull defect | | | | | |
| 62142 | C | | Remove skull plate/flap | | | | | |
| 62143 | C | | Replace skull plate/flap | | | | | |
| 62145 | C | | Repair of skull & brain | | | | | |
| 62146 | C | | Repair of skull with graft | | | | | |
| 62147 | C | | Repair of skull with graft | | | | | |
| 62148 | C | | Retr bone flap to fix skull | | | | | |
| 62160 | C | | Neuroendoscopy add-on | | | | | |
| 62161 | C | | Dissect brain w/scope | | | | | |
| 62162 | C | | Remove colloid cyst w/scope | | | | | |
| 62163 | C | | Neuroendoscopy w/fb removal | | | | | |
| 62164 | C | | Remove brain tumor w/scope | | | | | |
| 62165 | C | | Remove pituit tumor w/scope | | | | | |
| 62180 | C | | Establish brain cavity shunt | | | | | |
| 62190 | C | | Establish brain cavity shunt | | | | | |
| 62192 | C | | Establish brain cavity shunt | | | | | |
| 62194 | T | | Replace/irrigate catheter | 0121 | 2.1189 | $115.61 | $43.80 | $23.12 |
| 62200 | C | | Establish brain cavity shunt | | | | | |
| 62201 | C | | Establish brain cavity shunt | | | | | |
| 62220 | C | | Establish brain cavity shunt | | | | | |
| 62223 | C | | Establish brain cavity shunt | | | | | |
| 62225 | T | | Replace/irrigate catheter | 0122 | 8.8621 | $483.53 | $99.16 | $96.71 |
| 62230 | T | | Replace/revise brain shunt | 0224 | 34.1770 | $1,864.73 | $453.41 | $372.95 |
| 62252 | S | | Csf shunt reprogram | 0691 | 2.8066 | $153.13 | $76.56 | $30.63 |
| 62256 | C | | Remove brain cavity shunt | | | | | |
| 62258 | C | | Replace brain cavity shunt | | | | | |
| 62263 | T | | Lysis epidural adhesions | 0203 | 11.5969 | $632.74 | $276.76 | $126.55 |
| 62264 | T | | Epidural lysis on single day | 0203 | 11.5969 | $632.74 | $276.76 | $126.55 |
| 62268 | T | | Drain spinal cord cyst | 0212 | 2.9739 | $162.26 | $74.67 | $32.45 |
| 62269 | T | | Needle biopsy, spinal cord | 0005 | 3.2698 | $178.40 | $71.59 | $35.68 |
| 62270 | T | | Spinal fluid tap, diagnostic | 0206 | 5.2875 | $288.49 | $75.55 | $57.70 |
| 62272 | T | | Drain cerebro spinal fluid | 0206 | 5.2875 | $288.49 | $75.55 | $57.70 |
| 62273 | T | | Treat epidural spine lesion | 0206 | 5.2875 | $288.49 | $75.55 | $57.70 |
| 62280 | T | | Treat spinal cord lesion | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 62281 | T | | Treat spinal cord lesion | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 62282 | T | | Treat spinal canal lesion | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 62284 | N | | Injection for myelogram | | | | | |
| 62287 | T | | Percutaneous diskectomy | 0220 | 16.5554 | $903.28 | | $180.66 |
| 62290 | N | | Inject for spine disk x-ray | | | | | |
| 62291 | N | | Inject for spine disk x-ray | | | | | |
| 62292 | T | | Injection into disk lesion | 0212 | 2.9739 | $162.26 | $74.67 | $32.45 |
| 62294 | T | | Injection into spinal artery | 0212 | 2.9739 | $162.26 | $74.67 | $32.45 |
| 62310 | T | | Inject spine c/t | 0206 | 5.2875 | $288.49 | $75.55 | $57.70 |
| 62311 | T | | Inject spine l/s (cd) | 0206 | 5.2875 | $288.49 | $75.55 | $57.70 |
| 62318 | T | | Inject spine w/cath, c/t | 0206 | 5.2875 | $288.49 | $75.55 | $57.70 |
| 62319 | T | | Inject spine w/cath l/s (cd) | 0206 | 5.2875 | $288.49 | $75.55 | $57.70 |
| 62350 | T | | Implant spinal canal cath | 0223 | 26.7610 | $1,460.11 | | $292.02 |
| 62351 | T | | Implant spinal canal cath | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 62355 | T | | Remove spinal canal catheter | 0203 | 11.5969 | $632.74 | $276.76 | $126.55 |
| 62360 | T | | Insert spine infusion device | 0226 | 136.2989 | $7,436.60 | | $1,487.32 |
| 62361 | T | | Implant spine infusion pump | 0227 | 160.8363 | $8,775.39 | | $1,755.08 |
| 62362 | T | | Implant spine infusion pump | 0227 | 160.8363 | $8,775.39 | | $1,755.08 |
| 62365 | T | | Remove spine infusion device | 0203 | 11.5969 | $632.74 | $276.76 | $126.55 |
| 62367 | S | | Analyze spine infusion pump | 0691 | 2.8066 | $153.13 | $76.56 | $30.63 |
| 62368 | S | | Analyze spine infusion pump | 0691 | 2.8066 | $153.13 | $76.56 | $30.63 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 63001 | T | | Removal of spinal lamina | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63003 | T | | Removal of spinal lamina | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63005 | T | | Removal of spinal lamina | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63011 | T | | Removal of spinal lamina | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63012 | T | | Removal of spinal lamina | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63015 | T | | Removal of spinal lamina | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63016 | T | | Removal of spinal lamina | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63017 | T | | Removal of spinal lamina | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63020 | T | | Neck spine disk surgery | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63030 | T | | Low back disk surgery | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63035 | T | | Spinal disk surgery add-on | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63040 | T | | Laminotomy, single cervical | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63042 | T | | Laminotomy, single lumbar | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63043 | C | | Laminotomy, add'l cervical | | | | | |
| 63044 | C | | Laminotomy, add'l lumbar | | | | | |
| 63045 | T | | Removal of spinal lamina | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63046 | T | | Removal of spinal lamina | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63047 | T | | Removal of spinal lamina | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63048 | T | | Remove spinal lamina add-on | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63055 | T | | Decompress spinal cord | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63056 | T | | Decompress spinal cord | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63057 | T | | Decompress spine cord add-on | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63064 | T | | Decompress spinal cord | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63066 | T | | Decompress spine cord add-on | 0208 | 40.2830 | $2,197.88 | | $439.58 |
| 63075 | C | | Neck spine disk surgery | | | | | |
| 63076 | C | | Neck spine disk surgery | | | | | |
| 63077 | C | | Spine disk surgery, thorax | | | | | |
| 63078 | C | | Spine disk surgery, thorax | | | | | |
| 63081 | C | | Removal of vertebral body | | | | | |
| 63082 | C | | Remove vertebral body add-on | | | | | |
| 63085 | C | | Removal of vertebral body | | | | | |
| 63086 | C | | Remove vertebral body add-on | | | | | |
| 63087 | C | | Removal of vertebral body | | | | | |
| 63088 | C | | Remove vertebral body add-on | | | | | |
| 63090 | C | | Removal of vertebral body | | | | | |
| 63091 | C | | Remove vertebral body add-on | | | | | |
| 63101 | C | NI | Removal of vertebral body | | | | | |
| 63102 | C | NI | Removal of vertebral body | | | | | |
| 63103 | C | NI | Remove vertebral body add-on | | | | | |
| 63170 | C | | Incise spinal cord tract(s) | | | | | |
| 63172 | C | | Drainage of spinal cyst | | | | | |
| 63173 | C | | Drainage of spinal cyst | | | | | |
| 63180 | C | | Revise spinal cord ligaments | | | | | |
| 63182 | C | | Revise spinal cord ligaments | | | | | |
| 63185 | C | | Incise spinal column/nerves | | | | | |
| 63190 | C | | Incise spinal column/nerves | | | | | |
| 63191 | C | | Incise spinal column/nerves | | | | | |
| 63194 | C | | Incise spinal column & cord | | | | | |
| 63195 | C | | Incise spinal column & cord | | | | | |
| 63196 | C | | Incise spinal column & cord | | | | | |
| 63197 | C | | Incise spinal column & cord | | | | | |
| 63198 | C | | Incise spinal column & cord | | | | | |
| 63199 | C | | Incise spinal column & cord | | | | | |
| 63200 | C | | Release of spinal cord | | | | | |
| 63250 | C | | Revise spinal cord vessels | | | | | |
| 63251 | C | | Revise spinal cord vessels | | | | | |
| 63252 | C | | Revise spinal cord vessels | | | | | |
| 63265 | C | | Excise intraspinal lesion | | | | | |
| 63266 | C | | Excise intraspinal lesion | | | | | |
| 63267 | C | | Excise intraspinal lesion | | | | | |
| 63268 | C | | Excise intraspinal lesion | | | | | |
| 63270 | C | | Excise intraspinal lesion | | | | | |
| 63271 | C | | Excise intraspinal lesion | | | | | |
| 63272 | C | | Excise intraspinal lesion | | | | | |
| 63273 | C | | Excise intraspinal lesion | | | | | |
| 63275 | C | | Biopsy/excise spinal tumor | | | | | |
| 63276 | C | | Biopsy/excise spinal tumor | | | | | |
| 63277 | C | | Biopsy/excise spinal tumor | | | | | |
| 63278 | C | | Biopsy/excise spinal tumor | | | | | |
| 63280 | C | | Biopsy/excise spinal tumor | | | | | |
| 63281 | C | | Biopsy/excise spinal tumor | | | | | |
| 63282 | C | | Biopsy/excise spinal tumor | | | | | |
| 63283 | C | | Biopsy/excise spinal tumor | | | | | |
| 63285 | C | | Biopsy/excise spinal tumor | | | | | |
| 63286 | C | | Biopsy/excise spinal tumor | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 63287 | C | | Biopsy/excise spinal tumor | | | | | |
| 63290 | C | | Biopsy/excise spinal tumor | | | | | |
| 63300 | C | | Removal of vertebral body | | | | | |
| 63301 | C | | Removal of vertebral body | | | | | |
| 63302 | C | | Removal of vertebral body | | | | | |
| 63303 | C | | Removal of vertebral body | | | | | |
| 63304 | C | | Removal of vertebral body | | | | | |
| 63305 | C | | Removal of vertebral body | | | | | |
| 63306 | C | | Removal of vertebral body | | | | | |
| 63307 | C | | Removal of vertebral body | | | | | |
| 63308 | C | | Remove vertebral body add-on | | | | | |
| 63600 | T | | Remove spinal cord lesion | 0220 | 16.5554 | $903.28 | | $180.66 |
| 63610 | T | | Stimulation of spinal cord | 0220 | 16.5554 | $903.28 | | $180.66 |
| 63615 | T | | Remove lesion of spinal cord | 0220 | 16.5554 | $903.28 | | $180.66 |
| 63650 | S | | Implant neuroelectrodes | 0040 | 52.1002 | $2,842.64 | | $568.53 |
| 63655 | S | | Implant neuroelectrodes | 0225 | 206.0034 | $11,239.75 | | $2,247.95 |
| 63660 | T | | Revise/remove neuroelectrode | 0687 | 20.4416 | $1,115.31 | $513.05 | $223.06 |
| 63685 | T | | Implant neuroreceiver | 0222 | 232.2024 | $12,669.20 | | $2,533.84 |
| 63688 | T | | Revise/remove neuroreceiver | 0688 | 46.7347 | $2,549.89 | $1,249.45 | $509.98 |
| 63700 | C | | Repair of spinal herniation | | | | | |
| 63702 | C | | Repair of spinal herniation | | | | | |
| 63704 | C | | Repair of spinal herniation | | | | | |
| 63706 | C | | Repair of spinal herniation | | | | | |
| 63707 | C | | Repair spinal fluid leakage | | | | | |
| 63709 | C | | Repair spinal fluid leakage | | | | | |
| 63710 | C | | Graft repair of spine defect | | | | | |
| 63740 | C | | Install spinal shunt | | | | | |
| 63741 | T | | Install spinal shunt | 0228 | 52.2880 | $2,852.89 | $639.03 | $570.58 |
| 63744 | T | | Revision of spinal shunt | 0228 | 52.2880 | $2,852.89 | $639.03 | $570.58 |
| 63746 | T | | Removal of spinal shunt | 0109 | 7.4705 | $407.60 | $131.49 | $81.52 |
| 64400 | T | | N block inj, trigeminal | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64402 | T | | N block inj, facial | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64405 | T | | N block inj, occipital | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64408 | T | | N block inj, vagus | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64410 | T | | N block inj, phrenic | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64412 | T | | N block inj, spinal accessor | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64413 | T | | N block inj, cervical plexus | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64415 | T | | Injection for nerve block | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64416 | T | | N block cont infuse, b plex | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64417 | T | | N block inj, axillary | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64418 | T | | N block inj, suprascapular | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64420 | T | | N block inj, intercost, sng | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 64421 | T | | N block inj, intercost, mlt | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 64425 | T | | N block inj ilio-ing/hypogi | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64430 | T | | N block inj, pudendal | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64435 | T | | N block inj, paracervical | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64445 | T | | Injection for nerve block | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64446 | T | | N blk inj, sciatic, cont inf | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64447 | T | | N block inj fem, single | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64448 | T | | N block inj fem, cont inf | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64449 | T | NI | N block inj, lumbar plexus | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64450 | T | | N block, other peripheral | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64470 | T | | Inj paravertebral c/t | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 64472 | T | | Inj paravertebral c/t add-on | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 64475 | T | | Inj paravertebral l/s | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 64476 | T | | Inj paravertebral l/s add-on | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 64479 | T | | Inj foramen epidural c/t | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 64480 | T | | Inj foramen epidural add-on | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 64483 | T | | Inj foramen epidural l/s | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 64484 | T | | Inj foramen epidural add-on | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 64505 | T | | N block, spenopalatine gangl | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64508 | T | | N block, carotid sinus s/p | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64510 | T | | N block, stellate ganglion | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 64517 | T | NI | N block inj, hypogas plxs | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64520 | T | | N block, lumbar/thoracic | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 64530 | T | | N block inj, celiac pelus | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 64550 | A | | Apply neurostimulator | | | | | |
| 64553 | S | | Implant neuroelectrodes | 0225 | 206.0034 | $11,239.75 | | $2,247.95 |
| 64555 | S | | Implant neuroelectrodes | 0040 | 52.1002 | $2,842.64 | | $568.53 |
| 64560 | S | | Implant neuroelectrodes | 0040 | 52.1002 | $2,842.64 | | $568.53 |
| 64561 | S | | Implant neuroelectrodes | 0040 | 52.1002 | $2,842.64 | | $568.53 |
| 64565 | S | | Implant neuroelectrodes | 0040 | 52.1002 | $2,842.64 | | $568.53 |
| 64573 | S | | Implant neuroelectrodes | 0225 | 206.0034 | $11,239.75 | | $2,247.95 |
| 64575 | S | | Implant neuroelectrodes | 0040 | 52.1002 | $2,842.64 | | $568.53 |
| 64577 | S | | Implant neuroelectrodes | 0225 | 206.0034 | $11,239.75 | | $2,247.95 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 64580 | S | | Implant neuroelectrodes | 0225 | 206.0034 | $11,239.75 | | $2,247.95 |
| 64581 | S | | Implant neuroelectrodes | 0040 | 52.1002 | $2,842.64 | | $568.53 |
| 64585 | T | | Revise/remove neuroelectrode | 0687 | 20.4416 | $1,115.31 | $513.05 | $223.06 |
| 64590 | T | | Implant neuroreceiver | 0222 | 232.2024 | $12,669.20 | | $2,533.84 |
| 64595 | T | | Revise/remove neuroreceiver | 0688 | 46.7347 | $2,549.89 | $1,249.45 | $509.98 |
| 64600 | T | | Injection treatment of nerve | 0203 | 11.5969 | $632.74 | $276.76 | $126.55 |
| 64605 | T | | Injection treatment of nerve | 0203 | 11.5969 | $632.74 | $276.76 | $126.55 |
| 64610 | T | | Injection treatment of nerve | 0203 | 11.5969 | $632.74 | $276.76 | $126.55 |
| 64612 | T | | Destroy nerve, face muscle | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64613 | T | | Destroy nerve, spine muscle | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64614 | T | | Destroy nerve, extrem musc | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 64620 | T | | Injection treatment of nerve | 0203 | 11.5969 | $632.74 | $276.76 | $126.55 |
| 64622 | T | | Destr paravertebrl nerve l/s | 0203 | 11.5969 | $632.74 | $276.76 | $126.55 |
| 64623 | T | | Destr paravertebral n add-on | 0203 | 11.5969 | $632.74 | $276.76 | $126.55 |
| 64626 | T | | Destr paravertebrl nerve c/t | 0203 | 11.5969 | $632.74 | $276.76 | $126.55 |
| 64627 | T | | Destr paravertebral n add-on | 0203 | 11.5969 | $632.74 | $276.76 | $126.55 |
| 64630 | T | | Injection treatment of nerve | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 64640 | T | | Injection treatment of nerve | 0207 | 6.4554 | $352.21 | $123.69 | $70.44 |
| 64680 | T | | Injection treatment of nerve | 0203 | 11.5969 | $632.74 | $276.76 | $126.55 |
| 64681 | T | NI | Injection treatment of nerve | 0203 | 11.5969 | $632.74 | $276.76 | $126.55 |
| 64702 | T | | Revise finger/toe nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64704 | T | | Revise hand/foot nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64708 | T | | Revise arm/leg nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64712 | T | | Revision of sciatic nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64713 | T | | Revision of arm nerve(s) | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64714 | T | | Revise low back nerve(s) | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64716 | T | | Revision of cranial nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64718 | T | | Revise ulnar nerve at elbow | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64719 | T | | Revise ulnar nerve at wrist | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64721 | T | | Carpal tunnel surgery | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64722 | T | | Relieve pressure on nerve(s) | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64726 | T | | Release foot/toe nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64727 | T | | Internal nerve revision | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64732 | T | | Incision of brow nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64734 | T | | Incision of cheek nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64736 | T | | Incision of chin nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64738 | T | | Incision of jaw nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64740 | T | | Incision of tongue nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64742 | T | | Incision of facial nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64744 | T | | Incise nerve, back of head | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64746 | T | | Incise diaphragm nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64752 | C | | Incision of vagus nerve | | | | | |
| 64755 | C | | Incision of stomach nerves | | | | | |
| 64760 | C | | Incision of vagus nerve | | | | | |
| 64761 | T | | Incision of pelvis nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64763 | C | | Incise hip/thigh nerve | | | | | |
| 64766 | C | | Incise hip/thigh nerve | | | | | |
| 64771 | T | | Sever cranial nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64772 | T | | Incision of spinal nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64774 | T | | Remove skin nerve lesion | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64776 | T | | Remove digit nerve lesion | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64778 | T | | Digit nerve surgery add-on | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64782 | T | | Remove limb nerve lesion | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64783 | T | | Limb nerve surgery add-on | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64784 | T | | Remove nerve lesion | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64786 | T | | Remove sciatic nerve lesion | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64787 | T | | Implant nerve end | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64788 | T | | Remove skin nerve lesion | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64790 | T | | Removal of nerve lesion | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64792 | T | | Removal of nerve lesion | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64795 | T | | Biopsy of nerve | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64802 | T | | Remove sympathetic nerves | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64804 | C | | Remove sympathetic nerves | | | | | |
| 64809 | C | | Remove sympathetic nerves | | | | | |
| 64818 | C | | Remove sympathetic nerves | | | | | |
| 64820 | T | | Remove sympathetic nerves | 0220 | 16.5554 | $903.28 | | $180.66 |
| 64821 | T | | Remove sympathetic nerves | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 64822 | T | | Remove sympathetic nerves | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 64823 | T | | Remove sympathetic nerves | 0054 | 24.2456 | $1,322.86 | | $264.57 |
| 64831 | T | | Repair of digit nerve | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64832 | T | | Repair nerve add-on | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64834 | T | | Repair of hand or foot nerve | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64835 | T | | Repair of hand or foot nerve | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64836 | T | | Repair of hand or foot nerve | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64837 | T | | Repair nerve add-on | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 64840 | T | | Repair of leg nerve | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64856 | T | | Repair/transpose nerve | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64857 | T | | Repair arm/leg nerve | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64858 | T | | Repair sciatic nerve | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64859 | T | | Nerve surgery | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64861 | T | | Repair of arm nerves | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64862 | T | | Repair of low back nerves | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64864 | T | | Repair of facial nerve | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64865 | T | | Repair of facial nerve | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64866 | C | | Fusion of facial/other nerve | | | | | |
| 64868 | C | | Fusion of facial/other nerve | | | | | |
| 64870 | T | | Fusion of facial/other nerve | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64872 | T | | Subsequent repair of nerve | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64874 | T | | Repair & revise nerve add-on | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64876 | T | | Repair nerve/shorten bone | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64885 | T | | Nerve graft, head or neck | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64886 | T | | Nerve graft, head or neck | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64890 | T | | Nerve graft, hand or foot | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64891 | T | | Nerve graft, hand or foot | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64892 | T | | Nerve graft, arm or leg | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64893 | T | | Nerve graft, arm or leg | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64895 | T | | Nerve graft, hand or foot | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64896 | T | | Nerve graft, hand or foot | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64897 | T | | Nerve graft, arm or leg | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64898 | T | | Nerve graft, arm or leg | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64901 | T | | Nerve graft add-on | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64902 | T | | Nerve graft add-on | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64905 | T | | Nerve pedicle transfer | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64907 | T | | Nerve pedicle transfer | 0221 | 24.8875 | $1,357.89 | $463.62 | $271.58 |
| 64999 | T | | Nervous system surgery | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| 65091 | T | | Revise eye | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 65093 | T | | Revise eye with implant | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 65101 | T | | Removal of eye | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 65103 | T | | Remove eye/insert implant | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 65105 | T | | Remove eye/attach implant | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 65110 | T | | Removal of eye | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 65112 | T | | Remove eye/revise socket | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 65114 | T | | Remove eye/revise socket | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 65125 | T | | Revise ocular implant | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 65130 | T | | Insert ocular implant | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 65135 | T | | Insert ocular implant | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 65140 | T | | Attach ocular implant | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 65150 | T | | Revise ocular implant | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 65155 | T | | Reinsert ocular implant | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 65175 | T | | Removal of ocular implant | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 65205 | S | | Remove foreign body from eye | 0698 | 0.9599 | $52.37 | $18.72 | $10.47 |
| 65210 | S | | Remove foreign body from eye | 0231 | 2.1883 | $119.40 | $50.94 | $23.88 |
| 65220 | S | | Remove foreign body from eye | 0231 | 2.1883 | $119.40 | $50.94 | $23.88 |
| 65222 | S | | Remove foreign body from eye | 0231 | 2.1883 | $119.40 | $50.94 | $23.88 |
| 65235 | T | | Remove foreign body from eye | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 65260 | T | | Remove foreign body from eye | 0236 | 18.6701 | $1,018.66 | | $203.73 |
| 65265 | T | | Remove foreign body from eye | 0236 | 18.6701 | $1,018.66 | | $203.73 |
| 65270 | T | | Repair of eye wound | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 65272 | T | | Repair of eye wound | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 65273 | C | | Repair of eye wound | | | | | |
| 65275 | T | | Repair of eye wound | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 65280 | T | | Repair of eye wound | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 65285 | T | | Repair of eye wound | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 65286 | T | | Repair of eye wound | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 65290 | T | | Repair of eye socket wound | 0243 | 21.7323 | $1,185.74 | $431.39 | $237.15 |
| 65400 | T | | Removal of eye lesion | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 65410 | T | | Biopsy of cornea | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 65420 | T | | Removal of eye lesion | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 65426 | T | | Removal of eye lesion | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 65430 | S | | Corneal smear | 0230 | 0.7619 | $41.57 | $14.97 | $8.31 |
| 65435 | T | | Curette/treat cornea | 0239 | 6.1331 | $334.63 | | $66.93 |
| 65436 | T | | Curette/treat cornea | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 65450 | S | | Treatment of corneal lesion | 0231 | 2.1883 | $119.40 | $50.94 | $23.88 |
| 65600 | T | | Revision of cornea | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 65710 | T | | Corneal transplant | 0244 | 37.6284 | $2,053.04 | $803.26 | $410.61 |
| 65730 | T | | Corneal transplant | 0244 | 37.6284 | $2,053.04 | $803.26 | $410.61 |
| 65750 | T | | Corneal transplant | 0244 | 37.6284 | $2,053.04 | $803.26 | $410.61 |
| 65755 | T | | Corneal transplant | 0244 | 37.6284 | $2,053.04 | $803.26 | $410.61 |
| 65760 | E | | Revision of cornea | | | | | |
| 65765 | E | | Revision of cornea | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 65767 | E | | Corneal tissue transplant | | | | | |
| 65770 | T | | Revise cornea with implant | 0244 | 37.6284 | $2,053.04 | $803.26 | $410.61 |
| 65771 | E | | Radial keratotomy | | | | | |
| 65772 | T | | Correction of astigmatism | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 65775 | T | | Correction of astigmatism | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 65780 | T | NI | Ocular reconst, transplant | 0244 | 37.6284 | $2,053.04 | $803.26 | $410.61 |
| 65781 | T | NI | Ocular reconst, transplant | 0244 | 37.6284 | $2,053.04 | $803.26 | $410.61 |
| 65782 | T | NI | Ocular reconst, transplant | 0244 | 37.6284 | $2,053.04 | $803.26 | $410.61 |
| 65800 | T | | Drainage of eye | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 65805 | T | | Drainage of eye | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 65810 | T | | Drainage of eye | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 65815 | T | | Drainage of eye | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 65820 | T | | Relieve inner eye pressure | 0232 | 4.9206 | $268.47 | $103.17 | $53.69 |
| 65850 | T | | Incision of eye | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 65855 | T | | Laser surgery of eye | 0247 | 4.9482 | $269.98 | $104.31 | $54.00 |
| 65860 | T | | Incise inner eye adhesions | 0247 | 4.9482 | $269.98 | $104.31 | $54.00 |
| 65865 | T | | Incise inner eye adhesions | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 65870 | T | | Incise inner eye adhesions | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 65875 | T | | Incise inner eye adhesions | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 65880 | T | | Incise inner eye adhesions | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 65900 | T | | Remove eye lesion | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 65920 | T | | Remove implant of eye | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 65930 | T | | Remove blood clot from eye | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 66020 | T | | Injection treatment of eye | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 66030 | T | | Injection treatment of eye | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 66130 | T | | Remove eye lesion | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 66150 | T | | Glaucoma surgery | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 66155 | T | | Glaucoma surgery | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 66160 | T | | Glaucoma surgery | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 66165 | T | | Glaucoma surgery | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 66170 | T | | Glaucoma surgery | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 66172 | T | | Incision of eye | 0673 | 26.8390 | $1,464.36 | $649.56 | $292.87 |
| 66180 | T | | Implant eye shunt | 0673 | 26.8390 | $1,464.36 | $649.56 | $292.87 |
| 66185 | T | | Revise eye shunt | 0673 | 26.8390 | $1,464.36 | $649.56 | $292.87 |
| 66220 | T | | Repair eye lesion | 0236 | 18.6701 | $1,018.66 | | $203.73 |
| 66225 | T | | Repair/graft eye lesion | 0673 | 26.8390 | $1,464.36 | $649.56 | $292.87 |
| 66250 | T | | Follow-up surgery of eye | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 66500 | T | | Incision of iris | 0232 | 4.9206 | $268.47 | $103.17 | $53.69 |
| 66505 | T | | Incision of iris | 0232 | 4.9206 | $268.47 | $103.17 | $53.69 |
| 66600 | T | | Remove iris and lesion | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 66605 | T | | Removal of iris | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 66625 | T | | Removal of iris | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 66630 | T | | Removal of iris | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 66635 | T | | Removal of iris | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 66680 | T | | Repair iris & ciliary body | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 66682 | T | | Repair iris & ciliary body | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 66700 | T | | Destruction, ciliary body | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 66710 | T | | Destruction, ciliary body | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 66720 | T | | Destruction, ciliary body | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 66740 | T | | Destruction, ciliary body | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 66761 | T | | Revision of iris | 0247 | 4.9482 | $269.98 | $104.31 | $54.00 |
| 66762 | T | | Revision of iris | 0247 | 4.9482 | $269.98 | $104.31 | $54.00 |
| 66770 | T | | Removal of inner eye lesion | 0247 | 4.9482 | $269.98 | $104.31 | $54.00 |
| 66820 | T | | Incision, secondary cataract | 0232 | 4.9206 | $268.47 | $103.17 | $53.69 |
| 66821 | T | | After cataract laser surgery | 0247 | 4.9482 | $269.98 | $104.31 | $54.00 |
| 66825 | T | | Reposition intraocular lens | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 66830 | T | | Removal of lens lesion | 0232 | 4.9206 | $268.47 | $103.17 | $53.69 |
| 66840 | T | | Removal of lens material | 0245 | 12.2973 | $670.95 | $222.22 | $134.19 |
| 66850 | T | | Removal of lens material | 0249 | 27.7406 | $1,513.55 | $524.67 | $302.71 |
| 66852 | T | | Removal of lens material | 0249 | 27.7406 | $1,513.55 | $524.67 | $302.71 |
| 66920 | T | | Extraction of lens | 0249 | 27.7406 | $1,513.55 | $524.67 | $302.71 |
| 66930 | T | | Extraction of lens | 0249 | 27.7406 | $1,513.55 | $524.67 | $302.71 |
| 66940 | T | | Extraction of lens | 0245 | 12.2973 | $670.95 | $222.22 | $134.19 |
| 66982 | T | | Cataract surgery, complex | 0246 | 22.9755 | $1,253.57 | $495.96 | $250.71 |
| 66983 | T | | Cataract surg w/iol, 1 stage | 0246 | 22.9755 | $1,253.57 | $495.96 | $250.71 |
| 66984 | T | | Cataract surg w/iol, 1 stage | 0246 | 22.9755 | $1,253.57 | $495.96 | $250.71 |
| 66985 | T | | Insert lens prosthesis | 0246 | 22.9755 | $1,253.57 | $495.96 | $250.71 |
| 66986 | T | | Exchange lens prosthesis | 0246 | 22.9755 | $1,253.57 | $495.96 | $250.71 |
| 66990 | N | | Ophthalmic endoscope add-on | | | | | |
| 66999 | T | | Eye surgery procedure | 0232 | 4.9206 | $268.47 | $103.17 | $53.69 |
| 67005 | T | | Partial removal of eye fluid | 0237 | 34.1784 | $1,864.81 | $818.54 | $372.96 |
| 67010 | T | | Partial removal of eye fluid | 0237 | 34.1784 | $1,864.81 | $818.54 | $372.96 |
| 67015 | T | | Release of eye fluid | 0237 | 34.1784 | $1,864.81 | $818.54 | $372.96 |
| 67025 | T | | Replace eye fluid | 0236 | 18.6701 | $1,018.66 | | $203.73 |
| 67027 | T | | Implant eye drug system | 0237 | 34.1784 | $1,864.81 | $818.54 | $372.96 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 67028 | T | | Injection eye drug | 0235 | 5.0749 | $276.89 | $72.04 | $55.38 |
| 67030 | T | | Incise inner eye strands | 0236 | 18.6701 | $1,018.66 | | $203.73 |
| 67031 | T | | Laser surgery, eye strands | 0247 | 4.9482 | $269.98 | $104.31 | $54.00 |
| 67036 | T | | Removal of inner eye fluid | 0237 | 34.1784 | $1,864.81 | $818.54 | $372.96 |
| 67038 | T | | Strip retinal membrane | 0237 | 34.1784 | $1,864.81 | $818.54 | $372.96 |
| 67039 | T | | Laser treatment of retina | 0237 | 34.1784 | $1,864.81 | $818.54 | $372.96 |
| 67040 | T | | Laser treatment of retina | 0672 | 38.9476 | $2,125.02 | $988.43 | $425.00 |
| 67101 | T | | Repair detached retina | 0235 | 5.0749 | $276.89 | $72.04 | $55.38 |
| 67105 | T | | Repair detached retina | 0248 | 4.8223 | $263.11 | $95.08 | $52.62 |
| 67107 | T | | Repair detached retina | 0672 | 38.9476 | $2,125.02 | $988.43 | $425.00 |
| 67108 | T | | Repair detached retina | 0672 | 38.9476 | $2,125.02 | $988.43 | $425.00 |
| 67110 | T | | Repair detached retina | 0236 | 18.6701 | $1,018.66 | | $203.73 |
| 67112 | T | | Rerepair detached retina | 0672 | 38.9476 | $2,125.02 | $988.43 | $425.00 |
| 67115 | T | | Release encircling material | 0236 | 18.6701 | $1,018.66 | | $203.73 |
| 67120 | T | | Remove eye implant material | 0236 | 18.6701 | $1,018.66 | | $203.73 |
| 67121 | T | | Remove eye implant material | 0237 | 34.1784 | $1,864.81 | $818.54 | $372.96 |
| 67141 | T | | Treatment of retina | 0235 | 5.0749 | $276.89 | $72.04 | $55.38 |
| 67145 | T | | Treatment of retina | 0248 | 4.8223 | $263.11 | $95.08 | $52.62 |
| 67208 | T | | Treatment of retinal lesion | 0235 | 5.0749 | $276.89 | $72.04 | $55.38 |
| 67210 | T | | Treatment of retinal lesion | 0248 | 4.8223 | $263.11 | $95.08 | $52.62 |
| 67218 | T | | Treatment of retinal lesion | 0236 | 18.6701 | $1,018.66 | | $203.73 |
| 67220 | T | | Treatment of choroid lesion | 0235 | 5.0749 | $276.89 | $72.04 | $55.38 |
| 67221 | T | | Ocular photodynamic ther | 0235 | 5.0749 | $276.89 | $72.04 | $55.38 |
| 67225 | T | | Eye photodynamic ther add-on | 0235 | 5.0749 | $276.89 | $72.04 | $55.38 |
| 67227 | T | | Treatment of retinal lesion | 0235 | 5.0749 | $276.89 | $72.04 | $55.38 |
| 67228 | T | | Treatment of retinal lesion | 0248 | 4.8223 | $263.11 | $95.08 | $52.62 |
| 67250 | T | | Reinforce eye wall | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67255 | T | | Reinforce/graft eye wall | 0237 | 34.1784 | $1,864.81 | $818.54 | $372.96 |
| 67299 | T | | Eye surgery procedure | 0235 | 5.0749 | $276.89 | $72.04 | $55.38 |
| 67311 | T | | Revise eye muscle | 0243 | 21.7323 | $1,185.74 | $431.39 | $237.15 |
| 67312 | T | | Revise two eye muscles | 0243 | 21.7323 | $1,185.74 | $431.39 | $237.15 |
| 67314 | T | | Revise eye muscle | 0243 | 21.7323 | $1,185.74 | $431.39 | $237.15 |
| 67316 | T | | Revise two eye muscles | 0243 | 21.7323 | $1,185.74 | $431.39 | $237.15 |
| 67318 | T | | Revise eye muscle(s) | 0243 | 21.7323 | $1,185.74 | $431.39 | $237.15 |
| 67320 | T | | Revise eye muscle(s) add-on | 0243 | 21.7323 | $1,185.74 | $431.39 | $237.15 |
| 67331 | T | | Eye surgery follow-up add-on | 0243 | 21.7323 | $1,185.74 | $431.39 | $237.15 |
| 67332 | T | | Rerevise eye muscles add-on | 0243 | 21.7323 | $1,185.74 | $431.39 | $237.15 |
| 67334 | T | | Revise eye muscle w/suture | 0243 | 21.7323 | $1,185.74 | $431.39 | $237.15 |
| 67335 | T | | Eye suture during surgery | 0243 | 21.7323 | $1,185.74 | $431.39 | $237.15 |
| 67340 | T | | Revise eye muscle add-on | 0243 | 21.7323 | $1,185.74 | $431.39 | $237.15 |
| 67343 | T | | Release eye tissue | 0243 | 21.7323 | $1,185.74 | $431.39 | $237.15 |
| 67345 | T | | Destroy nerve of eye muscle | 0238 | 3.1954 | $174.34 | $58.96 | $34.87 |
| 67350 | T | | Biopsy eye muscle | 0699 | 2.2303 | $121.69 | $47.46 | $24.34 |
| 67399 | T | | Eye muscle surgery procedure | 0243 | 21.7323 | $1,185.74 | $431.39 | $237.15 |
| 67400 | T | | Explore/biopsy eye socket | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 67405 | T | | Explore/drain eye socket | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 67412 | T | | Explore/treat eye socket | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 67413 | T | | Explore/treat eye socket | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 67414 | T | | Explr/decompress eye socket | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 67415 | T | | Aspiration, orbital contents | 0239 | 6.1331 | $334.63 | | $66.93 |
| 67420 | T | | Explore/treat eye socket | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 67430 | T | | Explore/treat eye socket | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 67440 | T | | Explore/drain eye socket | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 67445 | T | | Explr/decompress eye socket | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 67450 | T | | Explore/biopsy eye socket | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 67500 | S | | Inject/treat eye socket | 0231 | 2.1883 | $119.40 | $50.94 | $23.88 |
| 67505 | T | | Inject/treat eye socket | 0238 | 3.1954 | $174.34 | $58.96 | $34.87 |
| 67515 | T | | Inject/treat eye socket | 0239 | 6.1331 | $334.63 | | $66.93 |
| 67550 | T | | Insert eye socket implant | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 67560 | T | | Revise eye socket implant | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 67570 | T | | Decompress optic nerve | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 67599 | T | | Orbit surgery procedure | 0239 | 6.1331 | $334.63 | | $66.93 |
| 67700 | T | | Drainage of eyelid abscess | 0238 | 3.1954 | $174.34 | $58.96 | $34.87 |
| 67710 | T | | Incision of eyelid | 0239 | 6.1331 | $334.63 | | $66.93 |
| 67715 | T | | Incision of eyelid fold | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67800 | T | | Remove eyelid lesion | 0238 | 3.1954 | $174.34 | $58.96 | $34.87 |
| 67801 | T | | Remove eyelid lesions | 0239 | 6.1331 | $334.63 | | $66.93 |
| 67805 | T | | Remove eyelid lesions | 0238 | 3.1954 | $174.34 | $58.96 | $34.87 |
| 67808 | T | | Remove eyelid lesion(s) | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67810 | T | | Biopsy of eyelid | 0238 | 3.1954 | $174.34 | $58.96 | $34.87 |
| 67820 | S | | Revise eyelashes | 0698 | 0.9599 | $52.37 | $18.72 | $10.47 |
| 67825 | T | | Revise eyelashes | 0238 | 3.1954 | $174.34 | $58.96 | $34.87 |
| 67830 | T | | Revise eyelashes | 0239 | 6.1331 | $334.63 | | $66.93 |
| 67835 | T | | Revise eyelashes | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67840 | T | | Remove eyelid lesion | 0239 | 6.1331 | $334.63 | | $66.93 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 67850 | T | | Treat eyelid lesion | 0239 | 6.1331 | $334.63 | | $66.93 |
| 67875 | T | | Closure of eyelid by suture | 0239 | 6.1331 | $334.63 | | $66.93 |
| 67880 | T | | Revision of eyelid | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 67882 | T | | Revision of eyelid | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67900 | T | | Repair brow defect | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67901 | T | | Repair eyelid defect | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67902 | T | | Repair eyelid defect | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67903 | T | | Repair eyelid defect | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67904 | T | | Repair eyelid defect | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67906 | T | | Repair eyelid defect | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67908 | T | | Repair eyelid defect | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67909 | T | | Revise eyelid defect | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67911 | T | | Revise eyelid defect | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67912 | T | NI | Correction eyelid w/ implant | 0239 | 6.1331 | $334.63 | | $66.93 |
| 67914 | T | | Repair eyelid defect | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67915 | T | | Repair eyelid defect | 0239 | 6.1331 | $334.63 | | $66.93 |
| 67916 | T | | Repair eyelid defect | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67917 | T | | Repair eyelid defect | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67921 | T | | Repair eyelid defect | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67922 | T | | Repair eyelid defect | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67923 | T | | Repair eyelid defect | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67924 | T | | Repair eyelid defect | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67930 | T | | Repair eyelid wound | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67935 | T | | Repair eyelid wound | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67938 | S | | Remove eyelid foreign body | 0698 | 0.9599 | $52.37 | $18.72 | $10.47 |
| 67950 | T | | Revision of eyelid | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67961 | T | | Revision of eyelid | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67966 | T | | Revision of eyelid | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67971 | T | | Reconstruction of eyelid | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 67973 | T | | Reconstruction of eyelid | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 67974 | T | | Reconstruction of eyelid | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 67975 | T | | Reconstruction of eyelid | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 67999 | T | | Revision of eyelid | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 68020 | T | | Incise/drain eyelid lining | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 68040 | S | | Treatment of eyelid lesions | 0698 | 0.9599 | $52.37 | $18.72 | $10.47 |
| 68100 | T | | Biopsy of eyelid lining | 0232 | 4.9206 | $268.47 | $103.17 | $53.69 |
| 68110 | T | | Remove eyelid lining lesion | 0699 | 2.2303 | $121.69 | $47.46 | $24.34 |
| 68115 | T | | Remove eyelid lining lesion | 0239 | 6.1331 | $334.63 | | $66.93 |
| 68130 | T | | Remove eyelid lining lesion | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 68135 | T | | Remove eyelid lining lesion | 0239 | 6.1331 | $334.63 | | $66.93 |
| 68200 | S | | Treat eyelid by injection | 0698 | 0.9599 | $52.37 | $18.72 | $10.47 |
| 68320 | T | | Revise/graft eyelid lining | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 68325 | T | | Revise/graft eyelid lining | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 68326 | T | | Revise/graft eyelid lining | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 68328 | T | | Revise/graft eyelid lining | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 68330 | T | | Revise eyelid lining | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 68335 | T | | Revise/graft eyelid lining | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 68340 | T | | Separate eyelid adhesions | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 68360 | T | | Revise eyelid lining | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 68362 | T | | Revise eyelid lining | 0234 | 21.4631 | $1,171.05 | $511.31 | $234.21 |
| 68371 | T | NI | Harvest eye tissue, alograft | 0233 | 14.4205 | $786.80 | $266.33 | $157.36 |
| 68399 | T | | Eyelid lining surgery | 0239 | 6.1331 | $334.63 | | $66.93 |
| 68400 | T | | Incise/drain tear gland | 0238 | 3.1954 | $174.34 | $58.96 | $34.87 |
| 68420 | T | | Incise/drain tear sac | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 68440 | T | | Incise tear duct opening | 0238 | 3.1954 | $174.34 | $58.96 | $34.87 |
| 68500 | T | | Removal of tear gland | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 68505 | T | | Partial removal, tear gland | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 68510 | T | | Biopsy of tear gland | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 68520 | T | | Removal of tear sac | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 68525 | T | | Biopsy of tear sac | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 68530 | T | | Clearance of tear duct | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 68540 | T | | Remove tear gland lesion | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 68550 | T | | Remove tear gland lesion | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 68700 | T | | Repair tear ducts | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 68705 | T | | Revise tear duct opening | 0238 | 3.1954 | $174.34 | $58.96 | $34.87 |
| 68720 | T | | Create tear sac drain | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 68745 | T | | Create tear duct drain | 0241 | 22.1969 | $1,211.09 | $384.47 | $242.22 |
| 68750 | T | | Create tear duct drain | 0242 | 29.4294 | $1,605.70 | $597.36 | $321.14 |
| 68760 | S | | Close tear duct opening | 0698 | 0.9599 | $52.37 | $18.72 | $10.47 |
| 68761 | S | | Close tear duct opening | 0231 | 2.1883 | $119.40 | $50.94 | $23.88 |
| 68770 | T | | Close tear system fistula | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 68801 | S | | Dilate tear duct opening | 0231 | 2.1883 | $119.40 | $50.94 | $23.88 |
| 68810 | T | | Probe nasolacrimal duct | 0699 | 2.2303 | $121.69 | $47.46 | $24.34 |
| 68811 | T | | Probe nasolacrimal duct | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |
| 68815 | T | | Probe nasolacrimal duct | 0240 | 17.4535 | $952.28 | $315.31 | $190.46 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 68840 | T | | Explore/irrigate tear ducts | 0699 | 2.2303 | $121.69 | $47.46 | $24.34 |
| 68850 | N | | Injection for tear sac x-ray | | | | | |
| 68899 | T | | Tear duct system surgery | 0699 | 2.2303 | $121.69 | $47.46 | $24.34 |
| 69000 | T | | Drain external ear lesion | 0006 | 1.6527 | $90.17 | $23.26 | $18.03 |
| 69005 | T | | Drain external ear lesion | 0007 | 11.8633 | $647.27 | | $129.45 |
| 69020 | T | | Drain outer ear canal lesion | 0006 | 1.6527 | $90.17 | $23.26 | $18.03 |
| 69090 | E | | Pierce earlobes | | | | | |
| 69100 | T | | Biopsy of external ear | 0019 | 3.9493 | $215.48 | $71.87 | $43.10 |
| 69105 | T | | Biopsy of external ear canal | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 69110 | T | | Remove external ear, partial | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 69120 | T | | Removal of external ear | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 69140 | T | | Remove ear canal lesion(s) | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 69145 | T | | Remove ear canal lesion(s) | 0021 | 14.3594 | $783.46 | $219.48 | $156.69 |
| 69150 | T | | Extensive ear canal surgery | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 69155 | C | | Extensive ear/neck surgery | | | | | |
| 69200 | X | | Clear outer ear canal | 0340 | 0.6314 | $34.45 | | $6.89 |
| 69205 | T | | Clear outer ear canal | 0022 | 18.7932 | $1,025.38 | $354.45 | $205.08 |
| 69210 | X | | Remove impacted ear wax | 0340 | 0.6314 | $34.45 | | $6.89 |
| 69220 | T | | Clean out mastoid cavity | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 69222 | T | | Clean out mastoid cavity | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 69300 | T | | Revise external ear | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 69310 | T | | Rebuild outer ear canal | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69320 | T | | Rebuild outer ear canal | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69399 | T | | Outer ear surgery procedure | 0251 | 1.7880 | $97.56 | | $19.51 |
| 69400 | T | | Inflate middle ear canal | 0251 | 1.7880 | $97.56 | | $19.51 |
| 69401 | T | | Inflate middle ear canal | 0251 | 1.7880 | $97.56 | | $19.51 |
| 69405 | T | | Catheterize middle ear canal | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 69410 | T | | Inset middle ear (baffle) | 0251 | 1.7880 | $97.56 | | $19.51 |
| 69420 | T | | Incision of eardrum | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 69421 | T | | Incision of eardrum | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 69424 | T | | Remove ventilating tube | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 69433 | T | | Create eardrum opening | 0252 | 6.4469 | $351.75 | $113.41 | $70.35 |
| 69436 | T | | Create eardrum opening | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 69440 | T | | Exploration of middle ear | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 69450 | T | | Eardrum revision | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69501 | T | | Mastoidectomy | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69502 | T | | Mastoidectomy | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 69505 | T | | Remove mastoid structures | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69511 | T | | Extensive mastoid surgery | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69530 | T | | Extensive mastoid surgery | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69535 | C | | Remove part of temporal bone | | | | | |
| 69540 | T | | Remove ear lesion | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 69550 | T | | Remove ear lesion | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69552 | T | | Remove ear lesion | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69554 | C | | Remove ear lesion | | | | | |
| 69601 | T | | Mastoid surgery revision | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69602 | T | | Mastoid surgery revision | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69603 | T | | Mastoid surgery revision | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69604 | T | | Mastoid surgery revision | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69605 | T | | Mastoid surgery revision | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69610 | T | | Repair of eardrum | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 69620 | T | | Repair of eardrum | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 69631 | T | | Repair eardrum structures | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69632 | T | | Rebuild eardrum structures | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69633 | T | | Rebuild eardrum structures | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69635 | T | | Repair eardrum structures | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69636 | T | | Rebuild eardrum structures | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69637 | T | | Rebuild eardrum structures | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69641 | T | | Revise middle ear & mastoid | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69642 | T | | Revise middle ear & mastoid | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69643 | T | | Revise middle ear & mastoid | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69644 | T | | Revise middle ear & mastoid | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69645 | T | | Revise middle ear & mastoid | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69646 | T | | Revise middle ear & mastoid | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69650 | T | | Release middle ear bone | 0254 | 21.8901 | $1,194.35 | $321.35 | $238.87 |
| 69660 | T | | Revise middle ear bone | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69661 | T | | Revise middle ear bone | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69662 | T | | Revise middle ear bone | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69666 | T | | Repair middle ear structures | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69667 | T | | Repair middle ear structures | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69670 | T | | Remove mastoid air cells | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69676 | T | | Remove middle ear nerve | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69700 | T | | Close mastoid fistula | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69710 | E | | Implant/replace hearing aid | | | | | |
| 69711 | T | | Remove/repair hearing aid | 0256 | 35.1548 | $1,918.08 | | $383.62 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 69714 | T | | Implant temple bone w/stimul | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69715 | T | | Temple bne implnt w/stimulat | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69717 | T | | Temple bone implant revision | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69718 | T | | Revise temple bone implant | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69720 | T | | Release facial nerve | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69725 | T | | Release facial nerve | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69740 | T | | Repair facial nerve | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69745 | T | | Repair facial nerve | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69799 | T | | Middle ear surgery procedure | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 69801 | T | | Incise inner ear | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69802 | T | | Incise inner ear | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69805 | T | | Explore inner ear | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69806 | T | | Explore inner ear | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69820 | T | | Establish inner ear window | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69840 | T | | Revise inner ear window | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69905 | T | | Remove inner ear | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69910 | T | | Remove inner ear & mastoid | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69915 | T | | Incise inner ear nerve | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69930 | T | | Implant cochlear device | 0259 | 392.8622 | $21,434.95 | $9,394.83 | $4,286.99 |
| 69949 | T | | Inner ear surgery procedure | 0253 | 15.2249 | $830.69 | $282.29 | $166.14 |
| 69950 | C | | Incise inner ear nerve | | | | | |
| 69955 | T | | Release facial nerve | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69960 | T | | Release inner ear canal | 0256 | 35.1548 | $1,918.08 | | $383.62 |
| 69970 | C | | Remove inner ear lesion | | | | | |
| 69979 | T | | Temporal bone surgery | 0251 | 1.7880 | $97.56 | | $19.51 |
| 69990 | N | | Microsurgery add-on | | | | | |
| 70010 | S | | Contrast x-ray of brain | 0274 | 3.5931 | $196.04 | $93.63 | $39.21 |
| 70015 | S | | Contrast x-ray of brain | 0274 | 3.5931 | $196.04 | $93.63 | $39.21 |
| 70030 | X | | X-ray eye for foreign body | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70100 | X | | X-ray exam of jaw | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70110 | X | | X-ray exam of jaw | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70120 | X | | X-ray exam of mastoids | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70130 | X | | X-ray exam of mastoids | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70134 | X | | X-ray exam of middle ear | 0261 | 1.3176 | $71.89 | | $14.38 |
| 70140 | X | | X-ray exam of facial bones | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70150 | X | | X-ray exam of facial bones | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70160 | X | | X-ray exam of nasal bones | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70170 | X | | X-ray exam of tear duct | 0263 | 2.1883 | $119.40 | $43.58 | $23.88 |
| 70190 | X | | X-ray exam of eye sockets | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70200 | X | | X-ray exam of eye sockets | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70210 | X | | X-ray exam of sinuses | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70220 | X | | X-ray exam of sinuses | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70240 | X | | X-ray exam, pituitary saddle | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70250 | X | | X-ray exam of skull | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70260 | X | | X-ray exam of skull | 0261 | 1.3176 | $71.89 | | $14.38 |
| 70300 | X | | X-ray exam of teeth | 0262 | 0.7540 | $41.14 | $9.82 | $8.23 |
| 70310 | X | | X-ray exam of teeth | 0262 | 0.7540 | $41.14 | $9.82 | $8.23 |
| 70320 | X | | Full mouth x-ray of teeth | 0262 | 0.7540 | $41.14 | $9.82 | $8.23 |
| 70328 | X | | X-ray exam of jaw joint | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70330 | X | | X-ray exam of jaw joints | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70332 | S | | X-ray exam of jaw joint | 0275 | 3.2775 | $178.82 | $69.09 | $35.76 |
| 70336 | S | | Magnetic image, jaw joint | 0335 | 6.3499 | $346.46 | $151.46 | $69.29 |
| 70350 | X | | X-ray head for orthodontia | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70355 | X | | Panoramic x-ray of jaws | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70360 | X | | X-ray exam of neck | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70370 | X | | Throat x-ray & fluoroscopy | 0272 | 1.4166 | $77.29 | $38.36 | $15.46 |
| 70371 | X | | Speech evaluation, complex | 0272 | 1.4166 | $77.29 | $38.36 | $15.46 |
| 70373 | X | | Contrast x-ray of larynx | 0263 | 2.1883 | $119.40 | $43.58 | $23.88 |
| 70380 | X | | X-ray exam of salivary gland | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 70390 | X | | X-ray exam of salivary duct | 0264 | 3.0287 | $165.25 | $79.41 | $33.05 |
| 70450 | S | | Ct head/brain w/o dye | 0332 | 3.3936 | $185.16 | $91.27 | $37.03 |
| 70460 | S | | Ct head/brain w/dye | 0283 | 4.6543 | $253.94 | $126.27 | $50.79 |
| 70470 | S | | Ct head/brain w/o & w/ dye | 0333 | 5.4241 | $295.94 | $146.98 | $59.19 |
| 70480 | S | | Ct orbit/ear/fossa w/o dye | 0332 | 3.3936 | $185.16 | $91.27 | $37.03 |
| 70481 | S | | Ct orbit/ear/fossa w/dye | 0283 | 4.6543 | $253.94 | $126.27 | $50.79 |
| 70482 | S | | Ct orbit/ear/fossa w/o&w dye | 0333 | 5.4241 | $295.94 | $146.98 | $59.19 |
| 70486 | S | | Ct maxillofacial w/o dye | 0332 | 3.3936 | $185.16 | $91.27 | $37.03 |
| 70487 | S | | Ct maxillofacial w/dye | 0283 | 4.6543 | $253.94 | $126.27 | $50.79 |
| 70488 | S | | Ct maxillofacial w/o & w dye | 0333 | 5.4241 | $295.94 | $146.98 | $59.19 |
| 70490 | S | | Ct soft tissue neck w/o dye | 0332 | 3.3936 | $185.16 | $91.27 | $37.03 |
| 70491 | S | | Ct soft tissue neck w/dye | 0283 | 4.6543 | $253.94 | $126.27 | $50.79 |
| 70492 | S | | Ct sft tsue nck w/o & w/dye | 0333 | 5.4241 | $295.94 | $146.98 | $59.19 |
| 70496 | S | | Ct angiography, head | 0662 | 5.8775 | $320.68 | $156.47 | $64.14 |
| 70498 | S | | Ct angiography, neck | 0662 | 5.8775 | $320.68 | $156.47 | $64.14 |
| 70540 | S | | Mri orbit/face/neck w/o dye | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 70542 | S | | Mri orbit/face/neck w/dye | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| 70543 | S | | Mri orbt/fac/nck w/o & w dye | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| 70544 | S | | Mr angiography head w/o dye | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| 70545 | S | | Mr angiography head w/dye | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| 70546 | S | | Mr angiograph head w/o&w dye | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| 70547 | S | | Mr angiography neck w/o dye | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| 70548 | S | | Mr angiography neck w/dye | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| 70549 | S | | Mr angiograph neck w/o&w dye | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| 70551 | S | | Mri brain w/o dye | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| 70552 | S | | Mri brain w/ dye | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| 70553 | S | | Mri brain w/o & w/ dye | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| 70557 | S | NI | Mri brain w/o dye | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| 70558 | S | NI | Mri brain w/ dye | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| 70559 | S | NI | Mri brain w/o & w/ dye | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| 71010 | X | | Chest x-ray | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 71015 | X | | Chest x-ray | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 71020 | X | | Chest x-ray | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 71021 | X | | Chest x-ray | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 71022 | X | | Chest x-ray | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 71023 | X | | Chest x-ray and fluoroscopy | 0272 | 1.4166 | $77.29 | $38.36 | $15.46 |
| 71030 | X | | Chest x-ray | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 71034 | X | | Chest x-ray and fluoroscopy | 0272 | 1.4166 | $77.29 | $38.36 | $15.46 |
| 71035 | X | | Chest x-ray | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 71040 | X | | Contrast x-ray of bronchi | 0263 | 2.1883 | $119.40 | $43.58 | $23.88 |
| 71060 | X | | Contrast x-ray of bronchi | 0264 | 3.0287 | $165.25 | $79.41 | $33.05 |
| 71090 | X | | X-ray & pacemaker insertion | 0272 | 1.4166 | $77.29 | $38.36 | $15.46 |
| 71100 | X | | X-ray exam of ribs | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 71101 | X | | X-ray exam of ribs/chest | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 71110 | X | | X-ray exam of ribs | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 71111 | X | | X-ray exam of ribs/ chest | 0261 | 1.3176 | $71.89 | | $14.38 |
| 71120 | X | | X-ray exam of breastbone | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 71130 | X | | X-ray exam of breastbone | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 71250 | S | | Ct thorax w/o dye | 0332 | 3.3936 | $185.16 | $91.27 | $37.03 |
| 71260 | S | | Ct thorax w/dye | 0283 | 4.6543 | $253.94 | $126.27 | $50.79 |
| 71270 | S | | Ct thorax w/o & w/ dye | 0333 | 5.4241 | $295.94 | $146.98 | $59.19 |
| 71275 | S | | Ct angiography, chest | 0662 | 5.8775 | $320.68 | $156.47 | $64.14 |
| 71550 | S | | Mri chest w/o dye | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| 71551 | S | | Mri chest w/dye | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| 71552 | S | | Mri chest w/o & w/dye | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| 71555 | B | | Mri angio chest w or w/o dye | | | | | |
| 72010 | X | | X-ray exam of spine | 0261 | 1.3176 | $71.89 | | $14.38 |
| 72020 | X | | X-ray exam of spine | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 72040 | X | | X-ray exam of neck spine | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 72050 | X | | X-ray exam of neck spine | 0261 | 1.3176 | $71.89 | | $14.38 |
| 72052 | X | | X-ray exam of neck spine | 0261 | 1.3176 | $71.89 | | $14.38 |
| 72069 | X | | X-ray exam of trunk spine | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 72070 | X | | X-ray exam of thoracic spine | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 72072 | X | | X-ray exam of thoracic spine | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 72074 | X | | X-ray exam of thoracic spine | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 72080 | X | | X-ray exam of trunk spine | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 72090 | X | | X-ray exam of trunk spine | 0261 | 1.3176 | $71.89 | | $14.38 |
| 72100 | X | | X-ray exam of lower spine | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 72110 | X | | X-ray exam of lower spine | 0261 | 1.3176 | $71.89 | | $14.38 |
| 72114 | X | | X-ray exam of lower spine | 0261 | 1.3176 | $71.89 | | $14.38 |
| 72120 | X | | X-ray exam of lower spine | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 72125 | S | | Ct neck spine w/o dye | 0332 | 3.3936 | $185.16 | $91.27 | $37.03 |
| 72126 | S | | Ct neck spine w/dye | 0283 | 4.6543 | $253.94 | $126.27 | $50.79 |
| 72127 | S | | Ct neck spine w/o & w/dye | 0333 | 5.4241 | $295.94 | $146.98 | $59.19 |
| 72128 | S | | Ct chest spine w/o dye | 0332 | 3.3936 | $185.16 | $91.27 | $37.03 |
| 72129 | S | | Ct chest spine w/dye | 0283 | 4.6543 | $253.94 | $126.27 | $50.79 |
| 72130 | S | | Ct chest spine w/o & w/dye | 0333 | 5.4241 | $295.94 | $146.98 | $59.19 |
| 72131 | S | | Ct lumbar spine w/o dye | 0332 | 3.3936 | $185.16 | $91.27 | $37.03 |
| 72132 | S | | Ct lumbar spine w/dye | 0283 | 4.6543 | $253.94 | $126.27 | $50.79 |
| 72133 | S | | Ct lumbar spine w/o & w/dye | 0333 | 5.4241 | $295.94 | $146.98 | $59.19 |
| 72141 | S | | Mri neck spine w/o dye | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| 72142 | S | | Mri neck spine w/dye | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| 72146 | S | | Mri chest spine w/o dye | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| 72147 | S | | Mri chest spine w/dye | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| 72148 | S | | Mri lumbar spine w/o dye | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| 72149 | S | | Mri lumbar spine w/dye | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| 72156 | S | | Mri neck spine w/o & w/dye | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| 72157 | S | | Mri chest spine w/o & w/dye | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| 72158 | S | | Mri lumbar spine w/o & w/dye | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| 72159 | E | | Mr angio spine w/o&w/dye | | | | | |
| 72170 | X | | X-ray exam of pelvis | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 72190 | X | | X-ray exam of pelvis | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 72191 | S | | Ct angiograph pelv w/o&w/dye | 0662 | 5.8775 | $320.68 | $156.47 | $64.14 |
| 72192 | S | | Ct pelvis w/o dye | 0332 | 3.3936 | $185.16 | $91.27 | $37.03 |
| 72193 | S | | Ct pelvis w/dye | 0283 | 4.6543 | $253.94 | $126.27 | $50.79 |
| 72194 | S | | Ct pelvis w/o & w/dye | 0333 | 5.4241 | $295.94 | $146.98 | $59.19 |
| 72195 | S | | Mri pelvis w/o dye | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| 72196 | S | | Mri pelvis w/dye | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| 72197 | S | | Mri pelvis w/o & w/dye | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| 72198 | E | | Mr angio pelvis w/o & w/dye | | | | | |
| 72200 | X | | X-ray exam sacroiliac joints | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 72202 | X | | X-ray exam sacroiliac joints | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 72220 | X | | X-ray exam of tailbone | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 72240 | S | | Contrast x-ray of neck spine | 0274 | 3.5931 | $196.04 | $93.63 | $39.21 |
| 72255 | S | | Contrast x-ray, thorax spine | 0274 | 3.5931 | $196.04 | $93.63 | $39.21 |
| 72265 | S | | Contrast x-ray, lower spine | 0274 | 3.5931 | $196.04 | $93.63 | $39.21 |
| 72270 | S | | Contrast x-ray, spine | 0274 | 3.5931 | $196.04 | $93.63 | $39.21 |
| 72275 | S | | Epidurography | 0274 | 3.5931 | $196.04 | $93.63 | $39.21 |
| 72285 | S | | X-ray c/t spine disk | 0388 | 11.6347 | $634.80 | $303.19 | $126.96 |
| 72295 | S | | X-ray of lower spine disk | 0388 | 11.6347 | $634.80 | $303.19 | $126.96 |
| 73000 | X | | X-ray exam of collar bone | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73010 | X | | X-ray exam of shoulder blade | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73020 | X | | X-ray exam of shoulder | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73030 | X | | X-ray exam of shoulder | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73040 | S | | Contrast x-ray of shoulder | 0275 | 3.2775 | $178.82 | $69.09 | $35.76 |
| 73050 | X | | X-ray exam of shoulders | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73060 | X | | X-ray exam of humerus | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73070 | X | | X-ray exam of elbow | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73080 | X | | X-ray exam of elbow | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73085 | S | | Contrast x-ray of elbow | 0275 | 3.2775 | $178.82 | $69.09 | $35.76 |
| 73090 | X | | X-ray exam of forearm | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73092 | X | | X-ray exam of arm, infant | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73100 | X | | X-ray exam of wrist | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73110 | X | | X-ray exam of wrist | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73115 | S | | Contrast x-ray of wrist | 0275 | 3.2775 | $178.82 | $69.09 | $35.76 |
| 73120 | X | | X-ray exam of hand | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73130 | X | | X-ray exam of hand | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73140 | X | | X-ray exam of finger(s) | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73200 | S | | Ct upper extremity w/o dye | 0332 | 3.3936 | $185.16 | $91.27 | $37.03 |
| 73201 | S | | Ct upper extremity w/dye | 0283 | 4.6543 | $253.94 | $126.27 | $50.79 |
| 73202 | S | | Ct uppr extremity w/o&w/dye | 0333 | 5.4241 | $295.94 | $146.98 | $59.19 |
| 73206 | S | | Ct angio upr extrm w/o&w/dye | 0662 | 5.8775 | $320.68 | $156.47 | $64.14 |
| 73218 | S | | Mri upper extremity w/o dye | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| 73219 | S | | Mri upper extremity w/dye | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| 73220 | S | | Mri uppr extremity w/o&w/dye | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| 73221 | S | | Mri joint upr extrem w/o dye | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| 73222 | S | | Mri joint upr extrem w/dye | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| 73223 | S | | Mri joint upr extr w/o&w/dye | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| 73225 | E | | Mr angio upr extr w/o&w/dye | | | | | |
| 73500 | X | | X-ray exam of hip | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73510 | X | | X-ray exam of hip | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73520 | X | | X-ray exam of hips | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73525 | S | | Contrast x-ray of hip | 0275 | 3.2775 | $178.82 | $69.09 | $35.76 |
| 73530 | X | | X-ray exam of hip | 0261 | 1.3176 | $71.89 | | $14.38 |
| 73540 | X | | X-ray exam of pelvis & hips | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73542 | S | | X-ray exam, sacroiliac joint | 0275 | 3.2775 | $178.82 | $69.09 | $35.76 |
| 73550 | X | | X-ray exam of thigh | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73560 | X | | X-ray exam of knee, 1 or 2 | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73562 | X | | X-ray exam of knee, 3 | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73564 | X | | X-ray exam, knee, 4 or more | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73565 | X | | X-ray exam of knees | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73580 | S | | Contrast x-ray of knee joint | 0275 | 3.2775 | $178.82 | $69.09 | $35.76 |
| 73590 | X | | X-ray exam of lower leg | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73592 | X | | X-ray exam of leg, infant | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73600 | X | | X-ray exam of ankle | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73610 | X | | X-ray exam of ankle | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73615 | S | | Contrast x-ray of ankle | 0275 | 3.2775 | $178.82 | $69.09 | $35.76 |
| 73620 | X | | X-ray exam of foot | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73630 | X | | X-ray exam of foot | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73650 | X | | X-ray exam of heel | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73660 | X | | X-ray exam of toe(s) | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 73700 | S | | Ct lower extremity w/o dye | 0332 | 3.3936 | $185.16 | $91.27 | $37.03 |
| 73701 | S | | Ct lower extremity w/dye | 0283 | 4.6543 | $253.94 | $126.27 | $50.79 |
| 73702 | S | | Ct lwr extremity w/o&w/dye | 0333 | 5.4241 | $295.94 | $146.98 | $59.19 |
| 73706 | S | | Ct angio lwr extr w/o&w/dye | 0662 | 5.8775 | $320.68 | $156.47 | $64.14 |
| 73718 | S | | Mri lower extremity w/o dye | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 73719 | S | | Mri lower extremity w/dye | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| 73720 | S | | Mri lwr extremity w/o&w/dye | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| 73721 | S | | Mri jnt of lwr extre w/o dye | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| 73722 | S | | Mri joint of lwr extr w/dye | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| 73723 | S | | Mri joint lwr extr w/o&w/dye | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| 73725 | B | | Mr ang lwr ext w or w/o dye | | | | | |
| 74000 | X | | X-ray exam of abdomen | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 74010 | X | | X-ray exam of abdomen | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 74020 | X | | X-ray exam of abdomen | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 74022 | X | | X-ray exam series, abdomen | 0261 | 1.3176 | $71.89 | | $14.38 |
| 74150 | S | | Ct abdomen w/o dye | 0332 | 3.3936 | $185.16 | $91.27 | $37.03 |
| 74160 | S | | Ct abdomen w/dye | 0283 | 4.6543 | $253.94 | $126.27 | $50.79 |
| 74170 | S | | Ct abdomen w/o &w /dye | 0333 | 5.4241 | $295.94 | $146.98 | $59.19 |
| 74175 | S | | Ct angio abdom w/o & w/dye | 0662 | 5.8775 | $320.68 | $156.47 | $64.14 |
| 74181 | S | | Mri abdomen w/o dye | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| 74182 | S | | Mri abdomen w/dye | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| 74183 | S | | Mri abdomen w/o & w/dye | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| 74185 | B | | Mri angio, abdom w orw/o dye | | | | | |
| 74190 | X | | X-ray exam of peritoneum | 0263 | 2.1883 | $119.40 | $43.58 | $23.88 |
| 74210 | S | | Contrst x-ray exam of throat | 0276 | 1.5906 | $86.78 | $41.72 | $17.36 |
| 74220 | S | | Contrast x-ray, esophagus | 0276 | 1.5906 | $86.78 | $41.72 | $17.36 |
| 74230 | S | | Cine/vid x-ray, throat/esoph | 0276 | 1.5906 | $86.78 | $41.72 | $17.36 |
| 74235 | S | | Remove esophagus obstruction | 0296 | 2.8635 | $156.24 | $69.20 | $31.25 |
| 74240 | S | | X-ray exam, upper gi tract | 0276 | 1.5906 | $86.78 | $41.72 | $17.36 |
| 74241 | S | | X-ray exam, upper gi tract | 0276 | 1.5906 | $86.78 | $41.72 | $17.36 |
| 74245 | S | | X-ray exam, upper gi tract | 0277 | 2.4444 | $133.37 | $60.47 | $26.67 |
| 74246 | S | | Contrst x-ray uppr gi tract | 0276 | 1.5906 | $86.78 | $41.72 | $17.36 |
| 74247 | S | | Contrst x-ray uppr gi tract | 0276 | 1.5906 | $86.78 | $41.72 | $17.36 |
| 74249 | S | | Contrst x-ray uppr gi tract | 0277 | 2.4444 | $133.37 | $60.47 | $26.67 |
| 74250 | S | | X-ray exam of small bowel | 0276 | 1.5906 | $86.78 | $41.72 | $17.36 |
| 74251 | S | | X-ray exam of small bowel | 0277 | 2.4444 | $133.37 | $60.47 | $26.67 |
| 74260 | S | | X-ray exam of small bowel | 0277 | 2.4444 | $133.37 | $60.47 | $26.67 |
| 74270 | S | | Contrast x-ray exam of colon | 0276 | 1.5906 | $86.78 | $41.72 | $17.36 |
| 74280 | S | | Contrast x-ray exam of colon | 0277 | 2.4444 | $133.37 | $60.47 | $26.67 |
| 74283 | S | | Contrast x-ray exam of colon | 0276 | 1.5906 | $86.78 | $41.72 | $17.36 |
| 74290 | S | | Contrast x-ray, gallbladder | 0276 | 1.5906 | $86.78 | $41.72 | $17.36 |
| 74291 | S | | Contrast x-rays, gallbladder | 0276 | 1.5906 | $86.78 | $41.72 | $17.36 |
| 74300 | X | | X-ray bile ducts/pancreas | 0263 | 2.1883 | $119.40 | $43.58 | $23.88 |
| 74301 | X | | X-rays at surgery add-on | 0263 | 2.1883 | $119.40 | $43.58 | $23.88 |
| 74305 | X | | X-ray bile ducts/pancreas | 0263 | 2.1883 | $119.40 | $43.58 | $23.88 |
| 74320 | X | | Contrast x-ray of bile ducts | 0264 | 3.0287 | $165.25 | $79.41 | $33.05 |
| 74327 | S | | X-ray bile stone removal | 0296 | 2.8635 | $156.24 | $69.20 | $31.25 |
| 74328 | N | | X-ray bile duct endoscopy | | | | | |
| 74329 | N | | X-ray for pancreas endoscopy | | | | | |
| 74330 | N | | X-ray bile/panc endoscopy | | | | | |
| 74340 | X | | X-ray guide for GI tube | 0272 | 1.4166 | $77.29 | $38.36 | $15.46 |
| 74350 | X | | X-ray guide, stomach tube | 0263 | 2.1883 | $119.40 | $43.58 | $23.88 |
| 74355 | X | | X-ray guide, intestinal tube | 0263 | 2.1883 | $119.40 | $43.58 | $23.88 |
| 74360 | S | | X-ray guide, GI dilation | 0296 | 2.8635 | $156.24 | $69.20 | $31.25 |
| 74363 | S | | X-ray, bile duct dilation | 0297 | 7.7145 | $420.91 | $172.51 | $84.18 |
| 74400 | S | | Contrst x-ray, urinary tract | 0278 | 2.7012 | $147.38 | $66.07 | $29.48 |
| 74410 | S | | Contrst x-ray, urinary tract | 0278 | 2.7012 | $147.38 | $66.07 | $29.48 |
| 74415 | S | | Contrst x-ray, urinary tract | 0278 | 2.7012 | $147.38 | $66.07 | $29.48 |
| 74420 | S | | Contrst x-ray, urinary tract | 0278 | 2.7012 | $147.38 | $66.07 | $29.48 |
| 74425 | S | | Contrst x-ray, urinary tract | 0278 | 2.7012 | $147.38 | $66.07 | $29.48 |
| 74430 | S | | Contrast x-ray, bladder | 0278 | 2.7012 | $147.38 | $66.07 | $29.48 |
| 74440 | S | | X-ray, male genital tract | 0278 | 2.7012 | $147.38 | $66.07 | $29.48 |
| 74445 | S | | X-ray exam of penis | 0278 | 2.7012 | $147.38 | $66.07 | $29.48 |
| 74450 | S | | X-ray, urethra/bladder | 0278 | 2.7012 | $147.38 | $66.07 | $29.48 |
| 74455 | S | | X-ray, urethra/bladder | 0278 | 2.7012 | $147.38 | $66.07 | $29.48 |
| 74470 | X | | X-ray exam of kidney lesion | 0264 | 3.0287 | $165.25 | $79.41 | $33.05 |
| 74475 | S | | X-ray control, cath insert | 0297 | 7.7145 | $420.91 | $172.51 | $84.18 |
| 74480 | S | | X-ray control, cath insert | 0296 | 2.8635 | $156.24 | $69.20 | $31.25 |
| 74485 | S | | X-ray guide, GU dilation | 0296 | 2.8635 | $156.24 | $69.20 | $31.25 |
| 74710 | X | | X-ray measurement of pelvis | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 74740 | X | | X-ray, female genital tract | 0264 | 3.0287 | $165.25 | $79.41 | $33.05 |
| 74742 | X | | X-ray, fallopian tube | 0263 | 2.1883 | $119.40 | $43.58 | $23.88 |
| 74775 | S | | X-ray exam of perineum | 0278 | 2.7012 | $147.38 | $66.07 | $29.48 |
| 75552 | S | | Heart mri for morph w/o dye | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| 75553 | S | | Heart mri for morph w/dye | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| 75554 | S | | Cardiac MRI/function | 0335 | 6.3499 | $346.46 | $151.46 | $69.29 |
| 75555 | S | | Cardiac MRI/limited study | 0335 | 6.3499 | $346.46 | $151.46 | $69.29 |
| 75556 | E | | Cardiac MRI/flow mapping | | | | | |
| 75600 | S | | Contrast x-ray exam of aorta | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75605 | S | | Contrast x-ray exam of aorta | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 75625 | S | | Contrast x-ray exam of aorta | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75630 | S | | X-ray aorta, leg arteries | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75635 | S | | Ct angio abdominal arteries | 0662 | 5.8775 | $320.68 | $156.47 | $64.14 |
| 75650 | S | | Artery x-rays, head & neck | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75658 | S | | Artery x-rays, arm | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75660 | S | | Artery x-rays, head & neck | 0279 | 10.7073 | $584.20 | $174.57 | $116.84 |
| 75662 | S | | Artery x-rays, head & neck | 0279 | 10.7073 | $584.20 | $174.57 | $116.84 |
| 75665 | S | | Artery x-rays, head & neck | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75671 | S | | Artery x-rays, head & neck | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75676 | S | | Artery x-rays, neck | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75680 | S | | Artery x-rays, neck | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75685 | S | | Artery x-rays, spine | 0279 | 10.7073 | $584.20 | $174.57 | $116.84 |
| 75705 | S | | Artery x-rays, spine | 0279 | 10.7073 | $584.20 | $174.57 | $116.84 |
| 75710 | S | | Artery x-rays, arm/leg | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75716 | S | | Artery x-rays, arms/legs | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75722 | S | | Artery x-rays, kidney | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75724 | S | | Artery x-rays, kidneys | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75726 | S | | Artery x-rays, abdomen | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75731 | S | | Artery x-rays, adrenal gland | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75733 | S | | Artery x-rays, adrenals | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75736 | S | | Artery x-rays, pelvis | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75741 | S | | Artery x-rays, lung | 0279 | 10.7073 | $584.20 | $174.57 | $116.84 |
| 75743 | S | | Artery x-rays, lungs | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75746 | S | | Artery x-rays, lung | 0279 | 10.7073 | $584.20 | $174.57 | $116.84 |
| 75756 | S | | Artery x-rays, chest | 0279 | 10.7073 | $584.20 | $174.57 | $116.84 |
| 75774 | S | | Artery x-ray, each vessel | 0668 | 10.2660 | $560.12 | $237.76 | $112.02 |
| 75790 | S | | Visualize A-V shunt | 0281 | 6.6031 | $360.27 | $115.16 | $72.05 |
| 75801 | X | | Lymph vessel x-ray, arm/leg | 0264 | 3.0287 | $165.25 | $79.41 | $33.05 |
| 75803 | X | | Lymph vessel x-ray,arms/legs | 0264 | 3.0287 | $165.25 | $79.41 | $33.05 |
| 75805 | X | | Lymph vessel x-ray, trunk | 0264 | 3.0287 | $165.25 | $79.41 | $33.05 |
| 75807 | X | | Lymph vessel x-ray, trunk | 0264 | 3.0287 | $165.25 | $79.41 | $33.05 |
| 75809 | X | | Nonvascular shunt, x-ray | 0263 | 2.1883 | $119.40 | $43.58 | $23.88 |
| 75810 | S | | Vein x-ray, spleen/liver | 0279 | 10.7073 | $584.20 | $174.57 | $116.84 |
| 75820 | S | | Vein x-ray, arm/leg | 0281 | 6.6031 | $360.27 | $115.16 | $72.05 |
| 75822 | S | | Vein x-ray, arms/legs | 0281 | 6.6031 | $360.27 | $115.16 | $72.05 |
| 75825 | S | | Vein x-ray, trunk | 0279 | 10.7073 | $584.20 | $174.57 | $116.84 |
| 75827 | S | | Vein x-ray, chest | 0279 | 10.7073 | $584.20 | $174.57 | $116.84 |
| 75831 | S | | Vein x-ray, kidney | 0287 | 6.4923 | $354.23 | $111.33 | $70.85 |
| 75833 | S | | Vein x-ray, kidneys | 0279 | 10.7073 | $584.20 | $174.57 | $116.84 |
| 75840 | S | | Vein x-ray, adrenal gland | 0287 | 6.4923 | $354.23 | $111.33 | $70.85 |
| 75842 | S | | Vein x-ray, adrenal glands | 0287 | 6.4923 | $354.23 | $111.33 | $70.85 |
| 75860 | S | | Vein x-ray, neck | 0287 | 6.4923 | $354.23 | $111.33 | $70.85 |
| 75870 | S | | Vein x-ray, skull | 0287 | 6.4923 | $354.23 | $111.33 | $70.85 |
| 75872 | S | | Vein x-ray, skull | 0287 | 6.4923 | $354.23 | $111.33 | $70.85 |
| 75880 | S | | Vein x-ray, eye socket | 0287 | 6.4923 | $354.23 | $111.33 | $70.85 |
| 75885 | S | | Vein x-ray, liver | 0279 | 10.7073 | $584.20 | $174.57 | $116.84 |
| 75887 | S | | Vein x-ray, liver | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75889 | S | | Vein x-ray, liver | 0279 | 10.7073 | $584.20 | $174.57 | $116.84 |
| 75891 | S | | Vein x-ray, liver | 0279 | 10.7073 | $584.20 | $174.57 | $116.84 |
| 75893 | N | | Venous sampling by catheter | | | | | |
| 75894 | S | | X-rays, transcath therapy | 0297 | 7.7145 | $420.91 | $172.51 | $84.18 |
| 75896 | S | | X-rays, transcath therapy | 0297 | 7.7145 | $420.91 | $172.51 | $84.18 |
| 75898 | X | | Follow-up angiography | 0264 | 3.0287 | $165.25 | $79.41 | $33.05 |
| 75900 | C | | Arterial catheter exchange | | | | | |
| 75901 | X | | Remove cva device obstruct | 0264 | 3.0287 | $165.25 | $79.41 | $33.05 |
| 75902 | X | | Remove cva lumen obstruct | 0263 | 2.1883 | $119.40 | $43.58 | $23.88 |
| 75940 | X | | X-ray placement, vein filter | 0187 | 4.4288 | $241.64 | $90.71 | $48.33 |
| 75945 | S | | Intravascular us | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 75946 | S | | Intravascular us add-on | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 75952 | C | | Endovasc repair abdom aorta | | | | | |
| 75953 | C | | Abdom aneurysm endovas rpr | | | | | |
| 75954 | C | | Iliac aneurysm endovas rpr | | | | | |
| 75960 | S | | Transcatheter intro, stent | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75961 | S | | Retrieval, broken catheter | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75962 | S | | Repair arterial blockage | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75964 | S | | Repair artery blockage, each | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75966 | S | | Repair arterial blockage | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75968 | S | | Repair artery blockage, each | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75970 | S | | Vascular biopsy | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75978 | S | | Repair venous blockage | 0668 | 10.2660 | $560.12 | $237.76 | $112.02 |
| 75980 | S | | Contrast xray exam bile duct | 0296 | 2.8635 | $156.24 | $69.20 | $31.25 |
| 75982 | S | | Contrast xray exam bile duct | 0297 | 7.7145 | $420.91 | $172.51 | $84.18 |
| 75984 | X | | Xray control catheter change | 0264 | 3.0287 | $165.25 | $79.41 | $33.05 |
| 75989 | N | | Abscess drainage under x-ray | | | | | |
| 75992 | S | | Atherectomy, x-ray exam | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 75993 | S | | Atherectomy, x-ray exam | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75994 | S | | Atherectomy, x-ray exam | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75995 | S | | Atherectomy, x-ray exam | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75996 | S | | Atherectomy, x-ray exam | 0280 | 19.1015 | $1,042.20 | $353.85 | $208.44 |
| 75998 | N | NI | Fluoroguide for vein device | | | | | |
| 76000 | X | | Fluoroscope examination | 0272 | 1.4166 | $77.29 | $38.36 | $15.46 |
| 76001 | N | | Fluoroscope exam, extensive | | | | | |
| 76003 | N | | Needle localization by x-ray | | | | | |
| 76005 | N | | Fluoroguide for spine inject | | | | | |
| 76006 | X | | X-ray stress view | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 76010 | X | | X-ray, nose to rectum | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 76012 | S | | Percut vertebroplasty fluor | 0274 | 3.5931 | $196.04 | $93.63 | $39.21 |
| 76013 | S | | Percut vertebroplasty, ct | 0274 | 3.5931 | $196.04 | $93.63 | $39.21 |
| 76020 | X | | X-rays for bone age | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 76040 | X | | X-rays, bone evaluation | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 76061 | X | | X-rays, bone survey | 0261 | 1.3176 | $71.89 | | $14.38 |
| 76062 | X | | X-rays, bone survey | 0261 | 1.3176 | $71.89 | | $14.38 |
| 76065 | X | | X-rays, bone evaluation | 0261 | 1.3176 | $71.89 | | $14.38 |
| 76066 | X | | Joint survey, single view | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 76070 | S | | CT scan, bone density study | 0288 | 1.2726 | $69.43 | | $13.89 |
| 76071 | S | | Ct bone density, peripheral | 0282 | 1.6834 | $91.85 | $44.51 | $18.37 |
| 76075 | S | | Dexa, axial skeleton study | 0288 | 1.2726 | $69.43 | | $13.89 |
| 76076 | S | | Dexa, peripheral study | 0665 | 0.7257 | $39.59 | | $7.92 |
| 76078 | X | | Radiographic absorptiometry | 0261 | 1.3176 | $71.89 | | $14.38 |
| 76080 | X | | X-ray exam of fistula | 0263 | 2.1883 | $119.40 | $43.58 | $23.88 |
| 76082 | S | NI | Computer mammogram add-on | 0410 | 0.1523 | $8.31 | | $1.66 |
| 76083 | A | NI | Computer mammogram add-on | | | | | |
| 76085 | D | DNG | Computer mammogram add-on | | | | | |
| 76086 | X | | X-ray of mammary duct | 0263 | 2.1883 | $119.40 | $43.58 | $23.88 |
| 76088 | X | | X-ray of mammary ducts | 0263 | 2.1883 | $119.40 | $43.58 | $23.88 |
| 76090 | S | | Mammogram, one breast | 0271 | 0.6499 | $35.46 | $16.80 | $7.09 |
| 76091 | S | | Mammogram, both breasts | 0271 | 0.6499 | $35.46 | $16.80 | $7.09 |
| 76092 | A | | Mammogram, screening | | | | | |
| 76093 | E | | Magnetic image, breast | | | | | |
| 76094 | E | | Magnetic image, both breasts | | | | | |
| 76095 | X | | Stereotactic breast biopsy | 0187 | 4.4288 | $241.64 | $90.71 | $48.33 |
| 76096 | X | | X-ray of needle wire, breast | 0289 | 3.4900 | $190.42 | $44.80 | $38.08 |
| 76098 | X | | X-ray exam, breast specimen | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 76100 | X | | X-ray exam of body section | 0261 | 1.3176 | $71.89 | | $14.38 |
| 76101 | X | | Complex body section x-ray | 0264 | 3.0287 | $165.25 | $79.41 | $33.05 |
| 76102 | X | | Complex body section x-rays | 0264 | 3.0287 | $165.25 | $79.41 | $33.05 |
| 76120 | X | | Cine/video x-rays | 0272 | 1.4166 | $77.29 | $38.36 | $15.46 |
| 76125 | X | | Cine/video x-rays add-on | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 76140 | E | | X-ray consultation | | | | | |
| 76150 | X | | X-ray exam, dry process | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 76350 | N | | Special x-ray contrast study | | | | | |
| 76355 | S | | Ct scan for localization | 0283 | 4.6543 | $253.94 | $126.27 | $50.79 |
| 76360 | S | | Ct scan for needle biopsy | 0283 | 4.6543 | $253.94 | $126.27 | $50.79 |
| 76362 | S | | Ct guide for tissue ablation | 0332 | 3.3936 | $185.16 | $91.27 | $37.03 |
| 76370 | S | | Ct scan for therapy guide | 0282 | 1.6834 | $91.85 | $44.51 | $18.37 |
| 76375 | S | | 3d/holograph reconstr add-on | 0282 | 1.6834 | $91.85 | $44.51 | $18.37 |
| 76380 | S | | CAT scan follow-up study | 0282 | 1.6834 | $91.85 | $44.51 | $18.37 |
| 76390 | E | | Mr spectroscopy | | | | | |
| 76393 | S | | Mr guidance for needle place | 0335 | 6.3499 | $346.46 | $151.46 | $69.29 |
| 76394 | S | | Mri for tissue ablation | 0335 | 6.3499 | $346.46 | $151.46 | $69.29 |
| 76400 | S | | Magnetic image, bone marrow | 0335 | 6.3499 | $346.46 | $151.46 | $69.29 |
| 76490 | S | DG | Us for tissue ablation | 0268 | 1.3081 | $71.37 | | $14.27 |
| 76496 | X | | Fluoroscopic procedure | 0272 | 1.4166 | $77.29 | $38.36 | $15.46 |
| 76497 | S | | Ct procedure | 0282 | 1.6834 | $91.85 | $44.51 | $18.37 |
| 76498 | S | | Mri procedure | 0335 | 6.3499 | $346.46 | $151.46 | $69.29 |
| 76499 | X | | Radiographic procedure | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 76506 | S | | Echo exam of head | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76511 | S | | Echo exam of eye | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76512 | S | | Echo exam of eye | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76513 | S | | Echo exam of eye, water bath | 0265 | 1.0289 | $56.14 | $28.07 | $11.23 |
| 76514 | S | NI | Echo exam of eye, thickness | 0265 | 1.0289 | $56.14 | $28.07 | $11.23 |
| 76516 | S | | Echo exam of eye | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76519 | S | | Echo exam of eye | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76529 | S | | Echo exam of eye | 0265 | 1.0289 | $56.14 | $28.07 | $11.23 |
| 76536 | S | | Us exam of head and neck | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76604 | S | | Us exam, chest, b-scan | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76645 | S | | Us exam, breast(s) | 0265 | 1.0289 | $56.14 | $28.07 | $11.23 |
| 76700 | S | | Us exam, abdom, complete | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76705 | S | | Echo exam of abdomen | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76770 | S | | Us exam abdo back wall, comp | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 76775 | S | | Us exam abdo back wall, lim | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76778 | S | | Us exam kidney transplant | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76800 | S | | Us exam, spinal canal | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76801 | S | | Ob us < 14 wks, single fetus | 0265 | 1.0289 | $56.14 | $28.07 | $11.23 |
| 76802 | S | | Ob us < 14 wks, add'l fetus | 0265 | 1.0289 | $56.14 | $28.07 | $11.23 |
| 76805 | S | | Us exam, pg uterus, compl | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76810 | S | | Us exam, pg uterus, mult | 0265 | 1.0289 | $56.14 | $28.07 | $11.23 |
| 76811 | S | | Ob us, detailed, sngl fetus | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 76812 | S | | Ob us, detailed, addl fetus | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76815 | S | | Us exam, pg uterus limit | 0265 | 1.0289 | $56.14 | $28.07 | $11.23 |
| 76816 | S | | Us exam pg uterus repeat | 0265 | 1.0289 | $56.14 | $28.07 | $11.23 |
| 76817 | S | | Transvaginal us, obstetric | 0265 | 1.0289 | $56.14 | $28.07 | $11.23 |
| 76818 | S | | Fetal biophys profile w/nst | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76819 | S | | Fetal biophys profil w/o nst | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76825 | S | | Echo exam of fetal heart | 0671 | 1.6384 | $89.39 | $44.69 | $17.88 |
| 76826 | S | | Echo exam of fetal heart | 0697 | 1.4415 | $78.65 | $39.32 | $15.73 |
| 76827 | S | | Echo exam of fetal heart | 0671 | 1.6384 | $89.39 | $44.69 | $17.88 |
| 76828 | S | | Echo exam of fetal heart | 0697 | 1.4415 | $78.65 | $39.32 | $15.73 |
| 76830 | S | | Transvaginal us, non-ob | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76831 | S | | Echo exam, uterus | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76856 | S | | Us exam, pelvic, complete | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76857 | S | | Us exam, pelvic, limited | 0265 | 1.0289 | $56.14 | $28.07 | $11.23 |
| 76870 | S | | Us exam, scrotum | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76872 | S | | Us, transrectal | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76873 | S | | Echograp trans r, pros study | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76880 | S | | Us exam, extremity | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76885 | S | | Us exam infant hips, dynamic | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76886 | S | | Us exam infant hips, static | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76930 | S | | Echo guide, cardiocentesis | 0268 | 1.3081 | $71.37 | | $14.27 |
| 76932 | S | | Echo guide for heart biopsy | 0268 | 1.3081 | $71.37 | | $14.27 |
| 76936 | S | | Echo guide for artery repair | 0268 | 1.3081 | $71.37 | | $14.27 |
| 76937 | N | NI | Us guide, vascular access | | | | | |
| 76940 | S | NI | Us guide, tissue ablation | 0268 | 1.3081 | $71.37 | | $14.27 |
| 76941 | S | | Echo guide for transfusion | 0268 | 1.3081 | $71.37 | | $14.27 |
| 76942 | S | | Echo guide for biopsy | 0268 | 1.3081 | $71.37 | | $14.27 |
| 76945 | S | | Echo guide, villus sampling | 0268 | 1.3081 | $71.37 | | $14.27 |
| 76946 | S | | Echo guide for amniocentesis | 0268 | 1.3081 | $71.37 | | $14.27 |
| 76948 | S | | Echo guide, ova aspiration | 0268 | 1.3081 | $71.37 | | $14.27 |
| 76950 | S | | Echo guidance radiotherapy | 0268 | 1.3081 | $71.37 | | $14.27 |
| 76965 | S | | Echo guidance radiotherapy | 0268 | 1.3081 | $71.37 | | $14.27 |
| 76970 | S | | Ultrasound exam follow-up | 0265 | 1.0289 | $56.14 | $28.07 | $11.23 |
| 76975 | S | | GI endoscopic ultrasound | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76977 | S | | Us bone density measure | 0340 | 0.6314 | $34.45 | | $6.89 |
| 76986 | S | | Ultrasound guide intraoper | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 76999 | S | | Echo examination procedure | 0265 | 1.0289 | $56.14 | $28.07 | $11.23 |
| 77261 | E | | Radiation therapy planning | | | | | |
| 77262 | E | | Radiation therapy planning | | | | | |
| 77263 | E | | Radiation therapy planning | | | | | |
| 77280 | X | | Set radiation therapy field | 0304 | 1.6742 | $91.35 | $41.52 | $18.27 |
| 77285 | X | | Set radiation therapy field | 0305 | 3.6767 | $200.60 | $91.38 | $40.12 |
| 77290 | X | | Set radiation therapy field | 0305 | 3.6767 | $200.60 | $91.38 | $40.12 |
| 77295 | X | | Set radiation therapy field | 0310 | 13.7165 | $748.39 | $325.27 | $149.68 |
| 77299 | E | | Radiation therapy planning | | | | | |
| 77300 | X | | Radiation therapy dose plan | 0304 | 1.6742 | $91.35 | $41.52 | $18.27 |
| 77301 | S | | Radiotherapy dose plan, imrt | 1510 | | $850.00 | | $170.00 |
| 77305 | X | | Teletx isodose plan simple | 0304 | 1.6742 | $91.35 | $41.52 | $18.27 |
| 77310 | X | | Teletx isodose plan intermed | 0304 | 1.6742 | $91.35 | $41.52 | $18.27 |
| 77315 | X | | Teletx isodose plan complex | 0305 | 3.6767 | $200.60 | $91.38 | $40.12 |
| 77321 | X | | Special teletx port plan | 0305 | 3.6767 | $200.60 | $91.38 | $40.12 |
| 77326 | X | | Radiation therapy dose plan | 0305 | 3.6767 | $200.60 | $91.38 | $40.12 |
| 77327 | X | | Brachytx isodose calc interm | 0305 | 3.6767 | $200.60 | $91.38 | $40.12 |
| 77328 | X | | Brachytx isodose plan compl | 0305 | 3.6767 | $200.60 | $91.38 | $40.12 |
| 77331 | X | | Special radiation dosimetry | 0304 | 1.6742 | $91.35 | $41.52 | $18.27 |
| 77332 | X | | Radiation treatment aid(s) | 0303 | 2.8835 | $157.33 | $66.95 | $31.47 |
| 77333 | X | | Radiation treatment aid(s) | 0303 | 2.8835 | $157.33 | $66.95 | $31.47 |
| 77334 | X | | Radiation treatment aid(s) | 0303 | 2.8835 | $157.33 | $66.95 | $31.47 |
| 77336 | X | | Radiation physics consult | 0304 | 1.6742 | $91.35 | $41.52 | $18.27 |
| 77370 | X | | Radiation physics consult | 0305 | 3.6767 | $200.60 | $91.38 | $40.12 |
| 77399 | X | | External radiation dosimetry | 0304 | 1.6742 | $91.35 | $41.52 | $18.27 |
| 77401 | S | | Radiation treatment delivery | 0300 | 1.4912 | $81.36 | | $16.27 |
| 77402 | S | | Radiation treatment delivery | 0300 | 1.4912 | $81.36 | | $16.27 |
| 77403 | S | | Radiation treatment delivery | 0300 | 1.4912 | $81.36 | | $16.27 |
| 77404 | S | | Radiation treatment delivery | 0300 | 1.4912 | $81.36 | | $16.27 |
| 77406 | S | | Radiation treatment delivery | 0300 | 1.4912 | $81.36 | | $16.27 |
| 77407 | S | | Radiation treatment delivery | 0300 | 1.4912 | $81.36 | | $16.27 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 77408 | S | | Radiation treatment delivery | 0300 | 1.4912 | $81.36 | | $16.27 |
| 77409 | S | | Radiation treatment delivery | 0300 | 1.4912 | $81.36 | | $16.27 |
| 77411 | S | | Radiation treatment delivery | 0300 | 1.4912 | $81.36 | | $16.27 |
| 77412 | S | | Radiation treatment delivery | 0301 | 2.1340 | $116.43 | | $23.29 |
| 77413 | S | | Radiation treatment delivery | 0301 | 2.1340 | $116.43 | | $23.29 |
| 77414 | S | | Radiation treatment delivery | 0301 | 2.1340 | $116.43 | | $23.29 |
| 77416 | S | | Radiation treatment delivery | 0301 | 2.1340 | $116.43 | | $23.29 |
| 77417 | X | | Radiology port film(s) | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| 77418 | S | | Radiation tx delivery, imrt | 0412 | 5.3904 | $294.11 | | $58.82 |
| 77427 | E | | Radiation tx management, x5 | | | | | |
| 77431 | E | | Radiation therapy management | | | | | |
| 77432 | E | | Stereotactic radiation trmt | | | | | |
| 77470 | S | | Special radiation treatment | 0299 | 5.7618 | $314.37 | | $62.87 |
| 77499 | E | | Radiation therapy management | | | | | |
| 77520 | S | | Proton trmt, simple w/o comp | 0664 | 9.7295 | $530.85 | | $106.17 |
| 77522 | S | | Proton trmt, simple w/comp | 0664 | 9.7295 | $530.85 | | $106.17 |
| 77523 | S | | Proton trmt, intermediate | 1511 | | $950.00 | | $190.00 |
| 77525 | S | | Proton treatment, complex | 1511 | | $950.00 | | $190.00 |
| 77600 | S | | Hyperthermia treatment | 0314 | 4.6041 | $251.20 | $101.77 | $50.24 |
| 77605 | S | | Hyperthermia treatment | 0314 | 4.6041 | $251.20 | $101.77 | $50.24 |
| 77610 | S | | Hyperthermia treatment | 0314 | 4.6041 | $251.20 | $101.77 | $50.24 |
| 77615 | S | | Hyperthermia treatment | 0314 | 4.6041 | $251.20 | $101.77 | $50.24 |
| 77620 | S | | Hyperthermia treatment | 0314 | 4.6041 | $251.20 | $101.77 | $50.24 |
| 77750 | S | | Infuse radioactive materials | 0300 | 1.4912 | $81.36 | | $16.27 |
| 77761 | S | | Apply intrcav radiat simple | 0312 | 3.6637 | $199.90 | | $39.98 |
| 77762 | S | | Apply intrcav radiat interm | 0312 | 3.6637 | $199.90 | | $39.98 |
| 77763 | S | | Apply intrcav radiat compl | 0312 | 3.6637 | $199.90 | | $39.98 |
| 77776 | S | | Apply interstit radiat simpl | 0312 | 3.6637 | $199.90 | | $39.98 |
| 77777 | S | | Apply interstit radiat inter | 0312 | 3.6637 | $199.90 | | $39.98 |
| 77778 | S | | Apply interstit radiat compl | 0651 | 10.2314 | $558.24 | | $111.65 |
| 77781 | S | | High intensity brachytherapy | 0313 | 16.2481 | $886.51 | | $177.30 |
| 77782 | S | | High intensity brachytherapy | 0313 | 16.2481 | $886.51 | | $177.30 |
| 77783 | S | | High intensity brachytherapy | 0313 | 16.2481 | $886.51 | | $177.30 |
| 77784 | S | | High intensity brachytherapy | 0313 | 16.2481 | $886.51 | | $177.30 |
| 77789 | S | | Apply surface radiation | 0300 | 1.4912 | $81.36 | | $16.27 |
| 77790 | N | | Radiation handling | | | | | |
| 77799 | S | | Radium/radioisotope therapy | 0313 | 16.2481 | $886.51 | | $177.30 |
| 78000 | S | | Thyroid, single uptake | 0389 | 1.6328 | $89.09 | $44.54 | $17.82 |
| 78001 | S | | Thyroid, multiple uptakes | 0389 | 1.6328 | $89.09 | $44.54 | $17.82 |
| 78003 | S | | Thyroid suppress/stimul | 0389 | 1.6328 | $89.09 | $44.54 | $17.82 |
| 78006 | S | | Thyroid imaging with uptake | 0390 | 2.7907 | $152.26 | $76.13 | $30.45 |
| 78007 | S | | Thyroid image, mult uptakes | 0391 | 3.1956 | $174.36 | $87.18 | $34.87 |
| 78010 | S | | Thyroid imaging | 0390 | 2.7907 | $152.26 | $76.13 | $30.45 |
| 78011 | S | | Thyroid imaging with flow | 0390 | 2.7907 | $152.26 | $76.13 | $30.45 |
| 78015 | S | | Thyroid met imaging | 0406 | 4.3955 | $239.82 | $119.91 | $47.96 |
| 78016 | S | | Thyroid met imaging/studies | 0406 | 4.3955 | $239.82 | $119.91 | $47.96 |
| 78018 | S | | Thyroid met imaging, body | 0406 | 4.3955 | $239.82 | $119.91 | $47.96 |
| 78020 | S | | Thyroid met uptake | 0399 | 1.5273 | $83.33 | $41.66 | $16.67 |
| 78070 | S | | Parathyroid nuclear imaging | 0391 | 3.1956 | $174.36 | $87.18 | $34.87 |
| 78075 | S | | Adrenal nuclear imaging | 0391 | 3.1956 | $174.36 | $87.18 | $34.87 |
| 78099 | S | | Endocrine nuclear procedure | 0390 | 2.7907 | $152.26 | $76.13 | $30.45 |
| 78102 | S | | Bone marrow imaging, ltd | 0400 | 3.8242 | $208.65 | $104.32 | $41.73 |
| 78103 | S | | Bone marrow imaging, mult | 0400 | 3.8242 | $208.65 | $104.32 | $41.73 |
| 78104 | S | | Bone marrow imaging, body | 0400 | 3.8242 | $208.65 | $104.32 | $41.73 |
| 78110 | S | | Plasma volume, single | 0393 | 4.4354 | $242.00 | $121.00 | $48.40 |
| 78111 | S | | Plasma volume, multiple | 0393 | 4.4354 | $242.00 | $121.00 | $48.40 |
| 78120 | S | | Red cell mass, single | 0393 | 4.4354 | $242.00 | $121.00 | $48.40 |
| 78121 | S | | Red cell mass, multiple | 0393 | 4.4354 | $242.00 | $121.00 | $48.40 |
| 78122 | S | | Blood volume | 0393 | 4.4354 | $242.00 | $121.00 | $48.40 |
| 78130 | S | | Red cell survival study | 0393 | 4.4354 | $242.00 | $121.00 | $48.40 |
| 78135 | S | | Red cell survival kinetics | 0393 | 4.4354 | $242.00 | $121.00 | $48.40 |
| 78140 | S | | Red cell sequestration | 0393 | 4.4354 | $242.00 | $121.00 | $48.40 |
| 78160 | S | | Plasma iron turnover | 0393 | 4.4354 | $242.00 | $121.00 | $48.40 |
| 78162 | S | | Radioiron absorption exam | 0393 | 4.4354 | $242.00 | $121.00 | $48.40 |
| 78170 | S | | Red cell iron utilization | 0393 | 4.4354 | $242.00 | $121.00 | $48.40 |
| 78172 | S | | Total body iron estimation | 0393 | 4.4354 | $242.00 | $121.00 | $48.40 |
| 78185 | S | | Spleen imaging | 0400 | 3.8242 | $208.65 | $104.32 | $41.73 |
| 78190 | S | | Platelet survival, kinetics | 0389 | 1.6328 | $89.09 | $44.54 | $17.82 |
| 78191 | S | | Platelet survival | 0389 | 1.6328 | $89.09 | $44.54 | $17.82 |
| 78195 | S | | Lymph system imaging | 0400 | 3.8242 | $208.65 | $104.32 | $41.73 |
| 78199 | S | | Blood/lymph nuclear exam | 0400 | 3.8242 | $208.65 | $104.32 | $41.73 |
| 78201 | S | | Liver imaging | 0394 | 4.3714 | $238.51 | $119.25 | $47.70 |
| 78202 | S | | Liver imaging with flow | 0394 | 4.3714 | $238.51 | $119.25 | $47.70 |
| 78205 | S | | Liver imaging (3D) | 0394 | 4.3714 | $238.51 | $119.25 | $47.70 |
| 78206 | S | | Liver image (3d) with flow | 0394 | 4.3714 | $238.51 | $119.25 | $47.70 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 78215 | S | | Liver and spleen imaging | 0394 | 4.3714 | $238.51 | $119.25 | $47.70 |
| 78216 | S | | Liver & spleen image/flow | 0394 | 4.3714 | $238.51 | $119.25 | $47.70 |
| 78220 | S | | Liver function study | 0394 | 4.3714 | $238.51 | $119.25 | $47.70 |
| 78223 | S | | Hepatobiliary imaging | 0394 | 4.3714 | $238.51 | $119.25 | $47.70 |
| 78230 | S | | Salivary gland imaging | 0395 | 3.9536 | $215.71 | $107.85 | $43.14 |
| 78231 | S | | Serial salivary imaging | 0395 | 3.9536 | $215.71 | $107.85 | $43.14 |
| 78232 | S | | Salivary gland function exam | 0395 | 3.9536 | $215.71 | $107.85 | $43.14 |
| 78258 | S | | Esophageal motility study | 0395 | 3.9536 | $215.71 | $107.85 | $43.14 |
| 78261 | S | | Gastric mucosa imaging | 0395 | 3.9536 | $215.71 | $107.85 | $43.14 |
| 78262 | S | | Gastroesophageal reflux exam | 0395 | 3.9536 | $215.71 | $107.85 | $43.14 |
| 78264 | S | | Gastric emptying study | 0395 | 3.9536 | $215.71 | $107.85 | $43.14 |
| 78267 | A | | Breath tst attain/anal c-14 | | | | | |
| 78268 | A | | Breath test analysis, c-14 | | | | | |
| 78270 | S | | Vit B-12 absorption exam | 0389 | 1.6328 | $89.09 | $44.54 | $17.82 |
| 78271 | S | | Vit b-12 absrp exam, int fac | 0389 | 1.6328 | $89.09 | $44.54 | $17.82 |
| 78272 | S | | Vit B-12 absorp, combined | 0389 | 1.6328 | $89.09 | $44.54 | $17.82 |
| 78278 | S | | Acute GI blood loss imaging | 0395 | 3.9536 | $215.71 | $107.85 | $43.14 |
| 78282 | S | | GI protein loss exam | 0395 | 3.9536 | $215.71 | $107.85 | $43.14 |
| 78290 | S | | Meckel's divert exam | 0395 | 3.9536 | $215.71 | $107.85 | $43.14 |
| 78291 | S | | Leveen/shunt patency exam | 0395 | 3.9536 | $215.71 | $107.85 | $43.14 |
| 78299 | S | | GI nuclear procedure | 0395 | 3.9536 | $215.71 | $107.85 | $43.14 |
| 78300 | S | | Bone imaging, limited area | 0396 | 4.1883 | $228.52 | $114.26 | $45.70 |
| 78305 | S | | Bone imaging, multiple areas | 0396 | 4.1883 | $228.52 | $114.26 | $45.70 |
| 78306 | S | | Bone imaging, whole body | 0396 | 4.1883 | $228.52 | $114.26 | $45.70 |
| 78315 | S | | Bone imaging, 3 phase | 0396 | 4.1883 | $228.52 | $114.26 | $45.70 |
| 78320 | S | | Bone imaging (3D) | 0396 | 4.1883 | $228.52 | $114.26 | $45.70 |
| 78350 | X | | Bone mineral, single photon | 0261 | 1.3176 | $71.89 | | $14.38 |
| 78351 | E | | Bone mineral, dual photon | | | | | |
| 78399 | S | | Musculoskeletal nuclear exam | 0396 | 4.1883 | $228.52 | $114.26 | $45.70 |
| 78414 | S | | Non-imaging heart function | 0398 | 4.5091 | $246.02 | $123.01 | $49.20 |
| 78428 | S | | Cardiac shunt imaging | 0398 | 4.5091 | $246.02 | $123.01 | $49.20 |
| 78445 | S | | Vascular flow imaging | 0397 | 2.2183 | $121.03 | $60.51 | $24.21 |
| 78455 | S | | Venous thrombosis study | 0397 | 2.2183 | $121.03 | $60.51 | $24.21 |
| 78456 | S | | Acute venous thrombus image | 0397 | 2.2183 | $121.03 | $60.51 | $24.21 |
| 78457 | S | | Venous thrombosis imaging | 0397 | 2.2183 | $121.03 | $60.51 | $24.21 |
| 78458 | S | | Ven thrombosis images, bilat | 0397 | 2.2183 | $121.03 | $60.51 | $24.21 |
| 78459 | S | | Heart muscle imaging (PET) | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| 78460 | S | | Heart muscle blood, single | 0398 | 4.5091 | $246.02 | $123.01 | $49.20 |
| 78461 | S | | Heart muscle blood, multiple | 0377 | 6.8830 | $375.54 | $187.76 | $75.11 |
| 78464 | S | | Heart image (3d), single | 0398 | 4.5091 | $246.02 | $123.01 | $49.20 |
| 78465 | S | | Heart image (3d), multiple | 0377 | 6.8830 | $375.54 | $187.76 | $75.11 |
| 78466 | S | | Heart infarct image | 0398 | 4.5091 | $246.02 | $123.01 | $49.20 |
| 78468 | S | | Heart infarct image (ef) | 0398 | 4.5091 | $246.02 | $123.01 | $49.20 |
| 78469 | S | | Heart infarct image (3D) | 0398 | 4.5091 | $246.02 | $123.01 | $49.20 |
| 78472 | S | | Gated heart, planar, single | 0398 | 4.5091 | $246.02 | $123.01 | $49.20 |
| 78473 | S | | Gated heart, multiple | 0376 | 4.4510 | $242.85 | $121.42 | $48.57 |
| 78478 | S | | Heart wall motion add-on | 0399 | 1.5273 | $83.33 | $41.66 | $16.67 |
| 78480 | S | | Heart function add-on | 0399 | 1.5273 | $83.33 | $41.66 | $16.67 |
| 78481 | S | | Heart first pass, single | 0398 | 4.5091 | $246.02 | $123.01 | $49.20 |
| 78483 | S | | Heart first pass, multiple | 0376 | 4.4510 | $242.85 | $121.42 | $48.57 |
| 78491 | E | | Heart image (pet), single | | | | | |
| 78492 | E | | Heart image (pet), multiple | | | | | |
| 78494 | S | | Heart image, spect | 0398 | 4.5091 | $246.02 | $123.01 | $49.20 |
| 78496 | S | | Heart first pass add-on | 0399 | 1.5273 | $83.33 | $41.66 | $16.67 |
| 78499 | S | | Cardiovascular nuclear exam | 0398 | 4.5091 | $246.02 | $123.01 | $49.20 |
| 78580 | S | | Lung perfusion imaging | 0401 | 3.3736 | $184.07 | $92.03 | $36.81 |
| 78584 | S | | Lung V/Q image single breath | 0378 | 5.4852 | $299.28 | $149.63 | $59.86 |
| 78585 | S | | Lung V/Q imaging | 0378 | 5.4852 | $299.28 | $149.63 | $59.86 |
| 78586 | S | | Aerosol lung image, single | 0401 | 3.3736 | $184.07 | $92.03 | $36.81 |
| 78587 | S | | Aerosol lung image, multiple | 0401 | 3.3736 | $184.07 | $92.03 | $36.81 |
| 78588 | S | | Perfusion lung image | 0378 | 5.4852 | $299.28 | $149.63 | $59.86 |
| 78591 | S | | Vent image, 1 breath, 1 proj | 0401 | 3.3736 | $184.07 | $92.03 | $36.81 |
| 78593 | S | | Vent image, 1 proj, gas | 0401 | 3.3736 | $184.07 | $92.03 | $36.81 |
| 78594 | S | | Vent image, mult proj, gas | 0401 | 3.3736 | $184.07 | $92.03 | $36.81 |
| 78596 | S | | Lung differential function | 0378 | 5.4852 | $299.28 | $149.63 | $59.86 |
| 78599 | S | | Respiratory nuclear exam | 0401 | 3.3736 | $184.07 | $92.03 | $36.81 |
| 78600 | S | | Brain imaging, ltd static | 0402 | 5.4063 | $294.97 | $147.48 | $58.99 |
| 78601 | S | | Brain imaging, ltd w/flow | 0402 | 5.4063 | $294.97 | $147.48 | $58.99 |
| 78605 | S | | Brain imaging, complete | 0402 | 5.4063 | $294.97 | $147.48 | $58.99 |
| 78606 | S | | Brain imaging, compl w/flow | 0402 | 5.4063 | $294.97 | $147.48 | $58.99 |
| 78607 | S | | Brain imaging (3D) | 0402 | 5.4063 | $294.97 | $147.48 | $58.99 |
| 78608 | E | | Brain imaging (PET) | | | | | |
| 78609 | E | | Brain imaging (PET) | | | | | |
| 78610 | S | | Brain flow imaging only | 0402 | 5.4063 | $294.97 | $147.48 | $58.99 |
| 78615 | S | | Cerebral vascular flow image | 0402 | 5.4063 | $294.97 | $147.48 | $58.99 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 78630 | S | | Cerebrospinal fluid scan | 0403 | 3.8402 | $209.53 | $104.76 | $41.91 |
| 78635 | S | | CSF ventriculography | 0403 | 3.8402 | $209.53 | $104.76 | $41.91 |
| 78645 | S | | CSF shunt evaluation | 0403 | 3.8402 | $209.53 | $104.76 | $41.91 |
| 78647 | S | | Cerebrospinal fluid scan | 0403 | 3.8402 | $209.53 | $104.76 | $41.91 |
| 78650 | S | | CSF leakage imaging | 0403 | 3.8402 | $209.53 | $104.76 | $41.91 |
| 78660 | S | | Nuclear exam of tear flow | 0403 | 3.8402 | $209.53 | $104.76 | $41.91 |
| 78699 | S | | Nervous system nuclear exam | 0402 | 5.4063 | $294.97 | $147.48 | $58.99 |
| 78700 | S | | Kidney imaging, static | 0404 | 3.7303 | $203.53 | $101.76 | $40.71 |
| 78701 | S | | Kidney imaging with flow | 0404 | 3.7303 | $203.53 | $101.76 | $40.71 |
| 78704 | S | | Imaging renogram | 0404 | 3.7303 | $203.53 | $101.76 | $40.71 |
| 78707 | S | | Kidney flow/function image | 0404 | 3.7303 | $203.53 | $101.76 | $40.71 |
| 78708 | S | | Kidney flow/function image | 0405 | 4.3432 | $236.97 | $118.48 | $47.39 |
| 78709 | S | | Kidney flow/function image | 0405 | 4.3432 | $236.97 | $118.48 | $47.39 |
| 78710 | S | | Kidney imaging (3D) | 0404 | 3.7303 | $203.53 | $101.76 | $40.71 |
| 78715 | S | | Renal vascular flow exam | 0404 | 3.7303 | $203.53 | $101.76 | $40.71 |
| 78725 | S | | Kidney function study | 0389 | 1.6328 | $89.09 | $44.54 | $17.82 |
| 78730 | S | | Urinary bladder retention | 0404 | 3.7303 | $203.53 | $101.76 | $40.71 |
| 78740 | S | | Ureteral reflux study | 0404 | 3.7303 | $203.53 | $101.76 | $40.71 |
| 78760 | S | | Testicular imaging | 0404 | 3.7303 | $203.53 | $101.76 | $40.71 |
| 78761 | S | | Testicular imaging/flow | 0404 | 3.7303 | $203.53 | $101.76 | $40.71 |
| 78799 | S | | Genitourinary nuclear exam | 0404 | 3.7303 | $203.53 | $101.76 | $40.71 |
| 78800 | S | | Tumor imaging, limited area | 0406 | 4.3955 | $239.82 | $119.91 | $47.96 |
| 78801 | S | | Tumor imaging, mult areas | 0406 | 4.3955 | $239.82 | $119.91 | $47.96 |
| 78802 | S | | Tumor imaging, whole body | 0406 | 4.3955 | $239.82 | $119.91 | $47.96 |
| 78803 | S | | Tumor imaging (3D) | 0406 | 4.3955 | $239.82 | $119.91 | $47.96 |
| 78804 | S | NI | Tumor imaging, whole body | 1508 | | $650.00 | | $130.00 |
| 78805 | S | | Abscess imaging, ltd area | 0406 | 4.3955 | $239.82 | $119.91 | $47.96 |
| 78806 | S | | Abscess imaging, whole body | 0406 | 4.3955 | $239.82 | $119.91 | $47.96 |
| 78807 | S | | Nuclear localization/abscess | 0406 | 4.3955 | $239.82 | $119.91 | $47.96 |
| 78810 | E | | Tumor imaging (PET) | | | | | |
| 78890 | N | | Nuclear medicine data proc | | | | | |
| 78891 | N | | Nuclear med data proc | | | | | |
| 78990 | E | | Provide diag radionuclide(s) | | | | | |
| 78999 | S | | Nuclear diagnostic exam | 0389 | 1.6328 | $89.09 | $44.54 | $17.82 |
| 79000 | S | | Init hyperthyroid therapy | 0407 | 3.5841 | $195.55 | $97.77 | $39.11 |
| 79001 | S | | Repeat hyperthyroid therapy | 0407 | 3.5841 | $195.55 | $97.77 | $39.11 |
| 79020 | S | | Thyroid ablation | 0407 | 3.5841 | $195.55 | $97.77 | $39.11 |
| 79030 | S | | Thyroid ablation, carcinoma | 0407 | 3.5841 | $195.55 | $97.77 | $39.11 |
| 79035 | S | | Thyroid metastatic therapy | 0407 | 3.5841 | $195.55 | $97.77 | $39.11 |
| 79100 | S | | Hematopoetic nuclear therapy | 0407 | 3.5841 | $195.55 | $97.77 | $39.11 |
| 79200 | S | | Intracavitary nuclear trmt | 0407 | 3.5841 | $195.55 | $97.77 | $39.11 |
| 79300 | S | | Interstitial nuclear therapy | 0407 | 3.5841 | $195.55 | $97.77 | $39.11 |
| 79400 | S | | Nonhemato nuclear therapy | 0407 | 3.5841 | $195.55 | $97.77 | $39.11 |
| 79403 | S | NI | Hematopoetic nuclear therapy | 1507 | | $550.00 | | $110.00 |
| 79420 | S | | Intravascular nuclear ther | 0407 | 3.5841 | $195.55 | $97.77 | $39.11 |
| 79440 | S | | Nuclear joint therapy | 0407 | 3.5841 | $195.55 | $97.77 | $39.11 |
| 79900 | N | | Provide ther radiopharm(s) | | | | | |
| 79999 | S | | Nuclear medicine therapy | 0407 | 3.5841 | $195.55 | $97.77 | $39.11 |
| 80048 | A | | Basic metabolic panel | | | | | |
| 80050 | E | | General health panel | | | | | |
| 80051 | A | | Electrolyte panel | | | | | |
| 80053 | A | | Comprehen metabolic panel | | | | | |
| 80055 | A | | Obstetric panel | | | | | |
| 80061 | A | | Lipid panel | | | | | |
| 80069 | A | | Renal function panel | | | | | |
| 80074 | A | | Acute hepatitis panel | | | | | |
| 80076 | A | | Hepatic function panel | | | | | |
| 80100 | A | | Drug screen, qualitate/multi | | | | | |
| 80101 | A | | Drug screen, single | | | | | |
| 80102 | A | | Drug confirmation | | | | | |
| 80103 | N | | Drug analysis, tissue prep | | | | | |
| 80150 | A | | Assay of amikacin | | | | | |
| 80152 | A | | Assay of amitriptyline | | | | | |
| 80154 | A | | Assay of benzodiazepines | | | | | |
| 80156 | A | | Assay, carbamazepine, total | | | | | |
| 80157 | A | | Assay, carbamazepine, free | | | | | |
| 80158 | A | | Assay of cyclosporine | | | | | |
| 80160 | A | | Assay of desipramine | | | | | |
| 80162 | A | | Assay of digoxin | | | | | |
| 80164 | A | | Assay, dipropylacetic acid | | | | | |
| 80166 | A | | Assay of doxepin | | | | | |
| 80168 | A | | Assay of ethosuximide | | | | | |
| 80170 | A | | Assay of gentamicin | | | | | |
| 80172 | A | | Assay of gold | | | | | |
| 80173 | A | | Assay of haloperidol | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 80174 | A | | Assay of imipramine | | | | | |
| 80176 | A | | Assay of lidocaine | | | | | |
| 80178 | A | | Assay of lithium | | | | | |
| 80182 | A | | Assay of nortriptyline | | | | | |
| 80184 | A | | Assay of phenobarbital | | | | | |
| 80185 | A | | Assay of phenytoin, total | | | | | |
| 80186 | A | | Assay of phenytoin, free | | | | | |
| 80188 | A | | Assay of primidone | | | | | |
| 80190 | A | | Assay of procainamide | | | | | |
| 80192 | A | | Assay of procainamide | | | | | |
| 80194 | A | | Assay of quinidine | | | | | |
| 80196 | A | | Assay of salicylate | | | | | |
| 80197 | A | | Assay of tacrolimus | | | | | |
| 80198 | A | | Assay of theophylline | | | | | |
| 80200 | A | | Assay of tobramycin | | | | | |
| 80201 | A | | Assay of topiramate | | | | | |
| 80202 | A | | Assay of vancomycin | | | | | |
| 80299 | A | | Quantitative assay, drug | | | | | |
| 80400 | A | | Acth stimulation panel | | | | | |
| 80402 | A | | Acth stimulation panel | | | | | |
| 80406 | A | | Acth stimulation panel | | | | | |
| 80408 | A | | Aldosterone suppression eval | | | | | |
| 80410 | A | | Calcitonin stimul panel | | | | | |
| 80412 | A | | CRH stimulation panel | | | | | |
| 80414 | A | | Testosterone response | | | | | |
| 80415 | A | | Estradiol response panel | | | | | |
| 80416 | A | | Renin stimulation panel | | | | | |
| 80417 | A | | Renin stimulation panel | | | | | |
| 80418 | A | | Pituitary evaluation panel | | | | | |
| 80420 | A | | Dexamethasone panel | | | | | |
| 80422 | A | | Glucagon tolerance panel | | | | | |
| 80424 | A | | Glucagon tolerance panel | | | | | |
| 80426 | A | | Gonadotropin hormone panel | | | | | |
| 80428 | A | | Growth hormone panel | | | | | |
| 80430 | A | | Growth hormone panel | | | | | |
| 80432 | A | | Insulin suppression panel | | | | | |
| 80434 | A | | Insulin tolerance panel | | | | | |
| 80435 | A | | Insulin tolerance panel | | | | | |
| 80436 | A | | Metyrapone panel | | | | | |
| 80438 | A | | TRH stimulation panel | | | | | |
| 80439 | A | | TRH stimulation panel | | | | | |
| 80440 | A | | TRH stimulation panel | | | | | |
| 80500 | X | | Lab pathology consultation | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 80502 | X | | Lab pathology consultation | 0342 | 0.2162 | $11.80 | $5.88 | $2.36 |
| 81000 | A | | Urinalysis, nonauto w/scope | | | | | |
| 81001 | A | | Urinalysis, auto w/scope | | | | | |
| 81002 | A | | Urinalysis nonauto w/o scope | | | | | |
| 81003 | A | | Urinalysis, auto, w/o scope | | | | | |
| 81005 | A | | Urinalysis | | | | | |
| 81007 | A | | Urine screen for bacteria | | | | | |
| 81015 | A | | Microscopic exam of urine | | | | | |
| 81020 | A | | Urinalysis, glass test | | | | | |
| 81025 | A | | Urine pregnancy test | | | | | |
| 81050 | A | | Urinalysis, volume measure | | | | | |
| 81099 | A | | Urinalysis test procedure | | | | | |
| 82000 | A | | Assay of blood acetaldehyde | | | | | |
| 82003 | A | | Assay of acetaminophen | | | | | |
| 82009 | A | | Test for acetone/ketones | | | | | |
| 82010 | A | | Acetone assay | | | | | |
| 82013 | A | | Acetylcholinesterase assay | | | | | |
| 82016 | A | | Acylcarnitines, qual | | | | | |
| 82017 | A | | Acylcarnitines, quant | | | | | |
| 82024 | A | | Assay of acth | | | | | |
| 82030 | A | | Assay of adp & amp | | | | | |
| 82040 | A | | Assay of serum albumin | | | | | |
| 82042 | A | | Assay of urine albumin | | | | | |
| 82043 | A | | Microalbumin, quantitative | | | | | |
| 82044 | A | | Microalbumin, semiquant | | | | | |
| 82055 | A | | Assay of ethanol | | | | | |
| 82075 | A | | Assay of breath ethanol | | | | | |
| 82085 | A | | Assay of aldolase | | | | | |
| 82088 | A | | Assay of aldosterone | | | | | |
| 82101 | A | | Assay of urine alkaloids | | | | | |
| 82103 | A | | Alpha-1-antitrypsin, total | | | | | |
| 82104 | A | | Alpha-1-antitrypsin, pheno | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 82105 | A | | Alpha-fetoprotein, serum | | | | | |
| 82106 | A | | Alpha-fetoprotein, amniotic | | | | | |
| 82108 | A | | Assay of aluminum | | | | | |
| 82120 | A | | Amines, vaginal fluid qual | | | | | |
| 82127 | A | | Amino acid, single qual | | | | | |
| 82128 | A | | Amino acids, mult qual | | | | | |
| 82131 | A | | Amino acids, single quant | | | | | |
| 82135 | A | | Assay, aminolevulinic acid | | | | | |
| 82136 | A | | Amino acids, quant, 2-5 | | | | | |
| 82139 | A | | Amino acids, quan, 6 or more | | | | | |
| 82140 | A | | Assay of ammonia | | | | | |
| 82143 | A | | Amniotic fluid scan | | | | | |
| 82145 | A | | Assay of amphetamines | | | | | |
| 82150 | A | | Assay of amylase | | | | | |
| 82154 | A | | Androstanediol glucuronide | | | | | |
| 82157 | A | | Assay of androstenedione | | | | | |
| 82160 | A | | Assay of androsterone | | | | | |
| 82163 | A | | Assay of angiotensin II | | | | | |
| 82164 | A | | Angiotensin I enzyme test | | | | | |
| 82172 | A | | Assay of apolipoprotein | | | | | |
| 82175 | A | | Assay of arsenic | | | | | |
| 82180 | A | | Assay of ascorbic acid | | | | | |
| 82190 | A | | Atomic absorption | | | | | |
| 82205 | A | | Assay of barbiturates | | | | | |
| 82232 | A | | Assay of beta-2 protein | | | | | |
| 82239 | A | | Bile acids, total | | | | | |
| 82240 | A | | Bile acids, cholylglycine | | | | | |
| 82247 | A | | Bilirubin, total | | | | | |
| 82248 | A | | Bilirubin, direct | | | | | |
| 82252 | A | | Fecal bilirubin test | | | | | |
| 82261 | A | | Assay of biotinidase | | | | | |
| 82270 | A | | Test for blood, feces | | | | | |
| 82273 | A | | Test for blood, other source | | | | | |
| 82274 | A | | Assay test for blood, fecal | | | | | |
| 82286 | A | | Assay of bradykinin | | | | | |
| 82300 | A | | Assay of cadmium | | | | | |
| 82306 | A | | Assay of vitamin D | | | | | |
| 82307 | A | | Assay of vitamin D | | | | | |
| 82308 | A | | Assay of calcitonin | | | | | |
| 82310 | A | | Assay of calcium | | | | | |
| 82330 | A | | Assay of calcium | | | | | |
| 82331 | A | | Calcium infusion test | | | | | |
| 82340 | A | | Assay of calcium in urine | | | | | |
| 82355 | A | | Calculus analysis, qual | | | | | |
| 82360 | A | | Calculus assay, quant | | | | | |
| 82365 | A | | Calculus spectroscopy | | | | | |
| 82370 | A | | X-ray assay, calculus | | | | | |
| 82373 | A | | Assay, c-d transfer measure | | | | | |
| 82374 | A | | Assay, blood carbon dioxide | | | | | |
| 82375 | A | | Assay, blood carbon monoxide | | | | | |
| 82376 | A | | Test for carbon monoxide | | | | | |
| 82378 | A | | Carcinoembryonic antigen | | | | | |
| 82379 | A | | Assay of carnitine | | | | | |
| 82380 | A | | Assay of carotene | | | | | |
| 82382 | A | | Assay, urine catecholamines | | | | | |
| 82383 | A | | Assay, blood catecholamines | | | | | |
| 82384 | A | | Assay, three catecholamines | | | | | |
| 82387 | A | | Assay of cathepsin-d | | | | | |
| 82390 | A | | Assay of ceruloplasmin | | | | | |
| 82397 | A | | Chemiluminescent assay | | | | | |
| 82415 | A | | Assay of chloramphenicol | | | | | |
| 82435 | A | | Assay of blood chloride | | | | | |
| 82436 | A | | Assay of urine chloride | | | | | |
| 82438 | A | | Assay, other fluid chlorides | | | | | |
| 82441 | A | | Test for chlorohydrocarbons | | | | | |
| 82465 | A | | Assay, bld/serum cholesterol | | | | | |
| 82480 | A | | Assay, serum cholinesterase | | | | | |
| 82482 | A | | Assay, rbc cholinesterase | | | | | |
| 82485 | A | | Assay, chondroitin sulfate | | | | | |
| 82486 | A | | Gas/liquid chromatography | | | | | |
| 82487 | A | | Paper chromatography | | | | | |
| 82488 | A | | Paper chromatography | | | | | |
| 82489 | A | | Thin layer chromatography | | | | | |
| 82491 | A | | Chromotography, quant, sing | | | | | |
| 82492 | A | | Chromotography, quant, mult | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 82495 | A | | Assay of chromium | | | | | |
| 82507 | A | | Assay of citrate | | | | | |
| 82520 | A | | Assay of cocaine | | | | | |
| 82523 | A | | Collagen crosslinks | | | | | |
| 82525 | A | | Assay of copper | | | | | |
| 82528 | A | | Assay of corticosterone | | | | | |
| 82530 | A | | Cortisol, free | | | | | |
| 82533 | A | | Total cortisol | | | | | |
| 82540 | A | | Assay of creatine | | | | | |
| 82541 | A | | Column chromotography, qual | | | | | |
| 82542 | A | | Column chromotography, quant | | | | | |
| 82543 | A | | Column chromotograph/isotope | | | | | |
| 82544 | A | | Column chromotograph/isotope | | | | | |
| 82550 | A | | Assay of ck (cpk) | | | | | |
| 82552 | A | | Assay of cpk in blood | | | | | |
| 82553 | A | | Creatine, MB fraction | | | | | |
| 82554 | A | | Creatine, isoforms | | | | | |
| 82565 | A | | Assay of creatinine | | | | | |
| 82570 | A | | Assay of urine creatinine | | | | | |
| 82575 | A | | Creatinine clearance test | | | | | |
| 82585 | A | | Assay of cryofibrinogen | | | | | |
| 82595 | A | | Assay of cryoglobulin | | | | | |
| 82600 | A | | Assay of cyanide | | | | | |
| 82607 | A | | Vitamin B-12 | | | | | |
| 82608 | A | | B-12 binding capacity | | | | | |
| 82615 | A | | Test for urine cystines | | | | | |
| 82626 | A | | Dehydroepiandrosterone | | | | | |
| 82627 | A | | Dehydroepiandrosterone | | | | | |
| 82633 | A | | Desoxycorticosterone | | | | | |
| 82634 | A | | Deoxycortisol | | | | | |
| 82638 | A | | Assay of dibucaine number | | | | | |
| 82646 | A | | Assay of dihydrocodeinone | | | | | |
| 82649 | A | | Assay of dihydromorphinone | | | | | |
| 82651 | A | | Assay of dihydrotestosterone | | | | | |
| 82652 | A | | Assay of dihydroxyvitamin d | | | | | |
| 82654 | A | | Assay of dimethadione | | | | | |
| 82657 | A | | Enzyme cell activity | | | | | |
| 82658 | A | | Enzyme cell activity, ra | | | | | |
| 82664 | A | | Electrophoretic test | | | | | |
| 82666 | A | | Assay of epiandrosterone | | | | | |
| 82668 | A | | Assay of erythropoietin | | | | | |
| 82670 | A | | Assay of estradiol | | | | | |
| 82671 | A | | Assay of estrogens | | | | | |
| 82672 | A | | Assay of estrogen | | | | | |
| 82677 | A | | Assay of estriol | | | | | |
| 82679 | A | | Assay of estrone | | | | | |
| 82690 | A | | Assay of ethchlorvynol | | | | | |
| 82693 | A | | Assay of ethylene glycol | | | | | |
| 82696 | A | | Assay of etiocholanolone | | | | | |
| 82705 | A | | Fats/lipids, feces, qual | | | | | |
| 82710 | A | | Fats/lipids, feces, quant | | | | | |
| 82715 | A | | Assay of fecal fat | | | | | |
| 82725 | A | | Assay of blood fatty acids | | | | | |
| 82726 | A | | Long chain fatty acids | | | | | |
| 82728 | A | | Assay of ferritin | | | | | |
| 82731 | A | | Assay of fetal fibronectin | | | | | |
| 82735 | A | | Assay of fluoride | | | | | |
| 82742 | A | | Assay of flurazepam | | | | | |
| 82746 | A | | Blood folic acid serum | | | | | |
| 82747 | A | | Assay of folic acid, rbc | | | | | |
| 82757 | A | | Assay of semen fructose | | | | | |
| 82759 | A | | Assay of rbc galactokinase | | | | | |
| 82760 | A | | Assay of galactose | | | | | |
| 82775 | A | | Assay galactose transferase | | | | | |
| 82776 | A | | Galactose transferase test | | | | | |
| 82784 | A | | Assay of gammaglobulin igm | | | | | |
| 82785 | A | | Assay of gammaglobulin ige | | | | | |
| 82787 | A | | Igg 1, 2, 3 or 4, each | | | | | |
| 82800 | A | | Blood pH | | | | | |
| 82803 | A | | Blood gases: pH, pO2 & pCO2 | | | | | |
| 82805 | A | | Blood gases W/02 saturation | | | | | |
| 82810 | A | | Blood gases, O2 sat only | | | | | |
| 82820 | A | | Hemoglobin-oxygen affinity | | | | | |
| 82926 | A | | Assay of gastric acid | | | | | |
| 82928 | A | | Assay of gastric acid | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 82938 | A | | Gastrin test | | | | | |
| 82941 | A | | Assay of gastrin | | | | | |
| 82943 | A | | Assay of glucagon | | | | | |
| 82945 | A | | Glucose other fluid | | | | | |
| 82946 | A | | Glucagon tolerance test | | | | | |
| 82947 | A | | Assay, glucose, blood quant | | | | | |
| 82948 | A | | Reagent strip/blood glucose | | | | | |
| 82950 | A | | Glucose test | | | | | |
| 82951 | A | | Glucose tolerance test (GTT) | | | | | |
| 82952 | A | | GTT-added samples | | | | | |
| 82953 | A | | Glucose-tolbutamide test | | | | | |
| 82955 | A | | Assay of g6pd enzyme | | | | | |
| 82960 | A | | Test for G6PD enzyme | | | | | |
| 82962 | A | | Glucose blood test | | | | | |
| 82963 | A | | Assay of glucosidase | | | | | |
| 82965 | A | | Assay of gdh enzyme | | | | | |
| 82975 | A | | Assay of glutamine | | | | | |
| 82977 | A | | Assay of GGT | | | | | |
| 82978 | A | | Assay of glutathione | | | | | |
| 82979 | A | | Assay, rbc glutathione | | | | | |
| 82980 | A | | Assay of glutethimide | | | | | |
| 82985 | A | | Glycated protein | | | | | |
| 83001 | A | | Gonadotropin (FSH) | | | | | |
| 83002 | A | | Gonadotropin (LH) | | | | | |
| 83003 | A | | Assay, growth hormone (hgh) | | | | | |
| 83008 | A | | Assay of guanosine | | | | | |
| 83010 | A | | Assay of haptoglobin, quant | | | | | |
| 83012 | A | | Assay of haptoglobins | | | | | |
| 83013 | A | | H pylori analysis | | | | | |
| 83014 | A | | H pylori drug admin/collect | | | | | |
| 83015 | A | | Heavy metal screen | | | | | |
| 83018 | A | | Quantitative screen, metals | | | | | |
| 83020 | A | | Hemoglobin electrophoresis | | | | | |
| 83021 | A | | Hemoglobin chromotography | | | | | |
| 83026 | A | | Hemoglobin, copper sulfate | | | | | |
| 83030 | A | | Fetal hemoglobin, chemical | | | | | |
| 83033 | A | | Fetal hemoglobin assay, qual | | | | | |
| 83036 | A | | Glycated hemoglobin test | | | | | |
| 83045 | A | | Blood methemoglobin test | | | | | |
| 83050 | A | | Blood methemoglobin assay | | | | | |
| 83051 | A | | Assay of plasma hemoglobin | | | | | |
| 83055 | A | | Blood sulfhemoglobin test | | | | | |
| 83060 | A | | Blood sulfhemoglobin assay | | | | | |
| 83065 | A | | Assay of hemoglobin heat | | | | | |
| 83068 | A | | Hemoglobin stability screen | | | | | |
| 83069 | A | | Assay of urine hemoglobin | | | | | |
| 83070 | A | | Assay of hemosiderin, qual | | | | | |
| 83071 | A | | Assay of hemosiderin, quant | | | | | |
| 83080 | A | | Assay of b hexosaminidase | | | | | |
| 83088 | A | | Assay of histamine | | | | | |
| 83090 | A | | Assay of homocystine | | | | | |
| 83150 | A | | Assay of for hva | | | | | |
| 83491 | A | | Assay of corticosteroids | | | | | |
| 83497 | A | | Assay of 5-hiaa | | | | | |
| 83498 | A | | Assay of progesterone | | | | | |
| 83499 | A | | Assay of progesterone | | | | | |
| 83500 | A | | Assay, free hydroxyproline | | | | | |
| 83505 | A | | Assay, total hydroxyproline | | | | | |
| 83516 | A | | Immunoassay, nonantibody | | | | | |
| 83518 | A | | Immunoassay, dipstick | | | | | |
| 83519 | A | | Immunoassay, nonantibody | | | | | |
| 83520 | A | | Immunoassay, RIA | | | | | |
| 83525 | A | | Assay of insulin | | | | | |
| 83527 | A | | Assay of insulin | | | | | |
| 83528 | A | | Assay of intrinsic factor | | | | | |
| 83540 | A | | Assay of iron | | | | | |
| 83550 | A | | Iron binding test | | | | | |
| 83570 | A | | Assay of idh enzyme | | | | | |
| 83582 | A | | Assay of ketogenic steroids | | | | | |
| 83586 | A | | Assay 17- ketosteroids | | | | | |
| 83593 | A | | Fractionation, ketosteroids | | | | | |
| 83605 | A | | Assay of lactic acid | | | | | |
| 83615 | A | | Lactate (LD) (LDH) enzyme | | | | | |
| 83625 | A | | Assay of ldh enzymes | | | | | |
| 83632 | A | | Placental lactogen | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 83633 | A | | Test urine for lactose | | | | | |
| 83634 | A | | Assay of urine for lactose | | | | | |
| 83655 | A | | Assay of lead | | | | | |
| 83661 | A | | L/s ratio, fetal lung | | | | | |
| 83662 | A | | Foam stability, fetal lung | | | | | |
| 83663 | A | | Fluoro polarize, fetal lung | | | | | |
| 83664 | A | | Lamellar bdy, fetal lung | | | | | |
| 83670 | A | | Assay of lap enzyme | | | | | |
| 83690 | A | | Assay of lipase | | | | | |
| 83715 | A | | Assay of blood lipoproteins | | | | | |
| 83716 | A | | Assay of blood lipoproteins | | | | | |
| 83718 | A | | Assay of lipoprotein | | | | | |
| 83719 | A | | Assay of blood lipoprotein | | | | | |
| 83721 | A | | Assay of blood lipoprotein | | | | | |
| 83727 | A | | Assay of lrh hormone | | | | | |
| 83735 | A | | Assay of magnesium | | | | | |
| 83775 | A | | Assay of md enzyme | | | | | |
| 83785 | A | | Assay of manganese | | | | | |
| 83788 | A | | Mass spectrometry qual | | | | | |
| 83789 | A | | Mass spectrometry quant | | | | | |
| 83805 | A | | Assay of meprobamate | | | | | |
| 83825 | A | | Assay of mercury | | | | | |
| 83835 | A | | Assay of metanephrines | | | | | |
| 83840 | A | | Assay of methadone | | | | | |
| 83857 | A | | Assay of methemalbumin | | | | | |
| 83858 | A | | Assay of methsuximide | | | | | |
| 83864 | A | | Mucopolysaccharides | | | | | |
| 83866 | A | | Mucopolysaccharides screen | | | | | |
| 83872 | A | | Assay synovial fluid mucin | | | | | |
| 83873 | A | | Assay of csf protein | | | | | |
| 83874 | A | | Assay of myoglobin | | | | | |
| 83880 | A | | Natriuretic peptide | | | | | |
| 83883 | A | | Assay, nephelometry not spec | | | | | |
| 83885 | A | | Assay of nickel | | | | | |
| 83887 | A | | Assay of nicotine | | | | | |
| 83890 | A | | Molecule isolate | | | | | |
| 83891 | A | | Molecule isolate nucleic | | | | | |
| 83892 | A | | Molecular diagnostics | | | | | |
| 83893 | A | | Molecule dot/slot/blot | | | | | |
| 83894 | A | | Molecule gel electrophor | | | | | |
| 83896 | A | | Molecular diagnostics | | | | | |
| 83897 | A | | Molecule nucleic transfer | | | | | |
| 83898 | A | | Molecule nucleic ampli | | | | | |
| 83901 | A | | Molecule nucleic ampli | | | | | |
| 83902 | A | | Molecular diagnostics | | | | | |
| 83903 | A | | Molecule mutation scan | | | | | |
| 83904 | A | | Molecule mutation identify | | | | | |
| 83905 | A | | Molecule mutation identify | | | | | |
| 83906 | A | | Molecule mutation identify | | | | | |
| 83912 | A | | Genetic examination | | | | | |
| 83915 | A | | Assay of nucleotidase | | | | | |
| 83916 | A | | Oligoclonal bands | | | | | |
| 83918 | A | | Organic acids, total, quant | | | | | |
| 83919 | A | | Organic acids, qual, each | | | | | |
| 83921 | A | | Organic acid, single, quant | | | | | |
| 83925 | A | | Assay of opiates | | | | | |
| 83930 | A | | Assay of blood osmolality | | | | | |
| 83935 | A | | Assay of urine osmolality | | | | | |
| 83937 | A | | Assay of osteocalcin | | | | | |
| 83945 | A | | Assay of oxalate | | | | | |
| 83950 | A | | Oncoprotein, her-2/neu | | | | | |
| 83970 | A | | Assay of parathormone | | | | | |
| 83986 | A | | Assay of body fluid acidity | | | | | |
| 83992 | A | | Assay for phencyclidine | | | | | |
| 84022 | A | | Assay of phenothiazine | | | | | |
| 84030 | A | | Assay of blood pku | | | | | |
| 84035 | A | | Assay of phenylketones | | | | | |
| 84060 | A | | Assay acid phosphatase | | | | | |
| 84061 | A | | Phosphatase, forensic exam | | | | | |
| 84066 | A | | Assay prostate phosphatase | | | | | |
| 84075 | A | | Assay alkaline phosphatase | | | | | |
| 84078 | A | | Assay alkaline phosphatase | | | | | |
| 84080 | A | | Assay alkaline phosphatases | | | | | |
| 84081 | A | | Amniotic fluid enzyme test | | | | | |
| 84085 | A | | Assay of rbc pg6d enzyme | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 84087 | A | | Assay phosphohexose enzymes | | | | | |
| 84100 | A | | Assay of phosphorus | | | | | |
| 84105 | A | | Assay of urine phosphorus | | | | | |
| 84106 | A | | Test for porphobilinogen | | | | | |
| 84110 | A | | Assay of porphobilinogen | | | | | |
| 84119 | A | | Test urine for porphyrins | | | | | |
| 84120 | A | | Assay of urine porphyrins | | | | | |
| 84126 | A | | Assay of feces porphyrins | | | | | |
| 84127 | A | | Assay of feces porphyrins | | | | | |
| 84132 | A | | Assay of serum potassium | | | | | |
| 84133 | A | | Assay of urine potassium | | | | | |
| 84134 | A | | Assay of prealbumin | | | | | |
| 84135 | A | | Assay of pregnanediol | | | | | |
| 84138 | A | | Assay of pregnanetriol | | | | | |
| 84140 | A | | Assay of pregnenolone | | | | | |
| 84143 | A | | Assay of 17-hydroxypregneno | | | | | |
| 84144 | A | | Assay of progesterone | | | | | |
| 84146 | A | | Assay of prolactin | | | | | |
| 84150 | A | | Assay of prostaglandin | | | | | |
| 84152 | A | | Assay of psa, complexed | | | | | |
| 84153 | A | | Assay of psa, total | | | | | |
| 84154 | A | | Assay of psa, free | | | | | |
| 84155 | A | | Assay of protein, serum | | | | | |
| 84156 | A | NI | Assay of protein, urine | | | | | |
| 84157 | A | NI | Assay of protein, other | | | | | |
| 84160 | A | | Assay of protein, any source | | | | | |
| 84165 | A | | Electrophoreisis of proteins | | | | | |
| 84181 | A | | Western blot test | | | | | |
| 84182 | A | | Protein, western blot test | | | | | |
| 84202 | A | | Assay RBC protoporphyrin | | | | | |
| 84203 | A | | Test RBC protoporphyrin | | | | | |
| 84206 | A | | Assay of proinsulin | | | | | |
| 84207 | A | | Assay of vitamin b-6 | | | | | |
| 84210 | A | | Assay of pyruvate | | | | | |
| 84220 | A | | Assay of pyruvate kinase | | | | | |
| 84228 | A | | Assay of quinine | | | | | |
| 84233 | A | | Assay of estrogen | | | | | |
| 84234 | A | | Assay of progesterone | | | | | |
| 84235 | A | | Assay of endocrine hormone | | | | | |
| 84238 | A | | Assay, nonendocrine receptor | | | | | |
| 84244 | A | | Assay of renin | | | | | |
| 84252 | A | | Assay of vitamin b-2 | | | | | |
| 84255 | A | | Assay of selenium | | | | | |
| 84260 | A | | Assay of serotonin | | | | | |
| 84270 | A | | Assay of sex hormone globul | | | | | |
| 84275 | A | | Assay of sialic acid | | | | | |
| 84285 | A | | Assay of silica | | | | | |
| 84295 | A | | Assay of serum sodium | | | | | |
| 84300 | A | | Assay of urine sodium | | | | | |
| 84302 | A | | Assay of sweat sodium | | | | | |
| 84305 | A | | Assay of somatomedin | | | | | |
| 84307 | A | | Assay of somatostatin | | | | | |
| 84311 | A | | Spectrophotometry | | | | | |
| 84315 | A | | Body fluid specific gravity | | | | | |
| 84375 | A | | Chromatogram assay, sugars | | | | | |
| 84376 | A | | Sugars, single, qual | | | | | |
| 84377 | A | | Sugars, multiple, qual | | | | | |
| 84378 | A | | Sugars, single, quant | | | | | |
| 84379 | A | | Sugars multiple quant | | | | | |
| 84392 | A | | Assay of urine sulfate | | | | | |
| 84402 | A | | Assay of testosterone | | | | | |
| 84403 | A | | Assay of total testosterone | | | | | |
| 84425 | A | | Assay of vitamin b-1 | | | | | |
| 84430 | A | | Assay of thiocyanate | | | | | |
| 84432 | A | | Assay of thyroglobulin | | | | | |
| 84436 | A | | Assay of total thyroxine | | | | | |
| 84437 | A | | Assay of neonatal thyroxine | | | | | |
| 84439 | A | | Assay of free thyroxine | | | | | |
| 84442 | A | | Assay of thyroid activity | | | | | |
| 84443 | A | | Assay thyroid stim hormone | | | | | |
| 84445 | A | | Assay of tsi | | | | | |
| 84446 | A | | Assay of vitamin e | | | | | |
| 84449 | A | | Assay of transcortin | | | | | |
| 84450 | A | | Transferase (AST) (SGOT) | | | | | |
| 84460 | A | | Alanine amino (ALT) (SGPT) | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 84466 | A | | Assay of transferrin | | | | | |
| 84478 | A | | Assay of triglycerides | | | | | |
| 84479 | A | | Assay of thyroid (t3 or t4) | | | | | |
| 84480 | A | | Assay, triiodothyronine (t3) | | | | | |
| 84481 | A | | Free assay (FT-3) | | | | | |
| 84482 | A | | T3 reverse | | | | | |
| 84484 | A | | Assay of troponin, quant | | | | | |
| 84485 | A | | Assay duodenal fluid trypsin | | | | | |
| 84488 | A | | Test feces for trypsin | | | | | |
| 84490 | A | | Assay of feces for trypsin | | | | | |
| 84510 | A | | Assay of tyrosine | | | | | |
| 84512 | A | | Assay of troponin, qual | | | | | |
| 84520 | A | | Assay of urea nitrogen | | | | | |
| 84525 | A | | Urea nitrogen semi-quant | | | | | |
| 84540 | A | | Assay of urine/urea-n | | | | | |
| 84545 | A | | Urea-N clearance test | | | | | |
| 84550 | A | | Assay of blood/uric acid | | | | | |
| 84560 | A | | Assay of urine/uric acid | | | | | |
| 84577 | A | | Assay of feces/urobilinogen | | | | | |
| 84578 | A | | Test urine urobilinogen | | | | | |
| 84580 | A | | Assay of urine urobilinogen | | | | | |
| 84583 | A | | Assay of urine urobilinogen | | | | | |
| 84585 | A | | Assay of urine vma | | | | | |
| 84586 | A | | Assay of vip | | | | | |
| 84588 | A | | Assay of vasopressin | | | | | |
| 84590 | A | | Assay of vitamin a | | | | | |
| 84591 | A | | Assay of nos vitamin | | | | | |
| 84597 | A | | Assay of vitamin k | | | | | |
| 84600 | A | | Assay of volatiles | | | | | |
| 84620 | A | | Xylose tolerance test | | | | | |
| 84630 | A | | Assay of zinc | | | | | |
| 84681 | A | | Assay of c-peptide | | | | | |
| 84702 | A | | Chorionic gonadotropin test | | | | | |
| 84703 | A | | Chorionic gonadotropin assay | | | | | |
| 84830 | A | | Ovulation tests | | | | | |
| 84999 | A | | Clinical chemistry test | | | | | |
| 85002 | A | | Bleeding time test | | | | | |
| 85004 | A | | Automated diff wbc count | | | | | |
| 85007 | A | | Differential WBC count | | | | | |
| 85008 | A | | Nondifferential WBC count | | | | | |
| 85009 | A | | Differential WBC count | | | | | |
| 85013 | A | | Spun microhematocrit | | | | | |
| 85014 | A | | Hematocrit | | | | | |
| 85018 | A | | Hemoglobin | | | | | |
| 85025 | A | | Automated hemogram | | | | | |
| 85027 | A | | Automated hemogram | | | | | |
| 85032 | A | | Manual cell count, each | | | | | |
| 85041 | A | | Red blood cell (RBC) count | | | | | |
| 85044 | A | | Reticulocyte count | | | | | |
| 85045 | A | | Reticulocyte count | | | | | |
| 85046 | A | | Reticyte/hgb concentrate | | | | | |
| 85048 | A | | White blood cell (WBC) count | | | | | |
| 85049 | A | | Automated platelet count | | | | | |
| 85055 | A | NI | Reticulated platelet assay | | | | | |
| 85060 | X | | Blood smear interpretation | 0342 | 0.2162 | $11.80 | $5.88 | $2.36 |
| 85097 | X | | Bone marrow interpretation | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 85130 | A | | Chromogenic substrate assay | | | | | |
| 85170 | A | | Blood clot retraction | | | | | |
| 85175 | A | | Blood clot lysis time | | | | | |
| 85210 | A | | Blood clot factor II test | | | | | |
| 85220 | A | | Blood clot factor V test | | | | | |
| 85230 | A | | Blood clot factor VII test | | | | | |
| 85240 | A | | Blood clot factor VIII test | | | | | |
| 85244 | A | | Blood clot factor VIII test | | | | | |
| 85245 | A | | Blood clot factor VIII test | | | | | |
| 85246 | A | | Blood clot factor VIII test | | | | | |
| 85247 | A | | Blood clot factor VIII test | | | | | |
| 85250 | A | | Blood clot factor IX test | | | | | |
| 85260 | A | | Blood clot factor X test | | | | | |
| 85270 | A | | Blood clot factor XI test | | | | | |
| 85280 | A | | Blood clot factor XII test | | | | | |
| 85290 | A | | Blood clot factor XIII test | | | | | |
| 85291 | A | | Blood clot factor XIII test | | | | | |
| 85292 | A | | Blood clot factor assay | | | | | |
| 85293 | A | | Blood clot factor assay | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 85300 | A | | Antithrombin III test | | | | | |
| 85301 | A | | Antithrombin III test | | | | | |
| 85302 | A | | Blood clot inhibitor antigen | | | | | |
| 85303 | A | | Blood clot inhibitor test | | | | | |
| 85305 | A | | Blood clot inhibitor assay | | | | | |
| 85306 | A | | Blood clot inhibitor test | | | | | |
| 85307 | A | | Assay activated protein c | | | | | |
| 85335 | A | | Factor inhibitor test | | | | | |
| 85337 | A | | Thrombomodulin | | | | | |
| 85345 | A | | Coagulation time | | | | | |
| 85347 | A | | Coagulation time | | | | | |
| 85348 | A | | Coagulation time | | | | | |
| 85360 | A | | Euglobulin lysis | | | | | |
| 85362 | A | | Fibrin degradation products | | | | | |
| 85366 | A | | Fibrinogen test | | | | | |
| 85370 | A | | Fibrinogen test | | | | | |
| 85378 | A | | Fibrin degradation | | | | | |
| 85379 | A | | Fibrin degradation, quant | | | | | |
| 85380 | A | | Fibrin degradation, vte | | | | | |
| 85384 | A | | Fibrinogen | | | | | |
| 85385 | A | | Fibrinogen | | | | | |
| 85390 | A | | Fibrinolysins screen | | | | | |
| 85396 | N | NI | Clotting assay, whole blood | | | | | |
| 85400 | A | | Fibrinolytic plasmin | | | | | |
| 85410 | A | | Fibrinolytic antiplasmin | | | | | |
| 85415 | A | | Fibrinolytic plasminogen | | | | | |
| 85420 | A | | Fibrinolytic plasminogen | | | | | |
| 85421 | A | | Fibrinolytic plasminogen | | | | | |
| 85441 | A | | Heinz bodies, direct | | | | | |
| 85445 | A | | Heinz bodies, induced | | | | | |
| 85460 | A | | Hemoglobin, fetal | | | | | |
| 85461 | A | | Hemoglobin, fetal | | | | | |
| 85475 | A | | Hemolysin | | | | | |
| 85520 | A | | Heparin assay | | | | | |
| 85525 | A | | Heparin neutralization | | | | | |
| 85530 | A | | Heparin-protamine tolerance | | | | | |
| 85536 | A | | Iron stain peripheral blood | | | | | |
| 85540 | A | | Wbc alkaline phosphatase | | | | | |
| 85547 | A | | RBC mechanical fragility | | | | | |
| 85549 | A | | Muramidase | | | | | |
| 85555 | A | | RBC osmotic fragility | | | | | |
| 85557 | A | | RBC osmotic fragility | | | | | |
| 85576 | A | | Blood platelet aggregation | | | | | |
| 85597 | A | | Platelet neutralization | | | | | |
| 85610 | A | | Prothrombin time | | | | | |
| 85611 | A | | Prothrombin test | | | | | |
| 85612 | A | | Viper venom prothrombin time | | | | | |
| 85613 | A | | Russell viper venom, diluted | | | | | |
| 85635 | A | | Reptilase test | | | | | |
| 85651 | A | | Rbc sed rate, nonautomated | | | | | |
| 85652 | A | | Rbc sed rate, automated | | | | | |
| 85660 | A | | RBC sickle cell test | | | | | |
| 85670 | A | | Thrombin time, plasma | | | | | |
| 85675 | A | | Thrombin time, titer | | | | | |
| 85705 | A | | Thromboplastin inhibition | | | | | |
| 85730 | A | | Thromboplastin time, partial | | | | | |
| 85732 | A | | Thromboplastin time, partial | | | | | |
| 85810 | A | | Blood viscosity examination | | | | | |
| 85999 | A | | Hematology procedure | | | | | |
| 86000 | A | | Agglutinins, febrile | | | | | |
| 86001 | A | | Allergen specific igg | | | | | |
| 86003 | A | | Allergen specific IgE | | | | | |
| 86005 | A | | Allergen specific IgE | | | | | |
| 86021 | A | | WBC antibody identification | | | | | |
| 86022 | A | | Platelet antibodies | | | | | |
| 86023 | A | | Immunoglobulin assay | | | | | |
| 86038 | A | | Antinuclear antibodies | | | | | |
| 86039 | A | | Antinuclear antibodies (ANA) | | | | | |
| 86060 | A | | Antistreptolysin o, titer | | | | | |
| 86063 | A | | Antistreptolysin o, screen | | | | | |
| 86077 | A | | Physician blood bank service | | | | | |
| 86078 | A | | Physician blood bank service | | | | | |
| 86079 | A | | Physician blood bank service | | | | | |
| 86140 | A | | C-reactive protein | | | | | |
| 86141 | A | | C-reactive protein, hs | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 86146 | A | | Glycoprotein antibody | | | | | |
| 86147 | A | | Cardiolipin antibody | | | | | |
| 86148 | A | | Phospholipid antibody | | | | | |
| 86155 | A | | Chemotaxis assay | | | | | |
| 86156 | A | | Cold agglutinin, screen | | | | | |
| 86157 | A | | Cold agglutinin, titer | | | | | |
| 86160 | A | | Complement, antigen | | | | | |
| 86161 | A | | Complement/function activity | | | | | |
| 86162 | A | | Complement, total (CH50) | | | | | |
| 86171 | A | | Complement fixation, each | | | | | |
| 86185 | A | | Counterimmunoelectrophoresis | | | | | |
| 86215 | A | | Deoxyribonuclease, antibody | | | | | |
| 86225 | A | | DNA antibody | | | | | |
| 86226 | A | | DNA antibody, single strand | | | | | |
| 86235 | A | | Nuclear antigen antibody | | | | | |
| 86243 | A | | Fc receptor | | | | | |
| 86255 | A | | Fluorescent antibody, screen | | | | | |
| 86256 | A | | Fluorescent antibody, titer | | | | | |
| 86277 | A | | Growth hormone antibody | | | | | |
| 86280 | A | | Hemagglutination inhibition | | | | | |
| 86294 | A | | Immunoassay, tumor, qual | | | | | |
| 86300 | A | | Immunoassay, tumor, ca 15-3 | | | | | |
| 86301 | A | | Immunoassay, tumor, ca 19-9 | | | | | |
| 86304 | A | | Immunoassay, tumor, ca 125 | | | | | |
| 86308 | A | | Heterophile antibodies | | | | | |
| 86309 | A | | Heterophile antibodies | | | | | |
| 86310 | A | | Heterophile antibodies | | | | | |
| 86316 | A | | Immunoassay, tumor other | | | | | |
| 86317 | A | | Immunoassay,infectious agent | | | | | |
| 86318 | A | | Immunoassay,infectious agent | | | | | |
| 86320 | A | | Serum immunoelectrophoresis | | | | | |
| 86325 | A | | Other immunoelectrophoresis | | | | | |
| 86327 | A | | Immunoelectrophoresis assay | | | | | |
| 86329 | A | | Immunodiffusion | | | | | |
| 86331 | A | | Immunodiffusion ouchterlony | | | | | |
| 86332 | A | | Immune complex assay | | | | | |
| 86334 | A | | Immunofixation procedure | | | | | |
| 86336 | A | | Inhibin A | | | | | |
| 86337 | A | | Insulin antibodies | | | | | |
| 86340 | A | | Intrinsic factor antibody | | | | | |
| 86341 | A | | Islet cell antibody | | | | | |
| 86343 | A | | Leukocyte histamine release | | | | | |
| 86344 | A | | Leukocyte phagocytosis | | | | | |
| 86353 | A | | Lymphocyte transformation | | | | | |
| 86359 | A | | T cells, total count | | | | | |
| 86360 | A | | T cell, absolute count/ratio | | | | | |
| 86361 | A | | T cell, absolute count | | | | | |
| 86376 | A | | Microsomal antibody | | | | | |
| 86378 | A | | Migration inhibitory factor | | | | | |
| 86382 | A | | Neutralization test, viral | | | | | |
| 86384 | A | | nitroblue tetrazolium dye | | | | | |
| 86403 | A | | Particle agglutination test | | | | | |
| 86406 | A | | Particle agglutination test | | | | | |
| 86430 | A | | Rheumatoid factor test | | | | | |
| 86431 | A | | Rheumatoid factor, quant | | | | | |
| 86485 | X | | Skin test, candida | 0341 | 0.1365 | $7.45 | $3.03 | $1.49 |
| 86490 | X | | Coccidioidomycosis skin test | 0341 | 0.1365 | $7.45 | $3.03 | $1.49 |
| 86510 | X | | Histoplasmosis skin test | 0341 | 0.1365 | $7.45 | $3.03 | $1.49 |
| 86580 | X | | TB intradermal test | 0341 | 0.1365 | $7.45 | $3.03 | $1.49 |
| 86585 | X | | TB tine test | 0341 | 0.1365 | $7.45 | $3.03 | $1.49 |
| 86586 | X | | Skin test, unlisted | 0341 | 0.1365 | $7.45 | $3.03 | $1.49 |
| 86590 | A | | Streptokinase, antibody | | | | | |
| 86592 | A | | Blood serology, qualitative | | | | | |
| 86593 | A | | Blood serology, quantitative | | | | | |
| 86602 | A | | Antinomyces antibody | | | | | |
| 86603 | A | | Adenovirus antibody | | | | | |
| 86606 | A | | Aspergillus antibody | | | | | |
| 86609 | A | | Bacterium antibody | | | | | |
| 86611 | A | | Bartonella antibody | | | | | |
| 86612 | A | | Blastomyces antibody | | | | | |
| 86615 | A | | Bordetella antibody | | | | | |
| 86617 | A | | Lyme disease antibody | | | | | |
| 86618 | A | | Lyme disease antibody | | | | | |
| 86619 | A | | Borrelia antibody | | | | | |
| 86622 | A | | Brucella antibody | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 86625 | A | | Campylobacter antibody | | | | | |
| 86628 | A | | Candida antibody | | | | | |
| 86631 | A | | Chlamydia antibody | | | | | |
| 86632 | A | | Chlamydia igm antibody | | | | | |
| 86635 | A | | Coccidioides antibody | | | | | |
| 86638 | A | | Q fever antibody | | | | | |
| 86641 | A | | Cryptococcus antibody | | | | | |
| 86644 | A | | CMV antibody | | | | | |
| 86645 | A | | CMV antibody, IgM | | | | | |
| 86648 | A | | Diphtheria antibody | | | | | |
| 86651 | A | | Encephalitis antibody | | | | | |
| 86652 | A | | Encephalitis antibody | | | | | |
| 86653 | A | | Encephalitis antibody | | | | | |
| 86654 | A | | Encephalitis antibody | | | | | |
| 86658 | A | | Enterovirus antibody | | | | | |
| 86663 | A | | Epstein-barr antibody | | | | | |
| 86664 | A | | Epstein-barr antibody | | | | | |
| 86665 | A | | Epstein-barr antibody | | | | | |
| 86666 | A | | Ehrlichia antibody | | | | | |
| 86668 | A | | Francisella tularensis | | | | | |
| 86671 | A | | Fungus antibody | | | | | |
| 86674 | A | | Giardia lamblia antibody | | | | | |
| 86677 | A | | Helicobacter pylori | | | | | |
| 86682 | A | | Helminth antibody | | | | | |
| 86684 | A | | Hemophilus influenza | | | | | |
| 86687 | A | | Htlv-i antibody | | | | | |
| 86688 | A | | Htlv-ii antibody | | | | | |
| 86689 | A | | HTLV/HIV confirmatory test | | | | | |
| 86692 | A | | Hepatitis, delta agent | | | | | |
| 86694 | A | | Herpes simplex test | | | | | |
| 86695 | A | | Herpes simplex test | | | | | |
| 86696 | A | | Herpes simplex type 2 | | | | | |
| 86698 | A | | Histoplasma | | | | | |
| 86701 | A | | HIV-1 | | | | | |
| 86702 | A | | HIV-2 | | | | | |
| 86703 | A | | HIV-1/HIV-2, single assay | | | | | |
| 86704 | A | | Hep b core antibody, total | | | | | |
| 86705 | A | | Hep b core antibody, igm | | | | | |
| 86706 | A | | Hep b surface antibody | | | | | |
| 86707 | A | | Hep be antibody | | | | | |
| 86708 | A | | Hep a antibody, total | | | | | |
| 86709 | A | | Hep a antibody, igm | | | | | |
| 86710 | A | | Influenza virus antibody | | | | | |
| 86713 | A | | Legionella antibody | | | | | |
| 86717 | A | | Leishmania antibody | | | | | |
| 86720 | A | | Leptospira antibody | | | | | |
| 86723 | A | | Listeria monocytogenes ab | | | | | |
| 86727 | A | | Lymph choriomeningitis ab | | | | | |
| 86729 | A | | Lympho venereum antibody | | | | | |
| 86732 | A | | Mucormycosis antibody | | | | | |
| 86735 | A | | Mumps antibody | | | | | |
| 86738 | A | | Mycoplasma antibody | | | | | |
| 86741 | A | | Neisseria meningitidis | | | | | |
| 86744 | A | | Nocardia antibody | | | | | |
| 86747 | A | | Parvovirus antibody | | | | | |
| 86750 | A | | Malaria antibody | | | | | |
| 86753 | A | | Protozoa antibody nos | | | | | |
| 86756 | A | | Respiratory virus antibody | | | | | |
| 86757 | A | | Rickettsia antibody | | | | | |
| 86759 | A | | Rotavirus antibody | | | | | |
| 86762 | A | | Rubella antibody | | | | | |
| 86765 | A | | Rubeola antibody | | | | | |
| 86768 | A | | Salmonella antibody | | | | | |
| 86771 | A | | Shigella antibody | | | | | |
| 86774 | A | | Tetanus antibody | | | | | |
| 86777 | A | | Toxoplasma antibody | | | | | |
| 86778 | A | | Toxoplasma antibody, igm | | | | | |
| 86781 | A | | Treponema pallidum, confirm | | | | | |
| 86784 | A | | Trichinella antibody | | | | | |
| 86787 | A | | Varicella-zoster antibody | | | | | |
| 86790 | A | | Virus antibody nos | | | | | |
| 86793 | A | | Yersinia antibody | | | | | |
| 86800 | A | | Thyroglobulin antibody | | | | | |
| 86803 | A | | Hepatitis c ab test | | | | | |
| 86804 | A | | Hep c ab test, confirm | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 86805 | A | | Lymphocytotoxicity assay | | | | | |
| 86806 | A | | Lymphocytotoxicity assay | | | | | |
| 86807 | A | | Cytotoxic antibody screening | | | | | |
| 86808 | A | | Cytotoxic antibody screening | | | | | |
| 86812 | A | | HLA typing, A, B, or C | | | | | |
| 86813 | A | | HLA typing, A, B, or C | | | | | |
| 86816 | A | | HLA typing, DR/DQ | | | | | |
| 86817 | A | | HLA typing, DR/DQ | | | | | |
| 86821 | A | | Lymphocyte culture, mixed | | | | | |
| 86822 | A | | Lymphocyte culture, primed | | | | | |
| 86849 | A | | Immunology procedure | | | | | |
| 86850 | X | | RBC antibody screen | 0345 | 0.2550 | $13.91 | $3.10 | $2.78 |
| 86860 | X | | RBC antibody elution | 0346 | 0.3866 | $21.09 | $5.32 | $4.22 |
| 86870 | X | | RBC antibody identification | 0346 | 0.3866 | $21.09 | $5.32 | $4.22 |
| 86880 | X | | Coombs test, direct | 0409 | 0.1390 | $7.58 | $2.32 | $1.52 |
| 86885 | X | | Coombs test, indirect, qual | 0409 | 0.1390 | $7.58 | $2.32 | $1.52 |
| 86886 | X | | Coombs test, indirect, titer | 0409 | 0.1390 | $7.58 | $2.32 | $1.52 |
| 86890 | X | | Autologous blood process | 0347 | 0.9610 | $52.43 | $13.20 | $10.49 |
| 86891 | X | | Autologous blood, op salvage | 0345 | 0.2550 | $13.91 | $3.10 | $2.78 |
| 86900 | X | | Blood typing, ABO | 0409 | 0.1390 | $7.58 | $2.32 | $1.52 |
| 86901 | X | | Blood typing, Rh (D) | 0409 | 0.1390 | $7.58 | $2.32 | $1.52 |
| 86903 | X | | Blood typing, antigen screen | 0345 | 0.2550 | $13.91 | $3.10 | $2.78 |
| 86904 | X | | Blood typing, patient serum | 0345 | 0.2550 | $13.91 | $3.10 | $2.78 |
| 86905 | X | | Blood typing, RBC antigens | 0345 | 0.2550 | $13.91 | $3.10 | $2.78 |
| 86906 | X | | Blood typing, Rh phenotype | 0345 | 0.2550 | $13.91 | $3.10 | $2.78 |
| 86910 | E | | Blood typing, paternity test | | | | | |
| 86911 | E | | Blood typing, antigen system | | | | | |
| 86920 | X | | Compatibility test | 0346 | 0.3866 | $21.09 | $5.32 | $4.22 |
| 86921 | X | | Compatibility test | 0345 | 0.2550 | $13.91 | $3.10 | $2.78 |
| 86922 | X | | Compatibility test | 0346 | 0.3866 | $21.09 | $5.32 | $4.22 |
| 86927 | X | | Plasma, fresh frozen | 0346 | 0.3866 | $21.09 | $5.32 | $4.22 |
| 86930 | X | | Frozen blood prep | 0347 | 0.9610 | $52.43 | $13.20 | $10.49 |
| 86931 | X | | Frozen blood thaw | 0347 | 0.9610 | $52.43 | $13.20 | $10.49 |
| 86932 | X | | Frozen blood freeze/thaw | 0347 | 0.9610 | $52.43 | $13.20 | $10.49 |
| 86940 | A | | Hemolysins/agglutinins, auto | | | | | |
| 86941 | A | | Hemolysins/agglutinins | | | | | |
| 86945 | X | | Blood product/irradiation | 0346 | 0.3866 | $21.09 | $5.32 | $4.22 |
| 86950 | X | | Leukacyte transfusion | 0347 | 0.9610 | $52.43 | $13.20 | $10.49 |
| 86965 | X | | Pooling blood platelets | 0346 | 0.3866 | $21.09 | $5.32 | $4.22 |
| 86970 | X | | RBC pretreatment | 0345 | 0.2550 | $13.91 | $3.10 | $2.78 |
| 86971 | X | | RBC pretreatment | 0345 | 0.2550 | $13.91 | $3.10 | $2.78 |
| 86972 | X | | RBC pretreatment | 0345 | 0.2550 | $13.91 | $3.10 | $2.78 |
| 86975 | X | | RBC pretreatment, serum | 0345 | 0.2550 | $13.91 | $3.10 | $2.78 |
| 86976 | X | | RBC pretreatment, serum | 0345 | 0.2550 | $13.91 | $3.10 | $2.78 |
| 86977 | X | | RBC pretreatment, serum | 0345 | 0.2550 | $13.91 | $3.10 | $2.78 |
| 86978 | X | | RBC pretreatment, serum | 0345 | 0.2550 | $13.91 | $3.10 | $2.78 |
| 86985 | X | | Split blood or products | 0347 | 0.9610 | $52.43 | $13.20 | $10.49 |
| 86999 | X | | Transfusion procedure | 0345 | 0.2550 | $13.91 | $3.10 | $2.78 |
| 87001 | A | | Small animal inoculation | | | | | |
| 87003 | A | | Small animal inoculation | | | | | |
| 87015 | A | | Specimen concentration | | | | | |
| 87040 | A | | Blood culture for bacteria | | | | | |
| 87045 | A | | Feces culture, bacteria | | | | | |
| 87046 | A | | Stool cultr, bacteria, each | | | | | |
| 87070 | A | | Culture, bacteria, other | | | | | |
| 87071 | A | | Culture bacteri aerobic othr | | | | | |
| 87073 | A | | Culture bacteria anaerobic | | | | | |
| 87075 | A | | Cultr bacteria, except blood | | | | | |
| 87076 | A | | Culture anaerobe ident, each | | | | | |
| 87077 | A | | Culture aerobic identify | | | | | |
| 87081 | A | | Culture screen only | | | | | |
| 87084 | A | | Culture of specimen by kit | | | | | |
| 87086 | A | | Urine culture/colony count | | | | | |
| 87088 | A | | Urine bacteria culture | | | | | |
| 87101 | A | | Skin fungi culture | | | | | |
| 87102 | A | | Fungus isolation culture | | | | | |
| 87103 | A | | Blood fungus culture | | | | | |
| 87106 | A | | Fungi identification, yeast | | | | | |
| 87107 | A | | Fungi identification, mold | | | | | |
| 87109 | A | | Mycoplasma | | | | | |
| 87110 | A | | Chlamydia culture | | | | | |
| 87116 | A | | Mycobacteria culture | | | | | |
| 87118 | A | | Mycobacteric identification | | | | | |
| 87140 | A | | Culture type immunofluoresc | | | | | |
| 87143 | A | | Culture typing, glc/hplc | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 87147 | A | | Culture type, immunologic | | | | | |
| 87149 | A | | Culture type, nucleic acid | | | | | |
| 87152 | A | | Culture type pulse field gel | | | | | |
| 87158 | A | | Culture typing, added method | | | | | |
| 87164 | A | | Dark field examination | | | | | |
| 87166 | A | | Dark field examination | | | | | |
| 87168 | A | | Macroscopic exam arthropod | | | | | |
| 87169 | A | | Macroscopic exam parasite | | | | | |
| 87172 | A | | Pinworm exam | | | | | |
| 87176 | A | | Tissue homogenization, cultr | | | | | |
| 87177 | A | | Ova and parasites smears | | | | | |
| 87181 | A | | Microbe susceptible, diffuse | | | | | |
| 87184 | A | | Microbe susceptible, disk | | | | | |
| 87185 | A | | Microbe susceptible, enzyme | | | | | |
| 87186 | A | | Microbe susceptible, mic | | | | | |
| 87187 | A | | Microbe susceptible, mlc | | | | | |
| 87188 | A | | Microbe suscept, macrobroth | | | | | |
| 87190 | A | | Microbe suscept, mycobacteri | | | | | |
| 87197 | A | | Bactericidal level, serum | | | | | |
| 87205 | A | | Smear, gram stain | | | | | |
| 87206 | A | | Smear, fluorescent/acid stai | | | | | |
| 87207 | A | | Smear, special stain | | | | | |
| 87210 | A | | Smear, wet mount, saline/ink | | | | | |
| 87220 | A | | Tissue exam for fungi | | | | | |
| 87230 | A | | Assay, toxin or antitoxin | | | | | |
| 87250 | A | | Virus inoculate, eggs/animal | | | | | |
| 87252 | A | | Virus inoculation, tissue | | | | | |
| 87253 | A | | Virus inoculate tissue, addl | | | | | |
| 87254 | A | | Virus inoculation, shell via | | | | | |
| 87255 | A | | Genet virus isolate, hsv | | | | | |
| 87260 | A | | Adenovirus ag, if | | | | | |
| 87265 | A | | Pertussis ag, if | | | | | |
| 87267 | A | | Enterovirus antibody, dfa | | | | | |
| 87269 | A | NI | Giardia ag, if | | | | | |
| 87270 | A | | Chlamydia trachomatis ag, if | | | | | |
| 87271 | A | | Cryptosporidum/gardia ag, if | | | | | |
| 87272 | A | | Cryptosporidium ag, if | | | | | |
| 87273 | A | | Herpes simplex 2, ag, if | | | | | |
| 87274 | A | | Herpes simplex 1, ag, if | | | | | |
| 87275 | A | | Influenza b, ag, if | | | | | |
| 87276 | A | | Influenza a, ag, if | | | | | |
| 87277 | A | | Legionella micdadei, ag, if | | | | | |
| 87278 | A | | Legion pneumophilia ag, if | | | | | |
| 87279 | A | | Parainfluenza, ag, if | | | | | |
| 87280 | A | | Respiratory syncytial ag, if | | | | | |
| 87281 | A | | Pneumocystis carinii, ag, if | | | | | |
| 87283 | A | | Rubeola, ag, if | | | | | |
| 87285 | A | | Treponema pallidum, ag, if | | | | | |
| 87290 | A | | Varicella zoster, ag, if | | | | | |
| 87299 | A | | Antibody detection, nos, if | | | | | |
| 87300 | A | | Ag detection, polyval, if | | | | | |
| 87301 | A | | Adenovirus ag, eia | | | | | |
| 87320 | A | | Chylmd trach ag, eia | | | | | |
| 87324 | A | | Clostridium ag, eia | | | | | |
| 87327 | A | | Cryptococcus neoform ag, eia | | | | | |
| 87328 | A | | Cryptosporidium ag, eia | | | | | |
| 87329 | A | NI | Giardia ag, eia | | | | | |
| 87332 | A | | Cytomegalovirus ag, eia | | | | | |
| 87335 | A | | E coli 0157 ag, eia | | | | | |
| 87336 | A | | Entamoeb hist dispr, ag, eia | | | | | |
| 87337 | A | | Entamoeb hist group, ag, eia | | | | | |
| 87338 | A | | Hpylori, stool, eia | | | | | |
| 87339 | A | | H pylori ag, eia | | | | | |
| 87340 | A | | Hepatitis b surface ag, eia | | | | | |
| 87341 | A | | Hepatitis b surface, ag, eia | | | | | |
| 87350 | A | | Hepatitis be ag, eia | | | | | |
| 87380 | A | | Hepatitis delta ag, eia | | | | | |
| 87385 | A | | Histoplasma capsul ag, eia | | | | | |
| 87390 | A | | Hiv-1 ag, eia | | | | | |
| 87391 | A | | Hiv-2 ag, eia | | | | | |
| 87400 | A | | Influenza a/b, ag, eia | | | | | |
| 87420 | A | | Resp syncytial ag, eia | | | | | |
| 87425 | A | | Rotavirus ag, eia | | | | | |
| 87427 | A | | Shiga-like toxin ag, eia | | | | | |
| 87430 | A | | Strep a ag, eia | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 87449 | A | | Ag detect nos, eia, mult | | | | | |
| 87450 | A | | Ag detect nos, eia, single | | | | | |
| 87451 | A | | Ag detect polyval, eia, mult | | | | | |
| 87470 | A | | Bartonella, dna, dir probe | | | | | |
| 87471 | A | | Bartonella, dna, amp probe | | | | | |
| 87472 | A | | Bartonella, dna, quant | | | | | |
| 87475 | A | | Lyme dis, dna, dir probe | | | | | |
| 87476 | A | | Lyme dis, dna, amp probe | | | | | |
| 87477 | A | | Lyme dis, dna, quant | | | | | |
| 87480 | A | | Candida, dna, dir probe | | | | | |
| 87481 | A | | Candida, dna, amp probe | | | | | |
| 87482 | A | | Candida, dna, quant | | | | | |
| 87485 | A | | Chylmd pneum, dna, dir probe | | | | | |
| 87486 | A | | Chylmd pneum, dna, amp probe | | | | | |
| 87487 | A | | Chylmd pneum, dna, quant | | | | | |
| 87490 | A | | Chylmd trach, dna, dir probe | | | | | |
| 87491 | A | | Chylmd trach, dna, amp probe | | | | | |
| 87492 | A | | Chylmd trach, dna, quant | | | | | |
| 87495 | A | | Cytomeg, dna, dir probe | | | | | |
| 87496 | A | | Cytomeg, dna, amp probe | | | | | |
| 87497 | A | | Cytomeg, dna, quant | | | | | |
| 87510 | A | | Gardner vag, dna, dir probe | | | | | |
| 87511 | A | | Gardner vag, dna, amp probe | | | | | |
| 87512 | A | | Gardner vag, dna, quant | | | | | |
| 87515 | A | | Hepatitis b, dna, dir probe | | | | | |
| 87516 | A | | Hepatitis b, dna, amp probe | | | | | |
| 87517 | A | | Hepatitis b, dna, quant | | | | | |
| 87520 | A | | Hepatitis c, rna, dir probe | | | | | |
| 87521 | A | | Hepatitis c, rna, amp probe | | | | | |
| 87522 | A | | Hepatitis c, rna, quant | | | | | |
| 87525 | A | | Hepatitis g, dna, dir probe | | | | | |
| 87526 | A | | Hepatitis g, dna, amp probe | | | | | |
| 87527 | A | | Hepatitis g, dna, quant | | | | | |
| 87528 | A | | Hsv, dna, dir probe | | | | | |
| 87529 | A | | Hsv, dna, amp probe | | | | | |
| 87530 | A | | Hsv, dna, quant | | | | | |
| 87531 | A | | Hhv-6, dna, dir probe | | | | | |
| 87532 | A | | Hhv-6, dna, amp probe | | | | | |
| 87533 | A | | Hhv-6, dna, quant | | | | | |
| 87534 | A | | Hiv-1, dna, dir probe | | | | | |
| 87535 | A | | Hiv-1, dna, amp probe | | | | | |
| 87536 | A | | Hiv-1, dna, quant | | | | | |
| 87537 | A | | Hiv-2, dna, dir probe | | | | | |
| 87538 | A | | Hiv-2, dna, amp probe | | | | | |
| 87539 | A | | Hiv-2, dna, quant | | | | | |
| 87540 | A | | Legion pneumo, dna, dir prob | | | | | |
| 87541 | A | | Legion pneumo, dna, amp prob | | | | | |
| 87542 | A | | Legion pneumo, dna, quant | | | | | |
| 87550 | A | | Mycobacteria, dna, dir probe | | | | | |
| 87551 | A | | Mycobacteria, dna, amp probe | | | | | |
| 87552 | A | | Mycobacteria, dna, quant | | | | | |
| 87555 | A | | M.tuberculo, dna, dir probe | | | | | |
| 87556 | A | | M.tuberculo, dna, amp probe | | | | | |
| 87557 | A | | M.tuberculo, dna, quant | | | | | |
| 87560 | A | | M.avium-intra, dna, dir prob | | | | | |
| 87561 | A | | M.avium-intra, dna, amp prob | | | | | |
| 87562 | A | | M.avium-intra, dna, quant | | | | | |
| 87580 | A | | M.pneumon, dna, dir probe | | | | | |
| 87581 | A | | M.pneumon, dna, amp probe | | | | | |
| 87582 | A | | M.pneumon, dna, quant | | | | | |
| 87590 | A | | N.gonorrhoeae, dna, dir prob | | | | | |
| 87591 | A | | N.gonorrhoeae, dna, amp prob | | | | | |
| 87592 | A | | N.gonorrhoeae, dna, quant | | | | | |
| 87620 | A | | Hpv, dna, dir probe | | | | | |
| 87621 | A | | Hpv, dna, amp probe | | | | | |
| 87622 | A | | Hpv, dna, quant | | | | | |
| 87650 | A | | Strep a, dna, dir probe | | | | | |
| 87651 | A | | Strep a, dna, amp probe | | | | | |
| 87652 | A | | Strep a, dna, quant | | | | | |
| 87660 | A | NI | Trichomonas vagin, dir probe | | | | | |
| 87797 | A | | Detect agent nos, dna, dir | | | | | |
| 87798 | A | | Detect agent nos, dna, amp | | | | | |
| 87799 | A | | Detect agent nos, dna, quant | | | | | |
| 87800 | A | | Detect agnt mult, dna, direc | | | | | |
| 87801 | A | | Detect agnt mult, dna, ampli | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 87802 | A | | Strep b assay w/optic | | | | | |
| 87803 | A | | Clostridium toxin a w/optic | | | | | |
| 87804 | A | | Influenza assay w/optic | | | | | |
| 87810 | A | | Chylmd trach assay w/optic | | | | | |
| 87850 | A | | N. gonorrhoeae assay w/optic | | | | | |
| 87880 | A | | Strep a assay w/optic | | | | | |
| 87899 | A | | Agent nos assay w/optic | | | | | |
| 87901 | A | | Genotype, dna, hiv reverse t | | | | | |
| 87902 | A | | Genotype, dna, hepatitis C | | | | | |
| 87903 | A | | Phenotype, dna hiv w/culture | | | | | |
| 87904 | A | | Phenotype, dna hiv w/clt add | | | | | |
| 87999 | A | | Microbiology procedure | | | | | |
| 88000 | E | | Autopsy (necropsy), gross | | | | | |
| 88005 | E | | Autopsy (necropsy), gross | | | | | |
| 88007 | E | | Autopsy (necropsy), gross | | | | | |
| 88012 | E | | Autopsy (necropsy), gross | | | | | |
| 88014 | E | | Autopsy (necropsy), gross | | | | | |
| 88016 | E | | Autopsy (necropsy), gross | | | | | |
| 88020 | E | | Autopsy (necropsy), complete | | | | | |
| 88025 | E | | Autopsy (necropsy), complete | | | | | |
| 88027 | E | | Autopsy (necropsy), complete | | | | | |
| 88028 | E | | Autopsy (necropsy), complete | | | | | |
| 88029 | E | | Autopsy (necropsy), complete | | | | | |
| 88036 | E | | Limited autopsy | | | | | |
| 88037 | E | | Limited autopsy | | | | | |
| 88040 | E | | Forensic autopsy (necropsy) | | | | | |
| 88045 | E | | Coroner's autopsy (necropsy) | | | | | |
| 88099 | E | | Necropsy (autopsy) procedure | | | | | |
| 88104 | X | | Cytopathology, fluids | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 88106 | X | | Cytopathology, fluids | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 88107 | X | | Cytopathology, fluids | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 88108 | X | | Cytopath, concentrate tech | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 88112 | X | NI | Cytopath, cell enhance tech | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 88125 | X | | Forensic cytopathology | 0342 | 0.2162 | $11.80 | $5.88 | $2.36 |
| 88130 | A | | Sex chromatin identification | | | | | |
| 88140 | A | | Sex chromatin identification | | | | | |
| 88141 | N | | Cytopath, c/v, interpret | | | | | |
| 88142 | A | | Cytopath, c/v, thin layer | | | | | |
| 88143 | A | | Cytopath c/v thin layer redo | | | | | |
| 88147 | A | | Cytopath, c/v, automated | | | | | |
| 88148 | A | | Cytopath, c/v, auto rescreen | | | | | |
| 88150 | A | | Cytopath, c/v, manual | | | | | |
| 88152 | A | | Cytopath, c/v, auto redo | | | | | |
| 88153 | A | | Cytopath, c/v, redo | | | | | |
| 88154 | A | | Cytopath, c/v, select | | | | | |
| 88155 | A | | Cytopath, c/v, index add-on | | | | | |
| 88160 | X | | Cytopath smear, other source | 0342 | 0.2162 | $11.80 | $5.88 | $2.36 |
| 88161 | X | | Cytopath smear, other source | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 88162 | X | | Cytopath smear, other source | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 88164 | A | | Cytopath tbs, c/v, manual | | | | | |
| 88165 | A | | Cytopath tbs, c/v, redo | | | | | |
| 88166 | A | | Cytopath tbs, c/v, auto redo | | | | | |
| 88167 | A | | Cytopath tbs, c/v, select | | | | | |
| 88172 | X | | Cytopathology eval of fna | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 88173 | X | | Cytopath eval, fna, report | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 88174 | A | | Cytopath, c/v auto, in fluid | | | | | |
| 88175 | A | | Cytopath c/v auto fluid redo | | | | | |
| 88180 | X | | Cell marker study | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 88182 | X | | Cell marker study | 0344 | 0.6291 | $34.32 | $17.16 | $6.86 |
| 88199 | A | | Cytopathology procedure | | | | | |
| 88230 | A | | Tissue culture, lymphocyte | | | | | |
| 88233 | A | | Tissue culture, skin/biopsy | | | | | |
| 88235 | A | | Tissue culture, placenta | | | | | |
| 88237 | A | | Tissue culture, bone marrow | | | | | |
| 88239 | A | | Tissue culture, tumor | | | | | |
| 88240 | A | | Cell cryopreserve/storage | | | | | |
| 88241 | A | | Frozen cell preparation | | | | | |
| 88245 | A | | Chromosome analysis, 20-25 | | | | | |
| 88248 | A | | Chromosome analysis, 50-100 | | | | | |
| 88249 | A | | Chromosome analysis, 100 | | | | | |
| 88261 | A | | Chromosome analysis, 5 | | | | | |
| 88262 | A | | Chromosome analysis, 15-20 | | | | | |
| 88263 | A | | Chromosome analysis, 45 | | | | | |
| 88264 | A | | Chromosome analysis, 20-25 | | | | | |
| 88267 | A | | Chromosome analys, placenta | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 88269 | A | | Chromosome analys, amniotic | | | | | |
| 88271 | A | | Cytogenetics, dna probe | | | | | |
| 88272 | A | | Cytogenetics, 3-5 | | | | | |
| 88273 | A | | Cytogenetics, 10-30 | | | | | |
| 88274 | A | | Cytogenetics, 25-99 | | | | | |
| 88275 | A | | Cytogenetics, 100-300 | | | | | |
| 88280 | A | | Chromosome karyotype study | | | | | |
| 88283 | A | | Chromosome banding study | | | | | |
| 88285 | A | | Chromosome count, additional | | | | | |
| 88289 | A | | Chromosome study, additional | | | | | |
| 88291 | A | | Cyto/molecular report | | | | | |
| 88299 | X | | Cytogenetic study | 0342 | 0.2162 | $11.80 | $5.88 | $2.36 |
| 88300 | X | | Surgical path, gross | 0342 | 0.2162 | $11.80 | $5.88 | $2.36 |
| 88302 | X | | Tissue exam by pathologist | 0342 | 0.2162 | $11.80 | $5.88 | $2.36 |
| 88304 | X | | Tissue exam by pathologist | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 88305 | X | | Tissue exam by pathologist | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 88307 | X | | Tissue exam by pathologist | 0344 | 0.6291 | $34.32 | $17.16 | $6.86 |
| 88309 | X | | Tissue exam by pathologist | 0344 | 0.6291 | $34.32 | $17.16 | $6.86 |
| 88311 | X | | Decalcify tissue | 0342 | 0.2162 | $11.80 | $5.88 | $2.36 |
| 88312 | X | | Special stains | 0342 | 0.2162 | $11.80 | $5.88 | $2.36 |
| 88313 | X | | Special stains | 0342 | 0.2162 | $11.80 | $5.88 | $2.36 |
| 88314 | X | | Histochemical stain | 0342 | 0.2162 | $11.80 | $5.88 | $2.36 |
| 88318 | X | | Chemical histochemistry | 0342 | 0.2162 | $11.80 | $5.88 | $2.36 |
| 88319 | X | | Enzyme histochemistry | 0342 | 0.2162 | $11.80 | $5.88 | $2.36 |
| 88321 | X | | Microslide consultation | 0342 | 0.2162 | $11.80 | $5.88 | $2.36 |
| 88323 | X | | Microslide consultation | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 88325 | X | | Comprehensive review of data | 0344 | 0.6291 | $34.32 | $17.16 | $6.86 |
| 88329 | X | | Path consult introp | 0342 | 0.2162 | $11.80 | $5.88 | $2.36 |
| 88331 | X | | Path consult intraop, 1 bloc | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 88332 | X | | Path consult intraop, add'l | 0342 | 0.2162 | $11.80 | $5.88 | $2.36 |
| 88342 | X | | Immunohistochemistry | 0344 | 0.6291 | $34.32 | $17.16 | $6.86 |
| 88346 | X | | Immunofluorescent study | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 88347 | X | | Immunofluorescent study | 0344 | 0.6291 | $34.32 | $17.16 | $6.86 |
| 88348 | X | | Electron microscopy | 0661 | 3.2576 | $177.74 | $88.87 | $35.55 |
| 88349 | X | | Scanning electron microscopy | 0661 | 3.2576 | $177.74 | $88.87 | $35.55 |
| 88355 | X | | Analysis, skeletal muscle | 0344 | 0.6291 | $34.32 | $17.16 | $6.86 |
| 88356 | X | | Analysis, nerve | 0344 | 0.6291 | $34.32 | $17.16 | $6.86 |
| 88358 | X | | Analysis, tumor | 0344 | 0.6291 | $34.32 | $17.16 | $6.86 |
| 88361 | X | NI | Immunohistochemistry, tumor | 0344 | 0.6291 | $34.32 | $17.16 | $6.86 |
| 88362 | X | | Nerve teasing preparations | 0344 | 0.6291 | $34.32 | $17.16 | $6.86 |
| 88365 | X | | Tissue hybridization | 0344 | 0.6291 | $34.32 | $17.16 | $6.86 |
| 88371 | A | | Protein, western blot tissue | | | | | |
| 88372 | A | | Protein analysis w/probe | | | | | |
| 88380 | A | | Microdissection | | | | | |
| 88399 | A | | Surgical pathology procedure | | | | | |
| 88400 | A | | Bilirubin total transcut | | | | | |
| 89050 | A | | Body fluid cell count | | | | | |
| 89051 | A | | Body fluid cell count | | | | | |
| 89055 | A | | Leukocyte assessment, fecal | | | | | |
| 89060 | A | | Exam,synovial fluid crystals | | | | | |
| 89100 | X | | Sample intestinal contents | 0360 | 1.7313 | $94.46 | $42.45 | $18.89 |
| 89105 | X | | Sample intestinal contents | 0360 | 1.7313 | $94.46 | $42.45 | $18.89 |
| 89125 | A | | Specimen fat stain | | | | | |
| 89130 | X | | Sample stomach contents | 0360 | 1.7313 | $94.46 | $42.45 | $18.89 |
| 89132 | X | | Sample stomach contents | 0360 | 1.7313 | $94.46 | $42.45 | $18.89 |
| 89135 | X | | Sample stomach contents | 0360 | 1.7313 | $94.46 | $42.45 | $18.89 |
| 89136 | X | | Sample stomach contents | 0360 | 1.7313 | $94.46 | $42.45 | $18.89 |
| 89140 | X | | Sample stomach contents | 0360 | 1.7313 | $94.46 | $42.45 | $18.89 |
| 89141 | X | | Sample stomach contents | 0360 | 1.7313 | $94.46 | $42.45 | $18.89 |
| 89160 | A | | Exam feces for meat fibers | | | | | |
| 89190 | A | | Nasal smear for eosinophils | | | | | |
| 89220 | X | NI | Sputum specimen collection | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 89225 | A | NI | Starch granules, feces | | | | | |
| 89230 | X | NI | Collect sweat for test | 0344 | 0.6291 | $34.32 | $17.16 | $6.86 |
| 89235 | A | NI | Water load test | | | | | |
| 89240 | A | NI | Pathology lab procedure | | | | | |
| 89250 | X | | Cultr oocyte/embryo <4 days | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89251 | X | | Cultr oocyte/embryo <4 days | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89252 | X | DG | Assist oocyte fertilization | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89253 | X | | Embryo hatching | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89254 | X | | Oocyte identification | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89255 | X | | Prepare embryo for transfer | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89256 | X | DG | Prepare cryopreserved embryo | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89257 | X | | Sperm identification | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89258 | X | | Cryopreservation; embryo(s) | 0348 | 0.8194 | $44.71 | | $8.94 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 89259 | X | | Cryopreservation, sperm | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89260 | X | | Sperm isolation, simple | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89261 | X | | Sperm isolation, complex | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89264 | X | | Identify sperm tissue | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89268 | X | NI | Insemination of oocytes | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89272 | X | NI | Extended culture of oocytes | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89280 | X | NI | Assist oocyte fertilization | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89281 | X | NI | Assist oocyte fertilization | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89290 | X | NI | Biopsy, oocyte polar body | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89291 | X | NI | Biopsy, oocyte polar body | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89300 | A | | Semen analysis w/huhner | | | | | |
| 89310 | A | | Semen analysis | | | | | |
| 89320 | A | | Semen analysis, complete | | | | | |
| 89321 | A | | Semen analysis & motility | | | | | |
| 89325 | A | | Sperm antibody test | | | | | |
| 89329 | A | | Sperm evaluation test | | | | | |
| 89330 | A | | Evaluation, cervical mucus | | | | | |
| 89335 | X | NI | Cryopreserve testicular tiss | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89342 | X | NI | Storage/year; embryo(s) | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89343 | X | NI | Storage/year; sperm/semen | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89344 | X | NI | Storage/year; reprod tissue | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89346 | X | NI | Storage/year; oocyte | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89350 | X | DG | Sputum specimen collection | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 89352 | X | NI | Thawing cryopresrved; embryo | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89353 | X | NI | Thawing cryopresrved; sperm | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89354 | X | NI | Thaw cryoprsvrd; reprod tiss | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89355 | A | DG | Exam feces for starch | | | | | |
| 89356 | X | NI | Thawing cryopresrved; oocyte | 0348 | 0.8194 | $44.71 | | $8.94 |
| 89360 | X | DG | Collect sweat for test | 0343 | 0.4617 | $25.19 | $12.55 | $5.04 |
| 89365 | A | DG | Water load test | | | | | |
| 89399 | A | DG | Pathology lab procedure | | | | | |
| 90281 | E | | Human ig, im | | | | | |
| 90283 | E | | Human ig, iv | | | | | |
| 90287 | E | | Botulinum antitoxin | | | | | |
| 90288 | E | | Botulism ig, iv | | | | | |
| 90291 | E | | Cmv ig, iv | | | | | |
| 90296 | K | | Diphtheria antitoxin | 0355 | 0.2749 | $15.00 | | $3.00 |
| 90371 | E | | Hep b ig, im | | | | | |
| 90375 | K | | Rabies ig, im/sc | 0356 | 0.7698 | $42.00 | | $8.40 |
| 90376 | K | | Rabies ig, heat treated | 0356 | 0.7698 | $42.00 | | $8.40 |
| 90378 | E | | Rsv ig, im, 50mg | | | | | |
| 90379 | K | | Rsv ig, iv | 0356 | 0.7698 | $42.00 | | $8.40 |
| 90384 | E | | Rh ig, full-dose, im | | | | | |
| 90385 | K | | Rh ig, minidose, im | 0356 | 0.7698 | $42.00 | | $8.40 |
| 90386 | E | | Rh ig, iv | | | | | |
| 90389 | N | | Tetanus ig, im | | | | | |
| 90393 | K | | Vaccina ig, im | 0356 | 0.7698 | $42.00 | | $8.40 |
| 90396 | K | | Varicella-zoster ig, im | 0356 | 0.7698 | $42.00 | | $8.40 |
| 90399 | E | | Immune globulin | | | | | |
| 90471 | N | | Immunization admin | | | | | |
| 90472 | N | | Immunization admin, each add | | | | | |
| 90473 | E | | Immune admin oral/nasal | | | | | |
| 90474 | E | | Immune admin oral/nasal addl | | | | | |
| 90476 | N | | Adenovirus vaccine, type 4 | | | | | |
| 90477 | N | | Adenovirus vaccine, type 7 | | | | | |
| 90581 | K | | Anthrax vaccine, sc | 0355 | 0.2749 | $15.00 | | $3.00 |
| 90585 | N | | Bcg vaccine, percut | | | | | |
| 90586 | K | | Bcg vaccine, intravesical | 0356 | 0.7698 | $42.00 | | $8.40 |
| 90632 | N | | Hep a vaccine, adult im | | | | | |
| 90633 | N | | Hep a vacc, ped/adol, 2 dose | | | | | |
| 90634 | N | | Hep a vacc, ped/adol, 3 dose | | | | | |
| 90636 | K | | Hep a/hep b vacc, adult im | 0355 | 0.2749 | $15.00 | | $3.00 |
| 90645 | N | | Hib vaccine, hboc, im | | | | | |
| 90646 | N | | Hib vaccine, prp-d, im | | | | | |
| 90647 | N | | Hib vaccine, prp-omp, im | | | | | |
| 90648 | N | | Hib vaccine, prp-t, im | | | | | |
| 90655 | L | NI | Flu vaccine, 6-35 mo, im | | | | | |
| 90657 | L | | Flu vaccine, 6-35 mo, im | | | | | |
| 90658 | L | | Flu vaccine, 3 yrs, im | | | | | |
| 90659 | L | DG | Flu vaccine, whole, im | | | | | |
| 90660 | E | | Flu vaccine, nasal | | | | | |
| 90665 | N | | Lyme disease vaccine, im | | | | | |
| 90669 | E | | Pneumococcal vacc, ped <5 | | | | | |
| 90675 | K | | Rabies vaccine, im | 0356 | 0.7698 | $42.00 | | $8.40 |
| 90676 | K | | Rabies vaccine, id | 0356 | 0.7698 | $42.00 | | $8.40 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 90680 | N | | Rotovirus vaccine, oral | | | | | |
| 90690 | N | | Typhoid vaccine, oral | | | | | |
| 90691 | N | | Typhoid vaccine, im | | | | | |
| 90692 | N | | Typhoid vaccine, h-p, sc/id | | | | | |
| 90693 | K | | Typhoid vaccine, akd, sc | 0356 | 0.7698 | $42.00 | | $8.40 |
| 90698 | N | NI | Dtap-hib-ip vaccine, im | | | | | |
| 90700 | N | | Dtap vaccine, im | | | | | |
| 90701 | N | | Dtp vaccine, im | | | | | |
| 90702 | N | | Dt vaccine < 7, im | | | | | |
| 90703 | N | | Tetanus vaccine, im | | | | | |
| 90704 | N | | Mumps vaccine, sc | | | | | |
| 90705 | N | | Measles vaccine, sc | | | | | |
| 90706 | N | | Rubella vaccine, sc | | | | | |
| 90707 | N | | Mmr vaccine, sc | | | | | |
| 90708 | N | | Measles-rubella vaccine, sc | | | | | |
| 90710 | N | | Mmrv vaccine, sc | | | | | |
| 90712 | N | | Oral poliovirus vaccine | | | | | |
| 90713 | N | | Poliovirus, ipv, sc | | | | | |
| 90715 | N | NI | Tdap vaccine > 7 im | | | | | |
| 90716 | K | | Chicken pox vaccine, sc | 0355 | 0.2749 | $15.00 | | $3.00 |
| 90717 | N | | Yellow fever vaccine, sc | | | | | |
| 90718 | N | | Td vaccine > 7, im | | | | | |
| 90719 | N | | Diphtheria vaccine, im | | | | | |
| 90720 | N | | Dtp/hib vaccine, im | | | | | |
| 90721 | N | | Dtap/hib vaccine, im | | | | | |
| 90723 | K | | Dtap-hep b-ipv vaccine, im | 0356 | 0.7698 | $42.00 | | $8.40 |
| 90725 | K | | Cholera vaccine, injectable | 0355 | 0.2749 | $15.00 | | $3.00 |
| 90727 | N | | Plague vaccine, im | | | | | |
| 90732 | L | | Pneumococcal vaccine | | | | | |
| 90733 | N | | Meningococcal vaccine, sc | | | | | |
| 90734 | N | NI | Meningococcal vaccine, im | | | | | |
| 90735 | N | | Encephalitis vaccine, sc | | | | | |
| 90740 | K | | Hepb vacc, ill pat 3 dose im | 0356 | 0.7698 | $42.00 | | $8.40 |
| 90743 | K | | Hep b vacc, adol, 2 dose, im | 0356 | 0.7698 | $42.00 | | $8.40 |
| 90744 | K | | Hepb vacc ped/adol 3 dose im | 0356 | 0.7698 | $42.00 | | $8.40 |
| 90746 | K | | Hep b vaccine, adult, im | 0356 | 0.7698 | $42.00 | | $8.40 |
| 90747 | K | | Hepb vacc, ill pat 4 dose im | 0356 | 0.7698 | $42.00 | | $8.40 |
| 90748 | K | | Hep b/hib vaccine, im | 0355 | 0.2749 | $15.00 | | $3.00 |
| 90749 | N | | Vaccine toxoid | | | | | |
| 90780 | B | | IV infusion therapy, 1 hour | | | | | |
| 90781 | B | | IV infusion, additional hour | | | | | |
| 90782 | X | | Injection, sc/im | 0353 | 0.3982 | $21.73 | | $4.35 |
| 90783 | X | | Injection, ia | 0359 | 0.8000 | $43.65 | | $8.73 |
| 90784 | X | | Injection, iv | 0359 | 0.8000 | $43.65 | | $8.73 |
| 90788 | X | | Injection of antibiotic | 0359 | 0.8000 | $43.65 | | $8.73 |
| 90799 | X | | Ther/prophylactic/dx inject | 0352 | 0.1230 | $6.71 | | $1.34 |
| 90801 | S | | Psy dx interview | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90802 | S | | Intac psy dx interview | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90804 | S | | Psytx, office, 20-30 min | 0322 | 1.2802 | $69.85 | | $13.97 |
| 90805 | S | | Psytx, off, 20-30 min w/e&m | 0322 | 1.2802 | $69.85 | | $13.97 |
| 90806 | S | | Psytx, off, 45-50 min | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90807 | S | | Psytx, off, 45-50 min w/e&m | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90808 | S | | Psytx, office, 75-80 min | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90809 | S | | Psytx, off, 75-80, w/e&m | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90810 | S | | Intac psytx, off, 20-30 min | 0322 | 1.2802 | $69.85 | | $13.97 |
| 90811 | S | | Intac psytx, 20-30, w/e&m | 0322 | 1.2802 | $69.85 | | $13.97 |
| 90812 | S | | Intac psytx, off, 45-50 min | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90813 | S | | Intac psytx, 45-50 min w/e&m | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90814 | S | | Intac psytx, off, 75-80 min | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90815 | S | | Intac psytx, 75-80 w/e&m | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90816 | S | | Psytx, hosp, 20-30 min | 0322 | 1.2802 | $69.85 | | $13.97 |
| 90817 | S | | Psytx, hosp, 20-30 min w/e&m | 0322 | 1.2802 | $69.85 | | $13.97 |
| 90818 | S | | Psytx, hosp, 45-50 min | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90819 | S | | Psytx, hosp, 45-50 min w/e&m | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90821 | S | | Psytx, hosp, 75-80 min | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90822 | S | | Psytx, hosp, 75-80 min w/e&m | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90823 | S | | Intac psytx, hosp, 20-30 min | 0322 | 1.2802 | $69.85 | | $13.97 |
| 90824 | S | | Intac psytx, hsp 20-30 w/e&m | 0322 | 1.2802 | $69.85 | | $13.97 |
| 90826 | S | | Intac psytx, hosp, 45-50 min | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90827 | S | | Intac psytx, hsp 45-50 w/e&m | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90828 | S | | Intac psytx, hosp, 75-80 min | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90829 | S | | Intac psytx, hsp 75-80 w/e&m | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90845 | S | | Psychoanalysis | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90846 | S | | Family psytx w/o patient | 0324 | 2.4473 | $133.53 | | $26.71 |
| 90847 | S | | Family psytx w/patient | 0324 | 2.4473 | $133.53 | | $26.71 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 90849 | S | | Multiple family group psytx | 0325 | 1.4865 | $81.10 | $18.27 | $16.22 |
| 90853 | S | | Group psychotherapy | 0325 | 1.4865 | $81.10 | $18.27 | $16.22 |
| 90857 | S | | Intac group psytx | 0325 | 1.4865 | $81.10 | $18.27 | $16.22 |
| 90862 | X | | Medication management | 0374 | 1.1252 | $61.39 | | $12.28 |
| 90865 | S | | Narcosynthesis | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90870 | S | | Electroconvulsive therapy | 0320 | 5.3785 | $293.46 | $80.06 | $58.69 |
| 90871 | E | | Electroconvulsive therapy | | | | | |
| 90875 | E | | Psychophysiological therapy | | | | | |
| 90876 | E | | Psychophysiological therapy | | | | | |
| 90880 | S | | Hypnotherapy | 0323 | 1.8689 | $101.97 | $21.26 | $20.39 |
| 90882 | E | | Environmental manipulation | | | | | |
| 90885 | N | | Psy evaluation of records | | | | | |
| 90887 | N | | Consultation with family | | | | | |
| 90889 | N | | Preparation of report | | | | | |
| 90899 | S | | Psychiatric service/therapy | 0322 | 1.2802 | $69.85 | | $13.97 |
| 90901 | A | | Biofeedback train, any meth | | | | | |
| 90911 | S | | Biofeedback peri/uro/rectal | 0321 | 1.2387 | $67.58 | $21.78 | $13.52 |
| 90918 | A | | ESRD related services, month | | | | | |
| 90919 | A | | ESRD related services, month | | | | | |
| 90920 | A | | ESRD related services, month | | | | | |
| 90921 | A | | ESRD related services, month | | | | | |
| 90922 | A | | ESRD related services, day | | | | | |
| 90923 | A | | Esrd related services, day | | | | | |
| 90924 | A | | Esrd related services, day | | | | | |
| 90925 | A | | Esrd related services, day | | | | | |
| 90935 | S | | Hemodialysis, one evaluation | 0170 | 5.9678 | $325.61 | | $65.12 |
| 90937 | E | | Hemodialysis, repeated eval | | | | | |
| 90939 | N | | Hemodialysis study, transcut | | | | | |
| 90940 | N | | Hemodialysis access study | | | | | |
| 90945 | S | | Dialysis, one evaluation | 0170 | 5.9678 | $325.61 | | $65.12 |
| 90947 | E | | Dialysis, repeated eval | | | | | |
| 90989 | B | | Dialysis training, complete | | | | | |
| 90993 | B | | Dialysis training, incompl | | | | | |
| 90997 | E | | Hemoperfusion | | | | | |
| 90999 | B | | Dialysis procedure | | | | | |
| 91000 | X | | Esophageal intubation | 0361 | 3.5510 | $193.75 | $83.23 | $38.75 |
| 91010 | X | | Esophagus motility study | 0361 | 3.5510 | $193.75 | $83.23 | $38.75 |
| 91011 | X | | Esophagus motility study | 0361 | 3.5510 | $193.75 | $83.23 | $38.75 |
| 91012 | X | | Esophagus motility study | 0361 | 3.5510 | $193.75 | $83.23 | $38.75 |
| 91020 | X | | Gastric motility | 0361 | 3.5510 | $193.75 | $83.23 | $38.75 |
| 91030 | X | | Acid perfusion of esophagus | 0361 | 3.5510 | $193.75 | $83.23 | $38.75 |
| 91032 | X | | Esophagus, acid reflux test | 0361 | 3.5510 | $193.75 | $83.23 | $38.75 |
| 91033 | X | | Prolonged acid reflux test | 0361 | 3.5510 | $193.75 | $83.23 | $38.75 |
| 91052 | X | | Gastric analysis test | 0361 | 3.5510 | $193.75 | $83.23 | $38.75 |
| 91055 | X | | Gastric intubation for smear | 0360 | 1.7313 | $94.46 | $42.45 | $18.89 |
| 91060 | X | | Gastric saline load test | 0360 | 1.7313 | $94.46 | $42.45 | $18.89 |
| 91065 | X | | Breath hydrogen test | 0360 | 1.7313 | $94.46 | $42.45 | $18.89 |
| 91100 | X | | Pass intestine bleeding tube | 0360 | 1.7313 | $94.46 | $42.45 | $18.89 |
| 91105 | X | | Gastric intubation treatment | 0360 | 1.7313 | $94.46 | $42.45 | $18.89 |
| 91110 | S | NI | Gi tract capsule endoscopy | 1508 | | $650.00 | | $130.00 |
| 91122 | T | | Anal pressure record | 0156 | 2.4747 | $135.02 | $40.52 | $27.00 |
| 91123 | N | | Irrigate fecal impaction | | | | | |
| 91132 | X | | Electrogastrography | 0360 | 1.7313 | $94.46 | $42.45 | $18.89 |
| 91133 | X | | Electrogastrography w/test | 0360 | 1.7313 | $94.46 | $42.45 | $18.89 |
| 91299 | X | | Gastroenterology procedure | 0360 | 1.7313 | $94.46 | $42.45 | $18.89 |
| 92002 | V | | Eye exam, new patient | 0601 | 0.9816 | $53.56 | | $10.71 |
| 92004 | V | | Eye exam, new patient | 0602 | 1.5041 | $82.07 | | $16.41 |
| 92012 | V | | Eye exam established pat | 0600 | 0.9278 | $50.62 | | $10.12 |
| 92014 | V | | Eye exam & treatment | 0602 | 1.5041 | $82.07 | | $16.41 |
| 92015 | E | | Refraction | | | | | |
| 92018 | T | | New eye exam & treatment | 0699 | 2.2303 | $121.69 | $47.46 | $24.34 |
| 92019 | S | | Eye exam & treatment | 0699 | 2.2303 | $121.69 | $47.46 | $24.34 |
| 92020 | S | | Special eye evaluation | 0230 | 0.7619 | $41.57 | $14.97 | $8.31 |
| 92060 | S | | Special eye evaluation | 0230 | 0.7619 | $41.57 | $14.97 | $8.31 |
| 92065 | S | | Orthoptic/pleoptic training | 0230 | 0.7619 | $41.57 | $14.97 | $8.31 |
| 92070 | N | | Fitting of contact lens | | | | | |
| 92081 | S | | Visual field examination(s) | 0230 | 0.7619 | $41.57 | $14.97 | $8.31 |
| 92082 | S | | Visual field examination(s) | 0698 | 0.9599 | $52.37 | $18.72 | $10.47 |
| 92083 | S | | Visual field examination(s) | 0698 | 0.9599 | $52.37 | $18.72 | $10.47 |
| 92100 | N | | Serial tonometry exam(s) | | | | | |
| 92120 | S | | Tonography & eye evaluation | 0230 | 0.7619 | $41.57 | $14.97 | $8.31 |
| 92130 | S | | Water provocation tonography | 0698 | 0.9599 | $52.37 | $18.72 | $10.47 |
| 92135 | S | | Opthalmic dx imaging | 0230 | 0.7619 | $41.57 | $14.97 | $8.31 |
| 92136 | S | | Ophthalmic biometry | 0230 | 0.7619 | $41.57 | $14.97 | $8.31 |
| 92140 | S | | Glaucoma provocative tests | 0698 | 0.9599 | $52.37 | $18.72 | $10.47 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 92225 | S | | Special eye exam, initial | 0698 | 0.9599 | $52.37 | $18.72 | $10.47 |
| 92226 | S | | Special eye exam, subsequent | 0698 | 0.9599 | $52.37 | $18.72 | $10.47 |
| 92230 | T | | Eye exam with photos | 0699 | 2.2303 | $121.69 | $47.46 | $24.34 |
| 92235 | T | | Eye exam with photos | 0699 | 2.2303 | $121.69 | $47.46 | $24.34 |
| 92240 | S | | Icg angiography | 0231 | 2.1883 | $119.40 | $50.94 | $23.88 |
| 92250 | S | | Eye exam with photos | 0230 | 0.7619 | $41.57 | $14.97 | $8.31 |
| 92260 | S | | Ophthalmoscopy/dynamometry | 0230 | 0.7619 | $41.57 | $14.97 | $8.31 |
| 92265 | S | | Eye muscle evaluation | 0231 | 2.1883 | $119.40 | $50.94 | $23.88 |
| 92270 | S | | Electro-oculography | 0698 | 0.9599 | $52.37 | $18.72 | $10.47 |
| 92275 | S | | Electroretinography | 0231 | 2.1883 | $119.40 | $50.94 | $23.88 |
| 92283 | S | | Color vision examination | 0230 | 0.7619 | $41.57 | $14.97 | $8.31 |
| 92284 | S | | Dark adaptation eye exam | 0698 | 0.9599 | $52.37 | $18.72 | $10.47 |
| 92285 | S | | Eye photography | 0230 | 0.7619 | $41.57 | $14.97 | $8.31 |
| 92286 | S | | Internal eye photography | 0698 | 0.9599 | $52.37 | $18.72 | $10.47 |
| 92287 | S | | Internal eye photography | 0231 | 2.1883 | $119.40 | $50.94 | $23.88 |
| 92310 | E | | Contact lens fitting | | | | | |
| 92311 | X | | Contact lens fitting | 0362 | 2.6984 | $147.23 | | $29.45 |
| 92312 | X | | Contact lens fitting | 0362 | 2.6984 | $147.23 | | $29.45 |
| 92313 | X | | Contact lens fitting | 0362 | 2.6984 | $147.23 | | $29.45 |
| 92314 | E | | Prescription of contact lens | | | | | |
| 92315 | X | | Prescription of contact lens | 0362 | 2.6984 | $147.23 | | $29.45 |
| 92316 | X | | Prescription of contact lens | 0362 | 2.6984 | $147.23 | | $29.45 |
| 92317 | X | | Prescription of contact lens | 0362 | 2.6984 | $147.23 | | $29.45 |
| 92325 | X | | Modification of contact lens | 0362 | 2.6984 | $147.23 | | $29.45 |
| 92326 | X | | Replacement of contact lens | 0362 | 2.6984 | $147.23 | | $29.45 |
| 92330 | S | | Fitting of artificial eye | 0230 | 0.7619 | $41.57 | $14.97 | $8.31 |
| 92335 | N | | Fitting of artificial eye | | | | | |
| 92340 | E | | Fitting of spectacles | | | | | |
| 92341 | E | | Fitting of spectacles | | | | | |
| 92342 | E | | Fitting of spectacles | | | | | |
| 92352 | X | | Special spectacles fitting | 0362 | 2.6984 | $147.23 | | $29.45 |
| 92353 | X | | Special spectacles fitting | 0362 | 2.6984 | $147.23 | | $29.45 |
| 92354 | X | | Special spectacles fitting | 0362 | 2.6984 | $147.23 | | $29.45 |
| 92355 | X | | Special spectacles fitting | 0362 | 2.6984 | $147.23 | | $29.45 |
| 92358 | X | | Eye prosthesis service | 0362 | 2.6984 | $147.23 | | $29.45 |
| 92370 | E | | Repair & adjust spectacles | | | | | |
| 92371 | X | | Repair & adjust spectacles | 0362 | 2.6984 | $147.23 | | $29.45 |
| 92390 | E | | Supply of spectacles | | | | | |
| 92391 | E | | Supply of contact lenses | | | | | |
| 92392 | E | | Supply of low vision aids | | | | | |
| 92393 | E | | Supply of artificial eye | | | | | |
| 92395 | E | | Supply of spectacles | | | | | |
| 92396 | E | | Supply of contact lenses | | | | | |
| 92499 | S | | Eye service or procedure | 0230 | 0.7619 | $41.57 | $14.97 | $8.31 |
| 92502 | T | | Ear and throat examination | 0251 | 1.7880 | $97.56 | | $19.51 |
| 92504 | N | | Ear microscopy examination | | | | | |
| 92506 | A | | Speech/hearing evaluation | | | | | |
| 92507 | A | | Speech/hearing therapy | | | | | |
| 92508 | A | | Speech/hearing therapy | | | | | |
| 92510 | A | | Rehab for ear implant | | | | | |
| 92511 | T | | Nasopharyngoscopy | 0071 | 0.8799 | $48.01 | $12.89 | $9.60 |
| 92512 | X | | Nasal function studies | 0363 | 0.8641 | $47.15 | $17.44 | $9.43 |
| 92516 | X | | Facial nerve function test | 0660 | 1.7353 | $94.68 | $30.66 | $18.94 |
| 92520 | X | | Laryngeal function studies | 0660 | 1.7353 | $94.68 | $30.66 | $18.94 |
| 92526 | A | | Oral function therapy | | | | | |
| 92531 | N | | Spontaneous nystagmus study | | | | | |
| 92532 | N | | Positional nystagmus test | | | | | |
| 92533 | N | | Caloric vestibular test | | | | | |
| 92534 | N | | Optokinetic nystagmus test | | | | | |
| 92541 | X | | Spontaneous nystagmus test | 0363 | 0.8641 | $47.15 | $17.44 | $9.43 |
| 92542 | X | | Positional nystagmus test | 0363 | 0.8641 | $47.15 | $17.44 | $9.43 |
| 92543 | X | | Caloric vestibular test | 0363 | 0.8641 | $47.15 | $17.44 | $9.43 |
| 92544 | X | | Optokinetic nystagmus test | 0363 | 0.8641 | $47.15 | $17.44 | $9.43 |
| 92545 | X | | Oscillating tracking test | 0363 | 0.8641 | $47.15 | $17.44 | $9.43 |
| 92546 | X | | Sinusoidal rotational test | 0660 | 1.7353 | $94.68 | $30.66 | $18.94 |
| 92547 | X | | Supplemental electrical test | 0363 | 0.8641 | $47.15 | $17.44 | $9.43 |
| 92548 | X | | Posturography | 0660 | 1.7353 | $94.68 | $30.66 | $18.94 |
| 92551 | E | | Pure tone hearing test, air | | | | | |
| 92552 | X | | Pure tone audiometry, air | 0364 | 0.4459 | $24.33 | $9.06 | $4.87 |
| 92553 | X | | Audiometry, air & bone | 0365 | 1.2132 | $66.19 | $18.95 | $13.24 |
| 92555 | X | | Speech threshold audiometry | 0364 | 0.4459 | $24.33 | $9.06 | $4.87 |
| 92556 | X | | Speech audiometry, complete | 0364 | 0.4459 | $24.33 | $9.06 | $4.87 |
| 92557 | X | | Comprehensive hearing test | 0365 | 1.2132 | $66.19 | $18.95 | $13.24 |
| 92559 | E | | Group audiometric testing | | | | | |
| 92560 | E | | Bekesy audiometry, screen | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 92561 | X | | Bekesy audiometry, diagnosis | 0365 | 1.2132 | $66.19 | $18.95 | $13.24 |
| 92562 | X | | Loudness balance test | 0364 | 0.4459 | $24.33 | $9.06 | $4.87 |
| 92563 | X | | Tone decay hearing test | 0364 | 0.4459 | $24.33 | $9.06 | $4.87 |
| 92564 | X | | Sisi hearing test | 0364 | 0.4459 | $24.33 | $9.06 | $4.87 |
| 92565 | X | | Stenger test, pure tone | 0364 | 0.4459 | $24.33 | $9.06 | $4.87 |
| 92567 | X | | Tympanometry | 0364 | 0.4459 | $24.33 | $9.06 | $4.87 |
| 92568 | X | | Acoustic reflex testing | 0364 | 0.4459 | $24.33 | $9.06 | $4.87 |
| 92569 | X | | Acoustic reflex decay test | 0364 | 0.4459 | $24.33 | $9.06 | $4.87 |
| 92571 | X | | Filtered speech hearing test | 0364 | 0.4459 | $24.33 | $9.06 | $4.87 |
| 92572 | X | | Staggered spondaic word test | 0364 | 0.4459 | $24.33 | $9.06 | $4.87 |
| 92573 | X | | Lombard test | 0364 | 0.4459 | $24.33 | $9.06 | $4.87 |
| 92575 | X | | Sensorineural acuity test | 0365 | 1.2132 | $66.19 | $18.95 | $13.24 |
| 92576 | X | | Synthetic sentence test | 0364 | 0.4459 | $24.33 | $9.06 | $4.87 |
| 92577 | X | | Stenger test, speech | 0365 | 1.2132 | $66.19 | $18.95 | $13.24 |
| 92579 | X | | Visual audiometry (vra) | 0365 | 1.2132 | $66.19 | $18.95 | $13.24 |
| 92582 | X | | Conditioning play audiometry | 0365 | 1.2132 | $66.19 | $18.95 | $13.24 |
| 92583 | X | | Select picture audiometry | 0364 | 0.4459 | $24.33 | $9.06 | $4.87 |
| 92584 | X | | Electrocochleography | 0660 | 1.7353 | $94.68 | $30.66 | $18.94 |
| 92585 | S | | Auditor evoke potent, compre | 0216 | 2.8535 | $155.69 | $67.98 | $31.14 |
| 92586 | S | | Auditor evoke potent, limit | 0218 | 1.1404 | $62.22 | | $12.44 |
| 92587 | X | | Evoked auditory test | 0363 | 0.8641 | $47.15 | $17.44 | $9.43 |
| 92588 | X | | Evoked auditory test | 0363 | 0.8641 | $47.15 | $17.44 | $9.43 |
| 92589 | X | | Auditory function test(s) | 0364 | 0.4459 | $24.33 | $9.06 | $4.87 |
| 92590 | E | | Hearing aid exam, one ear | | | | | |
| 92591 | E | | Hearing aid exam, both ears | | | | | |
| 92592 | E | | Hearing aid check, one ear | | | | | |
| 92593 | E | | Hearing aid check, both ears | | | | | |
| 92594 | E | | Electro hearng aid test, one | | | | | |
| 92595 | E | | Electro hearng aid tst, both | | | | | |
| 92596 | X | | Ear protector evaluation | 0365 | 1.2132 | $66.19 | $18.95 | $13.24 |
| 92597 | A | | Voice Prosthetic Evaluation | | | | | |
| 92601 | X | NI | Cochlear implt f/up exam < 7 | 0365 | 1.2132 | $66.19 | $18.95 | $13.24 |
| 92602 | X | NI | Reprogram cochlear implt < 7 | 0365 | 1.2132 | $66.19 | $18.95 | $13.24 |
| 92603 | X | NI | Cochlear implt f/up exam 7 > | 0365 | 1.2132 | $66.19 | $18.95 | $13.24 |
| 92604 | X | NI | Reprogram cochlear implt 7 > | 0365 | 1.2132 | $66.19 | $18.95 | $13.24 |
| 92605 | A | | Eval for nonspeech device rx | | | | | |
| 92606 | A | | Non-speech device service | | | | | |
| 92607 | A | | Ex for speech device rx, 1hr | | | | | |
| 92608 | A | | Ex for speech device rx addl | | | | | |
| 92609 | A | | Use of speech device service | | | | | |
| 92610 | A | | Evaluate swallowing function | | | | | |
| 92611 | A | | Motion fluoroscopy/swallow | | | | | |
| 92612 | A | | Endoscopy swallow tst (fees) | | | | | |
| 92613 | E | | Endoscopy swallow tst (fees) | | | | | |
| 92614 | A | | Laryngoscopic sensory test | | | | | |
| 92615 | E | | Eval laryngoscopy sense tst | | | | | |
| 92616 | A | | Fees w/laryngeal sense test | | | | | |
| 92617 | E | | Interprt fees/laryngeal test | | | | | |
| 92700 | X | | Ent procedure/service | 0364 | 0.4459 | $24.33 | $9.06 | $4.87 |
| 92950 | S | | Heart/lung resuscitation cpr | 0094 | 2.6345 | $143.74 | $48.58 | $28.75 |
| 92953 | S | | Temporary external pacing | 0094 | 2.6345 | $143.74 | $48.58 | $28.75 |
| 92960 | S | | Cardioversion electric, ext | 0679 | 5.4887 | $299.47 | $95.30 | $59.89 |
| 92961 | S | | Cardioversion, electric, int | 0679 | 5.4887 | $299.47 | $95.30 | $59.89 |
| 92970 | C | | Cardioassist, internal | | | | | |
| 92971 | C | | Cardioassist, external | | | | | |
| 92973 | T | | Percut coronary thrombectomy | 1541 | | $250.00 | | $50.00 |
| 92974 | T | | Cath place, cardio brachytx | 1559 | | $2,250.00 | | $450.00 |
| 92975 | C | | Dissolve clot, heart vessel | | | | | |
| 92977 | T | | Dissolve clot, heart vessel | 0676 | 2.7315 | $149.03 | $40.30 | $29.81 |
| 92978 | S | | Intravasc us, heart add-on | 0670 | 27.4483 | $1,497.61 | $542.37 | $299.52 |
| 92979 | S | | Intravasc us, heart add-on | 0670 | 27.4483 | $1,497.61 | $542.37 | $299.52 |
| 92980 | T | | Insert intracoronary stent | 0104 | 82.6713 | $4,510.63 | | $902.13 |
| 92981 | T | | Insert intracoronary stent | 0104 | 82.6713 | $4,510.63 | | $902.13 |
| 92982 | T | | Coronary artery dilation | 0083 | 59.2047 | $3,230.27 | | $646.05 |
| 92984 | T | | Coronary artery dilation | 0083 | 59.2047 | $3,230.27 | | $646.05 |
| 92986 | T | | Revision of aortic valve | 0083 | 59.2047 | $3,230.27 | | $646.05 |
| 92987 | T | | Revision of mitral valve | 0083 | 59.2047 | $3,230.27 | | $646.05 |
| 92990 | T | | Revision of pulmonary valve | 0083 | 59.2047 | $3,230.27 | | $646.05 |
| 92992 | C | | Revision of heart chamber | | | | | |
| 92993 | C | | Revision of heart chamber | | | | | |
| 92995 | T | | Coronary atherectomy | 0082 | 110.2196 | $6,013.69 | $1,293.59 | $1,202.74 |
| 92996 | T | | Coronary atherectomy add-on | 0082 | 110.2196 | $6,013.69 | $1,293.59 | $1,202.74 |
| 92997 | T | | Pul art balloon repr, percut | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 92998 | T | | Pul art balloon repr, percut | 0081 | 35.0285 | $1,911.19 | | $382.24 |
| 93000 | B | | Electrocardiogram, complete | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 93005 | S | | Electrocardiogram, tracing | 0099 | 0.3703 | $20.20 | | $4.04 |
| 93010 | A | | Electrocardiogram report | | | | | |
| 93012 | N | | Transmission of ecg | | | | | |
| 93014 | B | | Report on transmitted ecg | | | | | |
| 93015 | B | | Cardiovascular stress test | | | | | |
| 93016 | B | | Cardiovascular stress test | | | | | |
| 93017 | X | | Cardiovascular stress test | 0100 | 1.5862 | $86.54 | $41.44 | $17.31 |
| 93018 | B | | Cardiovascular stress test | | | | | |
| 93024 | X | | Cardiac drug stress test | 0100 | 1.5862 | $86.54 | $41.44 | $17.31 |
| 93025 | X | | Microvolt t-wave assess | 0100 | 1.5862 | $86.54 | $41.44 | $17.31 |
| 93040 | B | | Rhythm ECG with report | | | | | |
| 93041 | S | | Rhythm ECG, tracing | 0099 | 0.3703 | $20.20 | | $4.04 |
| 93042 | B | | Rhythm ECG, report | | | | | |
| 93224 | B | | ECG monitor/report, 24 hrs | | | | | |
| 93225 | X | | ECG monitor/record, 24 hrs | 0097 | 1.0635 | $58.03 | $23.80 | $11.61 |
| 93226 | X | | ECG monitor/report, 24 hrs | 0097 | 1.0635 | $58.03 | $23.80 | $11.61 |
| 93227 | B | | ECG monitor/review, 24 hrs | | | | | |
| 93230 | B | | ECG monitor/report, 24 hrs | | | | | |
| 93231 | X | | Ecg monitor/record, 24 hrs | 0097 | 1.0635 | $58.03 | $23.80 | $11.61 |
| 93232 | X | | ECG monitor/report, 24 hrs | 0097 | 1.0635 | $58.03 | $23.80 | $11.61 |
| 93233 | B | | ECG monitor/review, 24 hrs | | | | | |
| 93235 | B | | ECG monitor/report, 24 hrs | | | | | |
| 93236 | X | | ECG monitor/report, 24 hrs | 0097 | 1.0635 | $58.03 | $23.80 | $11.61 |
| 93237 | B | | ECG monitor/review, 24 hrs | | | | | |
| 93268 | B | | ECG record/review | | | | | |
| 93270 | X | | ECG recording | 0097 | 1.0635 | $58.03 | $23.80 | $11.61 |
| 93271 | X | | Ecg/monitoring and analysis | 0097 | 1.0635 | $58.03 | $23.80 | $11.61 |
| 93272 | B | | Ecg/review, interpret only | | | | | |
| 93278 | S | | ECG/signal-averaged | 0099 | 0.3703 | $20.20 | | $4.04 |
| 93303 | S | | Echo transthoracic | 0269 | 3.2309 | $176.28 | $87.24 | $35.26 |
| 93304 | S | | Echo transthoracic | 0697 | 1.4415 | $78.65 | $39.32 | $15.73 |
| 93307 | S | | Echo exam of heart | 0269 | 3.2309 | $176.28 | $87.24 | $35.26 |
| 93308 | S | | Echo exam of heart | 0697 | 1.4415 | $78.65 | $39.32 | $15.73 |
| 93312 | S | | Echo transesophageal | 0270 | 5.8546 | $319.43 | $146.79 | $63.89 |
| 93313 | S | | Echo transesophageal | 0270 | 5.8546 | $319.43 | $146.79 | $63.89 |
| 93314 | N | | Echo transesophageal | | | | | |
| 93315 | S | | Echo transesophageal | 0270 | 5.8546 | $319.43 | $146.79 | $63.89 |
| 93316 | S | | Echo transesophageal | 0270 | 5.8546 | $319.43 | $146.79 | $63.89 |
| 93317 | N | | Echo transesophageal | | | | | |
| 93318 | S | | Echo transesophageal intraop | 0270 | 5.8546 | $319.43 | $146.79 | $63.89 |
| 93320 | S | | Doppler echo exam, heart | 0671 | 1.6384 | $89.39 | $44.69 | $17.88 |
| 93321 | S | | Doppler echo exam, heart | 0697 | 1.4415 | $78.65 | $39.32 | $15.73 |
| 93325 | S | | Doppler color flow add-on | 0697 | 1.4415 | $78.65 | $39.32 | $15.73 |
| 93350 | S | | Echo transthoracic | 0269 | 3.2309 | $176.28 | $87.24 | $35.26 |
| 93501 | T | | Right heart catheterization | 0080 | 36.0160 | $1,965.07 | $838.92 | $393.01 |
| 93503 | T | | Insert/place heart catheter | 0103 | 11.6202 | $634.01 | $223.63 | $126.80 |
| 93505 | T | | Biopsy of heart lining | 0103 | 11.6202 | $634.01 | $223.63 | $126.80 |
| 93508 | T | | Cath placement, angiography | 0080 | 36.0160 | $1,965.07 | $838.92 | $393.01 |
| 93510 | T | | Left heart catheterization | 0080 | 36.0160 | $1,965.07 | $838.92 | $393.01 |
| 93511 | T | | Left heart catheterization | 0080 | 36.0160 | $1,965.07 | $838.92 | $393.01 |
| 93514 | T | | Left heart catheterization | 0080 | 36.0160 | $1,965.07 | $838.92 | $393.01 |
| 93524 | T | | Left heart catheterization | 0080 | 36.0160 | $1,965.07 | $838.92 | $393.01 |
| 93526 | T | | Rt & Lt heart catheters | 0080 | 36.0160 | $1,965.07 | $838.92 | $393.01 |
| 93527 | T | | Rt & Lt heart catheters | 0080 | 36.0160 | $1,965.07 | $838.92 | $393.01 |
| 93528 | T | | Rt & Lt heart catheters | 0080 | 36.0160 | $1,965.07 | $838.92 | $393.01 |
| 93529 | T | | Rt, lt heart catheterization | 0080 | 36.0160 | $1,965.07 | $838.92 | $393.01 |
| 93530 | T | | Rt heart cath, congenital | 0080 | 36.0160 | $1,965.07 | $838.92 | $393.01 |
| 93531 | T | | R & l heart cath, congenital | 0080 | 36.0160 | $1,965.07 | $838.92 | $393.01 |
| 93532 | T | | R & l heart cath, congenital | 0080 | 36.0160 | $1,965.07 | $838.92 | $393.01 |
| 93533 | T | | R & l heart cath, congenital | 0080 | 36.0160 | $1,965.07 | $838.92 | $393.01 |
| 93539 | N | | Injection, cardiac cath | | | | | |
| 93540 | N | | Injection, cardiac cath | | | | | |
| 93541 | N | | Injection for lung angiogram | | | | | |
| 93542 | N | | Injection for heart x-rays | | | | | |
| 93543 | N | | Injection for heart x-rays | | | | | |
| 93544 | N | | Injection for aortography | | | | | |
| 93545 | N | | Inject for coronary x-rays | | | | | |
| 93555 | N | | Imaging, cardiac cath | | | | | |
| 93556 | N | | Imaging, cardiac cath | | | | | |
| 93561 | N | | Cardiac output measurement | | | | | |
| 93562 | N | | Cardiac output measurement | | | | | |
| 93571 | N | | Heart flow reserve measure | | | | | |
| 93572 | N | | Heart flow reserve measure | | | | | |
| 93580 | T | | Transcath closure of asd | 1559 | | $2,250.00 | | $450.00 |
| 93581 | T | | Transcath closure of vsd | 1559 | | $2,250.00 | | $450.00 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 93600 | T | | Bundle of His recording | 0087 | 39.8161 | $2,172.41 | | $434.48 |
| 93602 | T | | Intra-atrial recording | 0087 | 39.8161 | $2,172.41 | | $434.48 |
| 93603 | T | | Right ventricular recording | 0087 | 39.8161 | $2,172.41 | | $434.48 |
| 93609 | T | | Map tachycardia, add-on | 0087 | 39.8161 | $2,172.41 | | $434.48 |
| 93610 | T | | Intra-atrial pacing | 0087 | 39.8161 | $2,172.41 | | $434.48 |
| 93612 | T | | Intraventricular pacing | 0087 | 39.8161 | $2,172.41 | | $434.48 |
| 93613 | T | | Electrophys map 3d, add-on | 0087 | 39.8161 | $2,172.41 | | $434.48 |
| 93615 | T | | Esophageal recording | 0087 | 39.8161 | $2,172.41 | | $434.48 |
| 93616 | T | | Esophageal recording | 0087 | 39.8161 | $2,172.41 | | $434.48 |
| 93618 | T | | Heart rhythm pacing | 0087 | 39.8161 | $2,172.41 | | $434.48 |
| 93619 | T | | Electrophysiology evaluation | 0085 | 35.4126 | $1,932.15 | $426.25 | $386.43 |
| 93620 | T | | Electrophysiology evaluation | 0085 | 35.4126 | $1,932.15 | $426.25 | $386.43 |
| 93621 | T | | Electrophysiology evaluation | 0085 | 35.4126 | $1,932.15 | $426.25 | $386.43 |
| 93622 | T | | Electrophysiology evaluation | 0085 | 35.4126 | $1,932.15 | $426.25 | $386.43 |
| 93623 | T | | Stimulation, pacing heart | 0087 | 39.8161 | $2,172.41 | | $434.48 |
| 93624 | S | | Electrophysiologic study | 0084 | 10.5226 | $574.12 | | $114.82 |
| 93631 | T | | Heart pacing, mapping | 0087 | 39.8161 | $2,172.41 | | $434.48 |
| 93640 | S | | Evaluation heart device | 0084 | 10.5226 | $574.12 | | $114.82 |
| 93641 | S | | Electrophysiology evaluation | 0084 | 10.5226 | $574.12 | | $114.82 |
| 93642 | S | | Electrophysiology evaluation | 0084 | 10.5226 | $574.12 | | $114.82 |
| 93650 | T | | Ablate heart dysrhythm focus | 0086 | 44.9389 | $2,451.91 | $833.33 | $490.38 |
| 93651 | T | | Ablate heart dysrhythm focus | 0086 | 44.9389 | $2,451.91 | $833.33 | $490.38 |
| 93652 | T | | Ablate heart dysrhythm focus | 0086 | 44.9389 | $2,451.91 | $833.33 | $490.38 |
| 93660 | S | | Tilt table evaluation | 0101 | 4.4040 | $240.29 | $105.27 | $48.06 |
| 93662 | S | | Intracardiac ecg (ice) | 0670 | 27.4483 | $1,497.61 | $542.37 | $299.52 |
| 93668 | E | | Peripheral vascular rehab | | | | | |
| 93701 | S | | Bioimpedance, thoracic | 0099 | 0.3703 | $20.20 | | $4.04 |
| 93720 | B | | Total body plethysmography | | | | | |
| 93721 | X | | Plethysmography tracing | 0368 | 0.9319 | $50.85 | $25.42 | $10.17 |
| 93722 | B | | Plethysmography report | | | | | |
| 93724 | S | | Analyze pacemaker system | 0690 | 0.4074 | $22.23 | $10.63 | $4.45 |
| 93727 | S | | Analyze ilr system | 0690 | 0.4074 | $22.23 | $10.63 | $4.45 |
| 93731 | S | | Analyze pacemaker system | 0690 | 0.4074 | $22.23 | $10.63 | $4.45 |
| 93732 | S | | Analyze pacemaker system | 0690 | 0.4074 | $22.23 | $10.63 | $4.45 |
| 93733 | S | | Telephone analy, pacemaker | 0690 | 0.4074 | $22.23 | $10.63 | $4.45 |
| 93734 | S | | Analyze pacemaker system | 0690 | 0.4074 | $22.23 | $10.63 | $4.45 |
| 93735 | S | | Analyze pacemaker system | 0690 | 0.4074 | $22.23 | $10.63 | $4.45 |
| 93736 | S | | Telephonic analy, pacemaker | 0690 | 0.4074 | $22.23 | $10.63 | $4.45 |
| 93740 | X | | Temperature gradient studies | 0367 | 0.5887 | $32.12 | $15.16 | $6.42 |
| 93741 | S | | Analyze ht pace device sngl | 0689 | 0.5533 | $30.19 | | $6.04 |
| 93742 | S | | Analyze ht pace device sngl | 0689 | 0.5533 | $30.19 | | $6.04 |
| 93743 | S | | Analyze ht pace device dual | 0689 | 0.5533 | $30.19 | | $6.04 |
| 93744 | S | | Analyze ht pace device dual | 0689 | 0.5533 | $30.19 | | $6.04 |
| 93760 | E | | Cephalic thermogram | | | | | |
| 93762 | E | | Peripheral thermogram | | | | | |
| 93770 | N | | Measure venous pressure | | | | | |
| 93784 | E | | Ambulatory BP monitoring | | | | | |
| 93786 | X | | Ambulatory BP recording | 0097 | 1.0635 | $58.03 | $23.80 | $11.61 |
| 93788 | E | | Ambulatory BP analysis | | | | | |
| 93790 | B | | Review/report BP recording | | | | | |
| 93797 | S | | Cardiac rehab | 0095 | 0.5994 | $32.70 | $16.35 | $6.54 |
| 93798 | S | | Cardiac rehab/monitor | 0095 | 0.5994 | $32.70 | $16.35 | $6.54 |
| 93799 | S | | Cardiovascular procedure | 0096 | 1.7176 | $93.71 | $46.85 | $18.74 |
| 93875 | S | | Extracranial study | 0096 | 1.7176 | $93.71 | $46.85 | $18.74 |
| 93880 | S | | Extracranial study | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 93882 | S | | Extracranial study | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 93886 | S | | Intracranial study | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 93888 | S | | Intracranial study | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 93922 | S | | Extremity study | 0096 | 1.7176 | $93.71 | $46.85 | $18.74 |
| 93923 | S | | Extremity study | 0096 | 1.7176 | $93.71 | $46.85 | $18.74 |
| 93924 | S | | Extremity study | 0096 | 1.7176 | $93.71 | $46.85 | $18.74 |
| 93925 | S | | Lower extremity study | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 93926 | S | | Lower extremity study | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 93930 | S | | Upper extremity study | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 93931 | S | | Upper extremity study | 0266 | 1.6117 | $87.94 | $43.97 | $17.59 |
| 93965 | S | | Extremity study | 0096 | 1.7176 | $93.71 | $46.85 | $18.74 |
| 93970 | S | | Extremity study | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 93971 | S | | Extremity study | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 93975 | S | | Vascular study | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 93976 | S | | Vascular study | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 93978 | S | | Vascular study | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 93979 | S | | Vascular study | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 93980 | S | | Penile vascular study | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 93981 | S | | Penile vascular study | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |
| 93990 | S | | Doppler flow testing | 0267 | 2.4586 | $134.14 | $65.52 | $26.83 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 94010 | X | | Breathing capacity test | 0368 | 0.9319 | $50.85 | $25.42 | $10.17 |
| 94014 | X | | Patient recorded spirometry | 0367 | 0.5887 | $32.12 | $15.16 | $6.42 |
| 94015 | X | | Patient recorded spirometry | 0369 | 2.4984 | $136.32 | $44.18 | $27.26 |
| 94016 | A | | Review patient spirometry | | | | | |
| 94060 | X | | Evaluation of wheezing | 0368 | 0.9319 | $50.85 | $25.42 | $10.17 |
| 94070 | X | | Evaluation of wheezing | 0369 | 2.4984 | $136.32 | $44.18 | $27.26 |
| 94150 | X | | Vital capacity test | 0367 | 0.5887 | $32.12 | $15.16 | $6.42 |
| 94200 | X | | Lung function test (MBC/MVV) | 0367 | 0.5887 | $32.12 | $15.16 | $6.42 |
| 94240 | X | | Residual lung capacity | 0368 | 0.9319 | $50.85 | $25.42 | $10.17 |
| 94250 | X | | Expired gas collection | 0367 | 0.5887 | $32.12 | $15.16 | $6.42 |
| 94260 | X | | Thoracic gas volume | 0368 | 0.9319 | $50.85 | $25.42 | $10.17 |
| 94350 | X | | Lung nitrogen washout curve | 0368 | 0.9319 | $50.85 | $25.42 | $10.17 |
| 94360 | X | | Measure airflow resistance | 0367 | 0.5887 | $32.12 | $15.16 | $6.42 |
| 94370 | X | | Breath airway closing volume | 0367 | 0.5887 | $32.12 | $15.16 | $6.42 |
| 94375 | X | | Respiratory flow volume loop | 0367 | 0.5887 | $32.12 | $15.16 | $6.42 |
| 94400 | X | | CO2 breathing response curve | 0367 | 0.5887 | $32.12 | $15.16 | $6.42 |
| 94450 | X | | Hypoxia response curve | 0367 | 0.5887 | $32.12 | $15.16 | $6.42 |
| 94620 | X | | Pulmonary stress test/simple | 0368 | 0.9319 | $50.85 | $25.42 | $10.17 |
| 94621 | X | | Pulm stress test/complex | 0369 | 2.4984 | $136.32 | $44.18 | $27.26 |
| 94640 | S | | Airway inhalation treatment | 0077 | 0.2837 | $15.48 | $7.74 | $3.10 |
| 94642 | S | | Aerosol inhalation treatment | 0078 | 0.7917 | $43.20 | $14.55 | $8.64 |
| 94656 | S | | Initial ventilator mgmt | 0079 | 2.1494 | $117.27 | | $23.45 |
| 94657 | S | | Continued ventilator mgmt | 0079 | 2.1494 | $117.27 | | $23.45 |
| 94660 | S | | Pos airway pressure, CPAP | 0068 | 1.0807 | $58.96 | $29.48 | $11.79 |
| 94662 | S | | Neg press ventilation, cnp | 0079 | 2.1494 | $117.27 | | $23.45 |
| 94664 | S | | Aerosol or vapor inhalations | 0077 | 0.2837 | $15.48 | $7.74 | $3.10 |
| 94667 | S | | Chest wall manipulation | 0077 | 0.2837 | $15.48 | $7.74 | $3.10 |
| 94668 | S | | Chest wall manipulation | 0077 | 0.2837 | $15.48 | $7.74 | $3.10 |
| 94680 | X | | Exhaled air analysis, o2 | 0367 | 0.5887 | $32.12 | $15.16 | $6.42 |
| 94681 | X | | Exhaled air analysis, o2/co2 | 0368 | 0.9319 | $50.85 | $25.42 | $10.17 |
| 94690 | X | | Exhaled air analysis | 0367 | 0.5887 | $32.12 | $15.16 | $6.42 |
| 94720 | X | | Monoxide diffusing capacity | 0368 | 0.9319 | $50.85 | $25.42 | $10.17 |
| 94725 | X | | Membrane diffusion capacity | 0368 | 0.9319 | $50.85 | $25.42 | $10.17 |
| 94750 | X | | Pulmonary compliance study | 0367 | 0.5887 | $32.12 | $15.16 | $6.42 |
| 94760 | N | | Measure blood oxygen level | | | | | |
| 94761 | N | | Measure blood oxygen level | | | | | |
| 94762 | N | | Measure blood oxygen level | | | | | |
| 94770 | X | | Exhaled carbon dioxide test | 0367 | 0.5887 | $32.12 | $15.16 | $6.42 |
| 94772 | X | | Breath recording, infant | 0369 | 2.4984 | $136.32 | $44.18 | $27.26 |
| 94799 | X | | Pulmonary service/procedure | 0367 | 0.5887 | $32.12 | $15.16 | $6.42 |
| 95004 | X | | Percut allergy skin tests | 0370 | 0.9185 | $50.11 | $11.58 | $10.02 |
| 95010 | X | | Percut allergy titrate test | 0370 | 0.9185 | $50.11 | $11.58 | $10.02 |
| 95015 | X | | Id allergy titrate-drug/bug | 0370 | 0.9185 | $50.11 | $11.58 | $10.02 |
| 95024 | X | | Id allergy test, drug/bug | 0370 | 0.9185 | $50.11 | $11.58 | $10.02 |
| 95027 | X | | Skin end point titration | 0370 | 0.9185 | $50.11 | $11.58 | $10.02 |
| 95028 | X | | Id allergy test-delayed type | 0370 | 0.9185 | $50.11 | $11.58 | $10.02 |
| 95044 | X | | Allergy patch tests | 0370 | 0.9185 | $50.11 | $11.58 | $10.02 |
| 95052 | X | | Photo patch test | 0370 | 0.9185 | $50.11 | $11.58 | $10.02 |
| 95056 | X | | Photosensitivity tests | 0370 | 0.9185 | $50.11 | $11.58 | $10.02 |
| 95060 | X | | Eye allergy tests | 0370 | 0.9185 | $50.11 | $11.58 | $10.02 |
| 95065 | X | | Nose allergy test | 0370 | 0.9185 | $50.11 | $11.58 | $10.02 |
| 95070 | X | | Bronchial allergy tests | 0369 | 2.4984 | $136.32 | $44.18 | $27.26 |
| 95071 | X | | Bronchial allergy tests | 0369 | 2.4984 | $136.32 | $44.18 | $27.26 |
| 95075 | X | | Ingestion challenge test | 0361 | 3.5510 | $193.75 | $83.23 | $38.75 |
| 95078 | X | | Provocative testing | 0370 | 0.9185 | $50.11 | $11.58 | $10.02 |
| 95115 | X | | Immunotherapy, one injection | 0352 | 0.1230 | $6.71 | | $1.34 |
| 95117 | X | | Immunotherapy injections | 0353 | 0.3982 | $21.73 | | $4.35 |
| 95120 | B | | Immunotherapy, one injection | | | | | |
| 95125 | B | | Immunotherapy, many antigens | | | | | |
| 95130 | B | | Immunotherapy, insect venom | | | | | |
| 95131 | B | | Immunotherapy, insect venoms | | | | | |
| 95132 | B | | Immunotherapy, insect venoms | | | | | |
| 95133 | B | | Immunotherapy, insect venoms | | | | | |
| 95134 | B | | Immunotherapy, insect venoms | | | | | |
| 95144 | X | | Antigen therapy services | 0371 | 0.4105 | $22.40 | | $4.48 |
| 95145 | X | | Antigen therapy services | 0371 | 0.4105 | $22.40 | | $4.48 |
| 95146 | X | | Antigen therapy services | 0371 | 0.4105 | $22.40 | | $4.48 |
| 95147 | X | | Antigen therapy services | 0371 | 0.4105 | $22.40 | | $4.48 |
| 95148 | X | | Antigen therapy services | 0371 | 0.4105 | $22.40 | | $4.48 |
| 95149 | X | | Antigen therapy services | 0371 | 0.4105 | $22.40 | | $4.48 |
| 95165 | X | | Antigen therapy services | 0371 | 0.4105 | $22.40 | | $4.48 |
| 95170 | X | | Antigen therapy services | 0371 | 0.4105 | $22.40 | | $4.48 |
| 95180 | X | | Rapid desensitization | 0370 | 0.9185 | $50.11 | $11.58 | $10.02 |
| 95199 | X | | Allergy immunology services | 0370 | 0.9185 | $50.11 | $11.58 | $10.02 |
| 95250 | T | | Glucose monitoring, cont | 1540 | | $150.00 | | $30.00 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 95805 | S | | Multiple sleep latency test | 0209 | 11.5435 | $629.82 | $280.58 | $125.96 |
| 95806 | S | | Sleep study, unattended | 0213 | 2.9055 | $158.53 | $65.74 | $31.71 |
| 95807 | S | | Sleep study, attended | 0209 | 11.5435 | $629.82 | $280.58 | $125.96 |
| 95808 | S | | Polysomnography, 1-3 | 0209 | 11.5435 | $629.82 | $280.58 | $125.96 |
| 95810 | S | | Polysomnography, 4 or more | 0209 | 11.5435 | $629.82 | $280.58 | $125.96 |
| 95811 | S | | Polysomnography w/cpap | 0209 | 11.5435 | $629.82 | $280.58 | $125.96 |
| 95812 | S | | Electroencephalogram (EEG) | 0213 | 2.9055 | $158.53 | $65.74 | $31.71 |
| 95813 | S | | Eeg, over 1 hour | 0213 | 2.9055 | $158.53 | $65.74 | $31.71 |
| 95816 | S | | Electroencephalogram (EEG) | 0214 | 2.2176 | $120.99 | $58.12 | $24.20 |
| 95819 | S | | Electroencephalogram (EEG) | 0214 | 2.2176 | $120.99 | $58.12 | $24.20 |
| 95822 | S | | Sleep electroencephalogram | 0214 | 2.2176 | $120.99 | $58.12 | $24.20 |
| 95824 | S | | Eeg, cerebral death only | 0214 | 2.2176 | $120.99 | $58.12 | $24.20 |
| 95827 | S | | night electroencephalogram | 0209 | 11.5435 | $629.82 | $280.58 | $125.96 |
| 95829 | S | | Surgery electrocorticogram | 0214 | 2.2176 | $120.99 | $58.12 | $24.20 |
| 95830 | B | | Insert electrodes for EEG | | | | | |
| 95831 | A | | Limb muscle testing, manual | | | | | |
| 95832 | A | | Hand muscle testing, manual | | | | | |
| 95833 | A | | Body muscle testing, manual | | | | | |
| 95834 | A | | Body muscle testing, manual | | | | | |
| 95851 | A | | Range of motion measurements | | | | | |
| 95852 | A | | Range of motion measurements | | | | | |
| 95857 | S | | Tensilon test | 0218 | 1.1404 | $62.22 | | $12.44 |
| 95858 | S | | Tensilon test & myogram | 0215 | 0.6457 | $35.23 | $15.76 | $7.05 |
| 95860 | S | | Muscle test, one limb | 0218 | 1.1404 | $62.22 | | $12.44 |
| 95861 | S | | Muscle test, 2 limbs | 0218 | 1.1404 | $62.22 | | $12.44 |
| 95863 | S | | Muscle test, 3 limbs | 0218 | 1.1404 | $62.22 | | $12.44 |
| 95864 | S | | Muscle test, 4 limbs | 0218 | 1.1404 | $62.22 | | $12.44 |
| 95867 | S | | Muscle test, head or neck | 0218 | 1.1404 | $62.22 | | $12.44 |
| 95868 | S | | Muscle test cran nerve bilat | 0218 | 1.1404 | $62.22 | | $12.44 |
| 95869 | S | | Muscle test, thor paraspinal | 0215 | 0.6457 | $35.23 | $15.76 | $7.05 |
| 95870 | S | | Muscle test, nonparaspinal | 0215 | 0.6457 | $35.23 | $15.76 | $7.05 |
| 95872 | S | | Muscle test, one fiber | 0218 | 1.1404 | $62.22 | | $12.44 |
| 95875 | S | | Limb exercise test | 0215 | 0.6457 | $35.23 | $15.76 | $7.05 |
| 95900 | S | | Motor nerve conduction test | 0215 | 0.6457 | $35.23 | $15.76 | $7.05 |
| 95903 | S | | Motor nerve conduction test | 0215 | 0.6457 | $35.23 | $15.76 | $7.05 |
| 95904 | S | | Sense nerve conduction test | 0215 | 0.6457 | $35.23 | $15.76 | $7.05 |
| 95920 | S | | Intraop nerve test add-on | 0216 | 2.8535 | $155.69 | $67.98 | $31.14 |
| 95921 | S | | Autonomic nerv function test | 0218 | 1.1404 | $62.22 | | $12.44 |
| 95922 | S | | Autonomic nerv function test | 0218 | 1.1404 | $62.22 | | $12.44 |
| 95923 | S | | Autonomic nerv function test | 0215 | 0.6457 | $35.23 | $15.76 | $7.05 |
| 95925 | S | | Somatosensory testing | 0216 | 2.8535 | $155.69 | $67.98 | $31.14 |
| 95926 | S | | Somatosensory testing | 0216 | 2.8535 | $155.69 | $67.98 | $31.14 |
| 95927 | S | | Somatosensory testing | 0216 | 2.8535 | $155.69 | $67.98 | $31.14 |
| 95930 | S | | Visual evoked potential test | 0218 | 1.1404 | $62.22 | | $12.44 |
| 95933 | S | | Blink reflex test | 0215 | 0.6457 | $35.23 | $15.76 | $7.05 |
| 95934 | S | | H-reflex test | 0215 | 0.6457 | $35.23 | $15.76 | $7.05 |
| 95936 | S | | H-reflex test | 0215 | 0.6457 | $35.23 | $15.76 | $7.05 |
| 95937 | S | | Neuromuscular junction test | 0218 | 1.1404 | $62.22 | | $12.44 |
| 95950 | S | | Ambulatory eeg monitoring | 0213 | 2.9055 | $158.53 | $65.74 | $31.71 |
| 95951 | S | | EEG monitoring/videorecord | 0209 | 11.5435 | $629.82 | $280.58 | $125.96 |
| 95953 | S | | EEG monitoring/computer | 0209 | 11.5435 | $629.82 | $280.58 | $125.96 |
| 95954 | S | | EEG monitoring/giving drugs | 0214 | 2.2176 | $120.99 | $58.12 | $24.20 |
| 95955 | S | | EEG during surgery | 0213 | 2.9055 | $158.53 | $65.74 | $31.71 |
| 95956 | S | | Eeg monitoring, cable/radio | 0214 | 2.2176 | $120.99 | $58.12 | $24.20 |
| 95957 | S | | EEG digital analysis | 0214 | 2.2176 | $120.99 | $58.12 | $24.20 |
| 95958 | S | | EEG monitoring/function test | 0213 | 2.9055 | $158.53 | $65.74 | $31.71 |
| 95961 | S | | Electrode stimulation, brain | 0216 | 2.8535 | $155.69 | $67.98 | $31.14 |
| 95962 | S | | Electrode stim, brain add-on | 0216 | 2.8535 | $155.69 | $67.98 | $31.14 |
| 95965 | S | | Meg, spontaneous | 1528 | | $5,250.00 | | $1,050.00 |
| 95966 | S | | Meg, evoked, single | 1516 | | $1,450.00 | | $290.00 |
| 95967 | S | | Meg, evoked, each add'l | 1511 | | $950.00 | | $190.00 |
| 95970 | S | | Analyze neurostim, no prog | 0692 | 1.1057 | $60.33 | $30.16 | $12.07 |
| 95971 | S | | Analyze neurostim, simple | 0692 | 1.1057 | $60.33 | $30.16 | $12.07 |
| 95972 | S | | Analyze neurostim, complex | 0692 | 1.1057 | $60.33 | $30.16 | $12.07 |
| 95973 | S | | Analyze neurostim, complex | 0692 | 1.1057 | $60.33 | $30.16 | $12.07 |
| 95974 | S | | Cranial neurostim, complex | 0692 | 1.1057 | $60.33 | $30.16 | $12.07 |
| 95975 | S | | Cranial neurostim, complex | 0692 | 1.1057 | $60.33 | $30.16 | $12.07 |
| 95990 | T | | Spin/brain pump refil & main | 0125 | 2.1606 | $117.88 | | $23.58 |
| 95991 | T | NI | Spin/brain pump refil & main | 0125 | 2.1606 | $117.88 | | $23.58 |
| 95999 | S | | Neurological procedure | 0215 | 0.6457 | $35.23 | $15.76 | $7.05 |
| 96000 | S | | Motion analysis, video/3d | 1503 | | $150.00 | | $30.00 |
| 96001 | S | | Motion test w/ft press meas | 1503 | | $150.00 | | $30.00 |
| 96002 | S | | Dynamic surface emg | 1503 | | $150.00 | | $30.00 |
| 96003 | S | | Dynamic fine wire emg | 1503 | | $150.00 | | $30.00 |
| 96004 | E | | Phys review of motion tests | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 96100 | X | | Psychological testing | 0373 | 2.0899 | $114.03 | | $22.81 |
| 96105 | A | | Assessment of aphasia | | | | | |
| 96110 | X | | Developmental test, lim | 0373 | 2.0899 | $114.03 | | $22.81 |
| 96111 | X | | Developmental test, extend | 0373 | 2.0899 | $114.03 | | $22.81 |
| 96115 | X | | Neurobehavior status exam | 0373 | 2.0899 | $114.03 | | $22.81 |
| 96117 | X | | Neuropsych test battery | 0373 | 2.0899 | $114.03 | | $22.81 |
| 96150 | S | | Assess lth/behave, init | 0322 | 1.2802 | $69.85 | | $13.97 |
| 96151 | S | | Assess hlth/behave, subseq | 0322 | 1.2802 | $69.85 | | $13.97 |
| 96152 | S | | Intervene hlth/behave, indiv | 0322 | 1.2802 | $69.85 | | $13.97 |
| 96153 | S | | Intervene hlth/behave, group | 0322 | 1.2802 | $69.85 | | $13.97 |
| 96154 | S | | Interv hlth/behav, fam w/pt | 0322 | 1.2802 | $69.85 | | $13.97 |
| 96155 | S | | Interv hlth/behav fam no pt | 0322 | 1.2802 | $69.85 | | $13.97 |
| 96400 | B | | Chemotherapy, sc/im | | | | | |
| 96405 | B | | Intralesional chemo admin | | | | | |
| 96406 | B | | Intralesional chemo admin | | | | | |
| 96408 | B | | Chemotherapy, push technique | | | | | |
| 96410 | B | | Chemotherapy,infusion method | | | | | |
| 96412 | B | | Chemo, infuse method add-on | | | | | |
| 96414 | B | | Chemo, infuse method add-on | | | | | |
| 96420 | B | | Chemotherapy, push technique | | | | | |
| 96422 | B | | Chemotherapy,infusion method | | | | | |
| 96423 | B | | Chemo, infuse method add-on | | | | | |
| 96425 | B | | Chemotherapy,infusion method | | | | | |
| 96440 | B | | Chemotherapy, intracavitary | | | | | |
| 96445 | B | | Chemotherapy, intracavitary | | | | | |
| 96450 | B | | Chemotherapy, into CNS | | | | | |
| 96520 | T | | Port pump refill & main | 0125 | 2.1606 | $117.88 | | $23.58 |
| 96530 | T | | Pump refilling, maintenance | 0125 | 2.1606 | $117.88 | | $23.58 |
| 96542 | B | | Chemotherapy injection | | | | | |
| 96545 | B | | Provide chemotherapy agent | | | | | |
| 96549 | B | | Chemotherapy, unspecified | | | | | |
| 96567 | T | | Photodynamic tx, skin | 1540 | | $150.00 | | $30.00 |
| 96570 | T | | Photodynamic tx, 30 min | 1541 | | $250.00 | | $50.00 |
| 96571 | T | | Photodynamic tx, addl 15 min | 1541 | | $250.00 | | $50.00 |
| 96900 | S | | Ultraviolet light therapy | 0001 | 0.4237 | $23.12 | $7.09 | $4.62 |
| 96902 | N | | Trichogram | | | | | |
| 96910 | S | | Photochemotherapy with UV-B | 0001 | 0.4237 | $23.12 | $7.09 | $4.62 |
| 96912 | S | | Photochemotherapy with UV-A | 0001 | 0.4237 | $23.12 | $7.09 | $4.62 |
| 96913 | S | | Photochemotherapy, UV-A or B | 0683 | 1.5489 | $84.51 | $30.42 | $16.90 |
| 96920 | T | | Laser tx, skin < 250 sq cm | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 96921 | T | | Laser tx, skin 250-500 sq cm | 0012 | 0.7694 | $41.98 | $11.18 | $8.40 |
| 96922 | T | | Laser tx, skin > 500 sq cm | 0013 | 1.1272 | $61.50 | $14.20 | $12.30 |
| 96999 | T | | Dermatological procedure | 0010 | 0.6480 | $35.36 | $10.08 | $7.07 |
| 97001 | A | | Pt evaluation | | | | | |
| 97002 | A | | Pt re-evaluation | | | | | |
| 97003 | A | | Ot evaluation | | | | | |
| 97004 | A | | Ot re-evaluation | | | | | |
| 97005 | E | | Athletic train eval | | | | | |
| 97006 | E | | Athletic train reeval | | | | | |
| 97010 | A | | Hot or cold packs therapy | | | | | |
| 97012 | A | | Mechanical traction therapy | | | | | |
| 97014 | E | | Electric stimulation therapy | | | | | |
| 97016 | A | | Vasopneumatic device therapy | | | | | |
| 97018 | A | | Paraffin bath therapy | | | | | |
| 97020 | A | | Microwave therapy | | | | | |
| 97022 | A | | Whirlpool therapy | | | | | |
| 97024 | A | | Diathermy treatment | | | | | |
| 97026 | A | | Infrared therapy | | | | | |
| 97028 | A | | Ultraviolet therapy | | | | | |
| 97032 | A | | Electrical stimulation | | | | | |
| 97033 | A | | Electric current therapy | | | | | |
| 97034 | A | | Contrast bath therapy | | | | | |
| 97035 | A | | Ultrasound therapy | | | | | |
| 97036 | A | | Hydrotherapy | | | | | |
| 97039 | A | | Physical therapy treatment | | | | | |
| 97110 | A | | Therapeutic exercises | | | | | |
| 97112 | A | | Neuromuscular reeducation | | | | | |
| 97113 | A | | Aquatic therapy/exercises | | | | | |
| 97116 | A | | Gait training therapy | | | | | |
| 97124 | A | | Massage therapy | | | | | |
| 97139 | A | | Physical medicine procedure | | | | | |
| 97140 | A | | Manual therapy | | | | | |
| 97150 | A | | Group therapeutic procedures | | | | | |
| 97504 | A | | Orthotic training | | | | | |
| 97520 | A | | Prosthetic training | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 97530 | A | | Therapeutic activities | | | | | |
| 97532 | A | | Cognitive skills development | | | | | |
| 97533 | A | | Sensory integration | | | | | |
| 97535 | A | | Self care mngment training | | | | | |
| 97537 | A | | Community/work reintegration | | | | | |
| 97542 | A | | Wheelchair mngment training | | | | | |
| 97545 | A | | Work hardening | | | | | |
| 97546 | A | | Work hardening add-on | | | | | |
| 97601 | A | | Wound(s) care, selective | | | | | |
| 97602 | N | | Wound(s) care non-selective | | | | | |
| 97703 | A | | Prosthetic checkout | | | | | |
| 97750 | A | | Physical performance test | | | | | |
| 97755 | A | NI | Assistive technology assess | | | | | |
| 97780 | E | | Acupuncture w/o stimul | | | | | |
| 97781 | E | | Acupuncture w/stimul | | | | | |
| 97799 | A | | Physical medicine procedure | | | | | |
| 97802 | A | | Medical nutrition, indiv, in | | | | | |
| 97803 | A | | Med nutrition, indiv, subseq | | | | | |
| 97804 | A | | Medical nutrition, group | | | | | |
| 98925 | S | | Osteopathic manipulation | 0060 | 0.2788 | $15.21 | | $3.04 |
| 98926 | S | | Osteopathic manipulation | 0060 | 0.2788 | $15.21 | | $3.04 |
| 98927 | S | | Osteopathic manipulation | 0060 | 0.2788 | $15.21 | | $3.04 |
| 98928 | S | | Osteopathic manipulation | 0060 | 0.2788 | $15.21 | | $3.04 |
| 98929 | S | | Osteopathic manipulation | 0060 | 0.2788 | $15.21 | | $3.04 |
| 98940 | S | | Chiropractic manipulation | 0060 | 0.2788 | $15.21 | | $3.04 |
| 98941 | S | | Chiropractic manipulation | 0060 | 0.2788 | $15.21 | | $3.04 |
| 98942 | S | | Chiropractic manipulation | 0060 | 0.2788 | $15.21 | | $3.04 |
| 98943 | E | | Chiropractic manipulation | | | | | |
| 99000 | B | | Specimen handling | | | | | |
| 99001 | B | | Specimen handling | | | | | |
| 99002 | E | | Device handling | | | | | |
| 99024 | B | | Postop follow-up visit | | | | | |
| 99025 | B | DG | Initial surgical evaluation | | | | | |
| 99026 | E | | In-hospital on call service | | | | | |
| 99027 | E | | Out-of-hosp on call service | | | | | |
| 99050 | B | | Medical services after hrs | | | | | |
| 99052 | B | | Medical services at night | | | | | |
| 99054 | B | | Medical servcs, unusual hrs | | | | | |
| 99056 | B | | Non-office medical services | | | | | |
| 99058 | B | | Office emergency care | | | | | |
| 99070 | B | | Special supplies | | | | | |
| 99071 | B | | Patient education materials | | | | | |
| 99075 | E | | Medical testimony | | | | | |
| 99078 | N | | Group health education | | | | | |
| 99080 | B | | Special reports or forms | | | | | |
| 99082 | B | | Unusual physician travel | | | | | |
| 99090 | B | | Computer data analysis | | | | | |
| 99091 | E | | Collect/review data from pt | | | | | |
| 99100 | B | | Special anesthesia service | | | | | |
| 99116 | B | | Anesthesia with hypothermia | | | | | |
| 99135 | B | | Special anesthesia procedure | | | | | |
| 99140 | E | | Emergency anesthesia | | | | | |
| 99141 | N | | Sedation, iv/im or inhalant | | | | | |
| 99142 | N | | Sedation, oral/rectal/nasal | | | | | |
| 99170 | T | | Anogenital exam, child | 0191 | 0.1853 | $10.11 | $2.93 | $2.02 |
| 99172 | E | | Ocular function screen | | | | | |
| 99173 | E | | Visual acuity screen | | | | | |
| 99175 | N | | Induction of vomiting | | | | | |
| 99183 | B | | Hyperbaric oxygen therapy | | | | | |
| 99185 | N | | Regional hypothermia | | | | | |
| 99186 | N | | Total body hypothermia | | | | | |
| 99190 | C | | Special pump services | | | | | |
| 99191 | C | | Special pump services | | | | | |
| 99192 | C | | Special pump services | | | | | |
| 99195 | X | | Phlebotomy | 0372 | 0.5607 | $30.59 | $10.09 | $6.12 |
| 99199 | B | | Special service/proc/report | | | | | |
| 99201 | V | | Office/outpatient visit, new | 0600 | 0.9278 | $50.62 | | $10.12 |
| 99202 | V | | Office/outpatient visit, new | 0600 | 0.9278 | $50.62 | | $10.12 |
| 99203 | V | | Office/outpatient visit, new | 0601 | 0.9816 | $53.56 | | $10.71 |
| 99204 | V | | Office/outpatient visit, new | 0602 | 1.5041 | $82.07 | | $16.41 |
| 99205 | V | | Office/outpatient visit, new | 0602 | 1.5041 | $82.07 | | $16.41 |
| 99211 | V | | Office/outpatient visit, est | 0600 | 0.9278 | $50.62 | | $10.12 |
| 99212 | V | | Office/outpatient visit, est | 0600 | 0.9278 | $50.62 | | $10.12 |
| 99213 | V | | Office/outpatient visit, est | 0601 | 0.9816 | $53.56 | | $10.71 |
| 99214 | V | | Office/outpatient visit, est | 0602 | 1.5041 | $82.07 | | $16.41 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 99215 | V | | Office/outpatient visit, est | 0602 | 1.5041 | $82.07 | | $16.41 |
| 99217 | N | | Observation care discharge | | | | | |
| 99218 | N | | Observation care | | | | | |
| 99219 | N | | Observation care | | | | | |
| 99220 | N | | Observation care | | | | | |
| 99221 | E | | Initial hospital care | | | | | |
| 99222 | E | | Initial hospital care | | | | | |
| 99223 | E | | Initial hospital care | | | | | |
| 99231 | E | | Subsequent hospital care | | | | | |
| 99232 | E | | Subsequent hospital care | | | | | |
| 99233 | E | | Subsequent hospital care | | | | | |
| 99234 | N | | Observ/hosp same date | | | | | |
| 99235 | N | | Observ/hosp same date | | | | | |
| 99236 | N | | Observ/hosp same date | | | | | |
| 99238 | E | | Hospital discharge day | | | | | |
| 99239 | E | | Hospital discharge day | | | | | |
| 99241 | V | | Office consultation | 0600 | 0.9278 | $50.62 | | $10.12 |
| 99242 | V | | Office consultation | 0600 | 0.9278 | $50.62 | | $10.12 |
| 99243 | V | | Office consultation | 0601 | 0.9816 | $53.56 | | $10.71 |
| 99244 | V | | Office consultation | 0602 | 1.5041 | $82.07 | | $16.41 |
| 99245 | V | | Office consultation | 0602 | 1.5041 | $82.07 | | $16.41 |
| 99251 | C | | Initial inpatient consult | | | | | |
| 99252 | C | | Initial inpatient consult | | | | | |
| 99253 | C | | Initial inpatient consult | | | | | |
| 99254 | C | | Initial inpatient consult | | | | | |
| 99255 | C | | Initial inpatient consult | | | | | |
| 99261 | C | | Follow-up inpatient consult | | | | | |
| 99262 | C | | Follow-up inpatient consult | | | | | |
| 99263 | C | | Follow-up inpatient consult | | | | | |
| 99271 | V | | Confirmatory consultation | 0600 | 0.9278 | $50.62 | | $10.12 |
| 99272 | V | | Confirmatory consultation | 0600 | 0.9278 | $50.62 | | $10.12 |
| 99273 | V | | Confirmatory consultation | 0601 | 0.9816 | $53.56 | | $10.71 |
| 99274 | V | | Confirmatory consultation | 0602 | 1.5041 | $82.07 | | $16.41 |
| 99275 | V | | Confirmatory consultation | 0602 | 1.5041 | $82.07 | | $16.41 |
| 99281 | V | | Emergency dept visit | 0610 | 1.3691 | $74.70 | $19.57 | $14.94 |
| 99282 | V | | Emergency dept visit | 0610 | 1.3691 | $74.70 | $19.57 | $14.94 |
| 99283 | V | | Emergency dept visit | 0611 | 2.3967 | $130.77 | $36.16 | $26.15 |
| 99284 | V | | Emergency dept visit | 0612 | 4.1476 | $226.30 | $54.12 | $45.26 |
| 99285 | V | | Emergency dept visit | 0612 | 4.1476 | $226.30 | $54.12 | $45.26 |
| 99288 | B | | Direct advanced life support | | | | | |
| 99289 | N | | Pt transport, 30-74 min | | | | | |
| 99290 | N | | Pt transport, addl 30 min | | | | | |
| 99291 | S | | Critical care, first hour | 0620 | 8.9992 | $491.01 | $142.30 | $98.20 |
| 99292 | N | | Critical care, add'l 30 min | | | | | |
| 99293 | C | | Ped critical care, initial | | | | | |
| 99294 | C | | Ped critical care, subseq | | | | | |
| 99295 | C | | Neonatal critical care | | | | | |
| 99296 | C | | Neonatal critical care | | | | | |
| 99298 | C | | Neonatal critical care | | | | | |
| 99299 | C | | Ic, lbw infant 1500-2500 gm | | | | | |
| 99301 | B | | Nursing facility care | | | | | |
| 99302 | B | | Nursing facility care | | | | | |
| 99303 | B | | Nursing facility care | | | | | |
| 99311 | B | | Nursing fac care, subseq | | | | | |
| 99312 | B | | Nursing fac care, subseq | | | | | |
| 99313 | B | | Nursing fac care, subseq | | | | | |
| 99315 | B | | Nursing fac discharge day | | | | | |
| 99316 | B | | Nursing fac discharge day | | | | | |
| 99321 | B | | Rest home visit, new patient | | | | | |
| 99322 | B | | Rest home visit, new patient | | | | | |
| 99323 | B | | Rest home visit, new patient | | | | | |
| 99331 | B | | Rest home visit, est pat | | | | | |
| 99332 | B | | Rest home visit, est pat | | | | | |
| 99333 | B | | Rest home visit, est pat | | | | | |
| 99341 | B | | Home visit, new patient | | | | | |
| 99342 | B | | Home visit, new patient | | | | | |
| 99343 | B | | Home visit, new patient | | | | | |
| 99344 | B | | Home visit, new patient | | | | | |
| 99345 | B | | Home visit, new patient | | | | | |
| 99347 | B | | Home visit, est patient | | | | | |
| 99348 | B | | Home visit, est patient | | | | | |
| 99349 | B | | Home visit, est patient | | | | | |
| 99350 | B | | Home visit, est patient | | | | | |
| 99354 | N | | Prolonged service, office | | | | | |
| 99355 | N | | Prolonged service, office | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 99356 | C | | Prolonged service, inpatient | | | | | |
| 99357 | C | | Prolonged service, inpatient | | | | | |
| 99358 | N | | Prolonged serv, w/o contact | | | | | |
| 99359 | N | | Prolonged serv, w/o contact | | | | | |
| 99360 | B | | Physician standby services | | | | | |
| 99361 | E | | Physician/team conference | | | | | |
| 99362 | E | | Physician/team conference | | | | | |
| 99371 | B | | Physician phone consultation | | | | | |
| 99372 | B | | Physician phone consultation | | | | | |
| 99373 | B | | Physician phone consultation | | | | | |
| 99374 | B | | Home health care supervision | | | | | |
| 99377 | B | | Hospice care supervision | | | | | |
| 99379 | B | | Nursing fac care supervision | | | | | |
| 99380 | B | | Nursing fac care supervision | | | | | |
| 99381 | E | | Prev visit, new, infant | | | | | |
| 99382 | E | | Prev visit, new, age 1-4 | | | | | |
| 99383 | E | | Prev visit, new, age 5-11 | | | | | |
| 99384 | E | | Prev visit, new, age 12-17 | | | | | |
| 99385 | E | | Prev visit, new, age 18-39 | | | | | |
| 99386 | E | | Prev visit, new, age 40-64 | | | | | |
| 99387 | E | | Prev visit, new, 65 & over | | | | | |
| 99391 | E | | Prev visit, est, infant | | | | | |
| 99392 | E | | Prev visit, est, age 1-4 | | | | | |
| 99393 | E | | Prev visit, est, age 5-11 | | | | | |
| 99394 | E | | Prev visit, est, age 12-17 | | | | | |
| 99395 | E | | Prev visit, est, age 18-39 | | | | | |
| 99396 | E | | Prev visit, est, age 40-64 | | | | | |
| 99397 | E | | Prev visit, est, 65 & over | | | | | |
| 99401 | E | | Preventive counseling, indiv | | | | | |
| 99402 | E | | Preventive counseling, indiv | | | | | |
| 99403 | E | | Preventive counseling, indiv | | | | | |
| 99404 | E | | Preventive counseling, indiv | | | | | |
| 99411 | E | | Preventive counseling, group | | | | | |
| 99412 | E | | Preventive counseling, group | | | | | |
| 99420 | E | | Health risk assessment test | | | | | |
| 99429 | E | | Unlisted preventive service | | | | | |
| 99431 | V | | Initial care, normal newborn | 0600 | 0.9278 | $50.62 | | $10.12 |
| 99432 | N | | Newborn care, not in hosp | | | | | |
| 99433 | C | | Normal newborn care/hospital | | | | | |
| 99435 | E | | Newborn discharge day hosp | | | | | |
| 99436 | N | | Attendance, birth | | | | | |
| 99440 | S | | Newborn resuscitation | 0094 | 2.6345 | $143.74 | $48.58 | $28.75 |
| 99450 | E | | Life/disability evaluation | | | | | |
| 99455 | B | | Disability examination | | | | | |
| 99456 | B | | Disability examination | | | | | |
| 99499 | B | | Unlisted e&m service | | | | | |
| 99500 | E | | Home visit, prenatal | | | | | |
| 99501 | E | | Home visit, postnatal | | | | | |
| 99502 | E | | Home visit, nb care | | | | | |
| 99503 | E | | Home visit, resp therapy | | | | | |
| 99504 | E | | Home visit mech ventilator | | | | | |
| 99505 | E | | Home visit, stoma care | | | | | |
| 99506 | E | | Home visit, im injection | | | | | |
| 99507 | E | | Home visit, cath maintain | | | | | |
| 99509 | E | | Home visit day life activity | | | | | |
| 99510 | E | | Home visit, sing/m/fam couns | | | | | |
| 99511 | E | | Home visit, fecal/enema mgmt | | | | | |
| 99512 | E | | Home visit for hemodialysis | | | | | |
| 99551 | E | DG | Home infus, pain mgmt, iv/sc | | | | | |
| 99552 | E | DG | Hm infus pain mgmt, epid/ith | | | | | |
| 99553 | E | DG | Home infuse, tocolytic tx | | | | | |
| 99554 | E | DG | Home infus, hormone/platelet | | | | | |
| 99555 | E | DG | Home infuse, chemotheraphy | | | | | |
| 99556 | E | DG | Home infus, antibio/fung/vir | | | | | |
| 99557 | E | DG | Home infuse, anticoagulant | | | | | |
| 99558 | E | DG | Home infuse, immunotherapy | | | | | |
| 99559 | E | DG | Home infus, periton dialysis | | | | | |
| 99560 | E | DG | Home infus, entero nutrition | | | | | |
| 99561 | E | DG | Home infuse, hydration tx | | | | | |
| 99562 | E | DG | Home infus, parent nutrition | | | | | |
| 99563 | E | DG | Home admin, pentamidine | | | | | |
| 99564 | E | DG | Hme infus, antihemophil agnt | | | | | |
| 99565 | E | DG | Home infus, proteinase inhib | | | | | |
| 99566 | E | DG | Home infuse, iv therapy | | | | | |
| 99567 | E | DG | Home infuse, sympath agent | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 99568 | E | DG | Home infus, misc drug, daily | | | | | |
| 99569 | E | DG | Home infuse, each addl tx | | | | | |
| 99600 | E | | Home visit nos | | | | | |
| 99601 | E | NI | Home infusion/visit, 2 hrs | | | | | |
| 99602 | E | NI | Home infusion, each addtl hr | | | | | |
| A0021 | E | | Outside state ambulance serv | | | | | |
| A0080 | E | | Noninterest escort in non er | | | | | |
| A0090 | E | | Interest escort in non er | | | | | |
| A0100 | E | | Nonemergency transport taxi | | | | | |
| A0110 | E | | Nonemergency transport bus | | | | | |
| A0120 | E | | Noner transport mini-bus | | | | | |
| A0130 | E | | Noner transport wheelch van | | | | | |
| A0140 | E | | Nonemergency transport air | | | | | |
| A0160 | E | | Noner transport case worker | | | | | |
| A0170 | E | | Noner transport parking fees | | | | | |
| A0180 | E | | Noner transport lodgng recip | | | | | |
| A0190 | E | | Noner transport meals recip | | | | | |
| A0200 | E | | Noner transport lodgng escrt | | | | | |
| A0210 | E | | Noner transport meals escort | | | | | |
| A0225 | A | | Neonatal emergency transport | | | | | |
| A0380 | A | | Basic life support mileage | | | | | |
| A0382 | A | | Basic support routine suppls | | | | | |
| A0384 | A | | Bls defibrillation supplies | | | | | |
| A0390 | A | | Advanced life support mileag | | | | | |
| A0392 | A | | Als defibrillation supplies | | | | | |
| A0394 | A | | Als IV drug therapy supplies | | | | | |
| A0396 | A | | Als esophageal intub suppls | | | | | |
| A0398 | A | | Als routine disposble suppls | | | | | |
| A0420 | A | | Ambulance waiting 1/2 hr | | | | | |
| A0422 | A | | Ambulance 02 life sustaining | | | | | |
| A0424 | A | | Extra ambulance attendant | | | | | |
| A0425 | A | | Ground mileage | | | | | |
| A0426 | A | | Als 1 | | | | | |
| A0427 | A | | ALS1-emergency | | | | | |
| A0428 | A | | bls | | | | | |
| A0429 | A | | BLS-emergency | | | | | |
| A0430 | A | | Fixed wing air transport | | | | | |
| A0431 | A | | Rotary wing air transport | | | | | |
| A0432 | A | | PI volunteer ambulance co | | | | | |
| A0433 | A | | als 2 | | | | | |
| A0434 | A | | Specialty care transport | | | | | |
| A0435 | A | | Fixed wing air mileage | | | | | |
| A0436 | A | | Rotary wing air mileage | | | | | |
| A0800 | A | | Amb trans 7pm-7am | | | | | |
| A0888 | E | | Noncovered ambulance mileage | | | | | |
| A0999 | A | | Unlisted ambulance service | | | | | |
| A4206 | A | | 1 CC sterile syringe&needle | | | | | |
| A4207 | A | | 2 CC sterile syringe&needle | | | | | |
| A4208 | A | | 3 CC sterile syringe&needle | | | | | |
| A4209 | E | | 5+ CC sterile syringe&needle | | | | | |
| A4210 | E | | Nonneedle injection device | | | | | |
| A4211 | B | | Supp for self-adm injections | | | | | |
| A4212 | B | | Non coring needle or stylet | | | | | |
| A4213 | E | | 20+ CC syringe only | | | | | |
| A4214 | A | DG | 30 CC sterile water/saline | | | | | |
| A4215 | E | | Sterile needle | | | | | |
| A4216 | A | NI | Sterile water/saline, 10 ml | | | | | |
| A4217 | A | NI | Sterile water/saline, 500 ml | | | | | |
| A4220 | N | NI | Infusion pump refill kit | | | | | |
| A4221 | A | | Maint drug infus cath per wk | | | | | |
| A4222 | A | | Drug infusion pump supplies | | | | | |
| A4230 | A | | Infus insulin pump non needl | | | | | |
| A4231 | A | | Infusion insulin pump needle | | | | | |
| A4232 | E | | Syringe w/needle insulin 3cc | | | | | |
| A4244 | E | | Alcohol or peroxide per pint | | | | | |
| A4245 | E | | Alcohol wipes per box | | | | | |
| A4246 | E | | Betadine/phisohex solution | | | | | |
| A4247 | E | | Betadine/iodine swabs/wipes | | | | | |
| A4248 | N | | Chlorhexidine antisept | | | | | |
| A4250 | E | | Urine reagent strips/tablets | | | | | |
| A4253 | A | | Blood glucose/reagent strips | | | | | |
| A4254 | A | | Battery for glucose monitor | | | | | |
| A4255 | A | | Glucose monitor platforms | | | | | |
| A4256 | A | | Calibrator solution/chips | | | | | |
| A4257 | A | | Replace Lensshield Cartridge | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| A4258 | A | | Lancet device each | | | | | |
| A4259 | A | | Lancets per box | | | | | |
| A4260 | E | | Levonorgestrel implant | | | | | |
| A4261 | E | | Cervical cap contraceptive | | | | | |
| A4262 | N | | Temporary tear duct plug | | | | | |
| A4263 | N | | Permanent tear duct plug | | | | | |
| A4265 | A | | Paraffin | | | | | |
| A4266 | E | | Diaphragm | | | | | |
| A4267 | E | | Male condom | | | | | |
| A4268 | E | | Female condom | | | | | |
| A4269 | E | | Spermicide | | | | | |
| A4270 | A | | Disposable endoscope sheath | | | | | |
| A4280 | A | | Brst prsths adhsv attchmnt | | | | | |
| A4281 | E | | Replacement breastpump tube | | | | | |
| A4282 | E | | Replacement breastpump adpt | | | | | |
| A4283 | E | | Replacement breastpump cap | | | | | |
| A4284 | E | | Replcmnt breast pump shield | | | | | |
| A4285 | E | | Replcmnt breast pump bottle | | | | | |
| A4286 | E | | Replcmnt breastpump lok ring | | | | | |
| A4290 | E | | Sacral nerve stim test lead | | | | | |
| A4300 | N | | Cath impl vasc access portal | | | | | |
| A4301 | N | | Implantable access syst perc | | | | | |
| A4305 | A | | Drug delivery system >=50 ML | | | | | |
| A4306 | A | | Drug delivery system <=5 ML | | | | | |
| A4310 | A | | Insert tray w/o bag/cath | | | | | |
| A4311 | A | | Catheter w/o bag 2-way latex | | | | | |
| A4312 | A | | Cath w/o bag 2-way silicone | | | | | |
| A4313 | A | | Catheter w/bag 3-way | | | | | |
| A4314 | A | | Cath w/drainage 2-way latex | | | | | |
| A4315 | A | | Cath w/drainage 2-way silcne | | | | | |
| A4316 | A | | Cath w/drainage 3-way | | | | | |
| A4319 | A | DG | Sterile H2O irrigation solut | | | | | |
| A4320 | A | | Irrigation tray | | | | | |
| A4321 | A | | Cath therapeutic irrig agent | | | | | |
| A4322 | A | | Irrigation syringe | | | | | |
| A4323 | A | DG | Saline irrigation solution | | | | | |
| A4324 | A | | Male ext cath w/adh coating | | | | | |
| A4325 | A | | Male ext cath w/adh strip | | | | | |
| A4326 | A | | Male external catheter | | | | | |
| A4327 | A | | Fem urinary collect dev cup | | | | | |
| A4328 | A | | Fem urinary collect pouch | | | | | |
| A4330 | A | | Stool collection pouch | | | | | |
| A4331 | A | | Extension drainage tubing | | | | | |
| A4332 | A | | Lubricant for cath insertion | | | | | |
| A4333 | A | | Urinary cath anchor device | | | | | |
| A4334 | A | | Urinary cath leg strap | | | | | |
| A4335 | A | | Incontinence supply | | | | | |
| A4338 | A | | Indwelling catheter latex | | | | | |
| A4340 | A | | Indwelling catheter special | | | | | |
| A4344 | A | | Cath indw foley 2 way silicn | | | | | |
| A4346 | A | | Cath indw foley 3 way | | | | | |
| A4347 | A | | Male external catheter | | | | | |
| A4348 | A | | Male ext cath extended wear | | | | | |
| A4351 | A | | Straight tip urine catheter | | | | | |
| A4352 | A | | Coude tip urinary catheter | | | | | |
| A4353 | A | | Intermittent urinary cath | | | | | |
| A4354 | A | | Cath insertion tray w/bag | | | | | |
| A4355 | A | | Bladder irrigation tubing | | | | | |
| A4356 | A | | Ext ureth clmp or compr dvc | | | | | |
| A4357 | A | | Bedside drainage bag | | | | | |
| A4358 | A | | Urinary leg or abdomen bag | | | | | |
| A4359 | A | | Urinary suspensory w/o leg b | | | | | |
| A4361 | A | | Ostomy face plate | | | | | |
| A4362 | A | | Solid skin barrier | | | | | |
| A4364 | A | | Adhesive, liquid or equal | | | | | |
| A4365 | A | | Adhesive remover wipes | | | | | |
| A4366 | A | | Ostomy vent | | | | | |
| A4367 | A | | Ostomy belt | | | | | |
| A4368 | A | | Ostomy filter | | | | | |
| A4369 | A | | Skin barrier liquid per oz | | | | | |
| A4371 | A | | Skin barrier powder per oz | | | | | |
| A4372 | A | | Skin barrier solid 4x4 equiv | | | | | |
| A4373 | A | | Skin barrier with flange | | | | | |
| A4375 | A | | Drainable plastic pch w fcpl | | | | | |
| A4376 | A | | Drainable rubber pch w fcplt | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| A4377 | A | | Drainable plstic pch w/o fp | | | | | |
| A4378 | A | | Drainable rubber pch w/o fp | | | | | |
| A4379 | A | | Urinary plastic pouch w fcpl | | | | | |
| A4380 | A | | Urinary rubber pouch w fcplt | | | | | |
| A4381 | A | | Urinary plastic pouch w/o fp | | | | | |
| A4382 | A | | Urinary hvy plstc pch w/o fp | | | | | |
| A4383 | A | | Urinary rubber pouch w/o fp | | | | | |
| A4384 | A | | Ostomy faceplt/silicone ring | | | | | |
| A4385 | A | | Ost skn barrier sld ext wear | | | | | |
| A4387 | A | | Ost clsd pouch w att st barr | | | | | |
| A4388 | A | | Drainable pch w ex wear barr | | | | | |
| A4389 | A | | Drainable pch w st wear barr | | | | | |
| A4390 | A | | Drainable pch ex wear convex | | | | | |
| A4391 | A | | Urinary pouch w ex wear barr | | | | | |
| A4392 | A | | Urinary pouch w st wear barr | | | | | |
| A4393 | A | | Urine pch w ex wear bar conv | | | | | |
| A4394 | A | | Ostomy pouch liq deodorant | | | | | |
| A4395 | A | | Ostomy pouch solid deodorant | | | | | |
| A4396 | A | | Peristomal hernia supprt blt | | | | | |
| A4397 | A | | Irrigation supply sleeve | | | | | |
| A4398 | A | | Ostomy irrigation bag | | | | | |
| A4399 | A | | Ostomy irrig cone/cath w brs | | | | | |
| A4400 | A | | Ostomy irrigation set | | | | | |
| A4402 | A | | Lubricant per ounce | | | | | |
| A4404 | A | | Ostomy ring each | | | | | |
| A4405 | A | | Nonpectin based ostomy paste | | | | | |
| A4406 | A | | Pectin based ostomy paste | | | | | |
| A4407 | A | | Ext wear ost skn barr <=4sq≧ | | | | | |
| A4408 | A | | Ext wear ost skn barr >4sq≧ | | | | | |
| A4409 | A | | Ost skn barr w flng <=4 sq≧ | | | | | |
| A4410 | A | | Ost skn barr w flng >4sq≧ | | | | | |
| A4413 | A | | 2 pc drainable ost pouch | | | | | |
| A4414 | A | | Ostomy sknbarr w flng <=4sq≧ | | | | | |
| A4415 | A | | Ostomy skn barr w flng >4sq≧ | | | | | |
| A4416 | A | NI | Ost pch clsd w barrier/filtr | | | | | |
| A4417 | A | NI | Ost pch w bar/bltinconv/fltr | | | | | |
| A4418 | A | NI | Ost pch clsd w/o bar w filtr | | | | | |
| A4419 | A | NI | Ost pch for bar w flange/flt | | | | | |
| A4420 | A | NI | Ost pch clsd for bar w lk fl | | | | | |
| A4421 | A | | Ostomy supply misc | | | | | |
| A4422 | A | | Ost pouch absorbent material | | | | | |
| A4424 | A | NI | Ost pch drain w bar & filter | | | | | |
| A4425 | A | NI | Ost pch drain for barrier fl | | | | | |
| A4426 | A | NI | Ost pch drain 2 piece system | | | | | |
| A4427 | A | NI | Ost pch drain/barr lk flng/f | | | | | |
| A4428 | A | NI | Urine ost pouch w faucet/tap | | | | | |
| A4429 | A | NI | Urine ost pch bar w lock fln | | | | | |
| A4430 | A | NI | Ost pch urine w lock flng/ft | | | | | |
| A4431 | A | NI | Urine ost pch bar w lock fln | | | | | |
| A4432 | A | NI | Ost pch urine w lock flng/ft | | | | | |
| A4433 | A | NI | Urine ost pch bar w lock fln | | | | | |
| A4434 | A | NI | Ost pch urine w lock flng/ft | | | | | |
| A4450 | A | | Non-waterproof tape | | | | | |
| A4452 | A | | Waterproof tape | | | | | |
| A4455 | A | | Adhesive remover per ounce | | | | | |
| A4458 | E | | Reusable enema bag | | | | | |
| A4462 | A | | Abdmnl drssng holder/binder | | | | | |
| A4465 | A | | Non-elastic extremity binder | | | | | |
| A4470 | A | | Gravlee jet washer | | | | | |
| A4480 | A | | Vabra aspirator | | | | | |
| A4481 | A | | Tracheostoma filter | | | | | |
| A4483 | A | | Moisture exchanger | | | | | |
| A4490 | E | | Above knee surgical stocking | | | | | |
| A4495 | E | | Thigh length surg stocking | | | | | |
| A4500 | E | | Below knee surgical stocking | | | | | |
| A4510 | E | | Full length surg stocking | | | | | |
| A4521 | E | | Adult size diaper sm each | | | | | |
| A4522 | E | | Adult size diaper med each | | | | | |
| A4523 | E | | Adult size diaper lg each | | | | | |
| A4524 | E | | Adult size diaper xl each | | | | | |
| A4525 | E | | Adult size brief sm each | | | | | |
| A4526 | E | | Adult size brief med each | | | | | |
| A4527 | E | | Adult size brief lg each | | | | | |
| A4528 | E | | Adult size brief xl each | | | | | |
| A4529 | E | | Child size diaper sm/med ea | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| A4530 | E | | Child size diaper lg each | | | | | |
| A4531 | E | | Child size brief sm/med each | | | | | |
| A4532 | E | | Child size brief lg each | | | | | |
| A4533 | E | | Youth size diaper each | | | | | |
| A4534 | E | | Youth size brief each | | | | | |
| A4535 | E | | Disp incont liner/shield ea | | | | | |
| A4536 | E | | Prot underwr wshbl any sz ea | | | | | |
| A4537 | E | | Under pad reusable any sz ea | | | | | |
| A4538 | E | | Reusable diaper from dpr svc | | | | | |
| A4550 | B | | Surgical trays | | | | | |
| A4554 | E | | Disposable underpads | | | | | |
| A4556 | A | | Electrodes, pair | | | | | |
| A4557 | A | | Lead wires, pair | | | | | |
| A4558 | A | | Conductive paste or gel | | | | | |
| A4561 | N | | Pessary rubber, any type | | | | | |
| A4562 | N | | Pessary, non rubber,any type | | | | | |
| A4565 | A | | Slings | | | | | |
| A4570 | E | | Splint | | | | | |
| A4575 | E | | Hyperbaric o2 chamber disps | | | | | |
| A4580 | E | | Cast supplies (plaster) | | | | | |
| A4590 | E | | Special casting material | | | | | |
| A4595 | A | | TENS suppl 2 lead per month | | | | | |
| A4606 | A | | Oxygen probe used w oximeter | | | | | |
| A4608 | A | | Transtracheal oxygen cath | | | | | |
| A4609 | A | | Trach suction cath clsed sys | | | | | |
| A4610 | A | | Trach sctn cath 72h clsedsys | | | | | |
| A4611 | A | | Heavy duty battery | | | | | |
| A4612 | A | | Battery cables | | | | | |
| A4613 | A | | Battery charger | | | | | |
| A4614 | A | | Hand-held PEFR meter | | | | | |
| A4615 | A | | Cannula nasal | | | | | |
| A4616 | A | | Tubing (oxygen) per foot | | | | | |
| A4617 | A | | Mouth piece | | | | | |
| A4618 | A | | Breathing circuits | | | | | |
| A4619 | A | | Face tent | | | | | |
| A4620 | A | | Variable concentration mask | | | | | |
| A4621 | A | DG | Tracheotomy mask or collar | | | | | |
| A4622 | A | DG | Tracheostomy or larngectomy | | | | | |
| A4623 | A | | Tracheostomy inner cannula | | | | | |
| A4624 | A | | Tracheal suction tube | | | | | |
| A4625 | A | | Trach care kit for new trach | | | | | |
| A4626 | A | | Tracheostomy cleaning brush | | | | | |
| A4627 | E | | Spacer bag/reservoir | | | | | |
| A4628 | A | | Oropharyngeal suction cath | | | | | |
| A4629 | A | | Tracheostomy care kit | | | | | |
| A4630 | A | | Repl bat t.e.n.s. own by pt | | | | | |
| A4631 | A | DG | Wheelchair battery | | | | | |
| A4632 | E | | Infus pump rplcemnt battery | | | | | |
| A4633 | A | | Uvl replacement bulb | | | | | |
| A4634 | A | | Replacement bulb th lightbox | | | | | |
| A4635 | A | | Underarm crutch pad | | | | | |
| A4636 | A | | Handgrip for cane etc | | | | | |
| A4637 | A | | Repl tip cane/crutch/walker | | | | | |
| A4638 | Y | NI | Repl batt pulse gen sys | | | | | |
| A4639 | A | | Infrared ht sys replcmnt pad | | | | | |
| A4640 | A | | Alternating pressure pad | | | | | |
| A4641 | N | | Diagnostic imaging agent | | | | | |
| A4642 | K | | Satumomab pendetide per dose | 0704 | 2.2811 | $124.46 | | $24.89 |
| A4643 | N | | High dose contrast MRI | | | | | |
| A4644 | N | DG | Contrast 100-199 MGs iodine | | | | | |
| A4645 | N | DG | Contrast 200-299 MGs iodine | | | | | |
| A4646 | N | DG | Contrast 300-399 MGs iodine | | | | | |
| A4647 | N | | Supp- paramagnetic contr mat | | | | | |
| A4649 | A | | Surgical supplies | | | | | |
| A4651 | A | | Calibrated microcap tube | | | | | |
| A4652 | A | | Microcapillary tube sealant | | | | | |
| A4653 | A | | PD catheter anchor belt | | | | | |
| A4656 | A | | Dialysis needle | | | | | |
| A4657 | A | | Dialysis syringe w/wo needle | | | | | |
| A4660 | A | | Sphyg/bp app w cuff and stet | | | | | |
| A4663 | A | | Dialysis blood pressure cuff | | | | | |
| A4670 | E | | Automatic bp monitor, dial | | | | | |
| A4671 | E | NI | Disposable cycler set | | | | | |
| A4672 | E | NI | Drainage ext line, dialysis | | | | | |
| A4673 | E | NI | Ext line w easy lock connect | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| A4674 | E | NI | Chem/antisept solution, 8oz | | | | | |
| A4680 | A | | Activated carbon filter, ea | | | | | |
| A4690 | A | | Dialyzer, each | | | | | |
| A4706 | A | | Bicarbonate conc sol per gal | | | | | |
| A4707 | A | | Bicarbonate conc pow per pac | | | | | |
| A4708 | A | | Acetate conc sol per gallon | | | | | |
| A4709 | A | | Acid conc sol per gallon | | | | | |
| A4712 | A | DG | Sterile water inj per 10 ml | | | | | |
| A4714 | A | | Treated water per gallon | | | | | |
| A4719 | A | | ≧Y set≧ tubing | | | | | |
| A4720 | A | | Dialysat sol fld vol > 249cc | | | | | |
| A4721 | A | | Dialysat sol fld vol > 999cc | | | | | |
| A4722 | A | | Dialys sol fld vol > 1999cc | | | | | |
| A4723 | A | | Dialys sol fld vol > 2999cc | | | | | |
| A4724 | A | | Dialys sol fld vol > 3999cc | | | | | |
| A4725 | A | | Dialys sol fld vol > 4999cc | | | | | |
| A4726 | A | | Dialys sol fld vol > 5999cc | | | | | |
| A4728 | E | NI | Dialysate solution, non-dex | | | | | |
| A4730 | A | | Fistula cannulation set, ea | | | | | |
| A4736 | A | | Topical anesthetic, per gram | | | | | |
| A4737 | A | | Inj anesthetic per 10 ml | | | | | |
| A4740 | A | | Shunt accessory | | | | | |
| A4750 | A | | Art or venous blood tubing | | | | | |
| A4755 | A | | Comb art/venous blood tubing | | | | | |
| A4760 | A | | Dialysate sol test kit, each | | | | | |
| A4765 | A | | Dialysate conc pow per pack | | | | | |
| A4766 | A | | Dialysate conc sol add 10 ml | | | | | |
| A4770 | A | | Blood collection tube/vacuum | | | | | |
| A4771 | A | | Serum clotting time tube | | | | | |
| A4772 | A | | Blood glucose test strips | | | | | |
| A4773 | A | | Occult blood test strips | | | | | |
| A4774 | A | | Ammonia test strips | | | | | |
| A4802 | A | | Protamine sulfate per 50 mg | | | | | |
| A4860 | A | | Disposable catheter tips | | | | | |
| A4870 | A | | Plumb/elec wk hm hemo equip | | | | | |
| A4890 | A | | Repair/maint cont hemo equip | | | | | |
| A4911 | A | | Drain bag/bottle | | | | | |
| A4913 | A | | Misc dialysis supplies noc | | | | | |
| A4918 | A | | Venous pressure clamp | | | | | |
| A4927 | A | | Non-sterile gloves | | | | | |
| A4928 | A | | Surgical mask | | | | | |
| A4929 | A | | Tourniquet for dialysis, ea | | | | | |
| A4930 | A | | Sterile, gloves per pair | | | | | |
| A4931 | A | | Reusable oral thermometer | | | | | |
| A4932 | E | | Reusable rectal thermometer | | | | | |
| A5051 | A | | Pouch clsd w barr attached | | | | | |
| A5052 | A | | Clsd ostomy pouch w/o barr | | | | | |
| A5053 | A | | Clsd ostomy pouch faceplate | | | | | |
| A5054 | A | | Clsd ostomy pouch w/flange | | | | | |
| A5055 | A | | Stoma cap | | | | | |
| A5061 | A | | Pouch drainable w barrier at | | | | | |
| A5062 | A | | Drnble ostomy pouch w/o barr | | | | | |
| A5063 | A | | Drain ostomy pouch w/flange | | | | | |
| A5071 | A | | Urinary pouch w/barrier | | | | | |
| A5072 | A | | Urinary pouch w/o barrier | | | | | |
| A5073 | A | | Urinary pouch on barr w/flng | | | | | |
| A5081 | A | | Continent stoma plug | | | | | |
| A5082 | A | | Continent stoma catheter | | | | | |
| A5093 | A | | Ostomy accessory convex inse | | | | | |
| A5102 | A | | Bedside drain btl w/wo tube | | | | | |
| A5105 | A | | Urinary suspensory | | | | | |
| A5112 | A | | Urinary leg bag | | | | | |
| A5113 | A | | Latex leg strap | | | | | |
| A5114 | A | | Foam/fabric leg strap | | | | | |
| A5119 | A | | Skin barrier wipes box pr 50 | | | | | |
| A5121 | A | | Solid skin barrier 6x6 | | | | | |
| A5122 | A | | Solid skin barrier 8x8 | | | | | |
| A5126 | A | | Disk/foam pad +or- adhesive | | | | | |
| A5131 | A | | Appliance cleaner | | | | | |
| A5200 | A | | Percutaneous catheter anchor | | | | | |
| A5500 | A | | Diab shoe for density insert | | | | | |
| A5501 | A | | Diabetic custom molded shoe | | | | | |
| A5503 | A | | Diabetic shoe w/roller/rockr | | | | | |
| A5504 | A | | Diabetic shoe with wedge | | | | | |
| A5505 | A | | Diab shoe w/metatarsal bar | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| A5506 | A | | Diabetic shoe w/off set heel | | | | | |
| A5507 | A | | Modification diabetic shoe | | | | | |
| A5508 | A | | Diabetic deluxe shoe | | | | | |
| A5509 | A | | Direct heat form shoe insert | | | | | |
| A5510 | A | | Compression form shoe insert | | | | | |
| A5511 | A | | Custom fab molded shoe inser | | | | | |
| A6000 | E | | Wound warming wound cover | | | | | |
| A6010 | A | | Collagen based wound filler | | | | | |
| A6011 | A | | Collagen gel/paste wound fil | | | | | |
| A6021 | A | | Collagen dressing <=16 sq in | | | | | |
| A6022 | A | | Collagen drsg>6<=48 sq in | | | | | |
| A6023 | A | | Collagen dressing >48 sq in | | | | | |
| A6024 | A | | Collagen dsg wound filler | | | | | |
| A6025 | E | | Silicone gel sheet, each | | | | | |
| A6154 | A | | Wound pouch each | | | | | |
| A6196 | A | | Alginate dressing <=16 sq in | | | | | |
| A6197 | A | | Alginate drsg >16 <=48 sq in | | | | | |
| A6198 | A | | alginate dressing > 48 sq in | | | | | |
| A6199 | A | | Alginate drsg wound filler | | | | | |
| A6200 | A | | Compos drsg <=16 no border | | | | | |
| A6201 | A | | Compos drsg >16<=48 no bdr | | | | | |
| A6202 | A | | Compos drsg >48 no border | | | | | |
| A6203 | A | | Composite drsg <= 16 sq in | | | | | |
| A6204 | A | | Composite drsg >16<=48 sq in | | | | | |
| A6205 | A | | Composite drsg > 48 sq in | | | | | |
| A6206 | A | | Contact layer <= 16 sq in | | | | | |
| A6207 | A | | Contact layer >16<= 48 sq in | | | | | |
| A6208 | A | | Contact layer > 48 sq in | | | | | |
| A6209 | A | | Foam drsg <=16 sq in w/o bdr | | | | | |
| A6210 | A | | Foam drg >16<=48 sq in w/o b | | | | | |
| A6211 | A | | Foam drg > 48 sq in w/o brdr | | | | | |
| A6212 | A | | Foam drg <=16 sq in w/border | | | | | |
| A6213 | A | | Foam drg >16<=48 sq in w/bdr | | | | | |
| A6214 | A | | Foam drg > 48 sq in w/border | | | | | |
| A6215 | A | | Foam dressing wound filler | | | | | |
| A6216 | A | | Non-sterile gauze<=16 sq in | | | | | |
| A6217 | A | | Non-sterile gauze>16<=48 sq | | | | | |
| A6218 | A | | Non-sterile gauze > 48 sq in | | | | | |
| A6219 | A | | Gauze <= 16 sq in w/border | | | | | |
| A6220 | A | | Gauze >16 <=48 sq in w/bordr | | | | | |
| A6221 | A | | Gauze > 48 sq in w/border | | | | | |
| A6222 | A | | Gauze <=16 in no w/sal w/o b | | | | | |
| A6223 | A | | Gauze >16<=48 no w/sal w/o b | | | | | |
| A6224 | A | | Gauze > 48 in no w/sal w/o b | | | | | |
| A6228 | A | | Gauze <= 16 sq in water/sal | | | | | |
| A6229 | A | | Gauze >16<=48 sq in watr/sal | | | | | |
| A6230 | A | | Gauze > 48 sq in water/salne | | | | | |
| A6231 | A | | Hydrogel dsg<=16 sq in | | | | | |
| A6232 | A | | Hydrogel dsg>16<=48 sq in | | | | | |
| A6233 | A | | Hydrogel dressing >48 sq in | | | | | |
| A6234 | A | | Hydrocolld drg <=16 w/o bdr | | | | | |
| A6235 | A | | Hydrocolld drg >16<=48 w/o b | | | | | |
| A6236 | A | | Hydrocolld drg > 48 in w/o b | | | | | |
| A6237 | A | | Hydrocolld drg <=16 in w/bdr | | | | | |
| A6238 | A | | Hydrocolld drg >16<=48 w/bdr | | | | | |
| A6239 | A | | Hydrocolld drg > 48 in w/bdr | | | | | |
| A6240 | A | | Hydrocolld drg filler paste | | | | | |
| A6241 | A | | Hydrocolloid drg filler dry | | | | | |
| A6242 | A | | Hydrogel drg <=16 in w/o bdr | | | | | |
| A6243 | A | | Hydrogel drg >16<=48 w/o bdr | | | | | |
| A6244 | A | | Hydrogel drg >48 in w/o bdr | | | | | |
| A6245 | A | | Hydrogel drg <= 16 in w/bdr | | | | | |
| A6246 | A | | Hydrogel drg >16<=48 in w/b | | | | | |
| A6247 | A | | Hydrogel drg > 48 sq in w/b | | | | | |
| A6248 | A | | Hydrogel drsg gel filler | | | | | |
| A6250 | A | | Skin seal protect moisturizr | | | | | |
| A6251 | A | | Absorpt drg <=16 sq in w/o b | | | | | |
| A6252 | A | | Absorpt drg >16 <=48 w/o bdr | | | | | |
| A6253 | A | | Absorpt drg > 48 sq in w/o b | | | | | |
| A6254 | A | | Absorpt drg <=16 sq in w/bdr | | | | | |
| A6255 | A | | Absorpt drg >16<=48 in w/bdr | | | | | |
| A6256 | A | | Absorpt drg > 48 sq in w/bdr | | | | | |
| A6257 | A | | Transparent film <= 16 sq in | | | | | |
| A6258 | A | | Transparent film >16<=48 in | | | | | |
| A6259 | A | | Transparent film > 48 sq in | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| A6260 | A | | Wound cleanser any type/size | | | | | |
| A6261 | A | | Wound filler gel/paste /oz | | | | | |
| A6262 | A | | Wound filler dry form / gram | | | | | |
| A6266 | A | | Impreg gauze no h20/sal/yard | | | | | |
| A6402 | A | | Sterile gauze <= 16 sq in | | | | | |
| A6403 | A | | Sterile gauze>16 <= 48 sq in | | | | | |
| A6404 | A | | Sterile gauze > 48 sq in | | | | | |
| A6407 | A | NI | Packing strips, non-impreg | | | | | |
| A6410 | A | | Sterile eye pad | | | | | |
| A6411 | A | | Non-sterile eye pad | | | | | |
| A6412 | E | | Occlusive eye patch | | | | | |
| A6421 | A | DG | Pad bandage >=3 <5in w /roll | | | | | |
| A6422 | A | DG | Conf bandage ns >=3<5≧w/roll | | | | | |
| A6424 | A | DG | Conf bandage ns >=5≧w /roll | | | | | |
| A6426 | A | DG | Conf bandage s >=3<5≧ w/roll | | | | | |
| A6428 | A | DG | Conf bandage s >=5≧ w /roll | | | | | |
| A6430 | A | DG | Lt compres bdg >=3<5≧w /roll | | | | | |
| A6432 | A | DG | Lt compres bdg >=5≧w /roll | | | | | |
| A6434 | A | DG | Mo compres bdg >=3<5≧w /roll | | | | | |
| A6436 | A | DG | Hi compres bdg >=3<5≧w /roll | | | | | |
| A6438 | A | DG | Self-adher bdg >=3<5≧w /roll | | | | | |
| A6440 | A | DG | Zinc paste bdg >=3<5≧w /roll | | | | | |
| A6441 | A | NI | Pad band w>=3≧ <5≧/yd | | | | | |
| A6442 | A | NI | Conform band n/s w<3≧/yd | | | | | |
| A6443 | A | NI | Conform band n/s w>=3≧<5≧/yd | | | | | |
| A6444 | A | NI | Conform band n/s w>=5≧/yd | | | | | |
| A6445 | A | NI | Conform band s w <3≧/yd | | | | | |
| A6446 | A | NI | Conform band s w>=3≧ <5≧/yd | | | | | |
| A6447 | A | NI | Conform band s w >=5≧/yd | | | | | |
| A6448 | A | NI | Lt compres band <3≧/yd | | | | | |
| A6449 | A | NI | Lt compres band >=3≧ <5≧/yd | | | | | |
| A6450 | A | NI | Lt compres band >=5≧/yd | | | | | |
| A6451 | A | NI | Mod compres band w>=3≧<5≧/yd | | | | | |
| A6452 | A | NI | High compres band w>=3≧<5≧yd | | | | | |
| A6453 | A | NI | Self-adher band w <3≧/yd | | | | | |
| A6454 | A | NI | Self-adher band w>=3≧ <5≧/yd | | | | | |
| A6455 | A | NI | Self-adher band >=5≧/yd | | | | | |
| A6456 | A | NI | Zinc paste band w >=3≧<5≧/yd | | | | | |
| A6501 | A | | Compres burngarment bodysuit | | | | | |
| A6502 | A | | Compres burngarment chinstrp | | | | | |
| A6503 | A | | Compres burngarment facehood | | | | | |
| A6504 | A | | Cmprsburngarment glove-wrist | | | | | |
| A6505 | A | | Cmprsburngarment glove-elbow | | | | | |
| A6506 | A | | Cmprsburngrmnt glove-axilla | | | | | |
| A6507 | A | | Cmprs burngarment foot-knee | | | | | |
| A6508 | A | | Cmprs burngarment foot-thigh | | | | | |
| A6509 | A | | Compres burn garment jacket | | | | | |
| A6510 | A | | Compres burn garment leotard | | | | | |
| A6511 | A | | Compres burn garment panty | | | | | |
| A6512 | A | | Compres burn garment, noc | | | | | |
| A6550 | Y | NI | Neg pres wound ther drsg set | | | | | |
| A6551 | Y | NI | Neg press wound ther canistr | | | | | |
| A7000 | A | | Disposable canister for pump | | | | | |
| A7001 | A | | Nondisposable pump canister | | | | | |
| A7002 | A | | Tubing used w suction pump | | | | | |
| A7003 | A | | Nebulizer administration set | | | | | |
| A7004 | A | | Disposable nebulizer sml vol | | | | | |
| A7005 | A | | Nondisposable nebulizer set | | | | | |
| A7006 | A | | Filtered nebulizer admin set | | | | | |
| A7007 | A | | Lg vol nebulizer disposable | | | | | |
| A7008 | A | | Disposable nebulizer prefill | | | | | |
| A7009 | A | | Nebulizer reservoir bottle | | | | | |
| A7010 | A | | Disposable corrugated tubing | | | | | |
| A7011 | A | | Nondispos corrugated tubing | | | | | |
| A7012 | A | | Nebulizer water collec devic | | | | | |
| A7013 | A | | Disposable compressor filter | | | | | |
| A7014 | A | | Compressor nondispos filter | | | | | |
| A7015 | A | | Aerosol mask used w nebulize | | | | | |
| A7016 | A | | Nebulizer dome & mouthpiece | | | | | |
| A7017 | A | | Nebulizer not used w oxygen | | | | | |
| A7018 | A | | Water distilled w/nebulizer | | | | | |
| A7019 | A | DG | Saline solution dispenser | | | | | |
| A7020 | A | DG | Sterile H2O or NSS w lgv neb | | | | | |
| A7025 | A | | Replace chest compress vest | | | | | |
| A7026 | A | | Replace chst cmprss sys hose | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| A7030 | A | | CPAP full face mask | | | | | |
| A7031 | A | | Replacement facemask interfa | | | | | |
| A7032 | A | | Replacement nasal cushion | | | | | |
| A7033 | A | | Replacement nasal pillows | | | | | |
| A7034 | A | | Nasal application device | | | | | |
| A7035 | A | | Pos airway press headgear | | | | | |
| A7036 | A | | Pos airway press chinstrap | | | | | |
| A7037 | A | | Pos airway pressure tubing | | | | | |
| A7038 | A | | Pos airway pressure filter | | | | | |
| A7039 | A | | Filter, non disposable w pap | | | | | |
| A7042 | A | | Implanted pleural catheter | | | | | |
| A7043 | A | | Vacuum drainagebottle/tubing | | | | | |
| A7044 | A | | PAP oral interface | | | | | |
| A7046 | Y | NI | Repl water chamber, PAP dev | | | | | |
| A7501 | A | | Tracheostoma valve w diaphra | | | | | |
| A7502 | A | | Replacement diaphragm/fplate | | | | | |
| A7503 | A | | HMES filter holder or cap | | | | | |
| A7504 | A | | Tracheostoma HMES filter | | | | | |
| A7505 | A | | HMES or trach valve housing | | | | | |
| A7506 | A | | HMES/trachvalve adhesivedisk | | | | | |
| A7507 | A | | Integrated filter & holder | | | | | |
| A7508 | A | | Housing & Integrated Adhesiv | | | | | |
| A7509 | A | | Heat & moisture exchange sys | | | | | |
| A7520 | A | NI | Trach/laryn tube non-cuffed | | | | | |
| A7521 | A | NI | Trach/laryn tube cuffed | | | | | |
| A7522 | A | NI | Trach/laryn tube stainless | | | | | |
| A7523 | A | NI | Tracheostomy shower protect | | | | | |
| A7524 | A | NI | Tracheostoma stent/stud/bttn | | | | | |
| A7525 | A | NI | Tracheostomy mask | | | | | |
| A7526 | A | NI | Tracheostomy tube collar | | | | | |
| A9150 | B | | Misc/exper non-prescript dru | | | | | |
| A9270 | E | | Non-covered item or service | | | | | |
| A9280 | E | NI | Alert device, noc | | | | | |
| A9300 | E | | Exercise equipment | | | | | |
| A9500 | K | | Technetium TC 99m sestamibi | 1600 | 1.1782 | $64.28 | | $12.86 |
| A9502 | K | | Technetium TC99M tetrofosmin | 0705 | 1.0642 | $58.06 | | $11.61 |
| A9503 | N | | Technetium TC 99m medronate | | | | | |
| A9504 | N | | Technetium tc 99m apcitide | | | | | |
| A9505 | K | | Thallous chloride TL 201/mci | 1603 | 0.3645 | $19.89 | | $3.98 |
| A9507 | K | | Indium/111 capromab pendetid | 1604 | 12.6045 | $687.71 | | $137.54 |
| A9508 | K | | Iobenguane sulfate I-131, per 0.5 mCi | 1045 | 3.0392 | $165.82 | | $33.16 |
| A9510 | N | | Technetium TC99m Disofenin | | | | | |
| A9511 | K | | Technetium TC 99m depreotide | 1095 | 0.6940 | $37.87 | | $7.57 |
| A9512 | N | | Technetiumtc99mpertechnetate | | | | | |
| A9513 | N | | Technetium tc-99m mebrofenin | | | | | |
| A9514 | N | | Technetiumtc99mpyrophosphate | | | | | |
| A9515 | N | | Technetium tc-99m pentetate | | | | | |
| A9516 | N | | I-123 sodium iodide capsule | | | | | |
| A9517 | K | | Th I131 so iodide cap millic | 1064 | 0.1004 | $5.48 | | $1.10 |
| A9518 | D | DNG | I-131 sodium iodide solution | | | | | |
| A9519 | N | | Technetiumtc-99mmacroag albu | | | | | |
| A9520 | N | | Technetiumtc-99m sulfur clld | | | | | |
| A9521 | K | | Technetiumtc-99m exametazine | 1096 | 3.8609 | $210.65 | | $42.13 |
| A9522 | B | | Indium111ibritumomabtiuxetan | | | | | |
| A9523 | B | | Yttrium90ibritumomabtiuxetan | | | | | |
| A9524 | K | | Iodinated I-131 serumalbumin, per 5uci | 9100 | 0.0066 | $0.36 | | $0.07 |
| A9525 | N | NI | Low/iso-osmolar contrast mat | | | | | |
| A9526 | K | NI | Ammonia N-13, per dose | 9025 | 2.6372 | $143.89 | | $28.78 |
| A9527 | B | NI | I-131 tositumomab therapeut | | | | | |
| A9528 | K | NI | Dx I131 so iodide cap millic | 1064 | 0.1004 | $5.48 | | $1.10 |
| A9529 | K | NI | Dx I131 so iodide sol millic | 1065 | 0.1189 | $6.49 | | $1.30 |
| A9530 | K | NI | Th I131 so iodide sol millic | 1065 | 0.1189 | $6.49 | | $1.30 |
| A9531 | N | NI | Dx I131 so iodide microcurie | | | | | |
| A9532 | N | NI | I-125 serum albumin micro | | | | | |
| A9533 | B | NI | I-131 tositumomab diagnostic | | | | | |
| A9534 | B | NI | I-131 tositumomab therapeut | | | | | |
| A9600 | K | | Strontium-89 chloride | 0701 | 7.3835 | $402.85 | | $80.57 |
| A9605 | K | | Samarium sm153 lexidronamm | 0702 | 16.0268 | $874.44 | | $174.89 |
| A9699 | N | | Noc therapeutic radiopharm | | | | | |
| A9700 | E | | Echocardiography Contrast | 9202 | 2.1737 | $118.60 | | $23.72 |
| A9900 | A | | Supply/accessory/service | | | | | |
| A9901 | A | | Delivery/set up/dispensing | | | | | |
| A9999 | Y | NI | DME supply or accessory, nos | | | | | |
| B4034 | A | | Enter feed supkit syr by day | | | | | |
| B4035 | A | | Enteral feed supp pump per d | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| B4036 | A | | Enteral feed sup kit grav by | | | | | |
| B4081 | A | | Enteral ng tubing w/ stylet | | | | | |
| B4082 | A | | Enteral ng tubing w/o stylet | | | | | |
| B4083 | A | | Enteral stomach tube levine | | | | | |
| B4086 | A | | Gastrostomy/jejunostomy tube | | | | | |
| B4100 | E | | Food thickener oral | | | | | |
| B4150 | A | | Enteral formulae category i | | | | | |
| B4151 | A | | Enteral formulae cat1natural | | | | | |
| B4152 | A | | Enteral formulae category ii | | | | | |
| B4153 | A | | Enteral formulae categoryIII | | | | | |
| B4154 | A | | Enteral formulae category IV | | | | | |
| B4155 | A | | Enteral formulae category v | | | | | |
| B4156 | A | | Enteral formulae category vi | | | | | |
| B4164 | A | | Parenteral 50% dextrose solu | | | | | |
| B4168 | A | | Parenteral sol amino acid 3. | | | | | |
| B4172 | A | | Parenteral sol amino acid 5. | | | | | |
| B4176 | A | | Parenteral sol amino acid 7- | | | | | |
| B4178 | A | | Parenteral sol amino acid > | | | | | |
| B4180 | A | | Parenteral sol carb > 50% | | | | | |
| B4184 | A | | Parenteral sol lipids 10% | | | | | |
| B4186 | A | | Parenteral sol lipids 20% | | | | | |
| B4189 | A | | Parenteral sol amino acid & | | | | | |
| B4193 | A | | Parenteral sol 52-73 gm prot | | | | | |
| B4197 | A | | Parenteral sol 74-100 gm pro | | | | | |
| B4199 | A | | Parenteral sol > 100gm prote | | | | | |
| B4216 | A | | Parenteral nutrition additiv | | | | | |
| B4220 | A | | Parenteral supply kit premix | | | | | |
| B4222 | A | | Parenteral supply kit homemi | | | | | |
| B4224 | A | | Parenteral administration ki | | | | | |
| B5000 | A | | Parenteral sol renal-amirosy | | | | | |
| B5100 | A | | Parenteral sol hepatic-fream | | | | | |
| B5200 | A | | Parenteral sol stres-brnch c | | | | | |
| B9000 | A | | Enter infusion pump w/o alrm | | | | | |
| B9002 | A | | Enteral infusion pump w/ ala | | | | | |
| B9004 | A | | Parenteral infus pump portab | | | | | |
| B9006 | A | | Parenteral infus pump statio | | | | | |
| B9998 | A | | Enteral supp not otherwise c | | | | | |
| B9999 | A | | Parenteral supp not othrws c | | | | | |
| C1010 | K | DG | Blood, L/R, CMV-NEG | 1010 | | $121.78 | | $24.36 |
| C1011 | K | DG | Platelets, HLA-m, L/R, unit | 1011 | | $499.77 | | $99.95 |
| C1015 | K | DG | Plt, pher,L/R,CMV, irrad | 1020 | | $495.22 | | $99.04 |
| C1016 | K | DG | BLOOD,L/R,FROZ/DEGLY/Washed | 1016 | | $301.68 | | $60.34 |
| C1017 | K | DG | Plt, APH/PHER,L/R,CMV-NEG | 1017 | | $393.15 | | $78.63 |
| C1018 | K | DG | Blood, L/R, IRRADIATED | 1018 | | $132.40 | | $26.48 |
| C1020 | K | DG | RBC, frz/deg/wsh, L/R, irrad | 1021 | | $336.04 | | $67.21 |
| C1021 | K | DG | RBC, L/R, CMV neg, irrad | 1022 | | $201.12 | | $40.22 |
| C1022 | K | DG | Plasma, frz within 24 hour | 0955 | | $95.00 | | $19.00 |
| C1079 | K | | CO 57/58 per 0.5 uCi | 1079 | 1.2556 | $68.51 | | $13.70 |
| C1080 | K | NI | I-131 tositumomab, dx | 1080 | | $2,260.00 | | $452.00 |
| C1081 | K | NI | I-131 tositumomab, tx | 1081 | | $19,565.00 | | $3,913.00 |
| C1082 | K | NF | In-111 ibritumomab tiuxetan | 9118 | | $2,260.00 | | $452.00 |
| C1083 | K | NF | Yttrium 90 ibritumomab tiuxetan | 9117 | | $19,565.00 | | $3,913.00 |
| C1088 | T | | LASER OPTIC TR Sys | 1557 | | $1,850.00 | | $370.00 |
| C1091 | K | | IN111 oxyquinoline,per0.5mCi | 1091 | 4.1151 | $224.52 | | $44.90 |
| C1092 | K | | IN 111 pentetate per 0.5 mCi | 1092 | 3.9855 | $217.45 | | $43.49 |
| C1122 | K | | Tc 99M ARCITUMOMAB PER VIAL | 1122 | 9.8014 | $534.77 | | $106.95 |
| C1166 | K | DG | CYTARABINE LIPOSOMAL, 10 mg | 1166 | 5.1134 | $278.99 | | $55.80 |
| C1167 | K | DG | EPIRUBICIN HCL, 2 mg | 1167 | 0.3744 | $20.43 | | $4.09 |
| C1178 | K | | BUSULFAN IV, 6 Mg | 1178 | 5.4930 | $299.70 | | $59.94 |
| C1200 | K | | TC 99M Sodium Glucoheptonat | 1200 | 0.5550 | $30.28 | | $6.06 |
| C1201 | K | | TC 99M SUCCIMER, PER Vial | 1201 | 1.4706 | $80.24 | | $16.05 |
| C1300 | S | | HYPERBARIC Oxygen | 0659 | 3.0228 | $164.93 | | $32.99 |
| C1305 | K | | Apligraf | 1305 | 15.0691 | $822.19 | | $164.44 |
| C1713 | N | NF | Anchor/screw bn/bn,tis/bn | | | | | |
| C1714 | N | NF | Cath, trans atherectomy, dir | | | | | |
| C1715 | N | NF | Brachytherapy needle | | | | | |
| C1716 | K | | Brachytx source, Gold 198 | 1716 | 1.3811 | $75.35 | | $15.07 |
| C1717 | N | NF | Brachytx source, HDR Ir-192 | | | | | |
| C1718 | K | | Brachytx source, Iodine 125 | 1718 | 0.6843 | $37.34 | | $7.47 |
| C1719 | K | | Brachytx sour,Non-HDR Ir-192 | 1719 | 0.3187 | $17.39 | | $3.48 |
| C1720 | K | | Brachytx sour, Palladium 103 | 1720 | 0.8187 | $44.67 | | $8.93 |
| C1721 | N | NF | AICD, dual chamber | | | | | |
| C1722 | N | NF | AICD, single chamber | | | | | |
| C1724 | N | NF | Cath, trans atherec,rotation | | | | | |
| C1725 | N | NF | Cath, translumin non-laser | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| C1726 | N | NF | Cath, bal dil, non-vascular | | | | | |
| C1727 | N | NF | Cath, bal tis dis, non-vas | | | | | |
| C1728 | N | NF | Cath, brachytx seed adm | | | | | |
| C1729 | N | NF | Cath, drainage | | | | | |
| C1730 | N | NF | Cath, EP, 19 or few elect | | | | | |
| C1731 | N | NF | Cath, EP, 20 or more elec | | | | | |
| C1732 | N | NF | Cath, EP, diag/abl, 3D/vect | | | | | |
| C1733 | N | NF | Cath, EP, othr than cool-tip | | | | | |
| C1750 | N | NF | Cath, hemodialysis,long-term | | | | | |
| C1751 | N | NF | Cath, inf, per/cent/midline | | | | | |
| C1752 | N | NF | Cath,hemodialysis,short-term | | | | | |
| C1753 | N | NF | Cath, intravas ultrasound | | | | | |
| C1754 | N | NF | Catheter, intradiscal | | | | | |
| C1755 | N | NF | Catheter, intraspinal | | | | | |
| C1756 | N | NF | Cath, pacing, transesoph | | | | | |
| C1757 | N | NF | Cath, thrombectomy/embolect | | | | | |
| C1758 | N | NF | Catheter, ureteral | | | | | |
| C1759 | N | NF | Cath, intra echocardiography | | | | | |
| C1760 | N | NF | Closure dev, vasc | | | | | |
| C1762 | N | NF | Conn tiss, human(inc fascia) | | | | | |
| C1763 | N | NF | Conn tiss, non-human | | | | | |
| C1764 | N | NF | Event recorder, cardiac | | | | | |
| C1765 | N | | Adhesion barrier | | | | | |
| C1766 | N | NF | Intro/sheath,strble,non-peel | | | | | |
| C1767 | N | NF | Generator, neurostim, imp | | | | | |
| C1768 | N | NF | Graft, vascular | | | | | |
| C1769 | N | NF | Guide wire | | | | | |
| C1770 | N | NF | Imaging coil, MR, insertable | | | | | |
| C1771 | N | NF | Rep dev, urinary, w/sling | | | | | |
| C1772 | N | NF | Infusion pump, programmable | | | | | |
| C1773 | N | NF | Ret dev, insertable | | | | | |
| C1774 | K | DG | Darbepoetin alfa, 1 mcg | 0734 | | $3.24 | | $0.65 |
| C1775 | K | | FDG, per dose (4-40 mCi/ml) | 1775 | 5.9471 | $324.48 | | $64.90 |
| C1776 | N | NF | Joint device (implantable) | | | | | |
| C1777 | N | NF | Lead, AICD, endo single coil | | | | | |
| C1778 | N | NF | Lead, neurostimulator | | | | | |
| C1779 | N | NF | Lead, pmkr, transvenous VDD | | | | | |
| C1780 | N | NF | Lens, intraocular (new tech) | | | | | |
| C1781 | N | NF | Mesh (implantable) | | | | | |
| C1782 | N | NF | Morcellator | | | | | |
| C1783 | H | | Ocular imp, aqueous drain ev | 1783 | | | | |
| C1784 | N | NF | Ocular dev, intraop, det ret | | | | | |
| C1785 | N | NF | Pmkr, dual, rate-resp | | | | | |
| C1786 | N | NF | Pmkr, single, rate-resp | | | | | |
| C1787 | N | NF | Patient progr, neurostim | | | | | |
| C1788 | N | NF | Port, indwelling, imp | | | | | |
| C1789 | N | NF | Prosthesis, breast, imp | | | | | |
| C1813 | N | NF | Prosthesis, penile, inflatab | | | | | |
| C1814 | H | NF | Retinal tamp, silicone oil | 1814 | | | | |
| C1815 | N | NF | Pros, urinary sph, imp | | | | | |
| C1816 | N | NF | Receiver/transmitter, neuro | | | | | |
| C1817 | N | NF | Septal defect imp sys | | | | | |
| C1818 | H | | Integrated keratoprosthesis | 1818 | | | | |
| C1819 | H | NI | Tissue localization-excision dev | 1819 | | | | |
| C1874 | N | NF | Stent, coated/cov w/del sys | | | | | |
| C1875 | N | NF | Stent, coated/cov w/o del sy | | | | | |
| C1876 | N | NF | Stent, non-coa/non-cov w/del | | | | | |
| C1877 | N | NF | Stent, non-coat/cov w/o del | | | | | |
| C1878 | N | NF | Matrl for vocal cord | | | | | |
| C1879 | N | NF | Tissue marker, implantable | | | | | |
| C1880 | N | NF | Vena cava filter | | | | | |
| C1881 | N | NF | Dialysis access system | | | | | |
| C1882 | N | NF | AICD, other than sing/dual | | | | | |
| C1883 | N | NF | Adapt/ext, pacing/neuro lead | | | | | |
| C1884 | H | NI | Embolization Protect syst | 1884 | | | | |
| C1885 | N | NF | Cath, translumin angio laser | | | | | |
| C1887 | N | NF | Catheter, guiding | | | | | |
| C1888 | H | | Catheter, ablation, non-cardiac, endovascular (implantable). | 1888 | | | | |
| C1891 | N | NF | Infusion pump,non-prog, perm | | | | | |
| C1892 | N | NF | Intro/sheath,fixed,peel-away | | | | | |
| C1893 | N | NF | Intro/sheath, fixed,non-peel | | | | | |
| C1894 | N | NF | Intro/sheath, non-laser | | | | | |
| C1895 | N | NF | Lead, AICD, endo dual coil | | | | | |
| C1896 | N | NF | Lead, AICD, non sing/dual | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| C1897 | N | NF | Lead, neurostim test kit | | | | | |
| C1898 | N | NF | Lead, pmkr, other than trans | | | | | |
| C1899 | N | NF | Lead, pmkr/AICD combination | | | | | |
| C1900 | H | | Lead coronary venous | 1900 | | | | |
| C2614 | H | | Probe, perc lumb disc | 2614 | | | | |
| C2615 | N | NF | Sealant, pulmonary, liquid | | | | | |
| C2616 | K | | Brachytx source, Yttrium-90 | 2616 | 176.2339 | $9,615.50 | | $1,923.10 |
| C2617 | N | NF | Stent, non-cor, tem w/o del | | | | | |
| C2618 | N | | Probe, cryoablation | | | | | |
| C2619 | N | NF | Pmkr, dual, non rate-resp | | | | | |
| C2620 | N | NF | Pmkr, single, non rate-resp | | | | | |
| C2621 | N | NF | Pmkr, other than sing/dual | | | | | |
| C2622 | N | NF | Prosthesis, penile, non-inf | | | | | |
| C2625 | N | NF | Stent, non-cor, tem w/del sy | | | | | |
| C2626 | N | NF | Infusion pump, non-prog,temp | | | | | |
| C2627 | N | NF | Cath, suprapubic/cystoscopic | | | | | |
| C2628 | N | NF | Catheter, occlusion | | | | | |
| C2629 | N | NF | Intro/sheath, laser | | | | | |
| C2630 | N | NF | Cath, EP, cool-tip | | | | | |
| C2631 | N | NF | Rep dev, urinary, w/o sling | | | | | |
| C2632 | H | | Brachytx sol, I-125, per mCi | 2632 | | | | |
| C2633 | K | NI | Brachytx source, Cesium-131 | 2633 | 0.8187 | $44.67 | | $8.93 |
| C8900 | S | | MRA w/cont, abd | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| C8901 | S | | MRA w/o cont, abd | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| C8902 | S | | MRA w/o fol w/cont, abd | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| C8903 | S | | MRI w/cont, breast, uni | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| C8904 | S | | MRI w/o cont, breast, uni | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| C8905 | S | | MRI w/o fol w/cont, brst, un | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| C8906 | S | | MRI w/cont, breast, bi | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| C8907 | S | | MRI w/o cont, breast, bi | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| C8908 | S | | MRI w/o fol w/cont, breast, | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| C8909 | S | | MRA w/cont, chest | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| C8910 | S | | MRA w/o cont, chest | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| C8911 | S | | MRA w/o fol w/cont, chest | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| C8912 | S | | MRA w/cont, lwr ext | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| C8913 | S | | MRA w/o cont, lwr ext | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| C8914 | S | | MRA w/o fol w/cont, lwr ext | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| C8918 | S | NF | MRA w/cont, pelvis | 0284 | 7.1165 | $388.28 | $194.13 | $77.66 |
| C8919 | S | NF | MRA w/o cont, pelvis | 0336 | 6.3897 | $348.63 | $174.31 | $69.73 |
| C8920 | S | NF | MRA w/o fol w/cont, pelvis | 0337 | 9.2075 | $502.37 | $240.77 | $100.47 |
| C9000 | N | | Na chromateCr51, per 0.25mCi | | | | | |
| C9003 | K | | Palivizumab, per 50 mg | 9003 | 6.3077 | $344.15 | | $68.83 |
| C9007 | N | | Baclofen Intrathecal kit-1am | | | | | |
| C9008 | K | | Baclofen Refill Kit-500mcg | 9008 | 0.1264 | $6.90 | | $1.38 |
| C9009 | K | | Baclofen Refill Kit-2000mcg | 9009 | 0.7499 | $40.92 | | $8.18 |
| C9010 | K | DG | Baclofen Refill Kit-4000mcg | 9010 | 0.7739 | $42.22 | | $8.44 |
| C9013 | K | | Co 57 cobaltous chloride | 9013 | 1.0386 | $56.67 | | $11.33 |
| C9102 | N | | 51 Na Chromate, 50mCi | | | | | |
| C9103 | N | | Na Iothalamate I-125, 10 uCi | | | | | |
| C9105 | K | | Hep B imm glob, per 1 ml | 9105 | 1.3074 | $71.33 | | $14.27 |
| C9109 | K | | Tirofiban hcl, 6.25 mg | 9109 | 2.1737 | $118.60 | | $23.72 |
| C9111 | D | DNG | Inj, bivalirudin, 250mg vial | | | | | |
| C9112 | G | | Perflutren lipid micro, 2ml | 9112 | | $148.20 | | $22.15 |
| C9113 | G | | Inj pantoprazole sodium, via | 9113 | | $25.08 | | $3.75 |
| C9116 | D | DNG | Ertapenem sodium, per 1 gm | | | $23.74 | | |
| C9119 | D | DNG | Injection, pegfilgrastim | | | | | |
| C9120 | D | DNG | Injection, fulvestrant | | | | | |
| C9121 | G | | Injection, argatroban | 9121 | | $16.35 | | $2.44 |
| C9123 | G | NF | Transcyte, per 247 sq cm | 9123 | | $770.93 | | $115.23 |
| C9200 | G | | Orcel, per 36 cm2 | 9200 | | $1,135.25 | $ | $169.69 |
| C9201 | G | | Dermagraft, per 37.5 sq cm | 9201 | | $577.60 | | $86.34 |
| C9202 | K | NF | Octafluoropropane | 9202 | 2.1737 | $118.60 | | $23.72 |
| C9203 | G | NF | Perflexane lipid micro | 9203 | | $142.50 | | $21.30 |
| C9204 | D | DNG | Ziprasidone mesylate | | | | | |
| C9205 | G | | Oxaliplatin | 9205 | | $94.46 | | $14.12 |
| C9207 | G | NI | Injection, bortezomib | 9207 | | $1,039.68 | | $155.40 |
| C9208 | G | NF | Injection, agalsidase beta | 9208 | | $123.78 | | $18.50 |
| C9209 | G | NF | Injection, laronidase | 9209 | | $644.10 | | $96.28 |
| C9210 | G | NI | Injection, palonosetron HCL | 9210 | | $307.80 | | $46.01 |
| C9211 | G | NI | Inj, alefacept, IV | 9211 | | $665.00 | | $99.40 |
| C9212 | G | NI | Inj, alefacept, IM | 9212 | | $472.63 | | $70.65 |
| C9503 | K | DG | Fresh frozen plasma, ea unit | 9503 | | $69.74 | | $13.95 |
| C9701 | T | | Stretta System | 1557 | | $1,850.00 | | $370.00 |
| C9703 | T | | Bard Endoscopic Suturing Sys | 1555 | | $1,650.00 | | $330.00 |
| C9704 | T | NI | Inj inert subs upper GI | 1556 | | $1,750.00 | | $350.00 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| C9711 | T | DG | H.E.L.P. Apheresis System | 1552 | | $1,350.00 | | $270.00 |
| D0120 | E | | Periodic oral evaluation | | | | | |
| D0140 | E | | Limit oral eval problm focus | | | | | |
| D0150 | S | | Comprehensve oral evaluation | 0330 | 0.5745 | $31.35 | | $6.27 |
| D0160 | E | | Extensv oral eval prob focus | | | | | |
| D0170 | E | | Re-eval,est pt,problem focus | | | | | |
| D0180 | E | | Comp periodontal evaluation | | | | | |
| D0210 | E | | Intraor complete film series | | | | | |
| D0220 | E | | Intraoral periapical first f | | | | | |
| D0230 | E | | Intraoral periapical ea add | | | | | |
| D0240 | S | | Intraoral occlusal film | 0330 | 0.5745 | $31.35 | | $6.27 |
| D0250 | S | | Extraoral first film | 0330 | 0.5745 | $31.35 | | $6.27 |
| D0260 | S | | Extraoral ea additional film | 0330 | 0.5745 | $31.35 | | $6.27 |
| D0270 | S | | Dental bitewing single film | 0330 | 0.5745 | $31.35 | | $6.27 |
| D0272 | S | | Dental bitewings two films | 0330 | 0.5745 | $31.35 | | $6.27 |
| D0274 | S | | Dental bitewings four films | 0330 | 0.5745 | $31.35 | | $6.27 |
| D0277 | S | | Vert bitewings-sev to eight | 0330 | 0.5745 | $31.35 | | $6.27 |
| D0290 | E | | Dental film skull/facial bon | | | | | |
| D0310 | E | | Dental saliography | | | | | |
| D0320 | E | | Dental tmj arthrogram incl i | | | | | |
| D0321 | E | | Dental other tmj films | | | | | |
| D0322 | E | | Dental tomographic survey | | | | | |
| D0330 | E | | Dental panoramic film | | | | | |
| D0340 | E | | Dental cephalometric film | | | | | |
| D0350 | E | | Oral/facial images | | | | | |
| D0415 | E | | Bacteriologic study | | | | | |
| D0425 | E | | Caries susceptibility test | | | | | |
| D0460 | S | | Pulp vitality test | 0330 | 0.5745 | $31.35 | | $6.27 |
| D0470 | E | | Diagnostic casts | | | | | |
| D0472 | S | | Gross exam, prep & report | 0330 | 0.5745 | $31.35 | | $6.27 |
| D0473 | S | | Micro exam, prep & report | 0330 | 0.5745 | $31.35 | | $6.27 |
| D0474 | S | | Micro w exam of surg margins | 0330 | 0.5745 | $31.35 | | $6.27 |
| D0480 | S | | Cytopath smear prep & report | 0330 | 0.5745 | $31.35 | | $6.27 |
| D0502 | S | | Other oral pathology procedu | 0330 | 0.5745 | $31.35 | | $6.27 |
| D0999 | S | | Unspecified diagnostic proce | 0330 | 0.5745 | $31.35 | | $6.27 |
| D1110 | E | | Dental prophylaxis adult | | | | | |
| D1120 | E | | Dental prophylaxis child | | | | | |
| D1201 | E | | Topical fluor w prophy child | | | | | |
| D1203 | E | | Topical fluor w/o prophy chi | | | | | |
| D1204 | E | | Topical fluor w/o prophy adu | | | | | |
| D1205 | E | | Topical fluoride w/ prophy a | | | | | |
| D1310 | E | | Nutri counsel-control caries | | | | | |
| D1320 | E | | Tobacco counseling | | | | | |
| D1330 | E | | Oral hygiene instruction | | | | | |
| D1351 | E | | Dental sealant per tooth | | | | | |
| D1510 | S | | Space maintainer fxd unilat | 0330 | 0.5745 | $31.35 | | $6.27 |
| D1515 | S | | Fixed bilat space maintainer | 0330 | 0.5745 | $31.35 | | $6.27 |
| D1520 | S | | Remove unilat space maintain | 0330 | 0.5745 | $31.35 | | $6.27 |
| D1525 | S | | Remove bilat space maintain | 0330 | 0.5745 | $31.35 | | $6.27 |
| D1550 | S | | Recement space maintainer | 0330 | 0.5745 | $31.35 | | $6.27 |
| D2140 | E | | Amalgam one surface permanen | | | | | |
| D2150 | E | | Amalgam two surfaces permane | | | | | |
| D2160 | E | | Amalgam three surfaces perma | | | | | |
| D2161 | E | | Amalgam 4 or > surfaces perm | | | | | |
| D2330 | E | | Resin one surface-anterior | | | | | |
| D2331 | E | | Resin two surfaces-anterior | | | | | |
| D2332 | E | | Resin three surfaces-anterio | | | | | |
| D2335 | E | | Resin 4/> surf or w incis an | | | | | |
| D2390 | E | | Ant resin-based cmpst crown | | | | | |
| D2391 | E | | Post 1 srfc resinbased cmpst | | | | | |
| D2392 | E | | Post 2 srfc resinbased cmpst | | | | | |
| D2393 | E | | Post 3 srfc resinbased cmpst | | | | | |
| D2394 | E | | Post >=4srfc resinbase cmpst | | | | | |
| D2410 | E | | Dental gold foil one surface | | | | | |
| D2420 | E | | Dental gold foil two surface | | | | | |
| D2430 | E | | Dental gold foil three surfa | | | | | |
| D2510 | E | | Dental inlay metalic 1 surf | | | | | |
| D2520 | E | | Dental inlay metallic 2 surf | | | | | |
| D2530 | E | | Dental inlay metl 3/more sur | | | | | |
| D2542 | E | | Dental onlay metallic 2 surf | | | | | |
| D2543 | E | | Dental onlay metallic 3 surf | | | | | |
| D2544 | E | | Dental onlay metl 4/more sur | | | | | |
| D2610 | E | | Inlay porcelain/ceramic 1 su | | | | | |
| D2620 | E | | Inlay porcelain/ceramic 2 su | | | | | |
| D2630 | E | | Dental onlay porc 3/more sur | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| D2642 | E | | Dental onlay porcelin 2 surf | | | | | |
| D2643 | E | | Dental onlay porcelin 3 surf | | | | | |
| D2644 | E | | Dental onlay porc 4/more sur | | | | | |
| D2650 | E | | Inlay composite/resin one su | | | | | |
| D2651 | E | | Inlay composite/resin two su | | | | | |
| D2652 | E | | Dental inlay resin 3/mre sur | | | | | |
| D2662 | E | | Dental onlay resin 2 surface | | | | | |
| D2663 | E | | Dental onlay resin 3 surface | | | | | |
| D2664 | E | | Dental onlay resin 4/mre sur | | | | | |
| D2710 | E | | Crown resin laboratory | | | | | |
| D2720 | E | | Crown resin w/ high noble me | | | | | |
| D2721 | E | | Crown resin w/ base metal | | | | | |
| D2722 | E | | Crown resin w/ noble metal | | | | | |
| D2740 | E | | Crown porcelain/ceramic subs | | | | | |
| D2750 | E | | Crown porcelain w/ h noble m | | | | | |
| D2751 | E | | Crown porcelain fused base m | | | | | |
| D2752 | E | | Crown porcelain w/ noble met | | | | | |
| D2780 | E | | Crown 3/4 cast hi noble met | | | | | |
| D2781 | E | | Crown 3/4 cast base metal | | | | | |
| D2782 | E | | Crown 3/4 cast noble metal | | | | | |
| D2783 | E | | Crown 3/4 porcelain/ceramic | | | | | |
| D2790 | E | | Crown full cast high noble m | | | | | |
| D2791 | E | | Crown full cast base metal | | | | | |
| D2792 | E | | Crown full cast noble metal | | | | | |
| D2799 | E | | Provisional crown | | | | | |
| D2910 | E | | Dental recement inlay | | | | | |
| D2920 | E | | Dental recement crown | | | | | |
| D2930 | E | | Prefab stnlss steel crwn pri | | | | | |
| D2931 | E | | Prefab stnlss steel crown pe | | | | | |
| D2932 | E | | Prefabricated resin crown | | | | | |
| D2933 | E | | Prefab stainless steel crown | | | | | |
| D2940 | E | | Dental sedative filling | | | | | |
| D2950 | E | | Core build-up incl any pins | | | | | |
| D2951 | E | | Tooth pin retention | | | | | |
| D2952 | E | | Post and core cast + crown | | | | | |
| D2953 | E | | Each addtnl cast post | | | | | |
| D2954 | E | | Prefab post/core + crown | | | | | |
| D2955 | E | | Post removal | | | | | |
| D2957 | E | | Each addtnl prefab post | | | | | |
| D2960 | E | | Laminate labial veneer | | | | | |
| D2961 | E | | Lab labial veneer resin | | | | | |
| D2962 | E | | Lab labial veneer porcelain | | | | | |
| D2970 | S | | Temporary- fractured tooth | 0330 | 0.5745 | $31.35 | | $6.27 |
| D2980 | E | | Crown repair | | | | | |
| D2999 | S | | Dental unspec restorative pr | 0330 | 0.5745 | $31.35 | | $6.27 |
| D3110 | E | | Pulp cap direct | | | | | |
| D3120 | E | | Pulp cap indirect | | | | | |
| D3220 | E | | Therapeutic pulpotomy | | | | | |
| D3221 | E | | Gross pulpal debridement | | | | | |
| D3230 | E | | Pulpal therapy anterior prim | | | | | |
| D3240 | E | | Pulpal therapy posterior pri | | | | | |
| D3310 | E | | Anterior | | | | | |
| D3320 | E | | Root canal therapy 2 canals | | | | | |
| D3330 | E | | Root canal therapy 3 canals | | | | | |
| D3331 | E | | Non-surg tx root canal obs | | | | | |
| D3332 | E | | Incomplete endodontic tx | | | | | |
| D3333 | E | | Internal root repair | | | | | |
| D3346 | E | | Retreat root canal anterior | | | | | |
| D3347 | E | | Retreat root canal bicuspid | | | | | |
| D3348 | E | | Retreat root canal molar | | | | | |
| D3351 | E | | Apexification/recalc initial | | | | | |
| D3352 | E | | Apexification/recalc interim | | | | | |
| D3353 | E | | Apexification/recalc final | | | | | |
| D3410 | E | | Apicoect/perirad surg anter | | | | | |
| D3421 | E | | Root surgery bicuspid | | | | | |
| D3425 | E | | Root surgery molar | | | | | |
| D3426 | E | | Root surgery ea add root | | | | | |
| D3430 | E | | Retrograde filling | | | | | |
| D3450 | E | | Root amputation | | | | | |
| D3460 | S | | Endodontic endosseous implan | 0330 | 0.5745 | $31.35 | | $6.27 |
| D3470 | E | | Intentional replantation | | | | | |
| D3910 | E | | Isolation- tooth w rubb dam | | | | | |
| D3920 | E | | Tooth splitting | | | | | |
| D3950 | E | | Canal prep/fitting of dowel | | | | | |
| D3999 | S | | Endodontic procedure | 0330 | 0.5745 | $31.35 | | $6.27 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| D4210 | E | | Gingivectomy/plasty per quad | | | | | |
| D4211 | E | | Gingivectomy/plasty per toot | | | | | |
| D4240 | E | | Gingival flap proc w/ planin | | | | | |
| D4241 | E | | Gngvl flap w rootplan 1-3 th | | | | | |
| D4245 | E | | Apically positioned flap | | | | | |
| D4249 | E | | Crown lengthen hard tissue | | | | | |
| D4260 | S | | Osseous surgery per quadrant | 0330 | 0.5745 | $31.35 | | $6.27 |
| D4261 | E | | Osseous surgl-3teethperquad | | | | | |
| D4263 | S | | Bone replce graft first site | 0330 | 0.5745 | $31.35 | | $6.27 |
| D4264 | S | | Bone replce graft each add | 0330 | 0.5745 | $31.35 | | $6.27 |
| D4265 | E | | Bio mtrls to aid soft/os reg | | | | | |
| D4266 | E | | Guided tiss regen resorble | | | | | |
| D4267 | E | | Guided tiss regen nonresorb | | | | | |
| D4268 | S | | Surgical revision procedure | 0330 | 0.5745 | $31.35 | | $6.27 |
| D4270 | S | | Pedicle soft tissue graft pr | 0330 | 0.5745 | $31.35 | | $6.27 |
| D4271 | S | | Free soft tissue graft proc | 0330 | 0.5745 | $31.35 | | $6.27 |
| D4273 | S | | Subepithelial tissue graft | 0330 | 0.5745 | $31.35 | | $6.27 |
| D4274 | E | | Distal/proximal wedge proc | | | | | |
| D4275 | E | | Soft tissue allograft | | | | | |
| D4276 | E | | Con tissue w dble ped graft | | | | | |
| D4320 | E | | Provision splnt intracoronal | | | | | |
| D4321 | E | | Provisional splint extracoro | | | | | |
| D4341 | E | | Periodontal scaling & root | | | | | |
| D4342 | E | | Periodontal scaling 1-3teeth | | | | | |
| D4355 | S | | Full mouth debridement | 0330 | 0.5745 | $31.35 | | $6.27 |
| D4381 | S | | Localized chemo delivery | 0330 | 0.5745 | $31.35 | | $6.27 |
| D4910 | E | | Periodontal maint procedures | | | | | |
| D4920 | E | | Unscheduled dressing change | | | | | |
| D4999 | E | | Unspecified periodontal proc | | | | | |
| D5110 | E | | Dentures complete maxillary | | | | | |
| D5120 | E | | Dentures complete mandible | | | | | |
| D5130 | E | | Dentures immediat maxillary | | | | | |
| D5140 | E | | Dentures immediat mandible | | | | | |
| D5211 | E | | Dentures maxill part resin | | | | | |
| D5212 | E | | Dentures mand part resin | | | | | |
| D5213 | E | | Dentures maxill part metal | | | | | |
| D5214 | E | | Dentures mandibl part metal | | | | | |
| D5281 | E | | Removable partial denture | | | | | |
| D5410 | E | | Dentures adjust cmplt maxil | | | | | |
| D5411 | E | | Dentures adjust cmplt mand | | | | | |
| D5421 | E | | Dentures adjust part maxill | | | | | |
| D5422 | E | | Dentures adjust part mandbl | | | | | |
| D5510 | E | | Dentur repr broken compl bas | | | | | |
| D5520 | E | | Replace denture teeth complt | | | | | |
| D5610 | E | | Dentures repair resin base | | | | | |
| D5620 | E | | Rep part denture cast frame | | | | | |
| D5630 | E | | Rep partial denture clasp | | | | | |
| D5640 | E | | Replace part denture teeth | | | | | |
| D5650 | E | | Add tooth to partial denture | | | | | |
| D5660 | E | | Add clasp to partial denture | | | | | |
| D5670 | E | | Replc tth&acrlc on mtl frmwk | | | | | |
| D5671 | E | | Replc tth&acrlc mandibular | | | | | |
| D5710 | E | | Dentures rebase cmplt maxil | | | | | |
| D5711 | E | | Dentures rebase cmplt mand | | | | | |
| D5720 | E | | Dentures rebase part maxill | | | | | |
| D5721 | E | | Dentures rebase part mandbl | | | | | |
| D5730 | E | | Denture reln cmplt maxil ch | | | | | |
| D5731 | E | | Denture reln cmplt mand chr | | | | | |
| D5740 | E | | Denture reln part maxil chr | | | | | |
| D5741 | E | | Denture reln part mand chr | | | | | |
| D5750 | E | | Denture reln cmplt max lab | | | | | |
| D5751 | E | | Denture reln cmplt mand lab | | | | | |
| D5760 | E | | Denture reln part maxil lab | | | | | |
| D5761 | E | | Denture reln part mand lab | | | | | |
| D5810 | E | | Denture interm cmplt maxill | | | | | |
| D5811 | E | | Denture interm cmplt mandbl | | | | | |
| D5820 | E | | Denture interm part maxill | | | | | |
| D5821 | E | | Denture interm part mandbl | | | | | |
| D5850 | E | | Denture tiss conditn maxill | | | | | |
| D5851 | E | | Denture tiss condtin mandbl | | | | | |
| D5860 | E | | Overdenture complete | | | | | |
| D5861 | E | | Overdenture partial | | | | | |
| D5862 | E | | Precision attachment | | | | | |
| D5867 | E | | Replacement of precision att | | | | | |
| D5875 | E | | Prosthesis modification | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| D5899 | E | | Removable prosthodontic proc | | | | | |
| D5911 | S | | Facial moulage sectional | 0330 | 0.5745 | $31.35 | | $6.27 |
| D5912 | S | | Facial moulage complete | 0330 | 0.5745 | $31.35 | | $6.27 |
| D5913 | E | | Nasal prosthesis | | | | | |
| D5914 | E | | Auricular prosthesis | | | | | |
| D5915 | E | | Orbital prosthesis | | | | | |
| D5916 | E | | Ocular prosthesis | | | | | |
| D5919 | E | | Facial prosthesis | | | | | |
| D5922 | E | | Nasal septal prosthesis | | | | | |
| D5923 | E | | Ocular prosthesis interim | | | | | |
| D5924 | E | | Cranial prosthesis | | | | | |
| D5925 | E | | Facial augmentation implant | | | | | |
| D5926 | E | | Replacement nasal prosthesis | | | | | |
| D5927 | E | | Auricular replacement | | | | | |
| D5928 | E | | Orbital replacement | | | | | |
| D5929 | E | | Facial replacement | | | | | |
| D5931 | E | | Surgical obturator | | | | | |
| D5932 | E | | Postsurgical obturator | | | | | |
| D5933 | E | | Refitting of obturator | | | | | |
| D5934 | E | | Mandibular flange prosthesis | | | | | |
| D5935 | E | | Mandibular denture prosth | | | | | |
| D5936 | E | | Temp obturator prosthesis | | | | | |
| D5937 | E | | Trismus appliance | | | | | |
| D5951 | E | | Feeding aid | | | | | |
| D5952 | E | | Pediatric speech aid | | | | | |
| D5953 | E | | Adult speech aid | | | | | |
| D5954 | E | | Superimposed prosthesis | | | | | |
| D5955 | E | | Palatal lift prosthesis | | | | | |
| D5958 | E | | Intraoral con def inter plt | | | | | |
| D5959 | E | | Intraoral con def mod palat | | | | | |
| D5960 | E | | Modify speech aid prosthesis | | | | | |
| D5982 | E | | Surgical stent | | | | | |
| D5983 | S | | Radiation applicator | 0330 | 0.5745 | $31.35 | | $6.27 |
| D5984 | S | | Radiation shield | 0330 | 0.5745 | $31.35 | | $6.27 |
| D5985 | S | | Radiation cone locator | 0330 | 0.5745 | $31.35 | | $6.27 |
| D5986 | E | | Fluoride applicator | | | | | |
| D5987 | S | | Commissure splint | 0330 | 0.5745 | $31.35 | | $6.27 |
| D5988 | E | | Surgical splint | | | | | |
| D5999 | E | | Maxillofacial prosthesis | | | | | |
| D6010 | E | | Odontics endosteal implant | | | | | |
| D6020 | E | | Odontics abutment placement | | | | | |
| D6040 | E | | Odontics eposteal implant | | | | | |
| D6050 | E | | Odontics transosteal implnt | | | | | |
| D6053 | E | | Implnt/abtmnt spprt remv dnt | | | | | |
| D6054 | E | | Implnt/abtmnt spprt remvprtl | | | | | |
| D6055 | E | | Implant connecting bar | | | | | |
| D6056 | E | | Prefabricated abutment | | | | | |
| D6057 | E | | Custom abutment | | | | | |
| D6058 | E | | Abutment supported crown | | | | | |
| D6059 | E | | Abutment supported mtl crown | | | | | |
| D6060 | E | | Abutment supported mtl crown | | | | | |
| D6061 | E | | Abutment supported mtl crown | | | | | |
| D6062 | E | | Abutment supported mtl crown | | | | | |
| D6063 | E | | Abutment supported mtl crown | | | | | |
| D6064 | E | | Abutment supported mtl crown | | | | | |
| D6065 | E | | Implant supported crown | | | | | |
| D6066 | E | | Implant supported mtl crown | | | | | |
| D6067 | E | | Implant supported mtl crown | | | | | |
| D6068 | E | | Abutment supported retainer | | | | | |
| D6069 | E | | Abutment supported retainer | | | | | |
| D6070 | E | | Abutment supported retainer | | | | | |
| D6071 | E | | Abutment supported retainer | | | | | |
| D6072 | E | | Abutment supported retainer | | | | | |
| D6073 | E | | Abutment supported retainer | | | | | |
| D6074 | E | | Abutment supported retainer | | | | | |
| D6075 | E | | Implant supported retainer | | | | | |
| D6076 | E | | Implant supported retainer | | | | | |
| D6077 | E | | Implant supported retainer | | | | | |
| D6078 | E | | Implnt/abut suprtd fixd dent | | | | | |
| D6079 | E | | Implnt/abut suprtd fixd dent | | | | | |
| D6080 | E | | Implant maintenance | | | | | |
| D6090 | E | | Repair implant | | | | | |
| D6095 | E | | Odontics repr abutment | | | | | |
| D6100 | E | | Removal of implant | | | | | |
| D6199 | E | | Implant procedure | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| D6210 | E | | Prosthodont high noble metal | | | | | |
| D6211 | E | | Bridge base metal cast | | | | | |
| D6212 | E | | Bridge noble metal cast | | | | | |
| D6240 | E | | Bridge porcelain high noble | | | | | |
| D6241 | E | | Bridge porcelain base metal | | | | | |
| D6242 | E | | Bridge porcelain nobel metal | | | | | |
| D6245 | E | | Bridge porcelain/ceramic | | | | | |
| D6250 | E | | Bridge resin w/high noble | | | | | |
| D6251 | E | | Bridge resin base metal | | | | | |
| D6252 | E | | Bridge resin w/noble metal | | | | | |
| D6253 | E | | Provisional pontic | | | | | |
| D6545 | E | | Dental retainr cast metl | | | | | |
| D6548 | E | | Porcelain/ceramic retainer | | | | | |
| D6600 | E | | Porcelain/ceramic inlay 2srf | | | | | |
| D6601 | E | | Porc/ceram inlay >= 3 surfac | | | | | |
| D6602 | E | | Cst hgh nble mtl inlay 2 srf | | | | | |
| D6603 | E | | Cst hgh nble mtl inlay >=3sr | | | | | |
| D6604 | E | | Cst bse mtl inlay 2 surfaces | | | | | |
| D6605 | E | | Cst bse mtl inlay >= 3 surfa | | | | | |
| D6606 | E | | Cast noble metal inlay 2 sur | | | | | |
| D6607 | E | | Cst noble mtl inlay >=3 surf | | | | | |
| D6608 | E | | Onlay porc/crmc 2 surfaces | | | | | |
| D6609 | E | | Onlay porc/crmc >=3 surfaces | | | | | |
| D6610 | E | | Onlay cst hgh nbl mtl 2 srfc | | | | | |
| D6611 | E | | Onlay cst hgh nbl mtl >=3srf | | | | | |
| D6612 | E | | Onlay cst base mtl 2 surface | | | | | |
| D6613 | E | | Onlay cst base mtl >=3 surfa | | | | | |
| D6614 | E | | Onlay cst nbl mtl 2 surfaces | | | | | |
| D6615 | E | | Onlay cst nbl mtl >=3 surfac | | | | | |
| D6720 | E | | Retain crown resin w hi nble | | | | | |
| D6721 | E | | Crown resin w/base metal | | | | | |
| D6722 | E | | Crown resin w/noble metal | | | | | |
| D6740 | E | | Crown porcelain/ceramic | | | | | |
| D6750 | E | | Crown porcelain high noble | | | | | |
| D6751 | E | | Crown porcelain base metal | | | | | |
| D6752 | E | | Crown porcelain noble metal | | | | | |
| D6780 | E | | Crown 3/4 high noble metal | | | | | |
| D6781 | E | | Crown 3/4 cast based metal | | | | | |
| D6782 | E | | Crown 3/4 cast noble metal | | | | | |
| D6783 | E | | Crown 3/4 porcelain/ceramic | | | | | |
| D6790 | E | | Crown full high noble metal | | | | | |
| D6791 | E | | Crown full base metal cast | | | | | |
| D6792 | E | | Crown full noble metal cast | | | | | |
| D6793 | E | | Provisional retainer crown | | | | | |
| D6920 | S | | Dental connector bar | 0330 | 0.5745 | $31.35 | | $6.27 |
| D6930 | E | | Dental recement bridge | | | | | |
| D6940 | E | | Stress breaker | | | | | |
| D6950 | E | | Precision attachment | | | | | |
| D6970 | E | | Post & core plus retainer | | | | | |
| D6971 | E | | Cast post bridge retainer | | | | | |
| D6972 | E | | Prefab post & core plus reta | | | | | |
| D6973 | E | | Core build up for retainer | | | | | |
| D6975 | E | | Coping metal | | | | | |
| D6976 | E | | Each addtnl cast post | | | | | |
| D6977 | E | | Each addtl prefab post | | | | | |
| D6980 | E | | Bridge repair | | | | | |
| D6985 | E | | Pediatric partial denture fx | | | | | |
| D6999 | E | | Fixed prosthodontic proc | | | | | |
| D7111 | S | | Coronal remnants deciduous t | 0330 | 0.5745 | $31.35 | | $6.27 |
| D7140 | S | | Extraction erupted tooth/exr | 0330 | 0.5745 | $31.35 | | $6.27 |
| D7210 | S | | Rem imp tooth w mucoper flp | 0330 | 0.5745 | $31.35 | | $6.27 |
| D7220 | S | | Impact tooth remov soft tiss | 0330 | 0.5745 | $31.35 | | $6.27 |
| D7230 | S | | Impact tooth remov part bony | 0330 | 0.5745 | $31.35 | | $6.27 |
| D7240 | S | | Impact tooth remov comp bony | 0330 | 0.5745 | $31.35 | | $6.27 |
| D7241 | S | | Impact tooth rem bony w/comp | 0330 | 0.5745 | $31.35 | | $6.27 |
| D7250 | S | | Tooth root removal | 0330 | 0.5745 | $31.35 | | $6.27 |
| D7260 | S | | Oral antral fistula closure | 0330 | 0.5745 | $31.35 | | $6.27 |
| D7261 | S | | Primary closure sinus perf | 0330 | 0.5745 | $31.35 | | $6.27 |
| D7270 | E | | Tooth reimplantation | | | | | |
| D7272 | E | | Tooth transplantation | | | | | |
| D7280 | E | | Exposure impact tooth orthod | | | | | |
| D7281 | E | | Exposure tooth aid eruption | | | | | |
| D7282 | E | | Mobilize erupted/malpos toot | | | | | |
| D7285 | E | | Biopsy of oral tissue hard | | | | | |
| D7286 | E | | Biopsy of oral tissue soft | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| D7287 | E | | Cytology sample collection | | | | | |
| D7290 | E | | Repositioning of teeth | | | | | |
| D7291 | S | | Transseptal fiberotomy | 0330 | 0.5745 | $31.35 | | $6.27 |
| D7310 | E | | Alveoplasty w/ extraction | | | | | |
| D7320 | E | | Alveoplasty w/o extraction | | | | | |
| D7340 | E | | Vestibuloplasty ridge extens | | | | | |
| D7350 | E | | Vestibuloplasty exten graft | | | | | |
| D7410 | E | | Rad exc lesion up to 1.25 cm | | | | | |
| D7411 | E | | Excision benign lesion>1.25c | | | | | |
| D7412 | E | | Excision benign lesion compl | | | | | |
| D7413 | E | | Excision malig lesion<=1.25c | | | | | |
| D7414 | E | | Excision malig lesion>1.25cm | | | | | |
| D7415 | E | | Excision malig les complicat | | | | | |
| D7440 | E | | Malig tumor exc to 1.25 cm | | | | | |
| D7441 | E | | Malig tumor > 1.25 cm | | | | | |
| D7450 | E | | Rem odontogen cyst to 1.25cm | | | | | |
| D7451 | E | | Rem odontogen cyst > 1.25 cm | | | | | |
| D7460 | E | | Rem nonodonto cyst to 1.25cm | | | | | |
| D7461 | E | | Rem nonodonto cyst > 1.25 cm | | | | | |
| D7465 | E | | Lesion destruction | | | | | |
| D7471 | E | | Rem exostosis any site | | | | | |
| D7472 | E | | Removal of torus palatinus | | | | | |
| D7473 | E | | Remove torus mandibularis | | | | | |
| D7485 | E | | Surg reduct osseoustuberosit | | | | | |
| D7490 | E | | Mandible resection | | | | | |
| D7510 | E | | I&d absc intraoral soft tiss | | | | | |
| D7520 | E | | I&d abscess extraoral | | | | | |
| D7530 | E | | Removal fb skin/areolar tiss | | | | | |
| D7540 | E | | Removal of fb reaction | | | | | |
| D7550 | E | | Removal of sloughed off bone | | | | | |
| D7560 | E | | Maxillary sinusotomy | | | | | |
| D7610 | E | | Maxilla open reduct simple | | | | | |
| D7620 | E | | Clsd reduct simpl maxilla fx | | | | | |
| D7630 | E | | Open red simpl mandible fx | | | | | |
| D7640 | E | | Clsd red simpl mandible fx | | | | | |
| D7650 | E | | Open red simp malar/zygom fx | | | | | |
| D7660 | E | | Clsd red simp malar/zygom fx | | | | | |
| D7670 | E | | Closd rductn splint alveolus | | | | | |
| D7671 | E | | Alveolus open reduction | | | | | |
| D7680 | E | | Reduct simple facial bone fx | | | | | |
| D7710 | E | | Maxilla open reduct compound | | | | | |
| D7720 | E | | Clsd reduct compd maxilla fx | | | | | |
| D7730 | E | | Open reduct compd mandble fx | | | | | |
| D7740 | E | | Clsd reduct compd mandble fx | | | | | |
| D7750 | E | | Open red comp malar/zygma fx | | | | | |
| D7760 | E | | Clsd red comp malar/zygma fx | | | | | |
| D7770 | E | | Open reduc compd alveolus fx | | | | | |
| D7771 | E | | Alveolus clsd reduc stblz te | | | | | |
| D7780 | E | | Reduct compnd facial bone fx | | | | | |
| D7810 | E | | Tmj open reduct-dislocation | | | | | |
| D7820 | E | | Closed tmp manipulation | | | | | |
| D7830 | E | | Tmj manipulation under anest | | | | | |
| D7840 | E | | Removal of tmj condyle | | | | | |
| D7850 | E | | Tmj meniscectomy | | | | | |
| D7852 | E | | Tmj repair of joint disc | | | | | |
| D7854 | E | | Tmj excisn of joint membrane | | | | | |
| D7856 | E | | Tmj cutting of a muscle | | | | | |
| D7858 | E | | Tmj reconstruction | | | | | |
| D7860 | E | | Tmj cutting into joint | | | | | |
| D7865 | E | | Tmj reshaping components | | | | | |
| D7870 | E | | Tmj aspiration joint fluid | | | | | |
| D7871 | E | | Lysis + lavage w catheters | | | | | |
| D7872 | E | | Tmj diagnostic arthroscopy | | | | | |
| D7873 | E | | Tmj arthroscopy lysis adhesn | | | | | |
| D7874 | E | | Tmj arthroscopy disc reposit | | | | | |
| D7875 | E | | Tmj arthroscopy synovectomy | | | | | |
| D7876 | E | | Tmj arthroscopy discectomy | | | | | |
| D7877 | E | | Tmj arthroscopy debridement | | | | | |
| D7880 | E | | Occlusal orthotic appliance | | | | | |
| D7899 | E | | Tmj unspecified therapy | | | | | |
| D7910 | E | | Dent sutur recent wnd to 5cm | | | | | |
| D7911 | E | | Dental suture wound to 5 cm | | | | | |
| D7912 | E | | Suture complicate wnd > 5 cm | | | | | |
| D7920 | E | | Dental skin graft | | | | | |
| D7940 | S | | Reshaping bone orthognathic | 0330 | 0.5745 | $31.35 | | $6.27 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| D7941 | E | | Bone cutting ramus closed | | | | | |
| D7943 | E | | Cutting ramus open w/graft | | | | | |
| D7944 | E | | Bone cutting segmented | | | | | |
| D7945 | E | | Bone cutting body mandible | | | | | |
| D7946 | E | | Reconstruction maxilla total | | | | | |
| D7947 | E | | Reconstruct maxilla segment | | | | | |
| D7948 | E | | Reconstruct midface no graft | | | | | |
| D7949 | E | | Reconstruct midface w/graft | | | | | |
| D7950 | E | | Mandible graft | | | | | |
| D7955 | E | | Repair maxillofacial defects | | | | | |
| D7960 | E | | Frenulectomy/frenulotomy | | | | | |
| D7970 | E | | Excision hyperplastic tissue | | | | | |
| D7971 | E | | Excision pericoronal gingiva | | | | | |
| D7972 | E | | Surg redct fibrous tuberosit | | | | | |
| D7980 | E | | Sialolithotomy | | | | | |
| D7981 | E | | Excision of salivary gland | | | | | |
| D7982 | E | | Sialodochoplasty | | | | | |
| D7983 | E | | Closure of salivary fistula | | | | | |
| D7990 | E | | Emergency tracheotomy | | | | | |
| D7991 | E | | Dental coronoidectomy | | | | | |
| D7995 | E | | Synthetic graft facial bones | | | | | |
| D7996 | E | | Implant mandible for augment | | | | | |
| D7997 | E | | Appliance removal | | | | | |
| D7999 | E | | Oral surgery procedure | | | | | |
| D8010 | E | | Limited dental tx primary | | | | | |
| D8020 | E | | Limited dental tx transition | | | | | |
| D8030 | E | | Limited dental tx adolescent | | | | | |
| D8040 | E | | Limited dental tx adult | | | | | |
| D8050 | E | | Intercep dental tx primary | | | | | |
| D8060 | E | | Intercep dental tx transitn | | | | | |
| D8070 | E | | Compre dental tx transition | | | | | |
| D8080 | E | | Compre dental tx adolescent | | | | | |
| D8090 | E | | Compre dental tx adult | | | | | |
| D8210 | E | | Orthodontic rem appliance tx | | | | | |
| D8220 | E | | Fixed appliance therapy habt | | | | | |
| D8660 | E | | Preorthodontic tx visit | | | | | |
| D8670 | E | | Periodic orthodontc tx visit | | | | | |
| D8680 | E | | Orthodontic retention | | | | | |
| D8690 | E | | Orthodontic treatment | | | | | |
| D8691 | E | | Repair ortho appliance | | | | | |
| D8692 | E | | Replacement retainer | | | | | |
| D8999 | E | | Orthodontic procedure | | | | | |
| D9110 | N | | Tx dental pain minor proc | | | | | |
| D9210 | E | | Dent anesthesia w/o surgery | | | | | |
| D9211 | E | | Regional block anesthesia | | | | | |
| D9212 | E | | Trigeminal block anesthesia | | | | | |
| D9215 | E | | Local anesthesia | | | | | |
| D9220 | E | | General anesthesia | | | | | |
| D9221 | E | | General anesthesia ea ad 15m | | | | | |
| D9230 | N | | Analgesia | | | | | |
| D9241 | E | | Intravenous sedation | | | | | |
| D9242 | E | | IV sedation ea ad 30 m | | | | | |
| D9248 | N | | Sedation (non-iv) | | | | | |
| D9310 | E | | Dental consultation | | | | | |
| D9410 | E | | Dental house call | | | | | |
| D9420 | E | | Hospital call | | | | | |
| D9430 | E | | Office visit during hours | | | | | |
| D9440 | E | | Office visit after hours | | | | | |
| D9450 | E | | Case presentation tx plan | | | | | |
| D9610 | E | | Dent therapeutic drug inject | | | | | |
| D9630 | S | | Other drugs/medicaments | 0330 | 0.5745 | $31.35 | | $6.27 |
| D9910 | E | | Dent appl desensitizing med | | | | | |
| D9911 | E | | Appl desensitizing resin | | | | | |
| D9920 | E | | Behavior management | | | | | |
| D9930 | S | | Treatment of complications | 0330 | 0.5745 | $31.35 | | $6.27 |
| D9940 | S | | Dental occlusal guard | 0330 | 0.5745 | $31.35 | | $6.27 |
| D9941 | E | | Fabrication athletic guard | | | | | |
| D9950 | S | | Occlusion analysis | 0330 | 0.5745 | $31.35 | | $6.27 |
| D9951 | S | | Limited occlusal adjustment | 0330 | 0.5745 | $31.35 | | $6.27 |
| D9952 | S | | Complete occlusal adjustment | 0330 | 0.5745 | $31.35 | | $6.27 |
| D9970 | E | | Enamel microabrasion | | | | | |
| D9971 | E | | Odontoplasty 1-2 teeth | | | | | |
| D9972 | E | | Extrnl bleaching per arch | | | | | |
| D9973 | E | | Extrnl bleaching per tooth | | | | | |
| D9974 | E | | Intrnl bleaching per tooth | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| D9999 | E | | Adjunctive procedure | | | | | |
| E0100 | A | | Cane adjust/fixed with tip | | | | | |
| E0105 | A | | Cane adjust/fixed quad/3 pro | | | | | |
| E0110 | A | | Crutch forearm pair | | | | | |
| E0111 | A | | Crutch forearm each | | | | | |
| E0112 | A | | Crutch underarm pair wood | | | | | |
| E0113 | A | | Crutch underarm each wood | | | | | |
| E0114 | A | | Crutch underarm pair no wood | | | | | |
| E0116 | A | | Crutch underarm each no wood | | | | | |
| E0117 | A | | Underarm springassist crutch | | | | | |
| E0118 | E | NI | Crutch substitute | | | | | |
| E0130 | A | | Walker rigid adjust/fixed ht | | | | | |
| E0135 | A | | Walker folding adjust/fixed | | | | | |
| E0140 | Y | NI | Walker w trunk support | | | | | |
| E0141 | A | | Rigid walker wheeled wo seat | | | | | |
| E0142 | A | DG | Walker rigid wheeled with se | | | | | |
| E0143 | A | | Walker folding wheeled w/o s | | | | | |
| E0144 | A | | Enclosed walker w rear seat | | | | | |
| E0145 | A | DG | Walker whled seat/crutch att | | | | | |
| E0146 | A | DG | Folding walker wheels w seat | | | | | |
| E0147 | A | | Walker variable wheel resist | | | | | |
| E0148 | A | | Heavyduty walker no wheels | | | | | |
| E0149 | A | | Heavy duty wheeled walker | | | | | |
| E0153 | A | | Forearm crutch platform atta | | | | | |
| E0154 | A | | Walker platform attachment | | | | | |
| E0155 | A | | Walker wheel attachment,pair | | | | | |
| E0156 | A | | Walker seat attachment | | | | | |
| E0157 | A | | Walker crutch attachment | | | | | |
| E0158 | A | | Walker leg extenders set of4 | | | | | |
| E0159 | A | | Brake for wheeled walker | | | | | |
| E0160 | A | | Sitz type bath or equipment | | | | | |
| E0161 | A | | Sitz bath/equipment w/faucet | | | | | |
| E0162 | A | | Sitz bath chair | | | | | |
| E0163 | A | | Commode chair stationry fxd | | | | | |
| E0164 | A | | Commode chair mobile fixed a | | | | | |
| E0165 | A | DG | Commode chair stationry det | | | | | |
| E0166 | A | | Commode chair mobile detach | | | | | |
| E0167 | A | | Commode chair pail or pan | | | | | |
| E0168 | A | | Heavyduty/wide commode chair | | | | | |
| E0169 | A | | Seatlift incorp commodechair | | | | | |
| E0175 | A | | Commode chair foot rest | | | | | |
| E0176 | A | | Air pressre pad/cushion nonp | | | | | |
| E0177 | A | | Water press pad/cushion nonp | | | | | |
| E0178 | A | | Gel pressre pad/cushion nonp | | | | | |
| E0179 | A | | Dry pressre pad/cushion nonp | | | | | |
| E0180 | A | | Press pad alternating w pump | | | | | |
| E0181 | A | | Press pad alternating w/ pum | | | | | |
| E0182 | A | | Pressure pad alternating pum | | | | | |
| E0184 | A | | Dry pressure mattress | | | | | |
| E0185 | A | | Gel pressure mattress pad | | | | | |
| E0186 | A | | Air pressure mattress | | | | | |
| E0187 | A | | Water pressure mattress | | | | | |
| E0188 | E | | Synthetic sheepskin pad | | | | | |
| E0189 | E | | Lambswool sheepskin pad | | | | | |
| E0190 | E | NI | Positioning cushion | | | | | |
| E0191 | A | | Protector heel or elbow | | | | | |
| E0192 | A | | Pad wheelchr low press/posit | | | | | |
| E0193 | A | | Powered air flotation bed | | | | | |
| E0194 | A | | Air fluidized bed | | | | | |
| E0196 | A | | Gel pressure mattress | | | | | |
| E0197 | A | | Air pressure pad for mattres | | | | | |
| E0198 | A | | Water pressure pad for mattr | | | | | |
| E0199 | A | | Dry pressure pad for mattres | | | | | |
| E0200 | A | | Heat lamp without stand | | | | | |
| E0202 | A | | Phototherapy light w/ photom | | | | | |
| E0203 | A | | Therapeutic lightbox tabletp | | | | | |
| E0205 | A | | Heat lamp with stand | | | | | |
| E0210 | A | | Electric heat pad standard | | | | | |
| E0215 | A | | Electric heat pad moist | | | | | |
| E0217 | A | | Water circ heat pad w pump | | | | | |
| E0218 | E | | Water circ cold pad w pump | | | | | |
| E0220 | A | | Hot water bottle | | | | | |
| E0221 | A | | Infrared heating pad system | | | | | |
| E0225 | A | | Hydrocollator unit | | | | | |
| E0230 | A | | Ice cap or collar | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| E0231 | E | | Wound warming device | | | | | |
| E0232 | E | | Warming card for NWT | | | | | |
| E0235 | A | | Paraffin bath unit portable | | | | | |
| E0236 | A | | Pump for water circulating p | | | | | |
| E0238 | A | | Heat pad non-electric moist | | | | | |
| E0239 | A | | Hydrocollator unit portable | | | | | |
| E0240 | E | NI | Bath/shower chair | | | | | |
| E0241 | E | | Bath tub wall rail | | | | | |
| E0242 | E | | Bath tub rail floor | | | | | |
| E0243 | E | | Toilet rail | | | | | |
| E0244 | E | | Toilet seat raised | | | | | |
| E0245 | E | | Tub stool or bench | | | | | |
| E0246 | E | | Transfer tub rail attachment | | | | | |
| E0247 | E | NI | Trans bench w/wo comm open | | | | | |
| E0248 | E | NI | HDtrans bench w/wo comm open | | | | | |
| E0249 | A | | Pad water circulating heat u | | | | | |
| E0250 | A | | Hosp bed fixed ht w/ mattres | | | | | |
| E0251 | A | | Hosp bed fixd ht w/o mattres | | | | | |
| E0255 | A | | Hospital bed var ht w/ mattr | | | | | |
| E0256 | A | | Hospital bed var ht w/o matt | | | | | |
| E0260 | A | | Hosp bed semi-electr w/ matt | | | | | |
| E0261 | A | | Hosp bed semi-electr w/o mat | | | | | |
| E0265 | A | | Hosp bed total electr w/ mat | | | | | |
| E0266 | A | | Hosp bed total elec w/o matt | | | | | |
| E0270 | E | | Hospital bed institutional t | | | | | |
| E0271 | A | | Mattress innerspring | | | | | |
| E0272 | A | | Mattress foam rubber | | | | | |
| E0273 | E | | Bed board | | | | | |
| E0274 | E | | Over-bed table | | | | | |
| E0275 | A | | Bed pan standard | | | | | |
| E0276 | A | | Bed pan fracture | | | | | |
| E0277 | A | | Powered pres-redu air mattrs | | | | | |
| E0280 | A | | Bed cradle | | | | | |
| E0290 | A | | Hosp bed fx ht w/o rails w/m | | | | | |
| E0291 | A | | Hosp bed fx ht w/o rail w/o | | | | | |
| E0292 | A | | Hosp bed var ht w/o rail w/o | | | | | |
| E0293 | A | | Hosp bed var ht w/o rail w/ | | | | | |
| E0294 | A | | Hosp bed semi-elect w/ mattr | | | | | |
| E0295 | A | | Hosp bed semi-elect w/o matt | | | | | |
| E0296 | A | | Hosp bed total elect w/ matt | | | | | |
| E0297 | A | | Hosp bed total elect w/o mat | | | | | |
| E0300 | Y | NI | Enclosed ped crib hosp grade | | | | | |
| E0301 | Y | NI | HD hosp bed, 350-600 lbs | | | | | |
| E0302 | Y | NI | Ex hd hosp bed > 600 lbs | | | | | |
| E0303 | Y | NI | Hosp bed hvy dty xtra wide | | | | | |
| E0304 | Y | NI | Hosp bed xtra hvy dty x wide | | | | | |
| E0305 | A | | Rails bed side half length | | | | | |
| E0310 | A | | Rails bed side full length | | | | | |
| E0315 | E | | Bed accessory brd/tbl/supprt | | | | | |
| E0316 | A | | Bed safety enclosure | | | | | |
| E0325 | A | | Urinal male jug-type | | | | | |
| E0326 | A | | Urinal female jug-type | | | | | |
| E0350 | E | | Control unit bowel system | | | | | |
| E0352 | E | | Disposable pack w/bowel syst | | | | | |
| E0370 | E | | Air elevator for heel | | | | | |
| E0371 | A | | Nonpower mattress overlay | | | | | |
| E0372 | A | | Powered air mattress overlay | | | | | |
| E0373 | A | | Nonpowered pressure mattress | | | | | |
| E0424 | A | | Stationary compressed gas 02 | | | | | |
| E0425 | E | | Gas system stationary compre | | | | | |
| E0430 | E | | Oxygen system gas portable | | | | | |
| E0431 | A | | Portable gaseous 02 | | | | | |
| E0434 | A | | Portable liquid 02 | | | | | |
| E0435 | E | | Oxygen system liquid portabl | | | | | |
| E0439 | A | | Stationary liquid 02 | | | | | |
| E0440 | E | | Oxygen system liquid station | | | | | |
| E0441 | A | | Oxygen contents, gaseous | | | | | |
| E0442 | A | | Oxygen contents, liquid | | | | | |
| E0443 | A | | Portable 02 contents, gas | | | | | |
| E0444 | A | | Portable 02 contents, liquid | | | | | |
| E0445 | A | | Oximeter non-invasive | | | | | |
| E0450 | A | | Volume vent stationary/porta | | | | | |
| E0454 | A | | Pressure ventilator | | | | | |
| E0455 | A | | Oxygen tent excl croup/ped t | | | | | |
| E0457 | A | | Chest shell | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| E0459 | A | | Chest wrap | | | | | |
| E0460 | A | | Neg press vent portabl/statn | | | | | |
| E0461 | A | | Vol vent noninvasive interfa | | | | | |
| E0462 | A | | Rocking bed w/ or w/o side r | | | | | |
| E0470 | Y | NI | RAD w/o backup non-inv intfc | | | | | |
| E0471 | Y | NI | RAD w/backup non inv intrfc | | | | | |
| E0472 | Y | NI | RAD w backup invasive intrfc | | | | | |
| E0480 | A | | Percussor elect/pneum home m | | | | | |
| E0481 | E | | Intrpulmnry percuss vent sys | | | | | |
| E0482 | A | | Cough stimulating device | | | | | |
| E0483 | A | | Chest compression gen system | | | | | |
| E0484 | A | | Non-elec oscillatory pep dvc | | | | | |
| E0500 | A | | Ippb all types | | | | | |
| E0550 | A | | Humidif extens supple w ippb | | | | | |
| E0555 | A | | Humidifier for use w/ regula | | | | | |
| E0560 | A | | Humidifier supplemental w/ i | | | | | |
| E0561 | Y | NI | Humidifier nonheated w PAP | | | | | |
| E0562 | Y | NI | Humidifier heated used w PAP | | | | | |
| E0565 | A | | Compressor air power source | | | | | |
| E0570 | A | | Nebulizer with compression | | | | | |
| E0571 | A | | Aerosol compressor for svneb | | | | | |
| E0572 | A | | Aerosol compressor adjust pr | | | | | |
| E0574 | A | | Ultrasonic generator w svneb | | | | | |
| E0575 | A | | Nebulizer ultrasonic | | | | | |
| E0580 | A | | Nebulizer for use w/ regulat | | | | | |
| E0585 | A | | Nebulizer w/ compressor & he | | | | | |
| E0590 | A | | Dispensing fee dme neb drug | | | | | |
| E0600 | A | | Suction pump portab hom modl | | | | | |
| E0601 | A | | Cont airway pressure device | | | | | |
| E0602 | E | | Manual breast pump | | | | | |
| E0603 | A | | Electric breast pump | | | | | |
| E0604 | A | | Hosp grade elec breast pump | | | | | |
| E0605 | A | | Vaporizer room type | | | | | |
| E0606 | A | | Drainage board postural | | | | | |
| E0607 | A | | Blood glucose monitor home | | | | | |
| E0610 | A | | Pacemaker monitr audible/vis | | | | | |
| E0615 | A | | Pacemaker monitr digital/vis | | | | | |
| E0616 | N | | Cardiac event recorder | | | | | |
| E0617 | A | | Automatic ext defibrillator | | | | | |
| E0618 | A | | Apnea monitor | | | | | |
| E0619 | A | | Apnea monitor w recorder | | | | | |
| E0620 | A | | Cap bld skin piercing laser | | | | | |
| E0621 | A | | Patient lift sling or seat | | | | | |
| E0625 | E | | Patient lift bathroom or toi | | | | | |
| E0627 | A | | Seat lift incorp lift-chair | | | | | |
| E0628 | A | | Seat lift for pt furn-electr | | | | | |
| E0629 | A | | Seat lift for pt furn-non-el | | | | | |
| E0630 | A | | Patient lift hydraulic | | | | | |
| E0635 | A | | Patient lift electric | | | | | |
| E0636 | A | | PT support & positioning sys | | | | | |
| E0637 | Y | NI | Sit-stand w seatlift wheeled | | | | | |
| E0638 | Y | NI | Standing frame sys wheeled | | | | | |
| E0650 | A | | Pneuma compresor non-segment | | | | | |
| E0651 | A | | Pneum compressor segmental | | | | | |
| E0652 | A | | Pneum compres w/cal pressure | | | | | |
| E0655 | A | | Pneumatic appliance half arm | | | | | |
| E0660 | A | | Pneumatic appliance full leg | | | | | |
| E0665 | A | | Pneumatic appliance full arm | | | | | |
| E0666 | A | | Pneumatic appliance half leg | | | | | |
| E0667 | A | | Seg pneumatic appl full leg | | | | | |
| E0668 | A | | Seg pneumatic appl full arm | | | | | |
| E0669 | A | | Seg pneumatic appli half leg | | | | | |
| E0671 | A | | Pressure pneum appl full leg | | | | | |
| E0672 | A | | Pressure pneum appl full arm | | | | | |
| E0673 | A | | Pressure pneum appl half leg | | | | | |
| E0675 | Y | NI | Pneumatic compression device | | | | | |
| E0691 | A | | Uvl pnl 2 sq ft or less | | | | | |
| E0692 | A | | Uvl sys panel 4 ft | | | | | |
| E0693 | A | | Uvl sys panel 6 ft | | | | | |
| E0694 | A | | Uvl md cabinet sys 6 ft | | | | | |
| E0700 | E | | Safety equipment | | | | | |
| E0701 | A | | Helmet w face guard prefab | | | | | |
| E0710 | E | | Restraints any type | | | | | |
| E0720 | A | | Tens two lead | | | | | |
| E0730 | A | | Tens four lead | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| E0731 | A | | Conductive garment for tens/ | | | | | |
| E0740 | E | | Incontinence treatment systm | | | | | |
| E0744 | A | | Neuromuscular stim for scoli | | | | | |
| E0745 | A | | Neuromuscular stim for shock | | | | | |
| E0746 | E | | Electromyograph biofeedback | | | | | |
| E0747 | A | | Elec osteogen stim not spine | | | | | |
| E0748 | A | | Elec osteogen stim spinal | | | | | |
| E0749 | N | | Elec osteogen stim implanted | | | | | |
| E0752 | N | | Neurostimulator electrode | | | | | |
| E0754 | A | | Pulsegenerator pt programmer | | | | | |
| E0755 | E | | Electronic salivary reflex s | | | | | |
| E0756 | N | | Implantable pulse generator | | | | | |
| E0757 | N | | Implantable RF receiver | | | | | |
| E0758 | A | | External RF transmitter | | | | | |
| E0759 | A | | Replace rdfrquncy transmittr | | | | | |
| E0760 | E | | Osteogen ultrasound stimltor | | | | | |
| E0761 | E | | Nontherm electromgntc device | | | | | |
| E0765 | E | | Nerve stimulator for tx n&v | | | | | |
| E0776 | A | | Iv pole | | | | | |
| E0779 | A | | Amb infusion pump mechanical | | | | | |
| E0780 | A | | Mech amb infusion pump <8hrs | | | | | |
| E0781 | A | | External ambulatory infus pu | | | | | |
| E0782 | N | | Non-programble infusion pump | | | | | |
| E0783 | N | | Programmable infusion pump | | | | | |
| E0784 | A | | Ext amb infusn pump insulin | | | | | |
| E0785 | N | | Replacement impl pump cathet | | | | | |
| E0786 | N | | Implantable pump replacement | | | | | |
| E0791 | A | | Parenteral infusion pump sta | | | | | |
| E0830 | N | | Ambulatory traction device | | | | | |
| E0840 | A | | Tract frame attach headboard | | | | | |
| E0850 | A | | Traction stand free standing | | | | | |
| E0855 | A | | Cervical traction equipment | | | | | |
| E0860 | A | | Tract equip cervical tract | | | | | |
| E0870 | A | | Tract frame attach footboard | | | | | |
| E0880 | A | | Trac stand free stand extrem | | | | | |
| E0890 | A | | Traction frame attach pelvic | | | | | |
| E0900 | A | | Trac stand free stand pelvic | | | | | |
| E0910 | A | | Trapeze bar attached to bed | | | | | |
| E0920 | A | | Fracture frame attached to b | | | | | |
| E0930 | A | | Fracture frame free standing | | | | | |
| E0935 | A | | Exercise device passive moti | | | | | |
| E0940 | A | | Trapeze bar free standing | | | | | |
| E0941 | A | | Gravity assisted traction de | | | | | |
| E0942 | A | | Cervical head harness/halter | | | | | |
| E0943 | A | DG | Cervical pillow | | | | | |
| E0944 | A | | Pelvic belt/harness/boot | | | | | |
| E0945 | A | | Belt/harness extremity | | | | | |
| E0946 | A | | Fracture frame dual w cross | | | | | |
| E0947 | A | | Fracture frame attachmnts pe | | | | | |
| E0948 | A | | Fracture frame attachmnts ce | | | | | |
| E0950 | E | | Tray | | | | | |
| E0951 | E | | Loop heel | | | | | |
| E0952 | E | | Toe loop/holder, each | | | | | |
| E0953 | E | | Pneumatic tire | | | | | |
| E0954 | E | | Wheelchair semi-pneumatic ca | | | | | |
| E0955 | Y | NI | Cushioned headrest | | | | | |
| E0956 | Y | NI | W/c lateral trunk/hip suppor | | | | | |
| E0957 | Y | NI | W/c medial thigh support | | | | | |
| E0958 | A | | Whlchr att- conv 1 arm drive | | | | | |
| E0959 | B | | Amputee adapter | | | | | |
| E0960 | Y | NI | W/c shoulder harness/straps | | | | | |
| E0961 | B | | Wheelchair brake extension | | | | | |
| E0962 | A | | Wheelchair 1 inch cushion | | | | | |
| E0963 | A | | Wheelchair 2 inch cushion | | | | | |
| E0964 | A | | Wheelchair 3 inch cushion | | | | | |
| E0965 | A | | Wheelchair 4 inch cushion | | | | | |
| E0966 | B | | Wheelchair head rest extensi | | | | | |
| E0967 | B | | Wheelchair hand rims | | | | | |
| E0968 | A | | Wheelchair commode seat | | | | | |
| E0969 | B | | Wheelchair narrowing device | | | | | |
| E0970 | B | | Wheelchair no. 2 footplates | | | | | |
| E0971 | B | | Wheelchair anti-tipping devi | | | | | |
| E0972 | A | | Transfer board or device | | | | | |
| E0973 | B | | Wheelchair adjustabl height | | | | | |
| E0974 | B | | Wheelchair grade-aid | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| E0975 | B | DG | Wheelchair reinforced seat u | | | | | |
| E0976 | B | DG | Wheelchair reinforced back u | | | | | |
| E0977 | B | | Wheelchair wedge cushion | | | | | |
| E0978 | B | | Wheelchair belt w/airplane b | | | | | |
| E0979 | B | DG | Wheelchair belt with velcro | | | | | |
| E0980 | B | | Wheelchair safety vest | | | | | |
| E0981 | Y | NI | Seat upholstery, replacement | | | | | |
| E0982 | Y | NI | Back upholstery, replacement | | | | | |
| E0983 | Y | NI | Add pwr joystick | | | | | |
| E0984 | Y | NI | Add pwr tiller | | | | | |
| E0985 | Y | NI | W/c seat lift mechanism | | | | | |
| E0986 | Y | NI | Man w/c push-rim pow assist | | | | | |
| E0990 | B | | Whellchair elevating leg res | | | | | |
| E0991 | B | DG | Wheelchair upholstry seat | | | | | |
| E0992 | B | | Wheelchair solid seat insert | | | | | |
| E0993 | B | DG | Wheelchair back upholstery | | | | | |
| E0994 | B | | Wheelchair arm rest | | | | | |
| E0995 | B | | Wheelchair calf rest | | | | | |
| E0996 | B | | Wheelchair tire solid | | | | | |
| E0997 | B | | Wheelchair caster w/ a fork | | | | | |
| E0998 | B | | Wheelchair caster w/o a fork | | | | | |
| E0999 | B | | Wheelchr pneumatic tire w/wh | | | | | |
| E1000 | B | | Wheelchair tire pneumatic ca | | | | | |
| E1001 | B | | Wheelchair wheel | | | | | |
| E1002 | Y | NI | Pwr seat tilt | | | | | |
| E1003 | Y | NI | Pwr seat recline | | | | | |
| E1004 | Y | NI | Pwr seat recline mech | | | | | |
| E1005 | Y | NI | Pwr seat recline pwr | | | | | |
| E1006 | Y | NI | Pwr seat combo w/o shear | | | | | |
| E1007 | Y | NI | Pwr seat combo w/shear | | | | | |
| E1008 | Y | NI | Pwr seat combo pwr shear | | | | | |
| E1009 | Y | NI | Add mech leg elevation | | | | | |
| E1010 | Y | NI | Add pwr leg elevation | | | | | |
| E1011 | A | | Ped wc modify width adjustm | | | | | |
| E1012 | A | | Int seat sys planar ped w/c | | | | | |
| E1013 | A | | Int seat sys contour ped w/c | | | | | |
| E1014 | A | | Reclining back add ped w/c | | | | | |
| E1015 | A | | Shock absorber for man w/c | | | | | |
| E1016 | A | | Shock absorber for power w/c | | | | | |
| E1017 | A | | HD shck absrbr for hd man wc | | | | | |
| E1018 | A | | HD shck absrber for hd powwc | | | | | |
| E1019 | Y | NI | HD feature power seat | | | | | |
| E1020 | A | | Residual limb support system | | | | | |
| E1021 | Y | NI | Ex hd feature power seat | | | | | |
| E1025 | A | | Pedwc lat/thor sup nocontour | | | | | |
| E1026 | A | | Pedwc contoured lat/thor sup | | | | | |
| E1027 | A | | Ped wc lat/ant support | | | | | |
| E1028 | Y | NI | W/c manual swingaway | | | | | |
| E1029 | Y | NI | W/c vent tray fixed | | | | | |
| E1030 | Y | NI | W/c vent tray gimbaled | | | | | |
| E1031 | A | | Rollabout chair with casters | | | | | |
| E1035 | B | | Patient transfer system | | | | | |
| E1037 | A | | Transport chair, ped size | | | | | |
| E1038 | A | | Transport chair, adult size | | | | | |
| E1050 | A | | Whelchr fxd full length arms | | | | | |
| E1060 | A | | Wheelchair detachable arms | | | | | |
| E1065 | B | | Wheelchair power attachment | | | | | |
| E1066 | B | DG | Wheelchair battery charger | | | | | |
| E1069 | B | DG | Wheelchair deep cycle batter | | | | | |
| E1070 | A | | Wheelchair detachable foot r | | | | | |
| E1083 | A | | Hemi-wheelchair fixed arms | | | | | |
| E1084 | A | | Hemi-wheelchair detachable a | | | | | |
| E1085 | A | | Hemi-wheelchair fixed arms | | | | | |
| E1086 | A | | Hemi-wheelchair detachable a | | | | | |
| E1087 | A | | Wheelchair lightwt fixed arm | | | | | |
| E1088 | A | | Wheelchair lightweight det a | | | | | |
| E1089 | A | | Wheelchair lightwt fixed arm | | | | | |
| E1090 | A | | Wheelchair lightweight det a | | | | | |
| E1091 | D | DNG | Wheelchair youth | | | | | |
| E1092 | A | | Wheelchair wide w/ leg rests | | | | | |
| E1093 | A | | Wheelchair wide w/ foot rest | | | | | |
| E1100 | A | | Whchr s-recl fxd arm leg res | | | | | |
| E1110 | A | | Wheelchair semi-recl detach | | | | | |
| E1130 | A | | Whlchr stand fxd arm ft rest | | | | | |
| E1140 | A | | Wheelchair standard detach a | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| E1150 | A | | Wheelchair standard w/ leg r | | | | | |
| E1160 | A | | Wheelchair fixed arms | | | | | |
| E1161 | A | | Manual adult wc w tiltinspac | | | | | |
| E1170 | A | | Whlchr ampu fxd arm leg rest | | | | | |
| E1171 | A | | Wheelchair amputee w/o leg r | | | | | |
| E1172 | A | | Wheelchair amputee detach ar | | | | | |
| E1180 | A | | Wheelchair amputee w/ foot r | | | | | |
| E1190 | A | | Wheelchair amputee w/ leg re | | | | | |
| E1195 | A | | Wheelchair amputee heavy dut | | | | | |
| E1200 | A | | Wheelchair amputee fixed arm | | | | | |
| E1210 | A | | Whlchr moto ful arm leg rest | | | | | |
| E1211 | A | | Wheelchair motorized w/ det | | | | | |
| E1212 | A | | Wheelchair motorized w full | | | | | |
| E1213 | A | | Wheelchair motorized w/ det | | | | | |
| E1220 | A | | Whlchr special size/constrc | | | | | |
| E1221 | A | | Wheelchair spec size w foot | | | | | |
| E1222 | A | | Wheelchair spec size w/ leg | | | | | |
| E1223 | A | | Wheelchair spec size w foot | | | | | |
| E1224 | A | | Wheelchair spec size w/ leg | | | | | |
| E1225 | A | | Wheelchair spec sz semi-recl | | | | | |
| E1226 | B | | W/ch access anti-rollback | | | | | |
| E1227 | B | | Wheelchair spec sz spec ht a | | | | | |
| E1228 | A | | Wheelchair spec sz spec ht b | | | | | |
| E1230 | A | | Power operated vehicle | | | | | |
| E1231 | A | | Rigid ped w/c tilt-in-space | | | | | |
| E1232 | A | | Folding ped wc tilt-in-space | | | | | |
| E1233 | A | | Rig ped wc tltnspc w/o seat | | | | | |
| E1234 | A | | Fld ped wc tltnspc w/o seat | | | | | |
| E1235 | A | | Rigid ped wc adjustable | | | | | |
| E1236 | A | | Folding ped wc adjustable | | | | | |
| E1237 | A | | Rgd ped wc adjstabl w/o seat | | | | | |
| E1238 | A | | Fld ped wc adjstabl w/o seat | | | | | |
| E1240 | A | | Whchr litwt det arm leg rest | | | | | |
| E1250 | A | | Wheelchair lightwt fixed arm | | | | | |
| E1260 | A | | Wheelchair lightwt foot rest | | | | | |
| E1270 | A | | Wheelchair lightweight leg r | | | | | |
| E1280 | A | | Whchr h-duty det arm leg res | | | | | |
| E1285 | A | | Wheelchair heavy duty fixed | | | | | |
| E1290 | A | | Wheelchair hvy duty detach a | | | | | |
| E1295 | A | | Wheelchair heavy duty fixed | | | | | |
| E1296 | A | | Wheelchair special seat heig | | | | | |
| E1297 | A | | Wheelchair special seat dept | | | | | |
| E1298 | A | | Wheelchair spec seat depth/w | | | | | |
| E1300 | E | | Whirlpool portable | | | | | |
| E1310 | A | | Whirlpool non-portable | | | | | |
| E1340 | A | | Repair for DME, per 15 min | | | | | |
| E1353 | A | | Oxygen supplies regulator | | | | | |
| E1355 | A | | Oxygen supplies stand/rack | | | | | |
| E1372 | A | | Oxy suppl heater for nebuliz | | | | | |
| E1390 | A | | Oxygen concentrator | | | | | |
| E1391 | Y | NI | Oxygen concentrator, dual | | | | | |
| E1399 | N | NI | Durable medical equipment mi | | | | | |
| E1405 | A | | O2/water vapor enrich w/heat | | | | | |
| E1406 | A | | O2/water vapor enrich w/o he | | | | | |
| E1500 | A | | Centrifuge | | | | | |
| E1510 | A | | Kidney dialysate delivry sys | | | | | |
| E1520 | A | | Heparin infusion pump | | | | | |
| E1530 | A | | Replacement air bubble detec | | | | | |
| E1540 | A | | Replacement pressure alarm | | | | | |
| E1550 | A | | Bath conductivity meter | | | | | |
| E1560 | A | | Replace blood leak detector | | | | | |
| E1570 | A | | Adjustable chair for esrd pt | | | | | |
| E1575 | A | | Transducer protect/fld bar | | | | | |
| E1580 | A | | Unipuncture control system | | | | | |
| E1590 | A | | Hemodialysis machine | | | | | |
| E1592 | A | | Auto interm peritoneal dialy | | | | | |
| E1594 | A | | Cycler dialysis machine | | | | | |
| E1600 | A | | Deli/install chrg hemo equip | | | | | |
| E1610 | A | | Reverse osmosis h2o puri sys | | | | | |
| E1615 | A | | Deionizer H2O puri system | | | | | |
| E1620 | A | | Replacement blood pump | | | | | |
| E1625 | A | | Water softening system | | | | | |
| E1630 | A | | Reciprocating peritoneal dia | | | | | |
| E1632 | A | | Wearable artificial kidney | | | | | |
| E1634 | E | NI | Peritoneal dialysis clamp | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| E1635 | A | | Compact travel hemodialyzer | | | | | |
| E1636 | A | | Sorbent cartridges per 10 | | | | | |
| E1637 | A | | Hemostats for dialysis, each | | | | | |
| E1639 | A | | Dialysis scale | | | | | |
| E1699 | A | | Dialysis equipment noc | | | | | |
| E1700 | A | | Jaw motion rehab system | | | | | |
| E1701 | A | | Repl cushions for jaw motion | | | | | |
| E1702 | A | | Repl measr scales jaw motion | | | | | |
| E1800 | A | | Adjust elbow ext/flex device | | | | | |
| E1801 | A | | SPS elbow device | | | | | |
| E1802 | A | | Adjst forearm pro/sup device | | | | | |
| E1805 | A | | Adjust wrist ext/flex device | | | | | |
| E1806 | A | | SPS wrist device | | | | | |
| E1810 | A | | Adjust knee ext/flex device | | | | | |
| E1811 | A | | SPS knee device | | | | | |
| E1815 | A | | Adjust ankle ext/flex device | | | | | |
| E1816 | A | | SPS ankle device | | | | | |
| E1818 | A | | SPS forearm device | | | | | |
| E1820 | A | | Soft interface material | | | | | |
| E1821 | A | | Replacement interface SPSD | | | | | |
| E1825 | A | | Adjust finger ext/flex devc | | | | | |
| E1830 | A | | Adjust toe ext/flex device | | | | | |
| E1840 | A | | Adj shoulder ext/flex device | | | | | |
| E1902 | A | | AAC non-electronic board | | | | | |
| E2000 | A | | Gastric suction pump hme mdl | | | | | |
| E2100 | A | | Bld glucose monitor w voice | | | | | |
| E2101 | A | | Bld glucose monitor w lance | | | | | |
| E2120 | Y | NI | Pulse gen sys tx endolymp fl | | | | | |
| E2201 | Y | NI | Man w/ch acc seat w>=20≧<24≧ | | | | | |
| E2202 | Y | NI | Seat width 24-27 in | | | | | |
| E2203 | Y | NI | Frame depth less than 22 in | | | | | |
| E2204 | Y | NI | Frame depth 22 to 25 in | | | | | |
| E2300 | Y | NI | Pwr seat elevation sys | | | | | |
| E2301 | Y | NI | Pwr standing | | | | | |
| E2310 | Y | NI | Electro connect btw control | | | | | |
| E2311 | Y | NI | Electro connect btw 2 sys | | | | | |
| E2320 | Y | NI | Hand chin control | | | | | |
| E2321 | Y | NI | Hand interface joystick | | | | | |
| E2322 | Y | NI | Mult mech switches | | | | | |
| E2323 | Y | NI | Special joystick handle | | | | | |
| E2324 | Y | NI | Chin cup interface | | | | | |
| E2325 | Y | NI | Sip and puff interface | | | | | |
| E2326 | Y | NI | Breath tube kit | | | | | |
| E2327 | Y | NI | Head control interface mech | | | | | |
| E2328 | Y | NI | Head/extremity control inter | | | | | |
| E2329 | Y | NI | Head control nonproportional | | | | | |
| E2330 | Y | NI | Head control proximity switc | | | | | |
| E2331 | Y | NI | Attendant control | | | | | |
| E2340 | Y | NI | W/c wdth 20-23 in seat frame | | | | | |
| E2341 | Y | NI | W/c wdth 24-27 in seat frame | | | | | |
| E2342 | Y | NI | W/c dpth 20-21 in seat frame | | | | | |
| E2343 | Y | NI | W/c dpth 22-25 in seat frame | | | | | |
| E2350 | Y | NI | W/c hd pt wt > 250 lbs | | | | | |
| E2351 | Y | NI | Electronic SGD interface | | | | | |
| E2360 | Y | NI | 22nf nonsealed leadacid | | | | | |
| E2361 | Y | NI | 22nf sealed leadacid battery | | | | | |
| E2362 | Y | NI | Gr24 nonsealed leadacid | | | | | |
| E2363 | Y | NI | Gr24 sealed leadacid battery | | | | | |
| E2364 | Y | NI | U1nonsealed leadacid battery | | | | | |
| E2365 | Y | NI | U1 sealed leadacid battery | | | | | |
| E2366 | Y | NI | Battery charger, single mode | | | | | |
| E2367 | Y | NI | Battery charger, dual mode | | | | | |
| E2399 | Y | NI | Noc interface | | | | | |
| E2402 | Y | NI | Neg press wound therapy pump | | | | | |
| E2500 | Y | NI | SGD digitized pre-rec <=8min | | | | | |
| E2502 | Y | NI | SGD prerec msg >8min <=20min | | | | | |
| E2504 | Y | NI | SGD prerec msg>20min <=40min | | | | | |
| E2506 | Y | NI | SGD prerec msg > 40 min | | | | | |
| E2508 | Y | NI | SGD spelling phys contact | | | | | |
| E2510 | Y | NI | SGD w multi methods msg/accs | | | | | |
| E2511 | Y | NI | SGD sftwre prgrm for PC/PDA | | | | | |
| E2512 | Y | NI | SGD accessory, mounting sys | | | | | |
| E2599 | Y | NI | SGD accessory noc | | | | | |
| G0001 | A | | Drawing blood for specimen | | | | | |
| G0008 | L | | Admin influenza virus vac | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| G0009 | L | | Admin pneumococcal vaccine | | | | | |
| G0010 | K | | Admin hepatitis b vaccine | 0355 | 0.2749 | $15.00 | | $3.00 |
| G0025 | D | DNG | Collagen skin test kit | | | | | |
| G0027 | A | NI | Semen analysis | | | | | |
| G0030 | S | | PET imaging prev PET single | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0031 | S | | PET imaging prev PET multple | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0032 | S | | PET follow SPECT 78464 singl | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0033 | S | | PET follow SPECT 78464 mult | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0034 | S | | PET follow SPECT 76865 singl | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0035 | S | | PET follow SPECT 78465 mult | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0036 | S | | PET follow cornry angio sing | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0037 | S | | PET follow cornry angio mult | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0038 | S | | PET follow myocard perf sing | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0039 | S | | PET follow myocard perf mult | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0040 | S | | PET follow stress echo singl | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0041 | S | | PET follow stress echo mult | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0042 | S | | PET follow ventriculogm sing | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0043 | S | | PET follow ventriculogm mult | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0044 | S | | PET following rest ECG singl | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0045 | S | | PET following rest ECG mult | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0046 | S | | PET follow stress ECG singl | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0047 | S | | PET follow stress ECG mult | 0285 | 14.1508 | $772.08 | $334.45 | $154.42 |
| G0101 | V | | CA screen;pelvic/breast exam | 0600 | 0.9278 | $50.62 | | $10.12 |
| G0102 | N | | Prostate ca screening; dre | | | | | |
| G0103 | A | | Psa, total screening | | | | | |
| G0104 | S | | CA screen;flexi sigmoidscope | 0159 | 2.7823 | $151.81 | | $37.95 |
| G0105 | T | | Colorectal scrn; hi risk ind | 0158 | 7.4244 | $405.08 | | $101.27 |
| G0106 | S | | Colon CA screen;barium enema | 0157 | 2.5693 | $140.18 | | $28.04 |
| G0107 | A | | CA screen; fecal blood test | | | | | |
| G0108 | A | | Diab manage trn per indiv | | | | | |
| G0109 | A | | Diab manage trn ind/group | | | | | |
| G0110 | A | DG | Nett pulm-rehab educ; ind | | | | | |
| G0111 | A | DG | Nett pulm-rehab educ; group | | | | | |
| G0112 | A | DG | Nett;nutrition guid, initial | | | | | |
| G0113 | A | DG | Nett;nutrition guid,subseqnt | | | | | |
| G0114 | A | DG | Nett; psychosocial consult | | | | | |
| G0115 | A | DG | Nett; psychological testing | | | | | |
| G0116 | A | DG | Nett; psychosocial counsel | | | | | |
| G0117 | S | | Glaucoma scrn hgh risk direc | 0230 | 0.7619 | $41.57 | $14.97 | $8.31 |
| G0118 | S | | Glaucoma scrn hgh risk direc | 0230 | 0.7619 | $41.57 | $14.97 | $8.31 |
| G0120 | S | | Colon ca scrn; barium enema | 0157 | 2.5693 | $140.18 | | $28.04 |
| G0121 | T | | Colon ca scrn not hi rsk ind | 0158 | 7.4244 | $405.08 | | $101.27 |
| G0122 | E | | Colon ca scrn; barium enema | | | | | |
| G0123 | A | | Screen cerv/vag thin layer | | | | | |
| G0124 | A | | Screen c/v thin layer by MD | | | | | |
| G0125 | S | | PET img WhBD sgl pulm ring | 1516 | | $1,450.00 | | $290.00 |
| G0127 | T | | Trim nail(s) | 0009 | 0.6652 | $36.29 | $8.34 | $7.26 |
| G0128 | B | | CORF skilled nursing service | | | | | |
| G0129 | P | | Partial hosp prog service | 0033 | 5.2569 | $286.82 | | $57.36 |
| G0130 | X | | Single energy x-ray study | 0260 | 0.7802 | $42.57 | $21.28 | $8.51 |
| G0141 | E | | Scr c/v cyto,autosys and md | | | | | |
| G0143 | A | | Scr c/v cyto,thinlayer,rescr | | | | | |
| G0144 | A | | Scr c/v cyto,thinlayer,rescr | | | | | |
| G0145 | A | | Scr c/v cyto,thinlayer,rescr | | | | | |
| G0147 | A | | Scr c/v cyto, automated sys | | | | | |
| G0148 | A | | Scr c/v cyto, autosys, rescr | | | | | |
| G0151 | B | | HHCP-serv of pt,ea 15 min | | | | | |
| G0152 | B | | HHCP-serv of ot,ea 15 min | | | | | |
| G0153 | B | | HHCP-svs of s/l path,ea 15mn | | | | | |
| G0154 | B | | HHCP-svs of rn,ea 15 min | | | | | |
| G0155 | B | | HHCP-svs of csw,ea 15 min | | | | | |
| G0156 | B | | HHCP-svs of aide,ea 15 min | | | | | |
| G0166 | T | | Extrnl counterpulse, per tx | 0678 | 2.0659 | $112.72 | | $22.54 |
| G0167 | B | DG | Hyperbaric oz tx;no md reqrd | | | | | |
| G0168 | X | | Wound closure by adhesive | 0340 | 0.6314 | $34.45 | | $6.89 |
| G0173 | S | | Stereo radoisurgery,complete | 1528 | | $5,250.00 | | $1,050.00 |
| G0175 | V | | OPPS Service,sched team conf | 0602 | 1.5041 | $82.07 | | $16.41 |
| G0176 | P | | OPPS/PHP;activity therapy | 0033 | 5.2569 | $286.82 | | $57.36 |
| G0177 | P | | OPPS/PHP; train & educ serv | 0033 | 5.2569 | $286.82 | | $57.36 |
| G0179 | E | | MD recertification HHA PT | | | | | |
| G0180 | E | | MD certification HHA patient | | | | | |
| G0181 | E | | Home health care supervision | | | | | |
| G0182 | E | | Hospice care supervision | | | | | |
| G0186 | T | | Dstry eye lesn,fdr vssl tech | 0235 | 5.0749 | $276.89 | $72.04 | $55.38 |
| G0202 | A | | Screeningmammographydigital | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| G0204 | S | | Diagnosticmammographydigital | 0669 | 0.9009 | $49.15 | | $9.83 |
| G0206 | S | | Diagnosticmammographydigital | 0669 | 0.9009 | $49.15 | | $9.83 |
| G0210 | S | | PET img whbd ring dxlung ca | 1516 | | $1,450.00 | | $290.00 |
| G0211 | S | | PET img whbd ring init lung | 1516 | | $1,450.00 | | $290.00 |
| G0212 | S | | PET img whbd ring restag lun | 1516 | | $1,450.00 | | $290.00 |
| G0213 | S | | PET img whbd ring dx colorec | 1516 | | $1,450.00 | | $290.00 |
| G0214 | S | | PET img whbd ring init colre | 1516 | | $1,450.00 | | $290.00 |
| G0215 | S | | PET img whbd restag col | 1516 | | $1,450.00 | | $290.00 |
| G0216 | S | | PET img whbd ring dx melanom | 1516 | | $1,450.00 | | $290.00 |
| G0217 | S | | PET img whbd ring init melan | 1516 | | $1,450.00 | | $290.00 |
| G0218 | S | | PET img whbd ring restag mel | 1516 | | $1,450.00 | | $290.00 |
| G0219 | E | | PET img whbd ring noncov ind | | | | | |
| G0220 | S | | PET img whbd ring dx lymphom | 1516 | | $1,450.00 | | $290.00 |
| G0221 | S | | PET img whbd ring init lymph | 1516 | | $1,450.00 | | $290.00 |
| G0222 | S | | PET img whbd ring resta lymp | 1516 | | $1,450.00 | | $290.00 |
| G0223 | S | | PET img whbd reg ring dx hea | 1516 | | $1,450.00 | | $290.00 |
| G0224 | S | | PETimg whbd reg ring ini hea | 1516 | | $1,450.00 | | $290.00 |
| G0225 | S | | PET img whbd ring restag hea | 1516 | | $1,450.00 | | $290.00 |
| G0226 | S | | PET img whbd dx esophag | 1516 | | $1,450.00 | | $290.00 |
| G0227 | S | | PET img whbd ring ini esopha | 1516 | | $1,450.00 | | $290.00 |
| G0228 | S | | PET img whbd ring restg esop | 1516 | | $1,450.00 | | $290.00 |
| G0229 | S | | PET img metabolic brain ring | 1516 | | $1,450.00 | | $290.00 |
| G0230 | S | | PET myocard viability ring | 1516 | | $1,450.00 | | $290.00 |
| G0231 | S | | PET WhBD colorec; gamma cam | 1516 | | $1,450.00 | | $290.00 |
| G0232 | S | | PET whbd lymphoma; gamma cam | 1516 | | $1,450.00 | | $290.00 |
| G0233 | S | | PET whbd melanoma; gamma cam | 1516 | | $1,450.00 | | $290.00 |
| G0234 | S | | PET WhBD pulm nod; gamma cam | 1516 | | $1,450.00 | | $290.00 |
| G0236 | D | DNG | Digital film convert diag ma | | | | | |
| G0237 | S | | Therapeutic procd strg endur | 0411 | 0.4367 | $23.83 | | $4.77 |
| G0238 | S | | Oth resp proc, indiv | 0411 | 0.4367 | $23.83 | | $4.77 |
| G0239 | S | | Oth resp proc, group | 0411 | 0.4367 | $23.83 | | $4.77 |
| G0242 | S | | Multisource photon ster plan | 1516 | | $1,450.00 | | $290.00 |
| G0243 | S | | Multisour photon stero treat | 1528 | | $5,250.00 | | $1,050.00 |
| G0244 | S | | Observ care by facility topt | 0339 | 3.8356 | $209.27 | | $41.85 |
| G0245 | V | | Initial Foot Exam PTLOPS | 0600 | 0.9278 | $50.62 | | $10.12 |
| G0246 | V | | Follow-up Eval of Foot PTLOPS | 0600 | 0.9278 | $50.62 | | $10.12 |
| G0247 | T | | Routine footcare w LOPS | 0009 | 0.6652 | $36.29 | $8.34 | $7.26 |
| G0248 | S | | Demonstrate use home INR mon | 1503 | | $150.00 | | $30.00 |
| G0249 | S | | Provide test material,equipm | 1503 | | $150.00 | | $30.00 |
| G0250 | E | | MD review interpret of test | | | | | |
| G0251 | S | | Linear acc based stero radio | 1513 | | $1,150.00 | | $230.00 |
| G0252 | E | | PET imaging initial dx | | | | | |
| G0253 | S | | PET image brst dection recur | 1516 | | $1,450.00 | | $290.00 |
| G0254 | S | | PET image brst eval to tx | 1516 | | $1,450.00 | | $290.00 |
| G0255 | E | | Current percep threshold tst | | | | | |
| G0256 | D | DNG | Prostate brachy w palladium | | | | | |
| G0257 | S | | Unsched dialysis ESRD pt hos | 0170 | 5.9678 | $325.61 | | $65.12 |
| G0259 | N | | Inject for sacroiliac joint | | | | | |
| G0260 | T | | Inj for sacroiliac jt anesth | 0204 | 2.1711 | $118.46 | $40.13 | $23.69 |
| G0261 | D | DNG | Prostate brachy w iodine see | | | | | |
| G0262 | S | DG | Sm intestinal image capsule | 1508 | | $650.00 | | $130.00 |
| G0263 | N | | Adm with CHF, CP, asthma | | | | | |
| G0264 | V | | Assmt otr CHF, CP, asthma | 0600 | 0.9278 | $50.62 | | $10.12 |
| G0265 | A | | Cryopresevation Freeze+stora | | | | | |
| G0266 | A | | Thawing + expansion froz cel | | | | | |
| G0267 | S | | Bone marrow or psc harvest | 0110 | 3.6718 | $200.34 | | $40.07 |
| G0268 | X | | Removal of impacted wax md | 0340 | 0.6314 | $34.45 | | $6.89 |
| G0269 | N | | Occlusive device in vein art | | | | | |
| G0270 | A | | MNT subs tx for change dx | | | | | |
| G0271 | A | | Group MNT 2 or more 30 mins | | | | | |
| G0272 | X | DG | Naso/oro gastric tube pl MD | 0272 | 1.4166 | $77.29 | $38.36 | $15.46 |
| G0273 | D | DNG | Pretx planning, non-Hodgkins | | | | | |
| G0274 | D | DNG | Radiopharm tx, non-Hodgkins | | | | | |
| G0275 | N | | Renal angio, cardiac cath | | | | | |
| G0278 | N | | Iliac art angio,cardiac cath | | | | | |
| G0279 | A | | Excorp shock tx, elbow epi | | | | | |
| G0280 | A | | Excorp shock tx other than | | | | | |
| G0281 | A | | Elec stim unattend for press | | | | | |
| G0282 | A | | Elect stim wound care not pd | | | | | |
| G0283 | A | | Elec stim other than wound | | | | | |
| G0288 | S | | Recon, CTA for pre & post sug | 1506 | | $450.00 | | $90.00 |
| G0289 | N | | Arthro, loose body + chondro | | | | | |
| G0290 | T | | Drug-eluting stents, single | 0656 | 103.4907 | $5,646.56 | | $1,129.31 |
| G0291 | T | | Drug-eluting stents,each add | 0656 | 103.4907 | $5,646.56 | | $1,129.31 |
| G0292 | S | | Adm exp drugs,clinical trial | 1503 | | $150.00 | | $30.00 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| G0293 | S | | Non-cov surg proc,clin trial | 1505 | | $350.00 | | $70.00 |
| G0294 | S | | Non-cov proc, clinical trial | 1502 | | $75.00 | | $15.00 |
| G0295 | E | | Electromagnetic therapy onc | | | | | |
| G0296 | S | NF | PET imge restag thyrod cance | 1516 | | $1,450.00 | | $290.00 |
| G0297 | T | NF | Insert single chamber/cd | 0107 | 337.1304 | $18,394.17 | $3,699.14 | $3,678.83 |
| G0298 | T | NF | Insert dual chamber/cd | 0107 | 337.1304 | $18,394.17 | $3,699.14 | $3,678.83 |
| G0299 | T | NF | Inser/repos single icd+leads | 0108 | 433.2998 | $23,641.27 | | $4,728.25 |
| G0300 | T | NF | Insert reposit lead dual+gen | 0108 | 433.2998 | $23,641.27 | | $4,728.25 |
| G0302 | S | NI | Pre-op service LVRS complete | 1509 | | $750.00 | | $150.00 |
| G0303 | S | NI | Pre-op service LVRS 10-15dos | 1507 | | $550.00 | | $110.00 |
| G0304 | S | NI | Pre-op service LVRS 1-9 dos | 1504 | | $250.00 | | $50.00 |
| G0305 | S | NI | Post op service LVRS min 6 | 1504 | | $250.00 | | $50.00 |
| G0306 | A | NI | CBC/diffwbc w/o platelet | | | | | |
| G0307 | A | NI | CBC without platelet | | | | | |
| G0323 | A | NI | ESRD related svs home mo 20+ | | | | | |
| G0324 | A | NI | ESRD related svs home/dy/2y | | | | | |
| G0325 | A | NI | ESRD relate home/dy 2-11yr | | | | | |
| G0326 | A | NI | ESRD relate home/dy 12-19y | | | | | |
| G0327 | A | NI | ESRD relate home/dy 20+yrs | | | | | |
| G0338 | S | NI | Linear accelerator stero pln | 1516 | | $1,450.00 | | $290.00 |
| G0339 | S | NI | Robot lin-radsurg com, first | 1528 | | $5,250.00 | | $1,050.00 |
| G0340 | S | NI | Robot lin-radsurg fractx 2-5 | 1525 | | $3,750.00 | | $750.00 |
| G3001 | S | NI | Admin + supply, tositumomab | 1522 | | $2,250.00 | | $450.00 |
| G9001 | B | | MCCD, initial rate | | | | | |
| G9002 | B | | MCCD,maintenance rate | | | | | |
| G9003 | B | | MCCD, risk adj hi, initial | | | | | |
| G9004 | B | | MCCD, risk adj lo, initial | | | | | |
| G9005 | B | | MCCD, risk adj, maintenance | | | | | |
| G9006 | B | | MCCD, Home monitoring | | | | | |
| G9007 | B | | MCCD, sch team conf | | | | | |
| G9008 | B | | Mccd,phys coor-care ovrsght | | | | | |
| G9009 | E | | MCCD, risk adj, level 3 | | | | | |
| G9010 | E | | MCCD, risk adj, level 4 | | | | | |
| G9011 | E | | MCCD, risk adj, level 5 | | | | | |
| G9012 | E | | Other Specified Case Mgmt | | | | | |
| G9016 | E | | Demo-smoking cessation coun | | | | | |
| J0120 | N | | Tetracyclin injection | | | | | |
| J0130 | K | | Abciximab injection | 1605 | 5.3048 | $289.44 | | $57.89 |
| J0150 | K | | Injection adenosine 6 MG | 0379 | 0.2078 | $11.34 | | $2.27 |
| J0151 | D | DNG | Adenosine injection | | | | | |
| J0152 | K | NI | Adenosine injection | 0917 | 1.0393 | $56.71 | | $11.34 |
| J0170 | N | | Adrenalin epinephrin inject | | | | | |
| J0190 | N | | Inj biperiden lactate/5 mg | | | | | |
| J0200 | N | | Alatrofloxacin mesylate | | | | | |
| J0205 | K | | Alglucerase injection | 0900 | | $37.13 | | $7.43 |
| J0207 | K | | Amifostine | 7000 | 5.3041 | $289.40 | | $57.88 |
| J0210 | N | | Methyldopate hcl injection | | | | | |
| J0215 | B | | Alefacept | | | | | |
| J0256 | K | | Alpha 1 proteinase inhibitor | 0901 | | $3.43 | | $0.69 |
| J0270 | B | | Alprostadil for injection | | | | | |
| J0275 | B | | Alprostadil urethral suppos | | | | | |
| J0280 | N | | Aminophyllin 250 MG inj | | | | | |
| J0282 | N | | Amiodarone HCl | | | | | |
| J0285 | N | | Amphotericin B | | | | | |
| J0287 | K | | Amphotericin b lipid complex | 9024 | 0.3823 | $20.86 | | $4.17 |
| J0288 | K | | Ampho b cholesteryl sulfate | 9024 | 0.3823 | $20.86 | | $4.17 |
| J0289 | K | | Amphotericin b liposome inj | 9024 | 0.3823 | $20.86 | | $4.17 |
| J0290 | N | | Ampicillin 500 MG inj | | | | | |
| J0295 | N | | Ampicillin sodium per 1.5 gm | | | | | |
| J0300 | N | | Amobarbital 125 MG inj | | | | | |
| J0330 | N | | Succinycholine chloride inj | | | | | |
| J0350 | K | | Injection anistreplase 30 u | 1606 | 27.7939 | $1,516.46 | | $303.29 |
| J0360 | N | | Hydralazine hcl injection | | | | | |
| J0380 | N | | Inj metaraminol bitartrate | | | | | |
| J0390 | N | | Chloroquine injection | | | | | |
| J0395 | N | | Arbutamine HCl injection | | | | | |
| J0456 | N | | Azithromycin | | | | | |
| J0460 | N | | Atropine sulfate injection | | | | | |
| J0470 | N | | Dimecaprol injection | | | | | |
| J0475 | N | | Baclofen 10 MG injection | | | | | |
| J0476 | B | | Baclofen intrathecal trial | | | | | |
| J0500 | N | | Dicyclomine injection | | | | | |
| J0515 | N | | Inj benztropine mesylate | | | | | |
| J0520 | N | | Bethanechol chloride inject | | | | | |
| J0530 | N | | Penicillin g benzathine inj | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| J0540 | N | | Penicillin g benzathine inj | | | | | |
| J0550 | N | | Penicillin g benzathine inj | | | | | |
| J0560 | N | | Penicillin g benzathine inj | | | | | |
| J0570 | N | | Penicillin g benzathine inj | | | | | |
| J0580 | N | | Penicillin g benzathine inj | | | | | |
| J0583 | G | NI | Bivalirudin | 9111 | | $1.60 | | $0.04 |
| J0585 | K | | Botulinum toxin a per unit | 0902 | 0.0588 | $3.21 | | $0.64 |
| J0587 | K | | Botulinum toxin type B | 9018 | 0.1279 | $6.98 | | $1.40 |
| J0592 | N | | Buprenorphine hydrochloride | | | | | |
| J0595 | N | NI | Butorphanol tartrate 1 mg | | | | | |
| J0600 | N | | Edetate calcium disodium inj | | | | | |
| J0610 | N | | Calcium gluconate injection | | | | | |
| J0620 | N | | Calcium glycer & lact/10 ML | | | | | |
| J0630 | N | | Calcitonin salmon injection | | | | | |
| J0636 | N | | Inj calcitriol per 0.1 mcg | | | | | |
| J0637 | K | | Caspofungin acetate | 9019 | 0.5432 | $29.64 | | $5.93 |
| J0640 | N | | Leucovorin calcium injection | | | | | |
| J0670 | N | | Inj mepivacaine HCL/10 ml | | | | | |
| J0690 | N | | Cefazolin sodium injection | | | | | |
| J0692 | N | | Cefepime HCl for injection | | | | | |
| J0694 | N | | Cefoxitin sodium injection | | | | | |
| J0696 | N | | Ceftriaxone sodium injection | | | | | |
| J0697 | N | | Sterile cefuroxime injection | | | | | |
| J0698 | N | | Cefotaxime sodium injection | | | | | |
| J0702 | N | | Betamethasone acet&sod phosp | | | | | |
| J0704 | N | | Betamethasone sod phosp/4 MG | | | | | |
| J0706 | N | | Caffeine citrate injection | | | | | |
| J0710 | N | | Cephapirin sodium injection | | | | | |
| J0713 | N | | Inj ceftazidime per 500 mg | | | | | |
| J0715 | N | | Ceftizoxime sodium / 500 MG | | | | | |
| J0720 | N | | Chloramphenicol sodium injec | | | | | |
| J0725 | N | | Chorionic gonadotropin/1000u | | | | | |
| J0735 | N | | Clonidine hydrochloride | | | | | |
| J0740 | N | | Cidofovir injection | | | | | |
| J0743 | N | | Cilastatin sodium injection | | | | | |
| J0744 | N | | Ciprofloxacin iv | | | | | |
| J0745 | N | | Inj codeine phosphate /30 MG | | | | | |
| J0760 | N | | Colchicine injection | | | | | |
| J0770 | N | | Colistimethate sodium inj | | | | | |
| J0780 | N | | Prochlorperazine injection | | | | | |
| J0800 | N | | Corticotropin injection | | | | | |
| J0835 | N | | Inj cosyntropin per 0.25 MG | | | | | |
| J0850 | K | | Cytomegalovirus imm IV /vial | 0903 | 5.3368 | $291.18 | | $58.24 |
| J0880 | E | | Darbepoetin alfa injection | | | | | |
| J0895 | N | | Deferoxamine mesylate inj | | | | | |
| J0900 | N | | Testosterone enanthate inj | | | | | |
| J0945 | N | | Brompheniramine maleate inj | | | | | |
| J0970 | N | | Estradiol valerate injection | | | | | |
| J1000 | N | | Depo-estradiol cypionate inj | | | | | |
| J1020 | N | | Methylprednisolone 20 MG inj | | | | | |
| J1030 | N | | Methylprednisolone 40 MG inj | | | | | |
| J1040 | N | | Methylprednisolone 80 MG inj | | | | | |
| J1051 | N | | Medroxyprogesterone inj | | | | | |
| J1055 | E | | Medrxyprogester acetate inj | | | | | |
| J1056 | E | | MA/EC contraceptiveinjection | | | | | |
| J1060 | N | | Testosterone cypionate 1 ML | | | | | |
| J1070 | N | | Testosterone cypionat 100 MG | | | | | |
| J1080 | N | | Testosterone cypionat 200 MG | | | | | |
| J1094 | N | | Inj dexamethasone acetate | | | | | |
| J1100 | N | | Dexamethasone sodium phos | | | | | |
| J1110 | N | | Inj dihydroergotamine mesylt | | | | | |
| J1120 | N | | Acetazolamid sodium injectio | | | | | |
| J1160 | N | | Digoxin injection | | | | | |
| J1165 | N | | Phenytoin sodium injection | | | | | |
| J1170 | N | | Hydromorphone injection | | | | | |
| J1180 | N | | Dyphylline injection | | | | | |
| J1190 | K | | Dexrazoxane HCl injection | 0726 | 2.0616 | $112.48 | | $22.50 |
| J1200 | N | | Diphenhydramine hcl injectio | | | | | |
| J1205 | N | | Chlorothiazide sodium inj | | | | | |
| J1212 | N | | Dimethyl sulfoxide 50% 50 ML | | | | | |
| J1230 | N | | Methadone injection | | | | | |
| J1240 | N | | Dimenhydrinate injection | | | | | |
| J1245 | K | | Dipyridamole injection | 0380 | 0.2525 | $13.78 | | $2.76 |
| J1250 | N | | Inj dobutamine HCL/250 mg | | | | | |
| J1260 | N | | Dolasetron mesylate | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| J1270 | N | | Injection, doxercalciferol | | | | | |
| J1320 | N | | Amitriptyline injection | | | | | |
| J1325 | N | | Epoprostenol injection | | | | | |
| J1327 | K | | Eptifibatide injection | 1607 | 0.1465 | $7.99 | | $1.60 |
| J1330 | N | | Ergonovine maleate injection | | | | | |
| J1335 | G | NI | Ertapenem injection | 9116 | | $23.74 | | $3.55 |
| J1364 | N | | Erythro lactobionate /500 MG | | | | | |
| J1380 | N | | Estradiol valerate 10 MG inj | | | | | |
| J1390 | N | | Estradiol valerate 20 MG inj | | | | | |
| J1410 | N | | Inj estrogen conjugate 25 MG | | | | | |
| J1435 | N | | Injection estrone per 1 MG | | | | | |
| J1436 | N | | Etidronate disodium inj | | | | | |
| J1438 | K | | Etanercept injection | 1608 | 1.8762 | $102.37 | | $20.47 |
| J1440 | K | | Filgrastim 300 mcg injection | 0728 | 2.2631 | $123.48 | | $24.70 |
| J1441 | K | | Filgrastim 480 mcg injection | 7049 | 3.2251 | $175.96 | | $35.19 |
| J1450 | N | | Fluconazole | | | | | |
| J1452 | N | | Intraocular Fomivirsen na | | | | | |
| J1455 | N | | Foscarnet sodium injection | | | | | |
| J1460 | N | | Gamma globulin 1 CC inj | | | | | |
| J1470 | B | | Gamma globulin 2 CC inj | | | | | |
| J1480 | B | | Gamma globulin 3 CC inj | | | | | |
| J1490 | B | | Gamma globulin 4 CC inj | | | | | |
| J1500 | B | | Gamma globulin 5 CC inj | | | | | |
| J1510 | B | | Gamma globulin 6 CC inj | | | | | |
| J1520 | B | | Gamma globulin 7 CC inj | | | | | |
| J1530 | B | | Gamma globulin 8 CC inj | | | | | |
| J1540 | B | | Gamma globulin 9 CC inj | | | | | |
| J1550 | B | | Gamma globulin 10 CC inj | | | | | |
| J1560 | B | | Gamma globulin > 10 CC inj | | | | | |
| J1563 | K | | Immune globulin, 1 g | 0905 | 0.8057 | $43.96 | | $8.79 |
| J1564 | K | | Immune globulin 10 mg | 9021 | 0.0080 | $0.44 | | $0.09 |
| J1565 | K | | RSV-ivig | 0906 | 0.8910 | $48.61 | | $9.72 |
| J1570 | K | | Ganciclovir sodium injection | 0907 | 0.5918 | $32.29 | | $6.46 |
| J1580 | N | | Garamycin gentamicin inj | | | | | |
| J1590 | N | | Gatifloxacin injection | | | | | |
| J1595 | N | | Injection glatiramer acetate | | | | | |
| J1600 | N | | Gold sodium thiomaleate inj | | | | | |
| J1610 | N | | Glucagon hydrochloride/1 MG | | | | | |
| J1620 | N | | Gonadorelin hydroch/ 100 mcg | | | | | |
| J1626 | K | | Granisetron HCl injection | 0764 | 0.1044 | $5.70 | | $1.14 |
| J1630 | N | | Haloperidol injection | | | | | |
| J1631 | N | | Haloperidol decanoate inj | | | | | |
| J1642 | N | | Inj heparin sodium per 10 u | | | | | |
| J1644 | N | | Inj heparin sodium per 1000u | | | | | |
| J1645 | N | | Dalteparin sodium | | | | | |
| J1650 | N | | Inj enoxaparin sodium | | | | | |
| J1652 | N | | Fondaparinux sodium | | | | | |
| J1655 | N | | Tinzaparin sodium injection | | | | | |
| J1670 | N | | Tetanus immune globulin inj | | | | | |
| J1700 | N | | Hydrocortisone acetate inj | | | | | |
| J1710 | N | | Hydrocortisone sodium ph inj | | | | | |
| J1720 | N | | Hydrocortisone sodium succ i | | | | | |
| J1730 | N | | Diazoxide injection | | | | | |
| J1742 | N | | Ibutilide fumarate injection | | | | | |
| J1745 | K | | Infliximab injection | 7043 | 0.7122 | $38.86 | | $7.77 |
| J1750 | N | | Iron dextran | | | | | |
| J1756 | N | | Iron sucrose injection | | | | | |
| J1785 | K | | Injection imiglucerase /unit | 0916 | | $3.71 | | $0.74 |
| J1790 | N | | Droperidol injection | | | | | |
| J1800 | N | | Propranolol injection | | | | | |
| J1810 | E | | Droperidol/fentanyl inj | | | | | |
| J1815 | N | | Insulin injection | | | | | |
| J1817 | N | | Insulin for insulin pump use | | | | | |
| J1825 | K | | Interferon beta-1a | 0909 | 3.3868 | $184.79 | | $36.96 |
| J1830 | K | | Interferon beta-1b / .25 MG | 0910 | 1.8421 | $100.51 | | $20.10 |
| J1835 | N | | Itraconazole injection | | | | | |
| J1840 | N | | Kanamycin sulfate 500 MG inj | | | | | |
| J1850 | N | | Kanamycin sulfate 75 MG inj | | | | | |
| J1885 | N | | Ketorolac tromethamine inj | | | | | |
| J1890 | N | | Cephalothin sodium injection | | | | | |
| J1910 | N | DG | Kutapressin injection | | | | | |
| J1940 | N | | Furosemide injection | | | | | |
| J1950 | K | | Leuprolide acetate /3.75 MG | 0800 | 3.3525 | $182.92 | | $36.58 |
| J1955 | B | | Inj levocarnitine per 1 gm | | | | | |
| J1956 | N | | Levofloxacin injection | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| J1960 | N | | Levorphanol tartrate inj | | | | | |
| J1980 | N | | Hyoscyamine sulfate inj | | | | | |
| J1990 | N | | Chlordiazepoxide injection | | | | | |
| J2000 | N | DG | Lidocaine injection | | | | | |
| J2001 | N | NI | Lidocaine injection | | | | | |
| J2010 | N | | Lincomycin injection | | | | | |
| J2020 | K | | Linezolid injection | 9001 | 0.2771 | $15.12 | | $3.02 |
| J2060 | N | | Lorazepam injection | | | | | |
| J2150 | N | | Mannitol injection | | | | | |
| J2175 | N | | Meperidine hydrochl /100 MG | | | | | |
| J2180 | N | | Meperidine/promethazine inj | | | | | |
| J2185 | N | NI | Meropenem | | | | | |
| J2210 | N | | Methylergonovin maleate inj | | | | | |
| J2250 | N | | Inj midazolam hydrochloride | | | | | |
| J2260 | K | | Inj milrinone lactate, per 5 mg | 7007 | 0.2129 | $11.62 | | $2.32 |
| J2270 | N | | Morphine sulfate injection | | | | | |
| J2271 | N | | Morphine so4 injection 100mg | | | | | |
| J2275 | N | | Morphine sulfate injection | | | | | |
| J2280 | N | NI | Inj, moxifloxacin 100 mg | | | | | |
| J2300 | N | | Inj nalbuphine hydrochloride | | | | | |
| J2310 | N | | Inj naloxone hydrochloride | | | | | |
| J2320 | N | | Nandrolone decanoate 50 MG | | | | | |
| J2321 | N | | Nandrolone decanoate 100 MG | | | | | |
| J2322 | N | | Nandrolone decanoate 200 MG | | | | | |
| J2324 | G | | Nesiritide, per 0.5 mg vial | 9114 | | $151.62 | | $22.66 |
| J2352 | D | DNG | Octreotide acetate injection | | | | | |
| J2353 | K | NI | Octreotide injection, depot | 1207 | 1.2049 | $65.74 | | $13.15 |
| J2354 | K | NI | Octreotide inj, non-depot | 7031 | 0.0264 | $1.44 | | $0.29 |
| J2355 | K | | Oprelvekin injection | 7011 | | $248.16 | | $49.63 |
| J2360 | N | | Orphenadrine injection | | | | | |
| J2370 | N | | Phenylephrine hcl injection | | | | | |
| J2400 | N | | Chloroprocaine hcl injection | | | | | |
| J2405 | N | | Ondansetron hcl injection | | | | | |
| J2410 | N | | Oxymorphone hcl injection | | | | | |
| J2430 | K | | Pamidronate disodium /30 MG | 0730 | 3.1949 | $174.32 | | $34.86 |
| J2440 | N | | Papaverin hcl injection | | | | | |
| J2460 | N | | Oxytetracycline injection | | | | | |
| J2501 | N | | Paricalcitol | | | | | |
| J2505 | G | NI | Injection, pegfilgrastim 6mg | 9119 | | $2,802.50 | | $418.90 |
| J2510 | N | | Penicillin g procaine inj | | | | | |
| J2515 | N | | Pentobarbital sodium inj | | | | | |
| J2540 | N | | Penicillin g potassium inj | | | | | |
| J2543 | N | | Piperacillin/tazobactam | | | | | |
| J2545 | Y | | Pentamidine isethionte/300mg | | | | | |
| J2550 | N | | Promethazine hcl injection | | | | | |
| J2560 | N | | Phenobarbital sodium inj | | | | | |
| J2590 | N | | Oxytocin injection | | | | | |
| J2597 | N | | Inj desmopressin acetate | | | | | |
| J2650 | N | | Prednisolone acetate inj | | | | | |
| J2670 | N | | Totazoline hcl injection | | | | | |
| J2675 | N | | Inj progesterone per 50 MG | | | | | |
| J2680 | N | | Fluphenazine decanoate 25 MG | | | | | |
| J2690 | N | | Procainamide hcl injection | | | | | |
| J2700 | N | | Oxacillin sodium injeciton | | | | | |
| J2710 | N | | Neostigmine methylslfte inj | | | | | |
| J2720 | N | | Inj protamine sulfate/10 MG | | | | | |
| J2725 | N | | Inj protirelin per 250 mcg | | | | | |
| J2730 | N | | Pralidoxime chloride inj | | | | | |
| J2760 | N | | Phentolaine mesylate inj | | | | | |
| J2765 | N | | Metoclopramide hcl injection | | | | | |
| J2770 | N | | Quinupristin/dalfopristin | | | | | |
| J2780 | N | | Ranitidine hydrochloride inj | | | | | |
| J2783 | N | NI | Rasburicase | | | | | |
| J2788 | K | | Rho d immune globulin 50 mcg | 9023 | 0.0310 | $1.69 | | $0.34 |
| J2790 | K | | Rho d immune globulin inj | 0884 | 0.1863 | $10.16 | | $2.03 |
| J2792 | K | | Rho(D) immune globulin h, sd | 1609 | 0.1789 | $9.76 | | $1.95 |
| J2795 | N | | Ropivacaine HCl injection | | | | | |
| J2800 | N | | Methocarbamol injection | | | | | |
| J2810 | N | | Inj theophylline per 40 MG | | | | | |
| J2820 | K | | Sargramostim injection | 0731 | 0.2991 | $16.32 | | $3.26 |
| J2910 | N | | Aurothioglucose injeciton | | | | | |
| J2912 | N | | Sodium chloride injection | | | | | |
| J2916 | N | | Na ferric gluconate complex | | | | | |
| J2920 | N | | Methylprednisolone injection | | | | | |
| J2930 | N | | Methylprednisolone injection | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| J2940 | N | | Somatrem injection | | | | | |
| J2941 | K | | Somatropin injection | 7034 | 0.7547 | $41.18 | | $8.24 |
| J2950 | N | | Promazine hcl injection | | | | | |
| J2993 | K | | Reteplase injection | 9005 | 10.4165 | $568.33 | | $113.67 |
| J2995 | K | | Inj streptokinase /250000 IU | 0911 | 1.5733 | $85.84 | | $17.17 |
| J2997 | K | | Alteplase recombinant | 7048 | 0.2856 | $15.58 | | $3.12 |
| J3000 | N | | Streptomycin injection | | | | | |
| J3010 | N | | Fentanyl citrate injeciton | | | | | |
| J3030 | N | | Sumatriptan succinate / 6 MG | | | | | |
| J3070 | N | | Pentazocine hcl injection | | | | | |
| J3100 | K | | Tenecteplase injection | 9002 | 23.7669 | $1,296.75 | | $259.35 |
| J3105 | N | | Terbutaline sulfate inj | | | | | |
| J3120 | N | | Testosterone enanthate inj | | | | | |
| J3130 | N | | Testosterone enanthate inj | | | | | |
| J3140 | N | | Testosterone suspension inj | | | | | |
| J3150 | N | | Testosteron propionate inj | | | | | |
| J3230 | N | | Chlorpromazine hcl injection | | | | | |
| J3240 | K | | Thyrotropin injection | 9108 | | $572.00 | | $114.40 |
| J3245 | K | | Tirofiban hydrochloride | 7041 | 4.176 | $227.85 | | $45.57 |
| J3250 | N | | Trimethobenzamide hcl inj | | | | | |
| J3260 | N | | Tobramycin sulfate injection | | | | | |
| J3265 | N | | Injection torsemide 10 mg/ml | | | | | |
| J3280 | N | | Thiethylperazine maleate inj | | | | | |
| J3301 | N | | Triamcinolone acetonide inj | | | | | |
| J3302 | N | | Triamcinolone diacetate inj | | | | | |
| J3303 | N | | Triamcinolone hexacetonl inj | | | | | |
| J3305 | K | | Inj trimetrexate glucoronate | 7045 | 1.1246 | $61.36 | | $12.27 |
| J3310 | N | | Perphenazine injeciton | | | | | |
| J3315 | G | | Triptorelin pamoate | 9122 | | $398.62 | | $59.58 |
| J3320 | N | | Spectinomycn di-hcl inj | | | | | |
| J3350 | N | | Urea injection | | | | | |
| J3360 | N | | Diazepam injection | | | | | |
| J3364 | N | | Urokinase 5000 IU injection | | | | | |
| J3365 | K | | Urokinase 250,000 IU inj | 7036 | 3.7855 | $206.54 | | $41.31 |
| J3370 | N | | Vancomycin hcl injection | | | | | |
| J3395 | K | | Verteporfin injection | 1203 | 16.4439 | $897.20 | | $179.44 |
| J3400 | N | | Triflupromazine hcl inj | | | | | |
| J3410 | N | | Hydroxyzine hcl injection | | | | | |
| J3411 | N | NI | Thiamine hcl 100 mg | | | | | |
| J3415 | N | NI | Pyridoxine hcl 100 mg | | | | | |
| J3420 | N | | Vitamin b12 injection | | | | | |
| J3430 | N | | Vitamin k phytonadione inj | | | | | |
| J3465 | N | NI | Injection, voriconazole | | | | | |
| J3470 | N | | Hyaluronidase injection | | | | | |
| J3475 | N | | Inj magnesium sulfate | | | | | |
| J3480 | N | | Inj potassium chloride | | | | | |
| J3485 | N | | Zidovudine | | | | | |
| J3486 | G | NI | Ziprasidone mesylate | 9204 | | $20.79 | | $3.11 |
| J3487 | G | | Zoledronic acid | 9115 | | $217.43 | | $32.50 |
| J3490 | N | | Drugs unclassified injection | | | | | |
| J3520 | E | | Edetate disodium per 150 mg | | | | | |
| J3530 | N | | Nasal vaccine inhalation | | | | | |
| J3535 | E | | Metered dose inhaler drug | | | | | |
| J3570 | E | | Laetrile amygdalin vit B17 | | | | | |
| J3590 | N | | Unclassified biologics | | | | | |
| J7030 | N | | Normal saline solution infus | | | | | |
| J7040 | N | | Normal saline solution infus | | | | | |
| J7042 | N | | 5% dextrose/normal saline | | | | | |
| J7050 | N | | Normal saline solution infus | | | | | |
| J7051 | N | | Sterile saline/water | | | | | |
| J7060 | N | | 5% dextrose/water | | | | | |
| J7070 | N | | D5w infusion | | | | | |
| J7100 | N | | Dextran 40 infusion | | | | | |
| J7110 | N | | Dextran 75 infusion | | | | | |
| J7120 | N | | Ringers lactate infusion | | | | | |
| J7130 | N | | Hypertonic saline solution | | | | | |
| J7190 | K | | Factor viii | 0925 | | $0.51 | | $0.10 |
| J7191 | K | | Factor VIII (porcine) | 0926 | | $1.52 | | $0.30 |
| J7192 | K | | Factor viii recombinant | 0927 | | $1.01 | | $0.20 |
| J7193 | K | | Factor IX non-recombinant | 0931 | | $0.51 | | $0.10 |
| J7194 | K | | Factor ix complex | 0928 | | $0.51 | | $0.10 |
| J7195 | K | | Factor IX recombinant | 0932 | | $1.01 | | $0.20 |
| J7197 | N | | Antithrombin iii injection | | | | | |
| J7198 | K | | Anti-inhibitor | 0929 | | $1.01 | | $0.20 |
| J7199 | B | | Hemophilia clot factor noc | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| J7300 | E | | Intraut copper contraceptive | | | | | |
| J7302 | E | | Levonorgestrel iu contracept | | | | | |
| J7303 | E | NI | Contraceptive vaginal ring | | | | | |
| J7308 | N | | Aminolevulinic acid hcl top | | | | | |
| J7310 | K | | Ganciclovir long act implant | 0913 | 1.5861 | $86.54 | | $17.31 |
| J7317 | K | | Sodium hyaluronate injection | 7316 | 2.5436 | $138.78 | | $27.76 |
| J7320 | K | | Hylan G-F 20 injection | 1611 | 2.2628 | $123.46 | | $24.69 |
| J7330 | E | | Cultured chondrocytes implnt | | | | | |
| J7340 | E | | Metabolic active D/E tissue | | | | | |
| J7342 | N | | Metabolically active tissue | | | | | |
| J7350 | N | | Injectable human tissue | | | | | |
| J7500 | N | | Azathioprine oral 50mg | | | | | |
| J7501 | N | | Azathioprine parenteral | | | | | |
| J7502 | K | | Cyclosporine oral 100 mg | 0888 | 0.0470 | $2.56 | | $0.51 |
| J7504 | K | | Lymphocyte immune globulin | 0890 | 2.3439 | $127.89 | | $25.58 |
| J7505 | K | | Monoclonal antibodies | 7038 | 5.8803 | $320.84 | | $64.17 |
| J7506 | N | | Prednisone oral | | | | | |
| J7507 | K | | Tacrolimus oral per 1 MG | 0891 | 0.0246 | $1.34 | | $0.27 |
| J7508 | B | DG | Tacrolimus oral per 5 MG | | | | | |
| J7509 | N | | Methylprednisolone oral | | | | | |
| J7510 | N | | Prednisolone oral per 5 mg | | | | | |
| J7511 | K | | Antithymocyte globuln rabbit | 9104 | 2.9978 | $163.56 | | $32.71 |
| J7513 | K | | Daclizumab, parenteral | 1612 | | $393.78 | | $78.76 |
| J7515 | N | | Cyclosporine oral 25 mg | | | | | |
| J7516 | N | | Cyclosporin parenteral 250mg | | | | | |
| J7517 | K | | Mycophenolate mofetil oral | 9015 | 0.0374 | $2.04 | | $0.41 |
| J7520 | K | | Sirolimus, oral | 9020 | 0.0529 | $2.89 | | $0.58 |
| J7525 | K | | Tacrolimus injection | 9006 | 0.1048 | $5.72 | | $1.14 |
| J7599 | N | | Immunosuppressive drug noc | | | | | |
| J7608 | Y | | Acetylcysteine inh sol u d | | | | | |
| J7618 | Y | | Albuterol inh sol con | | | | | |
| J7619 | Y | | Albuterol inh sol u d | | | | | |
| J7621 | Y | NI | (Levo)albuterol/Ipra-bromide | | | | | |
| J7622 | A | | Beclomethasone inhalatn sol | | | | | |
| J7624 | A | | Betamethasone inhalation sol | | | | | |
| J7626 | A | | Budesonide inhalation sol | | | | | |
| J7628 | Y | | Bitolterol mes inhal sol con | | | | | |
| J7629 | Y | | Bitolterol mes inh sol u d | | | | | |
| J7631 | Y | | Cromolyn sodium inh sol u d | | | | | |
| J7633 | N | | Budesonide concentrated sol | | | | | |
| J7635 | Y | | Atropine inhal sol con | | | | | |
| J7636 | Y | | Atropine inhal sol unit dose | | | | | |
| J7637 | Y | | Dexamethasone inhal sol con | | | | | |
| J7638 | Y | | Dexamethasone inhal sol u d | | | | | |
| J7639 | Y | | Dornase alpha inhal sol u d | | | | | |
| J7641 | A | | Flunisolide, inhalation sol | | | | | |
| J7642 | Y | | Glycopyrrolate inhal sol con | | | | | |
| J7643 | Y | | Glycopyrrolate inhal sol u d | | | | | |
| J7644 | Y | | Ipratropium brom inh sol u d | | | | | |
| J7648 | Y | | Isoetharine hcl inh sol con | | | | | |
| J7649 | Y | | Isoetharine hcl inh sol u d | | | | | |
| J7658 | Y | | Isoproterenolhcl inh sol con | | | | | |
| J7659 | Y | | Isoproterenol hcl inh sol ud | | | | | |
| J7668 | Y | | Metaproterenol inh sol con | | | | | |
| J7669 | Y | | Metaproterenol inh sol u d | | | | | |
| J7680 | Y | | Terbutaline so4 inh sol con | | | | | |
| J7681 | Y | | Terbutaline so4 inh sol u d | | | | | |
| J7682 | Y | | Tobramycin inhalation sol | | | | | |
| J7683 | Y | | Triamcinolone inh sol con | | | | | |
| J7684 | Y | | Triamcinolone inh sol u d | | | | | |
| J7699 | Y | | Inhalation solution for DME | | | | | |
| J7799 | Y | | Non-inhalation drug for DME | | | | | |
| J8499 | E | | Oral prescrip drug non chemo | | | | | |
| J8510 | K | | Oral busulfan | 7015 | 0.0288 | $1.57 | | $0.31 |
| J8520 | K | | Capecitabine, oral, 150 mg | 7042 | 0.0302 | $1.65 | | $0.33 |
| J8521 | E | | Capecitabine, oral, 500 mg | | | | | |
| J8530 | N | | Cyclophosphamide oral 25 MG | | | | | |
| J8560 | K | | Etoposide oral 50 MG | 0802 | 0.5016 | $27.37 | | $5.47 |
| J8600 | N | | Melphalan oral 2 MG | | | | | |
| J8610 | N | | Methotrexate oral 2.5 MG | | | | | |
| J8700 | K | | Temozolmide | 1086 | 0.0690 | $3.76 | | $0.75 |
| J8999 | B | | Oral prescription drug chemo | | | | | |
| J9000 | K | | Doxorubic hcl 10 MG vl chemo | 0847 | 0.1212 | $6.61 | | $1.32 |
| J9001 | K | | Doxorubicin hcl liposome inj | 7046 | 4.6982 | $256.34 | | $51.27 |
| J9010 | K | | Alemtuzumab injection | 9110 | 7.7873 | $424.88 | | $84.98 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| J9015 | K | | Aldesleukin/single use vial | 0807 | | $680.35 | | $136.07 |
| J9017 | K | | Arsenic trioxide | 9012 | 0.4933 | $26.91 | | $5.38 |
| J9020 | K | | Asparaginase injection | 0814 | 0.2957 | $16.13 | | $3.23 |
| J9031 | K | | Bcg live intravesical vac | 0809 | 1.9015 | $103.75 | | $20.75 |
| J9040 | K | | Bleomycin sulfate injection | 0857 | 2.9427 | $160.56 | | $32.11 |
| J9045 | K | | Carboplatin injection | 0811 | 1.5849 | $86.47 | | $17.29 |
| J9050 | N | | Carmus bischl nitro inj | | | | | |
| J9060 | K | | Cisplatin 10 MG injection | 0813 | 0.3985 | $21.74 | | $4.35 |
| J9062 | B | | Cisplatin 50 MG injection | | | | | |
| J9065 | K | | Inj cladribine per 1 MG | 0858 | 0.6931 | $37.82 | | $7.56 |
| J9070 | K | | Cyclophosphamide 100 MG inj | 0815 | 0.0868 | $4.74 | | $0.95 |
| J9080 | B | | Cyclophosphamide 200 MG inj | | | | | |
| J9090 | B | | Cyclophosphamide 500 MG inj | | | | | |
| J9091 | B | | Cyclophosphamide 1.0 grm inj | | | | | |
| J9092 | B | | Cyclophosphamide 2.0 grm inj | | | | | |
| J9093 | K | | Cyclophosphamide lyophilized | 0816 | 0.0825 | $4.50 | | $0.90 |
| J9094 | B | | Cyclophosphamide lyophilized | | | | | |
| J9095 | B | | Cyclophosphamide lyophilized | | | | | |
| J9096 | B | | Cyclophosphamide lyophilized | | | | | |
| J9097 | B | | Cyclophosphamide lyophilized | | | | | |
| J9098 | K | NI | Cytarabine liposome | 1166 | 5.1134 | $278.99 | | $55.80 |
| J9100 | K | | Cytarabine hcl 100 MG inj | 0817 | 0.0930 | $5.07 | | $1.01 |
| J9110 | B | | Cytarabine hcl 500 MG inj | | | | | |
| J9120 | N | | Dactinomycin actinomycin d | | | | | |
| J9130 | K | | Dacarbazine 100 mg inj | 0819 | 0.0974 | $5.31 | | $1.06 |
| J9140 | B | | Dacarbazine 200 MG inj | | | | | |
| J9150 | K | | Daunorubicin | 0820 | 1.3557 | $73.97 | | $14.79 |
| J9151 | K | | Daunorubicin citrate liposom | 0821 | 2.9976 | $163.55 | | $32.71 |
| J9160 | K | | Denileukin diftitox, 300 mcg | 1084 | | $1,232.88 | | $246.58 |
| J9165 | N | | Diethylstilbestrol injection | | | | | |
| J9170 | K | | Docetaxel | 0823 | 4.0499 | $220.97 | | $44.19 |
| J9178 | K | NI | Inj, epirubicin hcl, 2 mg | 1167 | 0.3744 | $20.43 | | $4.09 |
| J9180 | B | DG | Epirubicin HCl injection | | | | | |
| J9181 | K | | Etoposide 10 MG inj | 0824 | 0.0836 | $4.56 | | $0.91 |
| J9182 | B | | Etoposide 100 MG inj | | | | | |
| J9185 | K | | Fludarabine phosphate inj | 0842 | 3.7708 | $205.74 | | $41.15 |
| J9190 | N | | Fluorouracil injection | | | | | |
| J9200 | K | | Floxuridine injection | 0827 | 2.0928 | $114.19 | | $22.84 |
| J9201 | K | | Gemcitabine HCl | 0828 | 1.4742 | $80.43 | | $16.09 |
| J9202 | K | | Goserelin acetate implant | 0810 | 5.2265 | $285.16 | | $57.03 |
| J9206 | K | | Irinotecan injection | 0830 | 1.8428 | $100.55 | | $20.11 |
| J9208 | K | | Ifosfomide injection | 0831 | 1.9435 | $106.04 | | $21.21 |
| J9209 | K | | Mesna injection | 0732 | 0.5211 | $28.43 | | $5.69 |
| J9211 | K | | Idarubicin hcl injection | 0832 | 3.2663 | $178.21 | | $35.64 |
| J9212 | N | | Interferon alfacon-1 | | | | | |
| J9213 | K | | Interferon alfa-2a inj | 0834 | 0.3777 | $20.61 | | $4.12 |
| J9214 | K | | Interferon alfa-2b inj | 0836 | 0.2003 | $10.93 | | $2.19 |
| J9215 | K | | Interferon alfa-n3 inj | 0865 | 1.4598 | $79.65 | | $15.93 |
| J9216 | K | | Interferon gamma 1-b inj | 0838 | | $180.15 | | $36.03 |
| J9217 | K | | Leuprolide acetate suspnsion | 9217 | 5.7252 | $312.37 | | $62.47 |
| J9218 | K | | Leuprolide acetate injeciton | 0861 | 0.7991 | $43.60 | | $8.72 |
| J9219 | K | | Leuprolide acetate implant | 7051 | 67.2039 | $3,666.71 | | $733.34 |
| J9230 | N | | Mechlorethamine hcl inj | | | | | |
| J9245 | K | | Inj melphalan hydrochl 50 MG | 0840 | 4.6719 | $254.90 | | $50.98 |
| J9250 | N | | Methotrexate sodium inj | | | | | |
| J9260 | B | | Methotrexate sodium inj | | | | | |
| J9263 | B | NI | Oxaliplatin | | | | | |
| J9265 | K | | Paclitaxel injection | 0863 | 2.0553 | $112.14 | | $22.43 |
| J9266 | N | | Pegaspargase/singl dose vial | | | | | |
| J9268 | K | | Pentostatin injection | 0844 | 17.7045 | $965.98 | | $193.20 |
| J9270 | K | | Plicamycin (mithramycin) inj | 0860 | 0.2826 | $15.42 | | $3.08 |
| J9280 | K | | Mitomycin 5 MG inj | 0862 | 0.9719 | $53.03 | | $10.61 |
| J9290 | B | | Mitomycin 20 MG inj | | | | | |
| J9291 | B | | Mitomycin 40 MG inj | | | | | |
| J9293 | K | | Mitoxantrone hydrochl / 5 MG | 0864 | 3.1832 | $173.68 | | $34.74 |
| J9300 | K | | Gemtuzumab ozogamicin | 9004 | | $2,022.90 | | $404.58 |
| J9310 | K | | Rituximab cancer treatment | 0849 | 5.6158 | $306.40 | | $61.28 |
| J9320 | K | | Streptozocin injection | 0850 | 1.1948 | $65.19 | | $13.04 |
| J9340 | K | | Thiotepa injection | 0851 | 1.0984 | $59.93 | | $11.99 |
| J9350 | K | | Topotecan | 0852 | 7.9435 | $433.41 | | $86.68 |
| J9355 | K | | Trastuzumab | 1613 | 0.7434 | $40.56 | | $8.11 |
| J9357 | K | | Valrubicin, 200 mg | 1614 | 8.4635 | $461.78 | | $92.36 |
| J9360 | N | | Vinblastine sulfate inj | | | | | |
| J9370 | N | | Vincristine sulfate 1 MG inj | | | | | |
| J9375 | B | | Vincristine sulfate 2 MG inj | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| J9380 | B | | Vincristine sulfate 5 MG inj | | | | | |
| J9390 | K | | Vinorelbine tartrate/10 mg | 0855 | 1.1874 | $64.79 | | $12.96 |
| J9395 | G | NI | Injection, Fulvestrant | 9120 | | $87.58 | | $87.58 |
| J9600 | K | | Porfimer sodium | 0856 | 29.2205 | $1,594.30 | | $318.86 |
| J9999 | N | | Chemotherapy drug | | | | | |
| K0001 | A | | Standard wheelchair | | | | | |
| K0002 | A | | Stnd hemi (low seat) whlchr | | | | | |
| K0003 | A | | Lightweight wheelchair | | | | | |
| K0004 | A | | High strength ltwt whlchr | | | | | |
| K0005 | A | | Ultralightweight wheelchair | | | | | |
| K0006 | A | | Heavy duty wheelchair | | | | | |
| K0007 | A | | Extra heavy duty wheelchair | | | | | |
| K0009 | A | | Other manual wheelchair/base | | | | | |
| K0010 | A | | Stnd wt frame power whlchr | | | | | |
| K0011 | A | | Stnd wt pwr whlchr w control | | | | | |
| K0012 | A | | Ltwt portbl power whlchr | | | | | |
| K0014 | A | | Other power whlchr base | | | | | |
| K0015 | A | | Detach non-adjus hght armrst | | | | | |
| K0016 | A | DG | Detach adjust armrst cmplete | | | | | |
| K0017 | A | | Detach adjust armrest base | | | | | |
| K0018 | A | | Detach adjust armrst upper | | | | | |
| K0019 | A | | Arm pad each | | | | | |
| K0020 | A | | Fixed adjust armrest pair | | | | | |
| K0022 | A | DG | Reinforced back upholstery | | | | | |
| K0023 | A | | Planr back insrt foam w/strp | | | | | |
| K0024 | A | | Plnr back insrt foam w/hrdwr | | | | | |
| K0025 | A | DG | Hook-on headrest extension | | | | | |
| K0026 | A | DG | Back upholst lgtwt whlchr | | | | | |
| K0027 | A | DG | Back upholst other whlchr | | | | | |
| K0028 | A | DG | Manual fully reclining back | | | | | |
| K0029 | A | DG | Reinforced seat upholstery | | | | | |
| K0030 | A | DG | Solid plnr seat sngl dnsfoam | | | | | |
| K0031 | A | DG | Safety belt/pelvic strap | | | | | |
| K0032 | A | DG | Seat uphols lgtwt whlchr | | | | | |
| K0033 | A | DG | Seat upholstery other whlchr | | | | | |
| K0035 | A | DG | Heel loop with ankle strap | | | | | |
| K0036 | A | DG | Toe loop each | | | | | |
| K0037 | A | | High mount flip-up footrest | | | | | |
| K0038 | A | | Leg strap each | | | | | |
| K0039 | A | | Leg strap h style each | | | | | |
| K0040 | A | | Adjustable angle footplate | | | | | |
| K0041 | A | | Large size footplate each | | | | | |
| K0042 | A | | Standard size footplate each | | | | | |
| K0043 | A | | Ftrst lower extension tube | | | | | |
| K0044 | A | | Ftrst upper hanger bracket | | | | | |
| K0045 | A | | Footrest complete assembly | | | | | |
| K0046 | A | | Elevat legrst low extension | | | | | |
| K0047 | A | | Elevat legrst up hangr brack | | | | | |
| K0048 | A | DG | Elevate legrest complete | | | | | |
| K0049 | A | DG | Calf pad each | | | | | |
| K0050 | A | | Ratchet assembly | | | | | |
| K0051 | A | | Cam relese assem ftrst/lgrst | | | | | |
| K0052 | A | | Swingaway detach footrest | | | | | |
| K0053 | A | | Elevate footrest articulate | | | | | |
| K0054 | A | DG | Seat wdth 10-12/15/17/20 wc | | | | | |
| K0055 | A | DG | Seat dpth 15/17/18 ltwt wc | | | | | |
| K0056 | A | | Seat ht 17 or 21 ltwt wc | | | | | |
| K0057 | A | DG | Seat wdth 19/20 hvy dty wc | | | | | |
| K0058 | A | DG | Seat dpth 17/18 power wc | | | | | |
| K0059 | A | | Plastic coated handrim each | | | | | |
| K0060 | A | | Steel handrim each | | | | | |
| K0061 | A | | Aluminum handrim each | | | | | |
| K0062 | A | DG | Handrim 8-10 vert/obliq proj | | | | | |
| K0063 | A | DG | Hndrm 12-16 vert/obliq proj | | | | | |
| K0064 | A | | Zero pressure tube flat free | | | | | |
| K0065 | A | | Spoke protectors | | | | | |
| K0066 | A | | Solid tire any size each | | | | | |
| K0067 | A | | Pneumatic tire any size each | | | | | |
| K0068 | A | | Pneumatic tire tube each | | | | | |
| K0069 | A | | Rear whl complete solid tire | | | | | |
| K0070 | A | | Rear whl compl pneum tire | | | | | |
| K0071 | A | | Front castr compl pneum tire | | | | | |
| K0072 | A | | Frnt cstr cmpl sem-pneum tir | | | | | |
| K0073 | A | | Caster pin lock each | | | | | |
| K0074 | A | | Pneumatic caster tire each | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| K0075 | A | | Semi-pneumatic caster tire | | | | | |
| K0076 | A | | Solid caster tire each | | | | | |
| K0077 | A | | Front caster assem complete | | | | | |
| K0078 | A | | Pneumatic caster tire tube | | | | | |
| K0079 | A | DG | Wheel lock extension pair | | | | | |
| K0080 | A | DG | Anti-rollback device pair | | | | | |
| K0081 | A | | Wheel lock assembly complete | | | | | |
| K0082 | A | DG | 22 nf deep cycl acid battery | | | | | |
| K0083 | A | DG | 22 nf gel cell battery each | | | | | |
| K0084 | A | DG | Grp 24 deep cycl acid battry | | | | | |
| K0085 | A | DG | Group 24 gel cell battery | | | | | |
| K0086 | A | DG | U-1 lead acid battery each | | | | | |
| K0087 | A | DG | U-1 gel cell battery each | | | | | |
| K0088 | A | DG | Battry chrgr acid/gel cell | | | | | |
| K0089 | A | DG | Battery charger dual mode | | | | | |
| K0090 | A | | Rear tire power wheelchair | | | | | |
| K0091 | A | | Rear tire tube power whlchr | | | | | |
| K0092 | A | | Rear assem cmplt powr whlchr | | | | | |
| K0093 | A | | Rear zero pressure tire tube | | | | | |
| K0094 | A | | Wheel tire for power base | | | | | |
| K0095 | A | | Wheel tire tube each base | | | | | |
| K0096 | A | | Wheel assem powr base complt | | | | | |
| K0097 | A | | Wheel zero presure tire tube | | | | | |
| K0098 | A | | Drive belt power wheelchair | | | | | |
| K0099 | A | | Pwr wheelchair front caster | | | | | |
| K0100 | A | DG | Amputee adapter pair | | | | | |
| K0102 | A | | Crutch and cane holder | | | | | |
| K0103 | A | DG | Transfer board < 25≧ | | | | | |
| K0104 | A | | Cylinder tank carrier | | | | | |
| K0105 | A | | Iv hanger | | | | | |
| K0106 | A | | Arm trough each | | | | | |
| K0107 | A | DG | Wheelchair tray | | | | | |
| K0108 | A | | W/c component-accessory NOS | | | | | |
| K0112 | A | DG | Trunk vest supprt innr frame | | | | | |
| K0113 | A | DG | Trunk vest suprt w/o inr frm | | | | | |
| K0114 | A | | Whlchr back suprt inr frame | | | | | |
| K0115 | A | | Back module orthotic system | | | | | |
| K0116 | A | | Back & seat modul orthot sys | | | | | |
| K0195 | A | | Elevating whlchair leg rests | | | | | |
| K0268 | A | DG | Humidifier nonheated w PAP | | | | | |
| K0415 | B | | RX antiemetic drg, oral NOS | | | | | |
| K0416 | B | | Rx antiemetic drg,rectal NOS | | | | | |
| K0452 | A | | Wheelchair bearings | | | | | |
| K0455 | A | | Pump uninterrupted infusion | | | | | |
| K0460 | A | DG | WC power add-on joystick | | | | | |
| K0461 | A | DG | WC power add-on tiller cntrl | | | | | |
| K0462 | A | | Temporary replacement eqpmnt | | | | | |
| K0531 | A | DG | Heated humidifier used w pap | | | | | |
| K0532 | A | DG | Noninvasive assist wo backup | | | | | |
| K0533 | A | DG | Noninvasive assist w backup | | | | | |
| K0534 | A | DG | Invasive assist w backup | | | | | |
| K0538 | A | DG | Neg pressure wnd thrpy pump | | | | | |
| K0539 | A | DG | Neg pres wnd thrpy dsg set | | | | | |
| K0540 | A | DG | Neg pres wnd thrp canister | | | | | |
| K0541 | A | DG | SGD prerecorded msg <= 8 min | | | | | |
| K0542 | A | DG | SGD prerecorded msg > 8 min | | | | | |
| K0543 | A | DG | SGD msg formed by spelling | | | | | |
| K0544 | A | DG | SGD w multi methods msg/accs | | | | | |
| K0545 | A | DG | SGD sftwre prgrm for PC/PDA | | | | | |
| K0546 | A | DG | SGD accessory,mounting systm | | | | | |
| K0547 | A | DG | SGD accessory NOC | | | | | |
| K0548 | N | NI | Insulin lispro | | | | | |
| K0549 | A | DG | Hosp bed hvy dty xtra wide | | | | | |
| K0550 | A | DG | Hosp bed xtra hvy dty x wide | | | | | |
| K0552 | Y | NF | Supply/Ext inf pump syr type | | | | | |
| K0556 | A | DG | Socket insert w lock mech | | | | | |
| K0557 | A | DG | Socket insert w/o lock mech | | | | | |
| K0558 | A | DG | Intl custm cong/atyp insert | | | | | |
| K0559 | A | DG | Initial custom socket insert | | | | | |
| K0560 | N | DG | Mcp joint 2-piece for implant | | | | | |
| K0581 | A | DG | Ost pch clsd w barrier/filtr | | | | | |
| K0582 | A | DG | Ost pch w bar/bltinconv/fltr | | | | | |
| K0583 | A | DG | Ost pch clsd w/o bar w filtr | | | | | |
| K0584 | A | DG | Ost pch for bar w flange/flt | | | | | |
| K0585 | A | DG | Ost pch clsd for bar w lk fl | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| K0586 | A | DG | Ost pch for bar w lk fl/fltr | | | | | |
| K0587 | A | DG | Ost pch drain w bar & filter | | | | | |
| K0588 | A | DG | Ost pch drain for barrier fl | | | | | |
| K0589 | A | DG | Ost pch drain 2 piece system | | | | | |
| K0590 | A | DG | Ost pch drain/barr lk flng/f | | | | | |
| K0591 | A | DG | Urine ost pouch w faucet/tap | | | | | |
| K0592 | A | DG | Urine ost pouch w bltinconv | | | | | |
| K0593 | A | DG | Ost urine pch w b/bltin conv | | | | | |
| K0594 | A | DG | Ost pch urine w barrier/tapv | | | | | |
| K0595 | A | DG | Os pch urine w bar/fange/tap | | | | | |
| K0596 | A | DG | Urine ost pch bar w lock fln | | | | | |
| K0597 | A | DG | Ost pch urine w lock flng/ft | | | | | |
| K0600 | Y | NF | Functional neuromuscular stim | | | | | |
| K0601 | Y | NF | Repl batt silver oxide 1.5 v | | | | | |
| K0602 | Y | NF | Repl batt silver oxide 3 v | | | | | |
| K0603 | Y | NF | Repl batt alkaline 1.5 v | | | | | |
| K0604 | Y | NF | Repl batt lithium 3.6 v | | | | | |
| K0605 | Y | NF | Repl batt lithium 4.5 v | | | | | |
| K0606 | Y | NF | AED garment w/elec analysis | | | | | |
| K0607 | Y | NF | Repl batt for AED device | | | | | |
| K0608 | Y | NF | Repl garment for AED | | | | | |
| K0609 | Y | NF | Repl electrode for AED | | | | | |
| K0610 | E | DG | Peritoneal dialysis clamp | | | | | |
| K0611 | E | DG | Disposable cycler set | | | | | |
| K0612 | E | DG | Drainage ext line, dialysis | | | | | |
| K0613 | E | DG | Ext line w/easy lock connect | | | | | |
| K0614 | E | DG | Chem/antiseptic solution, 8oz | | | | | |
| K0615 | Y | DG | SGD prerec mes >8min <20min | | | | | |
| K0616 | Y | DG | SGD prerec mes >20min <40min | | | | | |
| K0617 | Y | DG | SGD prerec mes >40min | | | | | |
| K0618 | A | | TLSO 2 piece rigid shell | | | | | |
| K0619 | A | | TLSO 3 piece rigid shell | | | | | |
| K0620 | A | | Tubular elastic dressing | | | | | |
| K0621 | A | DG | Gauze, non-impreg pack strip | | | | | |
| K0622 | A | DG | Confrm band non str <3in/rol | | | | | |
| K0623 | A | DG | Confrm band sterl>3in/roll | | | | | |
| K0624 | A | DG | Lite compress wdth<3in/roll | | | | | |
| K0625 | A | DG | Self adher wdth <3 in, roll | | | | | |
| K0626 | A | DG | Self adher wdth >=5 in, roll | | | | | |
| L0100 | A | | Cranial orthosis/helmet mold | | | | | |
| L0110 | A | | Cranial orthosis/helmet nonm | | | | | |
| L0112 | A | NI | Cranial cervical orthosis | | | | | |
| L0120 | A | | Cerv flexible non-adjustable | | | | | |
| L0130 | A | | Flex thermoplastic collar mo | | | | | |
| L0140 | A | | Cervical semi-rigid adjustab | | | | | |
| L0150 | A | | Cerv semi-rig adj molded chn | | | | | |
| L0160 | A | | Cerv semi-rig wire occ/mand | | | | | |
| L0170 | A | | Cervical collar molded to pt | | | | | |
| L0172 | A | | Cerv col thermplas foam 2 pi | | | | | |
| L0174 | A | | Cerv col foam 2 piece w thor | | | | | |
| L0180 | A | | Cer post col occ/man sup adj | | | | | |
| L0190 | A | | Cerv collar supp adj cerv ba | | | | | |
| L0200 | A | | Cerv col supp adj bar & thor | | | | | |
| L0210 | A | | Thoracic rib belt | | | | | |
| L0220 | A | | Thor rib belt custom fabrica | | | | | |
| L0450 | A | | TLSO flex prefab thoracic | | | | | |
| L0452 | A | | tlso flex custom fab thoraci | | | | | |
| L0454 | A | | TLSO flex prefab sacrococ-T9 | | | | | |
| L0456 | A | | TLSO flex prefab | | | | | |
| L0458 | A | | TLSO 2Mod symphis-xipho pre | | | | | |
| L0460 | A | | TLSO2Mod symphysis-stern pre | | | | | |
| L0462 | A | | TLSO 3Mod sacro-scap pre | | | | | |
| L0464 | A | | TLSO 4Mod sacro-scap pre | | | | | |
| L0466 | A | | TLSO rigid frame pre soft ap | | | | | |
| L0468 | A | | TLSO rigid frame prefab pelv | | | | | |
| L0470 | A | | TLSO rigid frame pre subclav | | | | | |
| L0472 | A | | TLSO rigid frame hyperex pre | | | | | |
| L0474 | A | | TLSO rigid frame pre pelvic | | | | | |
| L0476 | A | | TLSO flexion compres jac pre | | | | | |
| L0478 | A | | TLSO flexion compres jac cus | | | | | |
| L0480 | A | | TLSO rigid plastic custom fa | | | | | |
| L0482 | A | | TLSO rigid lined custom fab | | | | | |
| L0484 | A | | TLSO rigid plastic cust fab | | | | | |
| L0486 | A | | TLSO rigidlined cust fab two | | | | | |
| L0488 | A | | TLSO rigid lined pre one pie | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L0490 | A | | TLSO rigid plastic pre one | | | | | |
| L0500 | A | | Lso flex surgical support | | | | | |
| L0510 | A | | Lso flexible custom fabricat | | | | | |
| L0515 | A | | Lso flex elas w/ rig post pa | | | | | |
| L0520 | A | | Lso a-p-l control with apron | | | | | |
| L0530 | A | | Lso ant-pos control w apron | | | | | |
| L0540 | A | | Lso lumbar flexion a-p-l | | | | | |
| L0550 | A | | Lso a-p-l control molded | | | | | |
| L0560 | A | | Lso a-p-l w interface | | | | | |
| L0561 | A | | Prefab lso | | | | | |
| L0565 | A | | Lso a-p-l control custom | | | | | |
| L0600 | A | | Sacroiliac flex surg support | | | | | |
| L0610 | A | | Sacroiliac flexible custm fa | | | | | |
| L0620 | A | | Sacroiliac semi-rig w apron | | | | | |
| L0700 | A | | Ctlso a-p-l control molded | | | | | |
| L0710 | A | | Ctlso a-p-l control w/ inter | | | | | |
| L0810 | A | | Halo cervical into jckt vest | | | | | |
| L0820 | A | | Halo cervical into body jack | | | | | |
| L0830 | A | | Halo cerv into milwaukee typ | | | | | |
| L0860 | A | | Magnetic resonanc image comp | | | | | |
| L0861 | A | NI | Halo repl liner/interface | | | | | |
| L0960 | A | | Post surgical support pads | | | | | |
| L0970 | A | | Tlso corset front | | | | | |
| L0972 | A | | Lso corset front | | | | | |
| L0974 | A | | Tlso full corset | | | | | |
| L0976 | A | | Lso full corset | | | | | |
| L0978 | A | | Axillary crutch extension | | | | | |
| L0980 | A | | Peroneal straps pair | | | | | |
| L0982 | A | | Stocking supp grips set of f | | | | | |
| L0984 | A | | Protective body sock each | | | | | |
| L0999 | A | | Add to spinal orthosis NOS | | | | | |
| L1000 | A | | Ctlso milwauke initial model | | | | | |
| L1005 | A | | Tension based scoliosis orth | | | | | |
| L1010 | A | | Ctlso axilla sling | | | | | |
| L1020 | A | | Kyphosis pad | | | | | |
| L1025 | A | | Kyphosis pad floating | | | | | |
| L1030 | A | | Lumbar bolster pad | | | | | |
| L1040 | A | | Lumbar or lumbar rib pad | | | | | |
| L1050 | A | | Sternal pad | | | | | |
| L1060 | A | | Thoracic pad | | | | | |
| L1070 | A | | Trapezius sling | | | | | |
| L1080 | A | | Outrigger | | | | | |
| L1085 | A | | Outrigger bil w/ vert extens | | | | | |
| L1090 | A | | Lumbar sling | | | | | |
| L1100 | A | | Ring flange plastic/leather | | | | | |
| L1110 | A | | Ring flange plas/leather mol | | | | | |
| L1120 | A | | Covers for upright each | | | | | |
| L1200 | A | | Furnsh initial orthosis only | | | | | |
| L1210 | A | | Lateral thoracic extension | | | | | |
| L1220 | A | | Anterior thoracic extension | | | | | |
| L1230 | A | | Milwaukee type superstructur | | | | | |
| L1240 | A | | Lumbar derotation pad | | | | | |
| L1250 | A | | Anterior asis pad | | | | | |
| L1260 | A | | Anterior thoracic derotation | | | | | |
| L1270 | A | | Abdominal pad | | | | | |
| L1280 | A | | Rib gusset (elastic) each | | | | | |
| L1290 | A | | Lateral trochanteric pad | | | | | |
| L1300 | A | | Body jacket mold to patient | | | | | |
| L1310 | A | | Post-operative body jacket | | | | | |
| L1499 | A | | Spinal orthosis NOS | | | | | |
| L1500 | A | | Thkao mobility frame | | | | | |
| L1510 | A | | Thkao standing frame | | | | | |
| L1520 | A | | Thkao swivel walker | | | | | |
| L1600 | A | | Abduct hip flex frejka w cvr | | | | | |
| L1610 | A | | Abduct hip flex frejka covr | | | | | |
| L1620 | A | | Abduct hip flex pavlik harne | | | | | |
| L1630 | A | | Abduct control hip semi-flex | | | | | |
| L1640 | A | | Pelv band/spread bar thigh c | | | | | |
| L1650 | A | | HO abduction hip adjustable | | | | | |
| L1652 | A | | HO bi thighcuffs w sprdr bar | | | | | |
| L1660 | A | | HO abduction static plastic | | | | | |
| L1680 | A | | Pelvic & hip control thigh c | | | | | |
| L1685 | A | | Post-op hip abduct custom fa | | | | | |
| L1686 | A | | HO post-op hip abduction | | | | | |
| L1690 | A | | Combination bilateral HO | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L1700 | A | | Leg perthes orth toronto typ | | | | | |
| L1710 | A | | Legg perthes orth newington | | | | | |
| L1720 | A | | Legg perthes orthosis trilat | | | | | |
| L1730 | A | | Legg perthes orth scottish r | | | | | |
| L1750 | A | | Legg perthes sling | | | | | |
| L1755 | A | | Legg perthes patten bottom t | | | | | |
| L1800 | A | | Knee orthoses elas w stays | | | | | |
| L1810 | A | | Ko elastic with joints | | | | | |
| L1815 | A | | Elastic with condylar pads | | | | | |
| L1820 | A | | Ko elas w/ condyle pads & jo | | | | | |
| L1825 | A | | Ko elastic knee cap | | | | | |
| L1830 | A | | Ko immobilizer canvas longit | | | | | |
| L1831 | A | NI | Knee orth pos locking joint | | | | | |
| L1832 | A | | KO adj jnt pos rigid support | | | | | |
| L1834 | A | | Ko w/0 joint rigid molded to | | | | | |
| L1836 | A | | Rigid KO wo joints | | | | | |
| L1840 | A | | Ko derot ant cruciate custom | | | | | |
| L1843 | A | | KO single upright custom fit | | | | | |
| L1844 | A | | Ko w/adj jt rot cntrl molded | | | | | |
| L1845 | A | | Ko w/ adj flex/ext rotat cus | | | | | |
| L1846 | A | | Ko w adj flex/ext rotat mold | | | | | |
| L1847 | A | | KO adjustable w air chambers | | | | | |
| L1850 | A | | Ko swedish type | | | | | |
| L1855 | A | | Ko plas doub upright jnt mol | | | | | |
| L1858 | A | | Ko polycentric pneumatic pad | | | | | |
| L1860 | A | | Ko supracondylar socket mold | | | | | |
| L1870 | A | | Ko doub upright lacers molde | | | | | |
| L1880 | A | | Ko doub upright cuffs/lacers | | | | | |
| L1885 | A | DG | Knee upright w/resistance | | | | | |
| L1900 | A | | Afo sprng wir drsflx calf bd | | | | | |
| L1901 | A | | Prefab ankle orthosis | | | | | |
| L1902 | A | | Afo ankle gauntlet | | | | | |
| L1904 | A | | Afo molded ankle gauntlet | | | | | |
| L1906 | A | | Afo multiligamentus ankle su | | | | | |
| L1907 | A | NI | AFO supramalleolar custom | | | | | |
| L1910 | A | | Afo sing bar clasp attach sh | | | | | |
| L1920 | A | | Afo sing upright w/ adjust s | | | | | |
| L1930 | A | | Afo plastic | | | | | |
| L1940 | A | | Afo molded to patient plasti | | | | | |
| L1945 | A | | Afo molded plas rig ant tib | | | | | |
| L1950 | A | | Afo spiral molded to pt plas | | | | | |
| L1951 | A | NI | AFO spiral prefabricated | | | | | |
| L1960 | A | | Afo pos solid ank plastic mo | | | | | |
| L1970 | A | | Afo plastic molded w/ankle j | | | | | |
| L1971 | A | NI | AFO w/ankle joint, prefab | | | | | |
| L1980 | A | | Afo sing solid stirrup calf | | | | | |
| L1990 | A | | Afo doub solid stirrup calf | | | | | |
| L2000 | A | | Kafo sing fre stirr thi/calf | | | | | |
| L2010 | A | | Kafo sng solid stirrup w/o j | | | | | |
| L2020 | A | | Kafo dbl solid stirrup band/ | | | | | |
| L2030 | A | | Kafo dbl solid stirrup w/o j | | | | | |
| L2035 | A | | KAFO plastic pediatric size | | | | | |
| L2036 | A | | Kafo plas doub free knee mol | | | | | |
| L2037 | A | | Kafo plas sing free knee mol | | | | | |
| L2038 | A | | Kafo w/o joint multi-axis an | | | | | |
| L2039 | A | | KAFO,plstic,medlat rotat con | | | | | |
| L2040 | A | | Hkafo torsion bil rot straps | | | | | |
| L2050 | A | | Hkafo torsion cable hip pelv | | | | | |
| L2060 | A | | Hkafo torsion ball bearing j | | | | | |
| L2070 | A | | Hkafo torsion unilat rot str | | | | | |
| L2080 | A | | Hkafo unilat torsion cable | | | | | |
| L2090 | A | | Hkafo unilat torsion ball br | | | | | |
| L2102 | E | DG | Afo tibial fx cast plstr mol | | | | | |
| L2104 | E | DG | Afo tib fx cast synthetic mo | | | | | |
| L2106 | A | | Afo tib fx cast plaster mold | | | | | |
| L2108 | A | | Afo tib fx cast molded to pt | | | | | |
| L2112 | A | | Afo tibial fracture soft | | | | | |
| L2114 | A | | Afo tib fx semi-rigid | | | | | |
| L2116 | A | | Afo tibial fracture rigid | | | | | |
| L2122 | E | DG | Kafo fem fx cast plaster mol | | | | | |
| L2124 | E | DG | Kafo fem fx cast synthet mol | | | | | |
| L2126 | A | | Kafo fem fx cast thermoplas | | | | | |
| L2128 | A | | Kafo fem fx cast molded to p | | | | | |
| L2132 | A | | Kafo femoral fx cast soft | | | | | |
| L2134 | A | | Kafo fem fx cast semi-rigid | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L2136 | A | | Kafo femoral fx cast rigid | | | | | |
| L2180 | A | | Plas shoe insert w ank joint | | | | | |
| L2182 | A | | Drop lock knee | | | | | |
| L2184 | A | | Limited motion knee joint | | | | | |
| L2186 | A | | Adj motion knee jnt lerman t | | | | | |
| L2188 | A | | Quadrilateral brim | | | | | |
| L2190 | A | | Waist belt | | | | | |
| L2192 | A | | Pelvic band & belt thigh fla | | | | | |
| L2200 | A | | Limited ankle motion ea jnt | | | | | |
| L2210 | A | | Dorsiflexion assist each joi | | | | | |
| L2220 | A | | Dorsi & plantar flex ass/res | | | | | |
| L2230 | A | | Split flat caliper stirr & p | | | | | |
| L2240 | A | | Round caliper and plate atta | | | | | |
| L2250 | A | | Foot plate molded stirrup at | | | | | |
| L2260 | A | | Reinforced solid stirrup | | | | | |
| L2265 | A | | Long tongue stirrup | | | | | |
| L2270 | A | | Varus/valgus strap padded/li | | | | | |
| L2275 | A | | Plastic mod low ext pad/line | | | | | |
| L2280 | A | | Molded inner boot | | | | | |
| L2300 | A | | Abduction bar jointed adjust | | | | | |
| L2310 | A | | Abduction bar-straight | | | | | |
| L2320 | A | | Non-molded lacer | | | | | |
| L2330 | A | | Lacer molded to patient mode | | | | | |
| L2335 | A | | Anterior swing band | | | | | |
| L2340 | A | | Pre-tibial shell molded to p | | | | | |
| L2350 | A | | Prosthetic type socket molde | | | | | |
| L2360 | A | | Extended steel shank | | | | | |
| L2370 | A | | Patten bottom | | | | | |
| L2375 | A | | Torsion ank & half solid sti | | | | | |
| L2380 | A | | Torsion straight knee joint | | | | | |
| L2385 | A | | Straight knee joint heavy du | | | | | |
| L2390 | A | | Offset knee joint each | | | | | |
| L2395 | A | | Offset knee joint heavy duty | | | | | |
| L2397 | A | | Suspension sleeve lower ext | | | | | |
| L2405 | A | | Knee joint drop lock ea jnt | | | | | |
| L2415 | A | | Knee joint cam lock each joi | | | | | |
| L2425 | A | | Knee disc/dial lock/adj flex | | | | | |
| L2430 | A | | Knee jnt ratchet lock ea jnt | | | | | |
| L2435 | A | | Knee joint polycentric joint | | | | | |
| L2492 | A | | Knee lift loop drop lock rin | | | | | |
| L2500 | A | | Thi/glut/ischia wgt bearing | | | | | |
| L2510 | A | | Th/wght bear quad-lat brim m | | | | | |
| L2520 | A | | Th/wght bear quad-lat brim c | | | | | |
| L2525 | A | | Th/wght bear nar m-l brim mo | | | | | |
| L2526 | A | | Th/wght bear nar m-l brim cu | | | | | |
| L2530 | A | | Thigh/wght bear lacer non-mo | | | | | |
| L2540 | A | | Thigh/wght bear lacer molded | | | | | |
| L2550 | A | | Thigh/wght bear high roll cu | | | | | |
| L2570 | A | | Hip clevis type 2 posit jnt | | | | | |
| L2580 | A | | Pelvic control pelvic sling | | | | | |
| L2600 | A | | Hip clevis/thrust bearing fr | | | | | |
| L2610 | A | | Hip clevis/thrust bearing lo | | | | | |
| L2620 | A | | Pelvic control hip heavy dut | | | | | |
| L2622 | A | | Hip joint adjustable flexion | | | | | |
| L2624 | A | | Hip adj flex ext abduct cont | | | | | |
| L2627 | A | | Plastic mold recipro hip & c | | | | | |
| L2628 | A | | Metal frame recipro hip & ca | | | | | |
| L2630 | A | | Pelvic control band & belt u | | | | | |
| L2640 | A | | Pelvic control band & belt b | | | | | |
| L2650 | A | | Pelv & thor control gluteal | | | | | |
| L2660 | A | | Thoracic control thoracic ba | | | | | |
| L2670 | A | | Thorac cont paraspinal uprig | | | | | |
| L2680 | A | | Thorac cont lat support upri | | | | | |
| L2750 | A | | Plating chrome/nickel pr bar | | | | | |
| L2755 | A | | Carbon graphite lamination | | | | | |
| L2760 | A | | Extension per extension per | | | | | |
| L2768 | A | | Ortho sidebar disconnect | | | | | |
| L2770 | A | | Low ext orthosis per bar/jnt | | | | | |
| L2780 | A | | Non-corrosive finish | | | | | |
| L2785 | A | | Drop lock retainer each | | | | | |
| L2795 | A | | Knee control full kneecap | | | | | |
| L2800 | A | | Knee cap medial or lateral p | | | | | |
| L2810 | A | | Knee control condylar pad | | | | | |
| L2820 | A | | Soft interface below knee se | | | | | |
| L2830 | A | | Soft interface above knee se | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L2840 | A | | Tibial length sock fx or equ | | | | | |
| L2850 | A | | Femoral lgth sock fx or equa | | | | | |
| L2860 | A | | Torsion mechanism knee/ankle | | | | | |
| L2999 | A | | Lower extremity orthosis NOS | | | | | |
| L3000 | B | | Ft insert ucb berkeley shell | | | | | |
| L3001 | B | | Foot insert remov molded spe | | | | | |
| L3002 | B | | Foot insert plastazote or eq | | | | | |
| L3003 | B | | Foot insert silicone gel eac | | | | | |
| L3010 | B | | Foot longitudinal arch suppo | | | | | |
| L3020 | B | | Foot longitud/metatarsal sup | | | | | |
| L3030 | B | | Foot arch support remov prem | | | | | |
| L3031 | E | NI | Foot lamin/prepreg composite | | | | | |
| L3040 | B | | Ft arch suprt premold longit | | | | | |
| L3050 | B | | Foot arch supp premold metat | | | | | |
| L3060 | B | | Foot arch supp longitud/meta | | | | | |
| L3070 | B | | Arch suprt att to sho longit | | | | | |
| L3080 | B | | Arch supp att to shoe metata | | | | | |
| L3090 | B | | Arch supp att to shoe long/m | | | | | |
| L3100 | B | | Hallus-valgus nght dynamic s | | | | | |
| L3140 | B | | Abduction rotation bar shoe | | | | | |
| L3150 | B | | Abduct rotation bar w/o shoe | | | | | |
| L3160 | B | | Shoe styled positioning dev | | | | | |
| L3170 | B | | Foot plastic heel stabilizer | | | | | |
| L3201 | B | | Oxford w supinat/pronat inf | | | | | |
| L3202 | B | | Oxford w/ supinat/pronator c | | | | | |
| L3203 | B | | Oxford w/ supinator/pronator | | | | | |
| L3204 | B | | Hightop w/ supp/pronator inf | | | | | |
| L3206 | B | | Hightop w/ supp/pronator chi | | | | | |
| L3207 | B | | Hightop w/ supp/pronator jun | | | | | |
| L3208 | B | | Surgical boot each infant | | | | | |
| L3209 | B | | Surgical boot each child | | | | | |
| L3211 | B | | Surgical boot each junior | | | | | |
| L3212 | B | | Benesch boot pair infant | | | | | |
| L3213 | B | | Benesch boot pair child | | | | | |
| L3214 | B | | Benesch boot pair junior | | | | | |
| L3215 | B | | Orthopedic ftwear ladies oxf | | | | | |
| L3216 | B | | Orthoped ladies shoes dpth i | | | | | |
| L3217 | B | | Ladies shoes hightop depth i | | | | | |
| L3219 | B | | Orthopedic mens shoes oxford | | | | | |
| L3221 | B | | Orthopedic mens shoes dpth i | | | | | |
| L3222 | B | | Mens shoes hightop depth inl | | | | | |
| L3224 | A | | Woman's shoe oxford brace | | | | | |
| L3225 | A | | Man's shoe oxford brace | | | | | |
| L3230 | B | | Custom shoes depth inlay | | | | | |
| L3250 | B | | Custom mold shoe remov prost | | | | | |
| L3251 | B | | Shoe molded to pt silicone s | | | | | |
| L3252 | B | | Shoe molded plastazote cust | | | | | |
| L3253 | B | | Shoe molded plastazote cust | | | | | |
| L3254 | B | | Orth foot non-stndard size/w | | | | | |
| L3255 | B | | Orth foot non-standard size/ | | | | | |
| L3257 | B | | Orth foot add charge split s | | | | | |
| L3260 | B | | Ambulatory surgical boot eac | | | | | |
| L3265 | B | | Plastazote sandal each | | | | | |
| L3300 | B | | Sho lift taper to metatarsal | | | | | |
| L3310 | B | | Shoe lift elev heel/sole neo | | | | | |
| L3320 | B | | Shoe lift elev heel/sole cor | | | | | |
| L3330 | B | | Lifts elevation metal extens | | | | | |
| L3332 | B | | Shoe lifts tapered to one-ha | | | | | |
| L3334 | B | | Shoe lifts elevation heel /i | | | | | |
| L3340 | B | | Shoe wedge sach | | | | | |
| L3350 | E | | Shoe heel wedge | | | | | |
| L3360 | B | | Shoe sole wedge outside sole | | | | | |
| L3370 | B | | Shoe sole wedge between sole | | | | | |
| L3380 | B | | Shoe clubfoot wedge | | | | | |
| L3390 | B | | Shoe outflare wedge | | | | | |
| L3400 | B | | Shoe metatarsal bar wedge ro | | | | | |
| L3410 | B | | Shoe metatarsal bar between | | | | | |
| L3420 | B | | Full sole/heel wedge btween | | | | | |
| L3430 | B | | Sho heel count plast reinfor | | | | | |
| L3440 | B | | Heel leather reinforced | | | | | |
| L3450 | B | | Shoe heel sach cushion type | | | | | |
| L3455 | B | | Shoe heel new leather standa | | | | | |
| L3460 | B | | Shoe heel new rubber standar | | | | | |
| L3465 | B | | Shoe heel thomas with wedge | | | | | |
| L3470 | B | | Shoe heel thomas extend to b | | | | | |

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| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L3480 | B | | Shoe heel pad & depress for | | | | | |
| L3485 | B | | Shoe heel pad removable for | | | | | |
| L3500 | B | | Ortho shoe add leather insol | | | | | |
| L3510 | B | | Orthopedic shoe add rub insl | | | | | |
| L3520 | B | | O shoe add felt w leath insl | | | | | |
| L3530 | B | | Ortho shoe add half sole | | | | | |
| L3540 | B | | Ortho shoe add full sole | | | | | |
| L3550 | B | | O shoe add standard toe tap | | | | | |
| L3560 | B | | O shoe add horseshoe toe tap | | | | | |
| L3570 | B | | O shoe add instep extension | | | | | |
| L3580 | B | | O shoe add instep velcro clo | | | | | |
| L3590 | B | | O shoe convert to sof counte | | | | | |
| L3595 | B | | Ortho shoe add march bar | | | | | |
| L3600 | B | | Trans shoe calip plate exist | | | | | |
| L3610 | B | | Trans shoe caliper plate new | | | | | |
| L3620 | B | | Trans shoe solid stirrup exi | | | | | |
| L3630 | B | | Trans shoe solid stirrup new | | | | | |
| L3640 | B | | Shoe dennis browne splint bo | | | | | |
| L3649 | B | | Orthopedic shoe modifica NOS | | | | | |
| L3650 | A | | Shlder fig 8 abduct restrain | | | | | |
| L3651 | A | | Prefab shoulder orthosis | | | | | |
| L3652 | A | | Prefab dbl shoulder orthosis | | | | | |
| L3660 | A | | Abduct restrainer canvas&web | | | | | |
| L3670 | A | | Acromio/clavicular canvas&we | | | | | |
| L3675 | A | | Canvas vest SO | | | | | |
| L3677 | E | | SO hard plastic stabilizer | | | | | |
| L3700 | A | | Elbow orthoses elas w stays | | | | | |
| L3701 | A | | Prefab elbow orthosis | | | | | |
| L3710 | A | | Elbow elastic with metal joi | | | | | |
| L3720 | A | | Forearm/arm cuffs free motio | | | | | |
| L3730 | A | | Forearm/arm cuffs ext/flex a | | | | | |
| L3740 | A | | Cuffs adj lock w/ active con | | | | | |
| L3760 | A | | EO withjoint, Prefabricated | | | | | |
| L3762 | A | | Rigid EO wo joints | | | | | |
| L3800 | A | | Whfo short opponen no attach | | | | | |
| L3805 | A | | Whfo long opponens no attach | | | | | |
| L3807 | A | | WHFO,no joint, prefabricated | | | | | |
| L3810 | A | | Whfo thumb abduction bar | | | | | |
| L3815 | A | | Whfo second m.p. abduction a | | | | | |
| L3820 | A | | Whfo ip ext asst w/ mp ext s | | | | | |
| L3825 | A | | Whfo m.p. extension stop | | | | | |
| L3830 | A | | Whfo m.p. extension assist | | | | | |
| L3835 | A | | Whfo m.p. spring extension a | | | | | |
| L3840 | A | | Whfo spring swivel thumb | | | | | |
| L3845 | A | | Whfo thumb ip ext ass w/ mp | | | | | |
| L3850 | A | | Action wrist w/ dorsiflex as | | | | | |
| L3855 | A | | Whfo adj m.p. flexion contro | | | | | |
| L3860 | A | | Whfo adj m.p. flex ctrl & i. | | | | | |
| L3890 | B | | Torsion mechanism wrist/elbo | | | | | |
| L3900 | A | | Hinge extension/flex wrist/f | | | | | |
| L3901 | A | | Hinge ext/flex wrist finger | | | | | |
| L3902 | A | | Whfo ext power compress gas | | | | | |
| L3904 | A | | Whfo electric custom fitted | | | | | |
| L3906 | A | | Wrist gauntlet molded to pt | | | | | |
| L3907 | A | | Whfo wrst gauntlt thmb spica | | | | | |
| L3908 | A | | Wrist cock-up non-molded | | | | | |
| L3909 | A | | Prefab wrist orthosis | | | | | |
| L3910 | A | | Whfo swanson design | | | | | |
| L3911 | A | | Prefab hand finger orthosis | | | | | |
| L3912 | A | | Flex glove w/elastic finger | | | | | |
| L3914 | A | | WHO wrist extension cock-up | | | | | |
| L3916 | A | | Whfo wrist extens w/ outrigg | | | | | |
| L3917 | A | NI | Prefab metacarpl fx orthosis | | | | | |
| L3918 | A | | HFO knuckle bender | | | | | |
| L3920 | A | | Knuckle bender with outrigge | | | | | |
| L3922 | A | | Knuckle bend 2 seg to flex j | | | | | |
| L3923 | A | | HFO, no joint, prefabricated | | | | | |
| L3924 | A | | Oppenheimer | | | | | |
| L3926 | A | | Thomas suspension | | | | | |
| L3928 | A | | Finger extension w/ clock sp | | | | | |
| L3930 | A | | Finger extension with wrist | | | | | |
| L3932 | A | | Safety pin spring wire | | | | | |
| L3934 | A | | Safety pin modified | | | | | |
| L3936 | A | | Palmer | | | | | |
| L3938 | A | | Dorsal wrist | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L3940 | A | | Dorsal wrist w/ outrigger at | | | | | |
| L3942 | A | | Reverse knuckle bender | | | | | |
| L3944 | A | | Reverse knuckle bend w/ outr | | | | | |
| L3946 | A | | HFO composite elastic | | | | | |
| L3948 | A | | Finger knuckle bender | | | | | |
| L3950 | A | | Oppenheimer w/ knuckle bend | | | | | |
| L3952 | A | | Oppenheimer w/ rev knuckle 2 | | | | | |
| L3954 | A | | Spreading hand | | | | | |
| L3956 | A | | Add joint upper ext orthosis | | | | | |
| L3960 | A | | Sewho airplan desig abdu pos | | | | | |
| L3962 | A | | Sewho erbs palsey design abd | | | | | |
| L3963 | A | | Molded w/ articulating elbow | | | | | |
| L3964 | A | | Seo mobile arm sup att to wc | | | | | |
| L3965 | A | | Arm supp att to wc rancho ty | | | | | |
| L3966 | A | | Mobile arm supports reclinin | | | | | |
| L3968 | A | | Friction dampening arm supp | | | | | |
| L3969 | A | | Monosuspension arm/hand supp | | | | | |
| L3970 | A | | Elevat proximal arm support | | | | | |
| L3972 | A | | Offset/lat rocker arm w/ ela | | | | | |
| L3974 | A | | Mobile arm support supinator | | | | | |
| L3980 | A | | Upp ext fx orthosis humeral | | | | | |
| L3982 | A | | Upper ext fx orthosis rad/ul | | | | | |
| L3984 | A | | Upper ext fx orthosis wrist | | | | | |
| L3985 | A | | Forearm hand fx orth w/ wr h | | | | | |
| L3986 | A | | Humeral rad/ulna wrist fx or | | | | | |
| L3995 | A | | Sock fracture or equal each | | | | | |
| L3999 | A | | Upper limb orthosis NOS | | | | | |
| L4000 | A | | Repl girdle milwaukee orth | | | | | |
| L4010 | A | | Replace trilateral socket br | | | | | |
| L4020 | A | | Replace quadlat socket brim | | | | | |
| L4030 | A | | Replace socket brim cust fit | | | | | |
| L4040 | A | | Replace molded thigh lacer | | | | | |
| L4045 | A | | Replace non-molded thigh lac | | | | | |
| L4050 | A | | Replace molded calf lacer | | | | | |
| L4055 | A | | Replace non-molded calf lace | | | | | |
| L4060 | A | | Replace high roll cuff | | | | | |
| L4070 | A | | Replace prox & dist upright | | | | | |
| L4080 | A | | Repl met band kafo-afo prox | | | | | |
| L4090 | A | | Repl met band kafo-afo calf/ | | | | | |
| L4100 | A | | Repl leath cuff kafo prox th | | | | | |
| L4110 | A | | Repl leath cuff kafo-afo cal | | | | | |
| L4130 | A | | Replace pretibial shell | | | | | |
| L4205 | A | | Ortho dvc repair per 15 min | | | | | |
| L4210 | A | | Orth dev repair/repl minor p | | | | | |
| L4350 | A | | Pneumatic ankle cntrl splint | | | | | |
| L4360 | A | | Pneumatic walking splint | | | | | |
| L4370 | A | | Pneumatic full leg splint | | | | | |
| L4380 | A | | Pneumatic knee splint | | | | | |
| L4386 | A | | Non-pneumatic walking splint | | | | | |
| L4392 | A | | Replace AFO soft interface | | | | | |
| L4394 | A | | Replace foot drop spint | | | | | |
| L4396 | A | | Static AFO | | | | | |
| L4398 | A | | Foot drop splint recumbent | | | | | |
| L5000 | A | | Sho insert w arch toe filler | | | | | |
| L5010 | A | | Mold socket ank hgt w/ toe f | | | | | |
| L5020 | A | | Tibial tubercle hgt w/ toe f | | | | | |
| L5050 | A | | Ank symes mold sckt sach ft | | | | | |
| L5060 | A | | Symes met fr leath socket ar | | | | | |
| L5100 | A | | Molded socket shin sach foot | | | | | |
| L5105 | A | | Plast socket jts/thgh lacer | | | | | |
| L5150 | A | | Mold sckt ext knee shin sach | | | | | |
| L5160 | A | | Mold socket bent knee shin s | | | | | |
| L5200 | A | | Kne sing axis fric shin sach | | | | | |
| L5210 | A | | No knee/ankle joints w/ ft b | | | | | |
| L5220 | A | | No knee joint with artic ali | | | | | |
| L5230 | A | | Fem focal defic constant fri | | | | | |
| L5250 | A | | Hip canad sing axi cons fric | | | | | |
| L5270 | A | | Tilt table locking hip sing | | | | | |
| L5280 | A | | Hemipelvect canad sing axis | | | | | |
| L5301 | A | | BK mold socket SACH ft endo | | | | | |
| L5311 | A | | Knee disart, SACH ft, endo | | | | | |
| L5321 | A | | AK open end SACH | | | | | |
| L5331 | A | | Hip disart canadian SACH ft | | | | | |
| L5341 | A | | Hemipelvectomy canadian SACH | | | | | |
| L5400 | A | | Postop dress & 1 cast chg bk | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L5410 | A | | Postop dsg bk ea add cast ch | | | | | |
| L5420 | A | | Postop dsg & 1 cast chg ak/d | | | | | |
| L5430 | A | | Postop dsg ak ea add cast ch | | | | | |
| L5450 | A | | Postop app non-wgt bear dsg | | | | | |
| L5460 | A | | Postop app non-wgt bear dsg | | | | | |
| L5500 | A | | Init bk ptb plaster direct | | | | | |
| L5505 | A | | Init ak ischal plstr direct | | | | | |
| L5510 | A | | Prep BK ptb plaster molded | | | | | |
| L5520 | A | | Perp BK ptb thermopls direct | | | | | |
| L5530 | A | | Prep BK ptb thermopls molded | | | | | |
| L5535 | A | | Prep BK ptb open end socket | | | | | |
| L5540 | A | | Prep BK ptb laminated socket | | | | | |
| L5560 | A | | Prep AK ischial plast molded | | | | | |
| L5570 | A | | Prep AK ischial direct form | | | | | |
| L5580 | A | | Prep AK ischial thermo mold | | | | | |
| L5585 | A | | Prep AK ischial open end | | | | | |
| L5590 | A | | Prep AK ischial laminated | | | | | |
| L5595 | A | | Hip disartic sach thermopls | | | | | |
| L5600 | A | | Hip disart sach laminat mold | | | | | |
| L5610 | A | | Above knee hydracadence | | | | | |
| L5611 | A | | Ak 4 bar link w/fric swing | | | | | |
| L5613 | A | | Ak 4 bar ling w/hydraul swig | | | | | |
| L5614 | A | | 4-bar link above knee w/swng | | | | | |
| L5616 | A | | Ak univ multiplex sys frict | | | | | |
| L5617 | A | | AK/BK self-aligning unit ea | | | | | |
| L5618 | A | | Test socket symes | | | | | |
| L5620 | A | | Test socket below knee | | | | | |
| L5622 | A | | Test socket knee disarticula | | | | | |
| L5624 | A | | Test socket above knee | | | | | |
| L5626 | A | | Test socket hip disarticulat | | | | | |
| L5628 | A | | Test socket hemipelvectomy | | | | | |
| L5629 | A | | Below knee acrylic socket | | | | | |
| L5630 | A | | Syme typ expandabl wall sckt | | | | | |
| L5631 | A | | Ak/knee disartic acrylic soc | | | | | |
| L5632 | A | | Symes type ptb brim design s | | | | | |
| L5634 | A | | Symes type poster opening so | | | | | |
| L5636 | A | | Symes type medial opening so | | | | | |
| L5637 | A | | Below knee total contact | | | | | |
| L5638 | A | | Below knee leather socket | | | | | |
| L5639 | A | | Below knee wood socket | | | | | |
| L5640 | A | | Knee disarticulat leather so | | | | | |
| L5642 | A | | Above knee leather socket | | | | | |
| L5643 | A | | Hip flex inner socket ext fr | | | | | |
| L5644 | A | | Above knee wood socket | | | | | |
| L5645 | A | | Bk flex inner socket ext fra | | | | | |
| L5646 | A | | Below knee air cushion socke | | | | | |
| L5647 | A | | Below knee suction socket | | | | | |
| L5648 | A | | Above knee air cushion socke | | | | | |
| L5649 | A | | Isch containmt/narrow m-l so | | | | | |
| L5650 | A | | Tot contact ak/knee disart s | | | | | |
| L5651 | A | | Ak flex inner socket ext fra | | | | | |
| L5652 | A | | Suction susp ak/knee disart | | | | | |
| L5653 | A | | Knee disart expand wall sock | | | | | |
| L5654 | A | | Socket insert symes | | | | | |
| L5655 | A | | Socket insert below knee | | | | | |
| L5656 | A | | Socket insert knee articulat | | | | | |
| L5658 | A | | Socket insert above knee | | | | | |
| L5661 | A | | Multi-durometer symes | | | | | |
| L5665 | A | | Multi-durometer below knee | | | | | |
| L5666 | A | | Below knee cuff suspension | | | | | |
| L5668 | A | | Socket insert w/o lock lower | | | | | |
| L5670 | A | | Bk molded supracondylar susp | | | | | |
| L5671 | A | | BK/AK locking mechanism | | | | | |
| L5672 | A | | Bk removable medial brim sus | | | | | |
| L5673 | A | NI | Socket insert w lock mech | | | | | |
| L5674 | A | | Bk suspension sleeve | | | | | |
| L5675 | A | | Bk heavy duty susp sleeve | | | | | |
| L5676 | A | | Bk knee joints single axis p | | | | | |
| L5677 | A | | Bk knee joints polycentric p | | | | | |
| L5678 | A | | Bk joint covers pair | | | | | |
| L5679 | A | NI | Socket insert w/o lock mech | | | | | |
| L5680 | A | | Bk thigh lacer non-molded | | | | | |
| L5681 | A | NI | Intl custm cong/latyp insert | | | | | |
| L5682 | A | | Bk thigh lacer glut/ischia m | | | | | |
| L5683 | A | NI | Initial custom socket insert | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L5684 | A | | Bk fork strap | | | | | |
| L5686 | A | | Bk back check | | | | | |
| L5688 | A | | Bk waist belt webbing | | | | | |
| L5690 | A | | Bk waist belt padded and lin | | | | | |
| L5692 | A | | Ak pelvic control belt light | | | | | |
| L5694 | A | | Ak pelvic control belt pad/l | | | | | |
| L5695 | A | | Ak sleeve susp neoprene/equa | | | | | |
| L5696 | A | | Ak/knee disartic pelvic join | | | | | |
| L5697 | A | | Ak/knee disartic pelvic band | | | | | |
| L5698 | A | | Ak/knee disartic silesian ba | | | | | |
| L5699 | A | | Shoulder harness | | | | | |
| L5700 | A | | Replace socket below knee | | | | | |
| L5701 | A | | Replace socket above knee | | | | | |
| L5702 | A | | Replace socket hip | | | | | |
| L5704 | A | | Custom shape cover BK | | | | | |
| L5705 | A | | Custom shape cover AK | | | | | |
| L5706 | A | | Custom shape cvr knee disart | | | | | |
| L5707 | A | | Custom shape cvr hip disart | | | | | |
| L5710 | A | | Kne-shin exo sng axi mnl loc | | | | | |
| L5711 | A | | Knee-shin exo mnl lock ultra | | | | | |
| L5712 | A | | Knee-shin exo frict swg & st | | | | | |
| L5714 | A | | Knee-shin exo variable frict | | | | | |
| L5716 | A | | Knee-shin exo mech stance ph | | | | | |
| L5718 | A | | Knee-shin exo frct swg & sta | | | | | |
| L5722 | A | | Knee-shin pneum swg frct exo | | | | | |
| L5724 | A | | Knee-shin exo fluid swing ph | | | | | |
| L5726 | A | | Knee-shin ext jnts fld swg e | | | | | |
| L5728 | A | | Knee-shin fluid swg & stance | | | | | |
| L5780 | A | | Knee-shin pneum/hydra pneum | | | | | |
| L5781 | A | | Lower limb pros vacuum pump | | | | | |
| L5782 | A | | HD low limb pros vacuum pump | | | | | |
| L5785 | A | | Exoskeletal bk ultralt mater | | | | | |
| L5790 | A | | Exoskeletal ak ultra-light m | | | | | |
| L5795 | A | | Exoskel hip ultra-light mate | | | | | |
| L5810 | A | | Endoskel knee-shin mnl lock | | | | | |
| L5811 | A | | Endo knee-shin mnl lck ultra | | | | | |
| L5812 | A | | Endo knee-shin frct swg & st | | | | | |
| L5814 | A | | Endo knee-shin hydral swg ph | | | | | |
| L5816 | A | | Endo knee-shin polyc mch sta | | | | | |
| L5818 | A | | Endo knee-shin frct swg & st | | | | | |
| L5822 | A | | Endo knee-shin pneum swg frc | | | | | |
| L5824 | A | | Endo knee-shin fluid swing p | | | | | |
| L5826 | A | | Miniature knee joint | | | | | |
| L5828 | A | | Endo knee-shin fluid swg/sta | | | | | |
| L5830 | A | | Endo knee-shin pneum/swg pha | | | | | |
| L5840 | A | | Multi-axial knee/shin system | | | | | |
| L5845 | A | | Knee-shin sys stance flexion | | | | | |
| L5846 | A | | Knee-shin sys microprocessor | | | | | |
| L5847 | A | | Microprocessor cntrl feature | | | | | |
| L5848 | A | | Knee-shin sys hydraul stance | | | | | |
| L5850 | A | | Endo ak/hip knee extens assi | | | | | |
| L5855 | A | | Mech hip extension assist | | | | | |
| L5910 | A | | Endo below knee alignable sy | | | | | |
| L5920 | A | | Endo ak/hip alignable system | | | | | |
| L5925 | A | | Above knee manual lock | | | | | |
| L5930 | A | | High activity knee frame | | | | | |
| L5940 | A | | Endo bk ultra-light material | | | | | |
| L5950 | A | | Endo ak ultra-light material | | | | | |
| L5960 | A | | Endo hip ultra-light materia | | | | | |
| L5962 | A | | Below knee flex cover system | | | | | |
| L5964 | A | | Above knee flex cover system | | | | | |
| L5966 | A | | Hip flexible cover system | | | | | |
| L5968 | A | | Multiaxial ankle w dorsiflex | | | | | |
| L5970 | A | | Foot external keel sach foot | | | | | |
| L5972 | A | | Flexible keel foot | | | | | |
| L5974 | A | | Foot single axis ankle/foot | | | | | |
| L5975 | A | | Combo ankle/foot prosthesis | | | | | |
| L5976 | A | | Energy storing foot | | | | | |
| L5978 | A | | Ft prosth multiaxial ankl/ft | | | | | |
| L5979 | A | | Multi-axial ankle/ft prosth | | | | | |
| L5980 | A | | Flex foot system | | | | | |
| L5981 | A | | Flex-walk sys low ext prosth | | | | | |
| L5982 | A | | Exoskeletal axial rotation u | | | | | |
| L5984 | A | | Endoskeletal axial rotation | | | | | |
| L5985 | A | | Lwr ext dynamic prosth pylon | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L5986 | A | | Multi-axial rotation unit | | | | | |
| L5987 | A | | Shank ft w vert load pylon | | | | | |
| L5988 | A | | Vertical shock reducing pylo | | | | | |
| L5989 | A | | Pylon w elctrnc force sensor | | | | | |
| L5990 | A | | User adjustable heel height | | | | | |
| L5995 | A | | Lower ext pros heavyduty fea | | | | | |
| L5999 | A | | Lowr extremity prosthes NOS | | | | | |
| L6000 | A | | Par hand robin-aids thum rem | | | | | |
| L6010 | A | | Hand robin-aids little/ring | | | | | |
| L6020 | A | | Part hand robin-aids no fing | | | | | |
| L6025 | A | | Part hand disart myoelectric | | | | | |
| L6050 | A | | Wrst MLd sck flx hng tri pad | | | | | |
| L6055 | A | | Wrst mold sock w/exp interfa | | | | | |
| L6100 | A | | Elb mold sock flex hinge pad | | | | | |
| L6110 | A | | Elbow mold sock suspension t | | | | | |
| L6120 | A | | Elbow mold doub splt soc ste | | | | | |
| L6130 | A | | Elbow stump activated lock h | | | | | |
| L6200 | A | | Elbow mold outsid lock hinge | | | | | |
| L6205 | A | | Elbow molded w/ expand inter | | | | | |
| L6250 | A | | Elbow inter loc elbow forarm | | | | | |
| L6300 | A | | Shlder disart int lock elbow | | | | | |
| L6310 | A | | Shoulder passive restor comp | | | | | |
| L6320 | A | | Shoulder passive restor cap | | | | | |
| L6350 | A | | Thoracic intern lock elbow | | | | | |
| L6360 | A | | Thoracic passive restor comp | | | | | |
| L6370 | A | | Thoracic passive restor cap | | | | | |
| L6380 | A | | Postop dsg cast chg wrst/elb | | | | | |
| L6382 | A | | Postop dsg cast chg elb dis/ | | | | | |
| L6384 | A | | Postop dsg cast chg shlder/t | | | | | |
| L6386 | A | | Postop ea cast chg & realign | | | | | |
| L6388 | A | | Postop applicat rigid dsg on | | | | | |
| L6400 | A | | Below elbow prosth tiss shap | | | | | |
| L6450 | A | | Elb disart prosth tiss shap | | | | | |
| L6500 | A | | Above elbow prosth tiss shap | | | | | |
| L6550 | A | | Shldr disar prosth tiss shap | | | | | |
| L6570 | A | | Scap thorac prosth tiss shap | | | | | |
| L6580 | A | | Wrist/elbow bowden cable mol | | | | | |
| L6582 | A | | Wrist/elbow bowden cbl dir f | | | | | |
| L6584 | A | | Elbow fair lead cable molded | | | | | |
| L6586 | A | | Elbow fair lead cable dir fo | | | | | |
| L6588 | A | | Shdr fair lead cable molded | | | | | |
| L6590 | A | | Shdr fair lead cable direct | | | | | |
| L6600 | A | | Polycentric hinge pair | | | | | |
| L6605 | A | | Single pivot hinge pair | | | | | |
| L6610 | A | | Flexible metal hinge pair | | | | | |
| L6615 | A | | Disconnect locking wrist uni | | | | | |
| L6616 | A | | Disconnect insert locking wr | | | | | |
| L6620 | A | | Flexion/extension wrist unit | | | | | |
| L6623 | A | | Spring-ass rot wrst w/ latch | | | | | |
| L6625 | A | | Rotation wrst w/ cable lock | | | | | |
| L6628 | A | | Quick disconn hook adapter o | | | | | |
| L6629 | A | | Lamination collar w/ couplin | | | | | |
| L6630 | A | | Stainless steel any wrist | | | | | |
| L6632 | A | | Latex suspension sleeve each | | | | | |
| L6635 | A | | Lift assist for elbow | | | | | |
| L6637 | A | | Nudge control elbow lock | | | | | |
| L6638 | A | | Elec lock on manual pw elbow | | | | | |
| L6640 | A | | Shoulder abduction joint pai | | | | | |
| L6641 | A | | Excursion amplifier pulley t | | | | | |
| L6642 | A | | Excursion amplifier lever ty | | | | | |
| L6645 | A | | Shoulder flexion-abduction j | | | | | |
| L6646 | A | | Multipo locking shoulder jnt | | | | | |
| L6647 | A | | Shoulder lock actuator | | | | | |
| L6648 | A | | Ext pwrd shlder lock/unlock | | | | | |
| L6650 | A | | Shoulder universal joint | | | | | |
| L6655 | A | | Standard control cable extra | | | | | |
| L6660 | A | | Heavy duty control cable | | | | | |
| L6665 | A | | Teflon or equal cable lining | | | | | |
| L6670 | A | | Hook to hand cable adapter | | | | | |
| L6672 | A | | Harness chest/shlder saddle | | | | | |
| L6675 | A | | Harness figure of 8 sing con | | | | | |
| L6676 | A | | Harness figure of 8 dual con | | | | | |
| L6680 | A | | Test sock wrist disart/bel e | | | | | |
| L6682 | A | | Test sock elbw disart/above | | | | | |
| L6684 | A | | Test socket shldr disart/tho | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L6686 | A | | Suction socket | | | | | |
| L6687 | A | | Frame typ socket bel elbow/w | | | | | |
| L6688 | A | | Frame typ sock above elb/dis | | | | | |
| L6689 | A | | Frame typ socket shoulder di | | | | | |
| L6690 | A | | Frame typ sock interscap-tho | | | | | |
| L6691 | A | | Removable insert each | | | | | |
| L6692 | A | | Silicone gel insert or equal | | | | | |
| L6693 | A | | Lockingelbow forearm cntrbal | | | | | |
| L6700 | A | | Terminal device model #3 | | | | | |
| L6705 | A | | Terminal device model #5 | | | | | |
| L6710 | A | | Terminal device model #5x | | | | | |
| L6715 | A | | Terminal device model #5xa | | | | | |
| L6720 | A | | Terminal device model #6 | | | | | |
| L6725 | A | | Terminal device model #7 | | | | | |
| L6730 | A | | Terminal device model #7lo | | | | | |
| L6735 | A | | Terminal device model #8 | | | | | |
| L6740 | A | | Terminal device model #8x | | | | | |
| L6745 | A | | Terminal device model #88x | | | | | |
| L6750 | A | | Terminal device model #10p | | | | | |
| L6755 | A | | Terminal device model #10x | | | | | |
| L6765 | A | | Terminal device model #12p | | | | | |
| L6770 | A | | Terminal device model #99x | | | | | |
| L6775 | A | | Terminal device model#555 | | | | | |
| L6780 | A | | Terminal device model #ss555 | | | | | |
| L6790 | A | | Hooks-accu hook or equal | | | | | |
| L6795 | A | | Hooks-2 load or equal | | | | | |
| L6800 | A | | Hooks-aprl vc or equal | | | | | |
| L6805 | A | | Modifier wrist flexion unit | | | | | |
| L6806 | A | | Trs grip vc or equal | | | | | |
| L6807 | A | | Term device grip1/2 or equal | | | | | |
| L6808 | A | | Term device infant or child | | | | | |
| L6809 | A | | Trs super sport passive | | | | | |
| L6810 | A | | Pincher tool otto bock or eq | | | | | |
| L6825 | A | | Hands dorrance vo | | | | | |
| L6830 | A | | Hand aprl vc | | | | | |
| L6835 | A | | Hand sierra vo | | | | | |
| L6840 | A | | Hand becker imperial | | | | | W≤ |
| L6845 | A | | Hand becker lock grip | | | | | |
| L6850 | A | | Term dvc-hand becker plylite | | | | | |
| L6855 | A | | Hand robin-aids vo | | | | | |
| L6860 | A | | Hand robin-aids vo soft | | | | | |
| L6865 | A | | Hand passive hand | | | | | |
| L6867 | A | | Hand detroit infant hand | | | | | |
| L6868 | A | | Passive inf hand steeper/hos | | | | | |
| L6870 | A | | Hand child mitt | | | | | |
| L6872 | A | | Hand nyu child hand | | | | | |
| L6873 | A | | Hand mech inf steeper or equ | | | | | |
| L6875 | A | | Hand bock vc | | | | | |
| L6880 | A | | Hand bock vo | | | | | |
| L6881 | A | | Autograsp feature ul term dv | | | | | |
| L6882 | A | | Microprocessor control uplmb | | | | | |
| L6890 | A | | Production glove | | | | | |
| L6895 | A | | Custom glove | | | | | |
| L6900 | A | | Hand restorat thumb/1 finger | | | | | |
| L6905 | A | | Hand restoration multiple fi | | | | | |
| L6910 | A | | Hand restoration no fingers | | | | | |
| L6915 | A | | Hand restoration replacmnt g | | | | | |
| L6920 | A | | Wrist disarticul switch ctrl | | | | | |
| L6925 | A | | Wrist disart myoelectronic c | | | | | |
| L6930 | A | | Below elbow switch control | | | | | |
| L6935 | A | | Below elbow myoelectronic ct | | | | | |
| L6940 | A | | Elbow disarticulation switch | | | | | |
| L6945 | A | | Elbow disart myoelectronic c | | | | | |
| L6950 | A | | Above elbow switch control | | | | | |
| L6955 | A | | Above elbow myoelectronic ct | | | | | |
| L6960 | A | | Shldr disartic switch contro | | | | | |
| L6965 | A | | Shldr disartic myoelectronic | | | | | |
| L6970 | A | | Interscapular-thor switch ct | | | | | |
| L6975 | A | | Interscap-thor myoelectronic | | | | | |
| L7010 | A | | Hand otto back steeper/eq sw | | | | | |
| L7015 | A | | Hand sys teknik village swit | | | | | |
| L7020 | A | | Electronic greifer switch ct | | | | | |
| L7025 | A | | Electron hand myoelectronic | | | | | |
| L7030 | A | | Hand sys teknik vill myoelec | | | | | |
| L7035 | A | | Electron greifer myoelectro | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L7040 | A | | Prehensile actuator hosmer s | | | | | |
| L7045 | A | | Electron hook child michigan | | | | | |
| L7170 | A | | Electronic elbow hosmer swit | | | | | |
| L7180 | A | | Electronic elbow utah myoele | | | | | |
| L7185 | A | | Electron elbow adolescent sw | | | | | |
| L7186 | A | | Electron elbow child switch | | | | | |
| L7190 | A | | Elbow adolescent myoelectron | | | | | |
| L7191 | A | | Elbow child myoelectronic ct | | | | | |
| L7260 | A | | Electron wrist rotator otto | | | | | |
| L7261 | A | | Electron wrist rotator utah | | | | | |
| L7266 | A | | Servo control steeper or equ | | | | | |
| L7272 | A | | Analogue control unb or equa | | | | | |
| L7274 | A | | Proportional ctl 12 volt uta | | | | | |
| L7360 | A | | Six volt bat otto bock/eq ea | | | | | |
| L7362 | A | | Battery chrgr six volt otto | | | | | |
| L7364 | A | | Twelve volt battery utah/equ | | | | | |
| L7366 | A | | Battery chrgr 12 volt utah/e | | | | | |
| L7367 | A | | Replacemnt lithium ionbatter | | | | | |
| L7368 | A | | Lithium ion battery charger | | | | | |
| L7499 | A | | Upper extremity prosthes NOS | | | | | |
| L7500 | A | | Prosthetic dvc repair hourly | | | | | |
| L7510 | A | | Prosthetic device repair rep | | | | | |
| L7520 | A | | Repair prosthesis per 15 min | | | | | |
| L7900 | A | | Male vacuum erection system | | | | | |
| L8000 | A | | Mastectomy bra | | | | | |
| L8001 | A | | Breast prosthesis bra & form | | | | | |
| L8002 | A | | Brst prsth bra & bilat form | | | | | |
| L8010 | A | | Mastectomy sleeve | | | | | |
| L8015 | A | | Ext breastprosthesis garment | | | | | |
| L8020 | A | | Mastectomy form | | | | | |
| L8030 | A | | Breast prosthesis silicone/e | | | | | |
| L8035 | A | | Custom breast prosthesis | | | | | |
| L8039 | A | | Breast prosthesis NOS | | | | | |
| L8040 | A | | Nasal prosthesis | | | | | |
| L8041 | A | | Midfacial prosthesis | | | | | |
| L8042 | A | | Orbital prosthesis | | | | | |
| L8043 | A | | Upper facial prosthesis | | | | | |
| L8044 | A | | Hemi-facial prosthesis | | | | | |
| L8045 | A | | Auricular prosthesis | | | | | |
| L8046 | A | | Partial facial prosthesis | | | | | |
| L8047 | A | | Nasal septal prosthesis | | | | | |
| L8048 | A | | Unspec maxillofacial prosth | | | | | |
| L8049 | A | | Repair maxillofacial prosth | | | | | |
| L8100 | E | | Compression stocking BK18-30 | | | | | |
| L8110 | A | | Compression stocking BK30-40 | | | | | |
| L8120 | A | | Compression stocking BK40-50 | | | | | |
| L8130 | E | | Gc stocking thighlngth 18-30 | | | | | |
| L8140 | E | | Gc stocking thighlngth 30-40 | | | | | |
| L8150 | E | | Gc stocking thighlngth 40-50 | | | | | |
| L8160 | E | | Gc stocking full lngth 18-30 | | | | | |
| L8170 | E | | Gc stocking full lngth 30-40 | | | | | |
| L8180 | E | | Gc stocking full lngth 40-50 | | | | | |
| L8190 | E | | Gc stocking waistlngth 18-30 | | | | | |
| L8195 | E | | Gc stocking waistlngth 30-40 | | | | | |
| L8200 | E | | Gc stocking waistlngth 40-50 | | | | | |
| L8210 | E | | Gc stocking custom made | | | | | |
| L8220 | E | | Gc stocking lymphedema | | | | | |
| L8230 | E | | Gc stocking garter belt | | | | | |
| L8239 | E | | G compression stocking NOS | | | | | |
| L8300 | A | | Truss single w/ standard pad | | | | | |
| L8310 | A | | Truss double w/ standard pad | | | | | |
| L8320 | A | | Truss addition to std pad wa | | | | | |
| L8330 | A | | Truss add to std pad scrotal | | | | | |
| L8400 | A | | Sheath below knee | | | | | |
| L8410 | A | | Sheath above knee | | | | | |
| L8415 | A | | Sheath upper limb | | | | | |
| L8417 | A | | Pros sheath/sock w gel cushn | | | | | |
| L8420 | A | | Prosthetic sock multi ply BK | | | | | |
| L8430 | A | | Prosthetic sock multi ply AK | | | | | |
| L8435 | A | | Pros sock multi ply upper lm | | | | | |
| L8440 | A | | Shrinker below knee | | | | | |
| L8460 | A | | Shrinker above knee | | | | | |
| L8465 | A | | Shrinker upper limb | | | | | |
| L8470 | A | | Pros sock single ply BK | | | | | |
| L8480 | A | | Pros sock single ply AK | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L8485 | A | | Pros sock single ply upper l | | | | | |
| L8490 | A | | Air seal suction reten systm | | | | | |
| L8499 | A | | Unlisted misc prosthetic ser | | | | | |
| L8500 | A | | Artificial larynx | | | | | |
| L8501 | A | | Tracheostomy speaking valve | | | | | |
| L8505 | A | | Artificial larynx, accessory | | | | | |
| L8507 | A | | Trach-esoph voice pros pt in | | | | | |
| L8509 | A | | Trach-esoph voice pros md in | | | | | |
| L8510 | A | | Voice amplifier | | | | | |
| L8511 | A | NI | Indwelling trach insert | | | | | |
| L8512 | A | NI | Gel cap for trach voice pros | | | | | |
| L8513 | A | NI | Trach pros cleaning device | | | | | |
| L8514 | A | NI | Repl trach puncture dilator | | | | | |
| L8600 | N | | Implant breast silicone/eq | | | | | |
| L8603 | N | | Collagen imp urinary 2.5 ml | | | | | |
| L8606 | N | | Synthetic implnt urinary 1ml | | | | | |
| L8610 | N | | Ocular implant | | | | | |
| L8612 | N | | Aqueous shunt prosthesis | | | | | |
| L8613 | N | | Ossicular implant | | | | | |
| L8614 | N | | Cochlear device/system | | | | | |
| L8619 | A | | Replace cochlear processor | | | | | |
| L8630 | N | | Metacarpophalangeal implant | | | | | |
| L8631 | A | NI | MCP joint repl 2 pc or more | | | | | |
| L8641 | N | | Metatarsal joint implant | | | | | |
| L8642 | N | | Hallux implant | | | | | |
| L8658 | N | | Interphalangeal joint spacer | | | | | |
| L8659 | A | NI | Interphalangeal joint repl | | | | | |
| L8670 | N | | Vascular graft, synthetic | | | | | |
| L8699 | N | | Prosthetic implant NOS | | | | | |
| L9900 | A | | O&P supply/accessory/service | | | | | |
| M0064 | X | | Visit for drug monitoring | 0374 | 1.1252 | $61.39 | | $12.28 |
| M0075 | E | | Cellular therapy | | | | | |
| M0076 | E | | Prolotherapy | | | | | |
| M0100 | E | | Intragastric hypothermia | | | | | |
| M0300 | E | | IV chelationtherapy | | | | | |
| M0301 | E | | Fabric wrapping of aneurysm | | | | | |
| P2028 | A | | Cephalin floculation test | | | | | |
| P2029 | A | | Congo red blood test | | | | | |
| P2031 | E | | Hair analysis | | | | | |
| P2033 | A | | Blood thymol turbidity | | | | | |
| P2038 | A | | Blood mucoprotein | | | | | |
| P3000 | A | | Screen pap by tech w md supv | | | | | |
| P3001 | B | | Screening pap smear by phys | | | | | |
| P7001 | E | | Culture bacterial urine | | | | | |
| P9010 | K | | Whole blood for transfusion | 0950 | | $87.93 | | $17.59 |
| P9011 | K | | Blood split unit | 0957 | | $41.44 | | $8.29 |
| P9012 | K | | Cryoprecipitate each unit | 0952 | | $29.31 | | $5.86 |
| P9016 | K | | RBC leukocytes reduced | 0954 | | $119.26 | | $23.85 |
| P9017 | K | | Plasma 1 donor frz w/in 8 hr | 0955 | | $95.00 | | $19.00 |
| P9019 | K | | Platelets, each unit | 0957 | | $41.44 | | $8.29 |
| P9020 | K | | Plaelet rich plasma unit | 0958 | | $53.56 | | $10.71 |
| P9021 | K | | Red blood cells unit | 0959 | | $86.41 | | $17.28 |
| P9022 | K | | Washed red blood cells unit | 0960 | | $160.69 | | $32.14 |
| P9023 | K | | Frozen plasma, pooled, sd | 0949 | | $124.31 | | $24.86 |
| P9031 | K | | Platelets leukocytes reduced | 1013 | | $49.52 | | $9.90 |
| P9032 | K | | Platelets, irradiated | 9500 | | $74.79 | | $14.96 |
| P9033 | K | | Platelets leukoreduced irrad | 0954 | | $119.26 | | $23.85 |
| P9034 | K | | Platelets, pheresis | 9501 | | $408.81 | | $81.76 |
| P9035 | K | | Platelet pheres leukoreduced | 9501 | | $408.81 | | $81.76 |
| P9036 | K | | Platelet pheresis irradiated | 9502 | | $443.68 | | $88.74 |
| P9037 | K | | Plate pheres leukoredu irrad | 1019 | | $406.28 | | $81.26 |
| P9038 | K | | RBC irradiated | 9505 | | $108.65 | | $21.73 |
| P9039 | K | | RBC deglycerolized | 9504 | | $183.44 | | $36.69 |
| P9040 | K | | RBC leukoreduced irradiated | 9504 | | $183.44 | | $36.69 |
| P9041 | K | | Albumin (human),5%, 50ml | 0961 | 0.2802 | $15.29 | | $3.06 |
| P9043 | K | | Plasma protein fract,5%,50ml | 0956 | | $92.98 | | $18.60 |
| P9044 | K | | Cryoprecipitatereducedplasma | 1009 | | $37.39 | | $7.48 |
| P9045 | K | | Albumin (human), 5%, 250 ml | 0963 | 1.0901 | $59.48 | | $11.90 |
| P9046 | K | | Albumin (human), 25%, 20 ml | 0964 | 0.3741 | $20.41 | | $4.08 |
| P9047 | K | | Albumin (human), 25%, 50ml | 0965 | 0.8869 | $48.39 | | $9.68 |
| P9048 | K | | Plasmaprotein fract,5%,250ml | 0966 | | $464.90 | | $92.98 |
| P9050 | K | | Granulocytes, pheresis unit | 9506 | | $1,248.66 | | $249.73 |
| P9051 | K | NI | Blood, l/r, cmv-neg | 1010 | | $121.78 | | $24.36 |
| P9052 | K | NI | Platelets, hla-m, l/r, unit | 1011 | | $499.77 | | $99.95 |
| P9053 | K | NI | Plt, pher, l/r cmv-neg, irr | 1020 | | $495.22 | | $99.04 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| P9054 | K | NI | Blood, l/r, froz/degly/wash | 1016 | | $301.68 | | $60.34 |
| P9055 | K | NI | Plt, aph/pher, l/r, cmv-neg | 1017 | | $393.15 | | $78.63 |
| P9056 | K | NI | Blood, l/r, irradiated | 1018 | | $132.40 | | $26.48 |
| P9057 | K | NI | RBC, frz/deg/wsh, l/r, irrad | 1021 | | $336.04 | | $67.21 |
| P9058 | K | NI | RBC, l/r, cmv-neg, irrad | 1022 | | $201.12 | | $40.22 |
| P9059 | K | NI | Plasma, frz between 8-24hour | 0955 | | $95.00 | | $19.00 |
| P9060 | K | NI | Fr frz plasma donor retested | 9503 | | $69.74 | | $13.95 |
| P9604 | A | | One-way allow prorated trip | | | | | |
| P9612 | N | | Catheterize for urine spec | | | | | |
| P9615 | N | | Urine specimen collect mult | | | | | |
| Q0035 | X | | Cardiokymography | 0100 | 1.5862 | $86.54 | $41.44 | $17.31 |
| Q0081 | T | | Infusion ther other than che | 0120 | 1.9114 | $104.29 | $28.21 | $20.86 |
| Q0083 | S | | Chemo by other than infusion | 0116 | 0.7996 | $43.63 | | $8.73 |
| Q0084 | S | | Chemotherapy by infusion | 0117 | 3.0360 | $165.65 | $42.54 | $33.13 |
| Q0085 | E | | Chemo by both infusion and o | | | | | |
| Q0086 | A | DG | Physical therapy evaluation/ | | | | | |
| Q0091 | T | | Obtaining screen pap smear | 0191 | 0.1853 | $10.11 | $2.93 | $2.02 |
| Q0092 | N | | Set up port xray equipment | | | | | |
| Q0111 | A | | Wet mounts/ w preparations | | | | | |
| Q0112 | A | | Potassium hydroxide preps | | | | | |
| Q0113 | A | | Pinworm examinations | | | | | |
| Q0114 | A | | Fern test | | | | | |
| Q0115 | A | | Post-coital mucous exam | | | | | |
| Q0136 | K | | Non esrd epoetin alpha inj | 0733 | 0.1802 | $9.83 | | $1.97 |
| Q0137 | K | NI | Darbepoetin alfa, non esrd | 0734 | | $3.24 | | $0.65 |
| Q0144 | E | | Azithromycin dihydrate, oral | | | | | |
| Q0163 | N | | Diphenhydramine HCl 50mg | | | | | |
| Q0164 | N | | Prochlorperazine maleate 5mg | | | | | |
| Q0165 | B | | Prochlorperazine maleate10mg | | | | | |
| Q0166 | K | | Granisetron HCl 1 mg oral | 0765 | 0.6322 | $34.49 | | $6.90 |
| Q0167 | N | | Dronabinol 2.5mg oral | | | | | |
| Q0168 | B | | Dronabinol 5mg oral | | | | | |
| Q0169 | N | | Promethazine HCl 12.5mg oral | | | | | |
| Q0170 | B | | Promethazine HCl 25 mg oral | | | | | |
| Q0171 | N | | Chlorpromazine HCl 10mg oral | | | | | |
| Q0172 | B | | Chlorpromazine HCl 25mg oral | | | | | |
| Q0173 | N | | Trimethobenzamide HCl 250mg | | | | | |
| Q0174 | N | | Thiethylperazine maleate10mg | | | | | |
| Q0175 | N | | Perphenazine 4mg oral | | | | | |
| Q0176 | B | | Perphenazine 8mg oral | | | | | |
| Q0177 | N | | Hydroxyzine pamoate 25mg | | | | | |
| Q0178 | B | | Hydroxyzine pamoate 50mg | | | | | |
| Q0179 | N | | Ondansetron HCl 8mg oral | | | | | |
| Q0180 | K | | Dolasetron mesylate oral | 0763 | 0.7514 | $41.00 | | $8.20 |
| Q0181 | E | | Unspecified oral anti-emetic | | | | | |
| Q0182 | B | NI | Nonmetabolic act d/e tissue | | | | | |
| Q0183 | N | | Nonmetabolic active tissue | | | | | |
| Q0187 | K | | Factor viia recombinant | 1409 | | $1,083.93 | | $216.79 |
| Q1001 | N | | Ntiol category 1 | | | | | |
| Q1002 | N | | Ntiol category 2 | | | | | |
| Q1003 | N | | Ntiol category 3 | | | | | |
| Q1004 | N | | Ntiol category 4 | | | | | |
| Q1005 | N | | Ntiol category 5 | | | | | |
| Q2001 | E | | Oral cabergoline 0.5 mg | | | | | |
| Q2002 | N | | Elliotts b solution per ml | | | | | |
| Q2003 | K | | Aprotinin, 10,000 kiu | 7019 | 0.0215 | $1.17 | | $0.23 |
| Q2004 | N | | Bladder calculi irrig sol | | | | | |
| Q2005 | K | | Corticorelin ovine triflutat | 7024 | 4.1221 | $224.91 | | $44.98 |
| Q2006 | K | | Digoxin immune fab (ovine) | 7025 | 4.9694 | $271.14 | | $54.23 |
| Q2007 | K | | Ethanolamine oleate 100 mg | 7026 | 0.5099 | $27.82 | | $5.56 |
| Q2008 | K | | Fomepizole, 15 mg | 7027 | 0.1325 | $7.23 | | $1.45 |
| Q2009 | K | | Fosphenytoin, 50 mg | 7028 | 0.0895 | $4.88 | | $0.98 |
| Q2010 | N | DG | Glatiramer acetate, per dose | | | | | |
| Q2011 | K | | Hemin, per 1 mg | 7030 | 0.0118 | $0.64 | | $0.13 |
| Q2012 | N | | Pegademase bovine, 25 iu | | | | | |
| Q2013 | K | | Pentastarch 10% solution | 7040 | 0.4838 | $26.40 | | $5.28 |
| Q2014 | N | | Sermorelin acetate, 0.5 mg | | | | | |
| Q2017 | K | | Teniposide, 50 mg | 7035 | 2.5185 | $137.41 | | $27.48 |
| Q2018 | K | | Urofollitropin, 75 iu | 7037 | 1.1634 | $63.48 | | $12.70 |
| Q2019 | K | | Basiliximab | 1615 | | $1,425.06 | | $285.01 |
| Q2020 | E | | Histrelin acetate | | | | | |
| Q2021 | N | | Lepirudin | | | | | |
| Q2022 | K | | VonWillebrandFactrCmplxperIU | 1618 | | $1.01 | | $0.20 |
| Q3000 | K | NF | Rubidium-Rb-82 | 9025 | 2.6372 | $143.89 | | $28.78 |
| Q3001 | N | | Brachytherapy Radioelements | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| Q3002 | K | | Gallium ga 67 | 1619 | 0.2056 | $11.22 | | $2.24 |
| Q3003 | K | | Technetium tc99m bicisate | 1620 | 3.3666 | $183.69 | | $36.74 |
| Q3004 | N | | Xenon xe 133 | | | | | |
| Q3005 | K | | Technetium tc99m mertiatide | 1622 | 0.3782 | $20.63 | | $4.13 |
| Q3006 | N | | Technetium tc99m glucepatate | | | | | |
| Q3007 | K | | Sodium phosphate p32 | 1624 | 1.2941 | $70.61 | | $14.12 |
| Q3008 | K | | Indium 111-in pentetreotide | 1625 | 8.2447 | $449.84 | | $89.97 |
| Q3009 | N | | Technetium tc99m oxidronate | | | | | |
| Q3010 | N | | Technetium tc99mlabeledrbcs | | | | | |
| Q3011 | K | | Chromic phosphate p32 | 1628 | 1.8057 | $98.52 | | $19.70 |
| Q3012 | K | | Cyanocobalamin cobalt co57 | 1089 | 1.0460 | $57.07 | | $11.41 |
| Q3014 | A | | Telehealth facility fee | | | | | |
| Q3019 | A | | ALS emer trans no ALS serv | | | | | |
| Q3020 | A | | ALS nonemer trans no ALS se | | | | | |
| Q3021 | E | | Ped hepatitis b vaccine inj | | | | | |
| Q3022 | E | | Hepatitis b vaccine adult ds | | | | | |
| Q3023 | E | | Injection hepatitis Bvaccine | | | | | |
| Q3025 | K | | IM inj interferon beta 1-a | 9022 | 1.1290 | $61.60 | | $12.32 |
| Q3026 | N | | Subc inj interferon beta-1a | | | | | |
| Q3031 | N | NI | Collagen skin test | | | | | |
| Q4001 | B | | Cast sup body cast plaster | | | | | |
| Q4002 | B | | Cast sup body cast fiberglas | | | | | |
| Q4003 | B | | Cast sup shoulder cast plstr | | | | | |
| Q4004 | B | | Cast sup shoulder cast fbrgl | | | | | |
| Q4005 | B | | Cast sup long arm adult plst | | | | | |
| Q4006 | B | | Cast sup long arm adult fbrg | | | | | |
| Q4007 | B | | Cast sup long arm ped plster | | | | | |
| Q4008 | B | | Cast sup long arm ped fbrgls | | | | | |
| Q4009 | B | | Cast sup sht arm adult plstr | | | | | |
| Q4010 | B | | Cast sup sht arm adult fbrgl | | | | | |
| Q4011 | B | | Cast sup sht arm ped plaster | | | | | |
| Q4012 | B | | Cast sup sht arm ped fbrglas | | | | | |
| Q4013 | B | | Cast sup gauntlet plaster | | | | | |
| Q4014 | B | | Cast sup gauntlet fiberglass | | | | | |
| Q4015 | B | | Cast sup gauntlet ped plster | | | | | |
| Q4016 | B | | Cast sup gauntlet ped fbrgls | | | | | |
| Q4017 | B | | Cast sup lng arm splint plst | | | | | |
| Q4018 | B | | Cast sup lng arm splint fbrg | | | | | |
| Q4019 | B | | Cast sup lng arm splnt ped p | | | | | |
| Q4020 | B | | Cast sup lng arm splnt ped f | | | | | |
| Q4021 | B | | Cast sup sht arm splint plst | | | | | |
| Q4022 | B | | Cast sup sht arm splint fbrg | | | | | |
| Q4023 | B | | Cast sup sht arm splnt ped p | | | | | |
| Q4024 | B | | Cast sup sht arm splnt ped f | | | | | |
| Q4025 | B | | Cast sup hip spica plaster | | | | | |
| Q4026 | B | | Cast sup hip spica fiberglas | | | | | |
| Q4027 | B | | Cast sup hip spica ped plstr | | | | | |
| Q4028 | B | | Cast sup hip spica ped fbrgl | | | | | |
| Q4029 | B | | Cast sup long leg plaster | | | | | |
| Q4030 | B | | Cast sup long leg fiberglass | | | | | |
| Q4031 | B | | Cast sup lng leg ped plaster | | | | | |
| Q4032 | B | | Cast sup lng leg ped fbrgls | | | | | |
| Q4033 | B | | Cast sup lng leg cylinder pl | | | | | |
| Q4034 | B | | Cast sup lng leg cylinder fb | | | | | |
| Q4035 | B | | Cast sup lngleg cylndr ped p | | | | | |
| Q4036 | B | | Cast sup lngleg cylndr ped f | | | | | |
| Q4037 | B | | Cast sup shrt leg plaster | | | | | |
| Q4038 | B | | Cast sup shrt leg fiberglass | | | | | |
| Q4039 | B | | Cast sup shrt leg ped plster | | | | | |
| Q4040 | B | | Cast sup shrt leg ped fbrgls | | | | | |
| Q4041 | B | | Cast sup lng leg splnt plstr | | | | | |
| Q4042 | B | | Cast sup lng leg splnt fbrgl | | | | | |
| Q4043 | B | | Cast sup lng leg splnt ped p | | | | | |
| Q4044 | B | | Cast sup lng leg splnt ped f | | | | | |
| Q4045 | B | | Cast sup sht leg splnt plstr | | | | | |
| Q4046 | B | | Cast sup sht leg splnt fbrgl | | | | | |
| Q4047 | B | | Cast sup sht leg splnt ped p | | | | | |
| Q4048 | B | | Cast sup sht leg splnt ped f | | | | | |
| Q4049 | B | | Finger splint, static | | | | | |
| Q4050 | B | | Cast supplies unlisted | | | | | |
| Q4051 | B | | Splint supplies misc | | | | | |
| Q4052 | K | DG | Octreotide injection, depot | 1207 | 1.2049 | $65.74 | | $13.15 |
| Q4053 | D | DNG | Pegfilgrastim, per 1 mg | | | | | |
| Q4054 | A | NI | Darbepoetin alfa, esrd use | | | | | |
| Q4055 | A | NI | Epoetin alfa, esrd use | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| Q4075 | N | NI | Acyclovir, 5 mg | | | | | |
| Q4076 | N | NI | Dopamine hcl, 40 mg | | | | | |
| Q4077 | N | NI | Treprostinil, 1 mg | | | | | |
| Q4078 | K | DG | Ammonia N-13, per dose | 9025 | 2.6372 | $143.89 | | $28.78 |
| Q9920 | A | DG | Epoetin with hct <= 20 | | | | | |
| Q9921 | A | DG | Epoetin with hct = 21 | | | | | |
| Q9922 | A | DG | Epoetin with hct = 22 | | | | | |
| Q9923 | A | DG | Epoetin with hct = 23 | | | | | |
| Q9924 | A | DG | Epoetin with hct = 24 | | | | | |
| Q9925 | A | DG | Epoetin with hct = 25 | | | | | |
| Q9926 | A | DG | Epoetin with hct = 26 | | | | | |
| Q9927 | A | DG | Epoetin with hct = 27 | | | | | |
| Q9928 | A | DG | Epoetin with hct = 28 | | | | | |
| Q9929 | A | DG | Epoetin with hct = 29 | | | | | |
| Q9930 | A | DG | Epoetin with hct = 30 | | | | | |
| Q9931 | A | DG | Epoetin with hct = 31 | | | | | |
| Q9932 | A | DG | Epoetin with hct = 32 | | | | | |
| Q9933 | A | DG | Epoetin with hct = 33 | | | | | |
| Q9934 | A | DG | Epoetin with hct = 34 | | | | | |
| Q9935 | A | DG | Epoetin with hct = 35 | | | | | |
| Q9936 | A | DG | Epoetin with hct = 36 | | | | | |
| Q9937 | A | DG | Epoetin with hct = 37 | | | | | |
| Q9938 | A | DG | Epoetin with hct = 38 | | | | | |
| Q9939 | A | DG | Epoetin with hct = 39 | | | | | |
| Q9940 | A | DG | Epoetin with hct >= 40 | | | | | |
| R0070 | N | | Transport portable x-ray | | | | | |
| R0075 | N | | Transport port x-ray multipl | | | | | |
| R0076 | N | | Transport portable EKG | | | | | |
| V2020 | A | | Vision svcs frames purchases | | | | | |
| V2025 | E | | Eyeglasses delux frames | | | | | |
| V2100 | A | | Lens spher single plano 4.00 | | | | | |
| V2101 | A | | Single visn sphere 4.12-7.00 | | | | | |
| V2102 | A | | Singl visn sphere 7.12-20.00 | | | | | |
| V2103 | A | | Spherocylindr 4.00d/12-2.00d | | | | | |
| V2104 | A | | Spherocylindr 4.00d/2.12-4d | | | | | |
| V2105 | A | | Spherocylinder 4.00d/4.25-6d | | | | | |
| V2106 | A | | Spherocylinder 4.00d/>6.00d | | | | | |
| V2107 | A | | Spherocylinder 4.25d/12-2d | | | | | |
| V2108 | A | | Spherocylinder 4.25d/2.12-4d | | | | | |
| V2109 | A | | Spherocylinder 4.25d/4.25-6d | | | | | |
| V2110 | A | | Spherocylinder 4.25d/over 6d | | | | | |
| V2111 | A | | Spherocylindr 7.25d/.25-2.25 | | | | | |
| V2112 | A | | Spherocylindr 7.25d/2.25-4d | | | | | |
| V2113 | A | | Spherocylindr 7.25d/4.25-6d | | | | | |
| V2114 | A | | Spherocylinder over 12.00d | | | | | |
| V2115 | A | | Lens lenticular bifocal | | | | | |
| V2116 | A | DG | Nonaspheric lens bifocal | | | | | |
| V2117 | A | DG | Aspheric lens bifocal | | | | | |
| V2118 | A | | Lens aniseikonic single | | | | | |
| V2121 | A | NI | Lenticular lens, single | | | | | |
| V2199 | A | | Lens single vision not oth c | | | | | |
| V2200 | A | | Lens spher bifoc plano 4.00d | | | | | |
| V2201 | A | | Lens sphere bifocal 4.12-7.0 | | | | | |
| V2202 | A | | Lens sphere bifocal 7.12-20. | | | | | |
| V2203 | A | | Lens sphcyl bifocal 4.00d/.1 | | | | | |
| V2204 | A | | Lens sphcy bifocal 4.00d/2.1 | | | | | |
| V2205 | A | | Lens sphcy bifocal 4.00d/4.2 | | | | | |
| V2206 | A | | Lens sphcy bifocal 4.00d/ove | | | | | |
| V2207 | A | | Lens sphcy bifocal 4.25-7d/. | | | | | |
| V2208 | A | | Lens sphcy bifocal 4.25-7/2. | | | | | |
| V2209 | A | | Lens sphcy bifocal 4.25-7/4. | | | | | |
| V2210 | A | | Lens sphcy bifocal 4.25-7/ov | | | | | |
| V2211 | A | | Lens sphcy bifo 7.25-12/.25- | | | | | |
| V2212 | A | | Lens sphcyl bifo 7.25-12/2.2 | | | | | |
| V2213 | A | | Lens sphcyl bifo 7.25-12/4.2 | | | | | |
| V2214 | A | | Lens sphcyl bifocal over 12. | | | | | |
| V2215 | A | | Lens lenticular bifocal | | | | | |
| V2216 | A | DG | Lens lenticular nonaspheric | | | | | |
| V2217 | A | DG | Lens lenticular aspheric bif | | | | | |
| V2218 | A | | Lens aniseikonic bifocal | | | | | |
| V2219 | A | | Lens bifocal seg width over | | | | | |
| V2220 | A | | Lens bifocal add over 3.25d | | | | | |
| V2221 | A | NI | Lenticular lens, bifocal | | | | | |
| V2299 | A | | Lens bifocal speciality | | | | | |
| V2300 | A | | Lens sphere trifocal 4.00d | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| V2301 | A | | Lens sphere trifocal 4.12-7. | | | | | |
| V2302 | A | | Lens sphere trifocal 7.12-20 | | | | | |
| V2303 | A | | Lens sphcy trifocal 4.0/.12- | | | | | |
| V2304 | A | | Lens sphcy trifocal 4.0/2.25 | | | | | |
| V2305 | A | | Lens sphcy trifocal 4.0/4.25 | | | | | |
| V2306 | A | | Lens sphcyl trifocal 4.00/>6 | | | | | |
| V2307 | A | | Lens sphcy trifocal 4.25-7/. | | | | | |
| V2308 | A | | Lens sphc trifocal 4.25-7/2. | | | | | |
| V2309 | A | | Lens sphc trifocal 4.25-7/4. | | | | | |
| V2310 | A | | Lens sphc trifocal 4.25-7/>6 | | | | | |
| V2311 | A | | Lens sphc trifo 7.25-12/.25- | | | | | |
| V2312 | A | | Lens sphc trifo 7.25-12/2.25 | | | | | |
| V2313 | A | | Lens sphc trifo 7.25-12/4.25 | | | | | |
| V2314 | A | | Lens sphcyl trifocal over 12 | | | | | |
| V2315 | A | | Lens lenticular trifocal | | | | | |
| V2316 | A | DG | Lens lenticular nonaspheric | | | | | |
| V2317 | A | DG | Lens lenticular aspheric tri | | | | | |
| V2318 | A | | Lens aniseikonic trifocal | | | | | |
| V2319 | A | | Lens trifocal seg width > 28 | | | | | |
| V2320 | A | | Lens trifocal add over 3.25d | | | | | |
| V2321 | A | NI | Lenticular lens, trifocal | | | | | |
| V2399 | A | | Lens trifocal speciality | | | | | |
| V2410 | A | | Lens variab asphericity sing | | | | | |
| V2430 | A | | Lens variable asphericity bi | | | | | |
| V2499 | A | | Variable asphericity lens | | | | | |
| V2500 | A | | Contact lens pmma spherical | | | | | |
| V2501 | A | | Cntct lens pmma-toric/prism | | | | | |
| V2502 | A | | Contact lens pmma bifocal | | | | | |
| V2503 | A | | Cntct lens pmma color vision | | | | | |
| V2510 | A | | Cntct gas permeable sphericl | | | | | |
| V2511 | A | | Cntct toric prism ballast | | | | | |
| V2512 | A | | Cntct lens gas permbl bifocl | | | | | |
| V2513 | A | | Contact lens extended wear | | | | | |
| V2520 | A | | Contact lens hydrophilic | | | | | |
| V2521 | A | | Cntct lens hydrophilic toric | | | | | |
| V2522 | A | | Cntct lens hydrophil bifocl | | | | | |
| V2523 | A | | Cntct lens hydrophil extend | | | | | |
| V2530 | A | | Contact lens gas impermeable | | | | | |
| V2531 | A | | Contact lens gas permeable | | | | | |
| V2599 | A | | Contact lens/es other type | | | | | |
| V2600 | A | | Hand held low vision aids | | | | | |
| V2610 | A | | Single lens spectacle mount | | | | | |
| V2615 | A | | Telescop/othr compound lens | | | | | |
| V2623 | A | | Plastic eye prosth custom | | | | | |
| V2624 | A | | Polishing artifical eye | | | | | |
| V2625 | A | | Enlargemnt of eye prosthesis | | | | | |
| V2626 | A | | Reduction of eye prosthesis | | | | | |
| V2627 | A | | Scleral cover shell | | | | | |
| V2628 | A | | Fabrication & fitting | | | | | |
| V2629 | A | | Prosthetic eye other type | | | | | |
| V2630 | N | | Anter chamber intraocul lens | | | | | |
| V2631 | N | | Iris support intraoclr lens | | | | | |
| V2632 | N | | Post chmbr intraocular lens | | | | | |
| V2700 | A | | Balance lens | | | | | |
| V2710 | A | | Glass/plastic slab off prism | | | | | |
| V2715 | A | | Prism lens/es | | | | | |
| V2718 | A | | Fresnell prism press-on lens | | | | | |
| V2730 | A | | Special base curve | | | | | |
| V2740 | A | DG | Rose tint plastic | | | | | |
| V2741 | A | DG | Non-rose tint plastic | | | | | |
| V2742 | A | DG | Rose tint glass | | | | | |
| V2743 | A | DG | Non-rose tint glass | | | | | |
| V2744 | A | | Tint photochromatic lens/es | | | | | |
| V2745 | A | NI | Tint, any color/solid/grad | | | | | |
| V2750 | A | | Anti-reflective coating | | | | | |
| V2755 | A | | UV lens/es | | | | | |
| V2756 | E | NI | Eye glass case | | | | | |
| V2760 | A | | Scratch resistant coating | | | | | |
| V2761 | E | NI | Mirror coating | | | | | |
| V2762 | A | NI | Polarization, any lens | | | | | |
| V2770 | A | | Occluder lens/es | | | | | |
| V2780 | A | | Oversize lens/es | | | | | |
| V2781 | B | | Progressive lens per lens | | | | | |
| V2782 | A | NI | Lens, 1.54-1.65 p/1.60-1.79g | | | | | |
| V2783 | A | NI | Lens, >= 1.66 p/>=1.80 g | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| V2784 | A | NI | Lens polycarb or equal | | | | | |
| V2785 | F | | Corneal tissue processing | | | | | |
| V2786 | A | NI | Occupational multifocal lens | | | | | |
| V2790 | N | | Amniotic membrane | | | | | |
| V2797 | A | NI | Vis item/svc in other code | | | | | |
| V2799 | A | | Miscellaneous vision service | | | | | |
| V5008 | E | | Hearing screening | | | | | |
| V5010 | E | | Assessment for hearing aid | | | | | |
| V5011 | E | | Hearing aid fitting/checking | | | | | |
| V5014 | E | | Hearing aid repair/modifying | | | | | |
| V5020 | E | | Conformity evaluation | | | | | |
| V5030 | E | | Body-worn hearing aid air | | | | | |
| V5040 | E | | Body-worn hearing aid bone | | | | | |
| V5050 | E | | Hearing aid monaural in ear | | | | | |
| V5060 | E | | Behind ear hearing aid | | | | | |
| V5070 | E | | Glasses air conduction | | | | | |
| V5080 | E | | Glasses bone conduction | | | | | |
| V5090 | E | | Hearing aid dispensing fee | | | | | |
| V5095 | E | | Implant mid ear hearing pros | | | | | |
| V5100 | E | | Body-worn bilat hearing aid | | | | | |
| V5110 | E | | Hearing aid dispensing fee | | | | | |
| V5120 | E | | Body-worn binaur hearing aid | | | | | |
| V5130 | E | | In ear binaural hearing aid | | | | | |
| V5140 | E | | Behind ear binaur hearing ai | | | | | |
| V5150 | E | | Glasses binaural hearing aid | | | | | |
| V5160 | E | | Dispensing fee binaural | | | | | |
| V5170 | E | | Within ear cros hearing aid | | | | | |
| V5180 | E | | Behind ear cros hearing aid | | | | | |
| V5190 | E | | Glasses cros hearing aid | | | | | |
| V5200 | E | | Cros hearing aid dispens fee | | | | | |
| V5210 | E | | In ear bicros hearing aid | | | | | |
| V5220 | E | | Behind ear bicros hearing ai | | | | | |
| V5230 | E | | Glasses bicros hearing aid | | | | | |
| V5240 | E | | Dispensing fee bicros | | | | | |
| V5241 | E | | Dispensing fee, monaural | | | | | |
| V5242 | E | | Hearing aid, monaural, cic | | | | | |
| V5243 | E | | Hearing aid, monaural, itc | | | | | |
| V5244 | E | | Hearing aid, prog, mon, cic | | | | | |
| V5245 | E | | Hearing aid, prog, mon, itc | | | | | |
| V5246 | E | | Hearing aid, prog, mon, ite | | | | | |
| V5247 | E | | Hearing aid, prog, mon, bte | | | | | |
| V5248 | E | | Hearing aid, binaural, cic | | | | | |
| V5249 | E | | Hearing aid, binaural, itc | | | | | |
| V5250 | E | | Hearing aid, prog, bin, cic | | | | | |
| V5251 | E | | Hearing aid, prog, bin, itc | | | | | |
| V5252 | E | | Hearing aid, prog, bin, ite | | | | | |
| V5253 | E | | Hearing aid, prog, bin, bte | | | | | |
| V5254 | E | | Hearing id, digit, mon, cic | | | | | |
| V5255 | E | | Hearing aid, digit, mon, itc | | | | | |
| V5256 | E | | Hearing aid, digit, mon, ite | | | | | |
| V5257 | E | | Hearing aid, digit, mon, bte | | | | | |
| V5258 | E | | Hearing aid, digit, bin, cic | | | | | |
| V5259 | E | | Hearing aid, digit, bin, itc | | | | | |
| V5260 | E | | Hearing aid, digit, bin, ite | | | | | |
| V5261 | E | | Hearing aid, digit, bin, bte | | | | | |
| V5262 | E | | Hearing aid, disp, monaural | | | | | |
| V5263 | E | | Hearing aid, disp, binaural | | | | | |
| V5264 | E | | Ear mold/insert | | | | | |
| V5265 | E | | Ear mold/insert, disp | | | | | |
| V5266 | E | | Battery for hearing device | | | | | |
| V5267 | E | | Hearing aid supply/accessory | | | | | |
| V5268 | E | | ALD Telephone Amplifier | | | | | |
| V5269 | E | | Alerting device, any type | | | | | |
| V5270 | E | | ALD, TV amplifier, any type | | | | | |
| V5271 | E | | ALD, TV caption decoder | | | | | |
| V5272 | E | | Tdd | | | | | |
| V5273 | E | | ALD for cochlear implant | | | | | |
| V5274 | E | | ALD unspecified | | | | | |
| V5275 | E | | Ear impression | | | | | |
| V5298 | E | | Hearing aid noc | | | | | |
| V5299 | B | | Hearing service | | | | | |
| V5336 | E | | Repair communication device | | | | | |
| V5362 | E | | Speech screening | | | | | |
| V5363 | E | | Language screening | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDER YEAR 2004—Continued

| CPT/HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| V5364 ..... | E ..... | ..... | Dysphagia screening ..... | ..... | ..... | ..... | ..... | ..... |

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ADDENDUM D1.—PAYMENT STATUS INDICATORS FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

| Indicator | Item/code/service | Status |
|---|---|---|
| A | Services furnished to a Hospital Outpatient that are paid under a Fee Schedule/Payment System other than OPPS, e.g.:<br>• Ambulance Services<br>• Clinical Diagnostic Laboratory Services<br>• Non-Implantable Prosthetic and Orthotic Devices<br>• EPO for ESRD Patients<br>• Physical, Occupational, and Speech Therapy<br>• Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital.<br>• Screening Mammography | Not paid under OPPS. Paid by Intermediaries under a Fee Schedule/Payment System other than OPPS. |
| B | Codes that are not recognized by OPPS when submitted on an Outpatient Hospital Part B bill type (12x, 13x, and 14x). | Not paid under OPPS.<br>• May be paid by Intermediaries when submitted on a different bill type, e.g., 75x (CORF), but not paid under OPPS.<br>• An alternate code that is recognized by OPPS when submitted on an Outpatient Hospital Part B bill type (12x, 13x, and 14x) may be available. |
| C | Inpatient Procedures | Not paid under OPPS. Admit patient; Bill as Inpatient. |
| D | Deleted Codes | Not paid under OPPS. Not paid under Medicare. |
| E | Items, Codes, and Services:<br>• That are not covered by Medicare based on Statutory Exclusion.<br>• That are not covered by Medicare for reasons other than Statutory Exclusion.<br>• That are not recognized by Medicare but for which an alternate code for the same item or service may be available.<br>• For which separate payment is not provided by Medicare | Not paid under OPPS. |
| F | Corneal Tissue Acquisition; Certain CRNA Services | Not paid under OPPS. Paid at reasonable cost. |
| G | Drug/Biological Pass-Through | Paid under OPPS; Separate APC payment includes Pass-Through amount. |
| H | Device Category Pass-Through | Paid under OPPS; Separate cost-based Pass-Through payment. |
| K | Non Pass-Through Drugs and Biologicals; Radiopharmaceutical Agents; Certain Brachytherapy Sources. | Paid under OPPS; Separate APC payment. |
| L | Influenza Vaccine; Pneumococcal Pneumonia Vaccine | Not paid under OPPS. Paid at reasonable cost; Not subject to deductible or coinsurance. |
| N | Items and Services packaged into APC Rates | Paid under OPPS. However, payment is packaged into payment for other services, including Outliers. Therefore, there is no separate APC payment. |
| P | Partial Hospitalization | Paid under OPPS; Per diem APC payment. |
| S | Significant Procedure, Not Discounted when Multiple | Paid under OPPS; Separate APC payment. |
| T | Significant Procedure, Multiple Procedure Reduction Applies | Paid under OPPS; Separate APC payment. |
| V | Clinic or Emergency Department Visit | Paid under OPPS; Separate APC payment. |
| Y | Non-Implantable Durable Medical Equipment | Not paid under OPPS. All institutional providers other than Home Health Agencies bill to DMERC. |
| X | Ancillary Service | Paid under OPPS; Separate APC payment. |

ADDENDUM D2.—CODE CONDITIONS

| Code condition | Descriptor |
|---|---|
| DG | Deleted code with a grace period; Payment will be made under the deleted code during the 90-day grace period. |
| DNG | Deleted code with no grace period; Payment will not be made under the deleted code after December 31, 2003. |
| NF | New code final APC assignment; Comments were accepted on a proposed APC assignment in the Proposed Rule; APC assignment is no longer open to comment. |
| NI | New code interim APC assignment; Comments will be accepted on the interim APC assignment for the new code. |

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES

[Calendar Year 2004]

| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 0001T | C | Endovas repr abdo ao aneurys |
| 0001T | C | Endovas repr abdo ao aneurys |
| 0005T | C | Perc cath stent/brain cv art |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 0006T | C | Perc cath stent/brain cv art |
| 0007T | C | Perc cath stent/brain cv art |
| 00174 | C | Anesth, pharyngeal surgery |
| 00176 | C | Anesth, pharyngeal surgery |
| 00192 | C | Anesth, facial bone surgery |
| 00214 | C | Anesth, skull drainage |
| 00215 | C | Anesth, skull repair/fract |
| 0021T | C | Fetal oximetry, trnsvag/cerv |
| 0024T | C | Transcath cardiac reduction |
| 0033T | C | Endovasc taa repr incl subcl |
| 0034T | C | Endovasc taa repr w/o subcl |
| 0035T | C | Insert endovasc prosth, taa |
| 0036T | C | Endovasc prosth, taa, add-on |
| 0037T | C | Artery transpose/endovas taa |
| 0038T | C | Rad endovasc taa rpr w/cover |
| 0039T | C | Rad s/i, endovasc taa repair |
| 00404 | C | Anesth, surgery of breast |
| 00406 | C | Anesth, surgery of breast |
| 0040T | C | Rad s/i, endovasc taa prosth |
| 00452 | C | Anesth, surgery of shoulder |
| 00474 | C | Anesth, surgery of rib(s) |
| 0048T | C | Implant ventricular device |
| 0049T | C | External circulation assist |
| 0050T | C | Removal circulation assist |
| 0051T | C | Implant total heart system |
| 00524 | C | Anesth, chest drainage |
| 0052T | C | Replace component heart syst |
| 0053T | C | Replace component heart syst |
| 00540 | C | Anesth, chest surgery |
| 00542 | C | Anesth, release of lung |
| 00580 | C | Anesth, heart/lung transplnt |
| 00604 | C | Anesth, sitting procedure |
| 00622 | C | Anesth, removal of nerves |
| 00632 | C | Anesth, removal of nerves |
| 00634 | C | Anesth for chemonucleolysis |
| 00670 | C | Anesth, spine, cord surgery |
| 00792 | C | Anesth, hemorr/excise liver |
| 00794 | C | Anesth, pancreas removal |
| 00796 | C | Anesth, for liver transplant |
| 00802 | C | Anesth, fat layer removal |
| 00844 | C | Anesth, pelvis surgery |
| 00846 | C | Anesth, hysterectomy |
| 00848 | C | Anesth, pelvic organ surg |
| 00864 | C | Anesth, removal of bladder |
| 00865 | C | Anesth, removal of prostate |
| 00866 | C | Anesth, removal of adrenal |
| 00868 | C | Anesth, kidney transplant |
| 00882 | C | Anesth, major vein ligation |
| 00904 | C | Anesth, perineal surgery |
| 00908 | C | Anesth, removal of prostate |
| 00928 | C | Anesth, removal of testis |
| 00932 | C | Anesth, amputation of penis |
| 00934 | C | Anesth, penis, nodes removal |
| 00936 | C | Anesth, penis, nodes removal |
| 00944 | C | Anesth, vaginal hysterectomy |
| 01140 | C | Anesth, amputation at pelvis |
| 01150 | C | Anesth, pelvic tumor surgery |
| 01190 | C | Anesth, pelvis nerve removal |
| 01212 | C | Anesth, hip disarticulation |
| 01214 | C | Anesth, hip arthroplasty |
| 01232 | C | Anesth, amputation of femur |
| 01234 | C | Anesth, radical femur surg |
| 01272 | C | Anesth, femoral artery surg |
| 01274 | C | Anesth, femoral embolectomy |
| 01402 | C | Anesth, knee arthroplasty |
| 01404 | C | Anesth, amputation at knee |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 01442 | C | Anesth, knee artery surg |
| 01444 | C | Anesth, knee artery repair |
| 01486 | C | Anesth, ankle replacement |
| 01502 | C | Anesth, lwr leg embolectomy |
| 01632 | C | Anesth, surgery of shoulder |
| 01634 | C | Anesth, shoulder joint amput |
| 01636 | C | Anesth, forequarter amput |
| 01638 | C | Anesth, shoulder replacement |
| 01652 | C | Anesth, shoulder vessel surg |
| 01654 | C | Anesth, shoulder vessel surg |
| 01656 | C | Anesth, arm-leg vessel surg |
| 01756 | C | Anesth, radical humerus surg |
| 01990 | C | Support for organ donor |
| 15756 | C | Free muscle flap, microvasc |
| 15757 | C | Free skin flap, microvasc |
| 15758 | C | Free fascial flap, microvasc |
| 16035 | C | Incision of burn scab, initi |
| 16036 | C | Incise burn scab, addl incis |
| 19200 | C | Removal of breast |
| 19220 | C | Removal of breast |
| 19271 | C | Revision of chest wall |
| 19272 | C | Extensive chest wall surgery |
| 19361 | C | Breast reconstruction |
| 19364 | C | Breast reconstruction |
| 19367 | C | Breast reconstruction |
| 19368 | C | Breast reconstruction |
| 19369 | C | Breast reconstruction |
| 20660 | C | Apply, rem fixation device |
| 20661 | C | Application of head brace |
| 20662 | C | Application of pelvis brace |
| 20663 | C | Application of thigh brace |
| 20664 | C | Halo brace application |
| 20802 | C | Replantation, arm, complete |
| 20805 | C | Replant forearm, complete |
| 20808 | C | Replantation hand, complete |
| 20816 | C | Replantation digit, complete |
| 20822 | C | Replantation digit, complete |
| 20824 | C | Replantation thumb, complete |
| 20827 | C | Replantation thumb, complete |
| 20838 | C | Replantation foot, complete |
| 20930 | C | Spinal bone allograft |
| 20931 | C | Spinal bone allograft |
| 20936 | C | Spinal bone autograft |
| 20937 | C | Spinal bone autograft |
| 20938 | C | Spinal bone autograft |
| 20955 | C | Fibula bone graft, microvasc |
| 20956 | C | Iliac bone graft, microvasc |
| 20957 | C | Mt bone graft, microvasc |
| 20962 | C | Other bone graft, microvasc |
| 20969 | C | Bone/skin graft, microvasc |
| 20970 | C | Bone/skin graft, iliac crest |
| 20972 | C | Bone/skin graft, metatarsal |
| 20973 | C | Bone/skin graft, great toe |
| 21045 | C | Extensive jaw surgery |
| 21141 | C | Reconstruct midface, lefort |
| 21142 | C | Reconstruct midface, lefort |
| 21143 | C | Reconstruct midface, lefort |
| 21145 | C | Reconstruct midface, lefort |
| 21146 | C | Reconstruct midface, lefort |
| 21147 | C | Reconstruct midface, lefort |
| 21150 | C | Reconstruct midface, lefort |
| 21151 | C | Reconstruct midface, lefort |
| 21154 | C | Reconstruct midface, lefort |
| 21155 | C | Reconstruct midface, lefort |
| 21159 | C | Reconstruct midface, lefort |
| 21160 | C | Reconstruct midface, lefort |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 21172 | C | Reconstruct orbit/forehead |
| 21175 | C | Reconstruct orbit/forehead |
| 21179 | C | Reconstruct entire forehead |
| 21180 | C | Reconstruct entire forehead |
| 21182 | C | Reconstruct cranial bone |
| 21183 | C | Reconstruct cranial bone |
| 21184 | C | Reconstruct cranial bone |
| 21188 | C | Reconstruction of midface |
| 21193 | C | Reconst lwr jaw w/o graft |
| 21194 | C | Reconst lwr jaw w/graft |
| 21195 | C | Reconst lwr jaw w/o fixation |
| 21196 | C | Reconst lwr jaw w/fixation |
| 21247 | C | Reconstruct lower jaw bone |
| 21255 | C | Reconstruct lower jaw bone |
| 21256 | C | Reconstruction of orbit |
| 21268 | C | Revise eye sockets |
| 21343 | C | Treatment of sinus fracture |
| 21344 | C | Treatment of sinus fracture |
| 21346 | C | Treat nose/jaw fracture |
| 21347 | C | Treat nose/jaw fracture |
| 21348 | C | Treat nose/jaw fracture |
| 21356 | C | Treat cheek bone fracture |
| 21360 | C | Treat cheek bone fracture |
| 21365 | C | Treat cheek bone fracture |
| 21366 | C | Treat cheek bone fracture |
| 21385 | C | Treat eye socket fracture |
| 21386 | C | Treat eye socket fracture |
| 21387 | C | Treat eye socket fracture |
| 21395 | C | Treat eye socket fracture |
| 21408 | C | Treat eye socket fracture |
| 21422 | C | Treat mouth roof fracture |
| 21423 | C | Treat mouth roof fracture |
| 21431 | C | Treat craniofacial fracture |
| 21432 | C | Treat craniofacial fracture |
| 21433 | C | Treat craniofacial fracture |
| 21435 | C | Treat craniofacial fracture |
| 21436 | C | Treat craniofacial fracture |
| 21495 | C | Treat hyoid bone fracture |
| 21510 | C | Drainage of bone lesion |
| 21557 | C | Remove tumor, neck/chest |
| 21615 | C | Removal of rib |
| 21616 | C | Removal of rib and nerves |
| 21620 | C | Partial removal of sternum |
| 21627 | C | Sternal debridement |
| 21630 | C | Extensive sternum surgery |
| 21632 | C | Extensive sternum surgery |
| 21705 | C | Revision of neck muscle/rib |
| 21740 | C | Reconstruction of sternum |
| 21750 | C | Repair of sternum separation |
| 21810 | C | Treatment of rib fracture(s) |
| 21825 | C | Treat sternum fracture |
| 22110 | C | Remove part of neck vertebra |
| 22112 | C | Remove part, thorax vertebra |
| 22114 | C | Remove part, lumbar vertebra |
| 22116 | C | Remove extra spine segment |
| 22210 | C | Revision of neck spine |
| 22212 | C | Revision of thorax spine |
| 22214 | C | Revision of lumbar spine |
| 22216 | C | Revise, extra spine segment |
| 22220 | C | Revision of neck spine |
| 22222 | C | Revision of thorax spine |
| 22224 | C | Revision of lumbar spine |
| 22226 | C | Revise, extra spine segment |
| 22318 | C | Treat odontoid fx w/o graft |
| 22319 | C | Treat odontoid fx w/graft |
| 22325 | C | Treat spine fracture |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 22326 | C | Treat neck spine fracture |
| 22327 | C | Treat thorax spine fracture |
| 22328 | C | Treat each add spine fx |
| 22532 | C | Lat thorax spine fusion |
| 22533 | C | Lat lumbar spine fusion |
| 22534 | C | Lat thor/lumb, add'l seg |
| 22548 | C | Neck spine fusion |
| 22554 | C | Neck spine fusion |
| 22556 | C | Thorax spine fusion |
| 22558 | C | Lumbar spine fusion |
| 22585 | C | Additional spinal fusion |
| 22590 | C | Spine & skull spinal fusion |
| 22595 | C | Neck spinal fusion |
| 22600 | C | Neck spine fusion |
| 22610 | C | Thorax spine fusion |
| 22630 | C | Lumbar spine fusion |
| 22632 | C | Spine fusion, extra segment |
| 22800 | C | Fusion of spine |
| 22802 | C | Fusion of spine |
| 22804 | C | Fusion of spine |
| 22808 | C | Fusion of spine |
| 22810 | C | Fusion of spine |
| 22812 | C | Fusion of spine |
| 22818 | C | Kyphectomy, 1-2 segments |
| 22819 | C | Kyphectomy, 3 or more |
| 22830 | C | Exploration of spinal fusion |
| 22840 | C | Insert spine fixation device |
| 22841 | C | Insert spine fixation device |
| 22842 | C | Insert spine fixation device |
| 22843 | C | Insert spine fixation device |
| 22844 | C | Insert spine fixation device |
| 22845 | C | Insert spine fixation device |
| 22846 | C | Insert spine fixation device |
| 22847 | C | Insert spine fixation device |
| 22848 | C | Insert pelv fixation device |
| 22849 | C | Reinsert spinal fixation |
| 22850 | C | Remove spine fixation device |
| 22851 | C | Apply spine prosth device |
| 22852 | C | Remove spine fixation device |
| 22855 | C | Remove spine fixation device |
| 23200 | C | Removal of collar bone |
| 23210 | C | Removal of shoulder blade |
| 23220 | C | Partial removal of humerus |
| 23221 | C | Partial removal of humerus |
| 23222 | C | Partial removal of humerus |
| 23332 | C | Remove shoulder foreign body |
| 23472 | C | Reconstruct shoulder joint |
| 23900 | C | Amputation of arm & girdle |
| 23920 | C | Amputation at shoulder joint |
| 24149 | C | Radical resection of elbow |
| 24900 | C | Amputation of upper arm |
| 24920 | C | Amputation of upper arm |
| 24930 | C | Amputation follow-up surgery |
| 24931 | C | Amputate upper arm & implant |
| 24940 | C | Revision of upper arm |
| 25900 | C | Amputation of forearm |
| 25905 | C | Amputation of forearm |
| 25909 | C | Amputation follow-up surgery |
| 25915 | C | Amputation of forearm |
| 25920 | C | Amputate hand at wrist |
| 25924 | C | Amputation follow-up surgery |
| 25927 | C | Amputation of hand |
| 25931 | C | Amputation follow-up surgery |
| 26551 | C | Great toe-hand transfer |
| 26553 | C | Single transfer, toe-hand |
| 26554 | C | Double transfer, toe-hand |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 26556 | C | Toe joint transfer |
| 26992 | C | Drainage of bone lesion |
| 27005 | C | Incision of hip tendon |
| 27006 | C | Incision of hip tendons |
| 27025 | C | Incision of hip/thigh fascia |
| 27030 | C | Drainage of hip joint |
| 27036 | C | Excision of hip joint/muscle |
| 27054 | C | Removal of hip joint lining |
| 27070 | C | Partial removal of hip bone |
| 27071 | C | Partial removal of hip bone |
| 27075 | C | Extensive hip surgery |
| 27076 | C | Extensive hip surgery |
| 27077 | C | Extensive hip surgery |
| 27078 | C | Extensive hip surgery |
| 27079 | C | Extensive hip surgery |
| 27090 | C | Removal of hip prosthesis |
| 27091 | C | Removal of hip prosthesis |
| 27120 | C | Reconstruction of hip socket |
| 27122 | C | Reconstruction of hip socket |
| 27125 | C | Partial hip replacement |
| 27130 | C | Total hip arthroplasty |
| 27132 | C | Total hip arthroplasty |
| 27134 | C | Revise hip joint replacement |
| 27137 | C | Revise hip joint replacement |
| 27138 | C | Revise hip joint replacement |
| 27140 | C | Transplant femur ridge |
| 27146 | C | Incision of hip bone |
| 27147 | C | Revision of hip bone |
| 27151 | C | Incision of hip bones |
| 27156 | C | Revision of hip bones |
| 27158 | C | Revision of pelvis |
| 27161 | C | Incision of neck of femur |
| 27165 | C | Incision/fixation of femur |
| 27170 | C | Repair/graft femur head/neck |
| 27175 | C | Treat slipped epiphysis |
| 27176 | C | Treat slipped epiphysis |
| 27177 | C | Treat slipped epiphysis |
| 27178 | C | Treat slipped epiphysis |
| 27179 | C | Revise head/neck of femur |
| 27181 | C | Treat slipped epiphysis |
| 27185 | C | Revision of femur epiphysis |
| 27187 | C | Reinforce hip bones |
| 27215 | C | Treat pelvic fracture(s) |
| 27217 | C | Treat pelvic ring fracture |
| 27218 | C | Treat pelvic ring fracture |
| 27222 | C | Treat hip socket fracture |
| 27226 | C | Treat hip wall fracture |
| 27227 | C | Treat hip fracture(s) |
| 27228 | C | Treat hip fracture(s) |
| 27232 | C | Treat thigh fracture |
| 27236 | C | Treat thigh fracture |
| 27240 | C | Treat thigh fracture |
| 27244 | C | Treat thigh fracture |
| 27245 | C | Treat thigh fracture |
| 27248 | C | Treat thigh fracture |
| 27253 | C | Treat hip dislocation |
| 27254 | C | Treat hip dislocation |
| 27258 | C | Treat hip dislocation |
| 27259 | C | Treat hip dislocation |
| 27280 | C | Fusion of sacroiliac joint |
| 27282 | C | Fusion of pubic bones |
| 27284 | C | Fusion of hip joint |
| 27286 | C | Fusion of hip joint |
| 27290 | C | Amputation of leg at hip |
| 27295 | C | Amputation of leg at hip |
| 27303 | C | Drainage of bone lesion |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 27365 | C | Extensive leg surgery |
| 27445 | C | Revision of knee joint |
| 27447 | C | Total knee arthroplasty |
| 27448 | C | Incision of thigh |
| 27450 | C | Incision of thigh |
| 27454 | C | Realignment of thigh bone |
| 27455 | C | Realignment of knee |
| 27457 | C | Realignment of knee |
| 27465 | C | Shortening of thigh bone |
| 27466 | C | Lengthening of thigh bone |
| 27468 | C | Shorten/lengthen thighs |
| 27470 | C | Repair of thigh |
| 27472 | C | Repair/graft of thigh |
| 27475 | C | Surgery to stop leg growth |
| 27477 | C | Surgery to stop leg growth |
| 27479 | C | Surgery to stop leg growth |
| 27485 | C | Surgery to stop leg growth |
| 27486 | C | Revise/replace knee joint |
| 27487 | C | Revise/replace knee joint |
| 27488 | C | Removal of knee prosthesis |
| 27495 | C | Reinforce thigh |
| 27506 | C | Treatment of thigh fracture |
| 27507 | C | Treatment of thigh fracture |
| 27511 | C | Treatment of thigh fracture |
| 27513 | C | Treatment of thigh fracture |
| 27514 | C | Treatment of thigh fracture |
| 27519 | C | Treat thigh fx growth plate |
| 27535 | C | Treat knee fracture |
| 27536 | C | Treat knee fracture |
| 27540 | C | Treat knee fracture |
| 27556 | C | Treat knee dislocation |
| 27557 | C | Treat knee dislocation |
| 27558 | C | Treat knee dislocation |
| 27580 | C | Fusion of knee |
| 27590 | C | Amputate leg at thigh |
| 27591 | C | Amputate leg at thigh |
| 27592 | C | Amputate leg at thigh |
| 27596 | C | Amputation follow-up surgery |
| 27598 | C | Amputate lower leg at knee |
| 27645 | C | Extensive lower leg surgery |
| 27646 | C | Extensive lower leg surgery |
| 27702 | C | Reconstruct ankle joint |
| 27703 | C | Reconstruction, ankle joint |
| 27712 | C | Realignment of lower leg |
| 27715 | C | Revision of lower leg |
| 27720 | C | Repair of tibia |
| 27722 | C | Repair/graft of tibia |
| 27724 | C | Repair/graft of tibia |
| 27725 | C | Repair of lower leg |
| 27727 | C | Repair of lower leg |
| 27880 | C | Amputation of lower leg |
| 27881 | C | Amputation of lower leg |
| 27882 | C | Amputation of lower leg |
| 27886 | C | Amputation follow-up surgery |
| 27888 | C | Amputation of foot at ankle |
| 28800 | C | Amputation of midfoot |
| 28805 | C | Amputation thru metatarsal |
| 31225 | C | Removal of upper jaw |
| 31230 | C | Removal of upper jaw |
| 31290 | C | Nasal/sinus endoscopy, surg |
| 31291 | C | Nasal/sinus endoscopy, surg |
| 31292 | C | Nasal/sinus endoscopy, surg |
| 31293 | C | Nasal/sinus endoscopy, surg |
| 31294 | C | Nasal/sinus endoscopy, surg |
| 31360 | C | Removal of larynx |
| 31365 | C | Removal of larynx |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 31367 | C | Partial removal of larynx |
| 31368 | C | Partial removal of larynx |
| 31370 | C | Partial removal of larynx |
| 31375 | C | Partial removal of larynx |
| 31380 | C | Partial removal of larynx |
| 31382 | C | Partial removal of larynx |
| 31390 | C | Removal of larynx & pharynx |
| 31395 | C | Reconstruct larynx & pharynx |
| 31584 | C | Treat larynx fracture |
| 31587 | C | Revision of larynx |
| 31725 | C | Clearance of airways |
| 31760 | C | Repair of windpipe |
| 31766 | C | Reconstruction of windpipe |
| 31770 | C | Repair/graft of bronchus |
| 31775 | C | Reconstruct bronchus |
| 31780 | C | Reconstruct windpipe |
| 31781 | C | Reconstruct windpipe |
| 31786 | C | Remove windpipe lesion |
| 31800 | C | Repair of windpipe injury |
| 31805 | C | Repair of windpipe injury |
| 32035 | C | Exploration of chest |
| 32036 | C | Exploration of chest |
| 32095 | C | Biopsy through chest wall |
| 32100 | C | Exploration/biopsy of chest |
| 32110 | C | Explore/repair chest |
| 32120 | C | Re-exploration of chest |
| 32124 | C | Explore chest free adhesions |
| 32140 | C | Removal of lung lesion(s) |
| 32141 | C | Remove/treat lung lesions |
| 32150 | C | Removal of lung lesion(s) |
| 32151 | C | Remove lung foreign body |
| 32160 | C | Open chest heart massage |
| 32200 | C | Drain, open, lung lesion |
| 32215 | C | Treat chest lining |
| 32220 | C | Release of lung |
| 32225 | C | Partial release of lung |
| 32310 | C | Removal of chest lining |
| 32320 | C | Free/remove chest lining |
| 32402 | C | Open biopsy chest lining |
| 32440 | C | Removal of lung |
| 32442 | C | Sleeve pneumonectomy |
| 32445 | C | Removal of lung |
| 32480 | C | Partial removal of lung |
| 32482 | C | Bilobectomy |
| 32484 | C | Segmentectomy |
| 32486 | C | Sleeve lobectomy |
| 32488 | C | Completion pneumonectomy |
| 32491 | C | Lung volume reduction |
| 32500 | C | Partial removal of lung |
| 32501 | C | Repair bronchus add-on |
| 32520 | C | Remove lung & revise chest |
| 32522 | C | Remove lung & revise chest |
| 32525 | C | Remove lung & revise chest |
| 32540 | C | Removal of lung lesion |
| 32650 | C | Thoracoscopy, surgical |
| 32651 | C | Thoracoscopy, surgical |
| 32652 | C | Thoracoscopy, surgical |
| 32653 | C | Thoracoscopy, surgical |
| 32654 | C | Thoracoscopy, surgical |
| 32655 | C | Thoracoscopy, surgical |
| 32656 | C | Thoracoscopy, surgical |
| 32657 | C | Thoracoscopy, surgical |
| 32658 | C | Thoracoscopy, surgical |
| 32659 | C | Thoracoscopy, surgical |
| 32660 | C | Thoracoscopy, surgical |
| 32661 | C | Thoracoscopy, surgical |

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| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 32662 | C | Thoracoscopy, surgical |
| 32663 | C | Thoracoscopy, surgical |
| 32664 | C | Thoracoscopy, surgical |
| 32665 | C | Thoracoscopy, surgical |
| 32800 | C | Repair lung hernia |
| 32810 | C | Close chest after drainage |
| 32815 | C | Close bronchial fistula |
| 32820 | C | Reconstruct injured chest |
| 32850 | C | Donor pneumonectomy |
| 32851 | C | Lung transplant, single |
| 32852 | C | Lung transplant with bypass |
| 32853 | C | Lung transplant, double |
| 32854 | C | Lung transplant with bypass |
| 32900 | C | Removal of rib(s) |
| 32905 | C | Revise & repair chest wall |
| 32906 | C | Revise & repair chest wall |
| 32940 | C | Revision of lung |
| 32997 | C | Total lung lavage |
| 33015 | C | Incision of heart sac |
| 33020 | C | Incision of heart sac |
| 33025 | C | Incision of heart sac |
| 33030 | C | Partial removal of heart sac |
| 33031 | C | Partial removal of heart sac |
| 33050 | C | Removal of heart sac lesion |
| 33120 | C | Removal of heart lesion |
| 33130 | C | Removal of heart lesion |
| 33140 | C | Heart revascularize (tmr) |
| 33141 | C | Heart tmr w/other procedure |
| 33200 | C | Insertion of heart pacemaker |
| 33201 | C | Insertion of heart pacemaker |
| 33236 | C | Remove electrode/thoracotomy |
| 33237 | C | Remove electrode/thoracotomy |
| 33238 | C | Remove electrode/thoracotomy |
| 33243 | C | Remove eltrd/thoracotomy |
| 33245 | C | Insert epic eltrd pace-defib |
| 33246 | C | Insert epic eltrd/generator |
| 33250 | C | Ablate heart dysrhythm focus |
| 33251 | C | Ablate heart dysrhythm focus |
| 33253 | C | Reconstruct atria |
| 33261 | C | Ablate heart dysrhythm focus |
| 33300 | C | Repair of heart wound |
| 33305 | C | Repair of heart wound |
| 33310 | C | Exploratory heart surgery |
| 33315 | C | Exploratory heart surgery |
| 33320 | C | Repair major blood vessel(s) |
| 33321 | C | Repair major vessel |
| 33322 | C | Repair major blood vessel(s) |
| 33330 | C | Insert major vessel graft |
| 33332 | C | Insert major vessel graft |
| 33335 | C | Insert major vessel graft |
| 33400 | C | Repair of aortic valve |
| 33401 | C | Valvuloplasty, open |
| 33403 | C | Valvuloplasty, w/cp bypass |
| 33404 | C | Prepare heart-aorta conduit |
| 33405 | C | Replacement of aortic valve |
| 33406 | C | Replacement of aortic valve |
| 33410 | C | Replacement of aortic valve |
| 33411 | C | Replacement of aortic valve |
| 33412 | C | Replacement of aortic valve |
| 33413 | C | Replacement of aortic valve |
| 33414 | C | Repair of aortic valve |
| 33415 | C | Revision, subvalvular tissue |
| 33416 | C | Revise ventricle muscle |
| 33417 | C | Repair of aortic valve |
| 33420 | C | Revision of mitral valve |
| 33422 | C | Revision of mitral valve |

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| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 33425 | C | Repair of mitral valve |
| 33426 | C | Repair of mitral valve |
| 33427 | C | Repair of mitral valve |
| 33430 | C | Replacement of mitral valve |
| 33460 | C | Revision of tricuspid valve |
| 33463 | C | Valvuloplasty, tricuspid |
| 33464 | C | Valvuloplasty, tricuspid |
| 33465 | C | Replace tricuspid valve |
| 33468 | C | Revision of tricuspid valve |
| 33470 | C | Revision of pulmonary valve |
| 33471 | C | Valvotomy, pulmonary valve |
| 33472 | C | Revision of pulmonary valve |
| 33474 | C | Revision of pulmonary valve |
| 33475 | C | Replacement, pulmonary valve |
| 33476 | C | Revision of heart chamber |
| 33478 | C | Revision of heart chamber |
| 33496 | C | Repair, prosth valve clot |
| 33500 | C | Repair heart vessel fistula |
| 33501 | C | Repair heart vessel fistula |
| 33502 | C | Coronary artery correction |
| 33503 | C | Coronary artery graft |
| 33504 | C | Coronary artery graft |
| 33505 | C | Repair artery w/tunnel |
| 33506 | C | Repair artery, translocation |
| 33510 | C | CABG, vein, single |
| 33511 | C | CABG, vein, two |
| 33512 | C | CABG, vein, three |
| 33513 | C | CABG, vein, four |
| 33514 | C | CABG, vein, five |
| 33516 | C | Cabg, vein, six or more |
| 33517 | C | CABG, artery-vein, single |
| 33518 | C | CABG, artery-vein, two |
| 33519 | C | CABG, artery-vein, three |
| 33521 | C | CABG, artery-vein, four |
| 33522 | C | CABG, artery-vein, five |
| 33523 | C | Cabg, art-vein, six or more |
| 33530 | C | Coronary artery, bypass/reop |
| 33533 | C | CABG, arterial, single |
| 33534 | C | CABG, arterial, two |
| 33535 | C | CABG, arterial, three |
| 33536 | C | Cabg, arterial, four or more |
| 33542 | C | Removal of heart lesion |
| 33545 | C | Repair of heart damage |
| 33572 | C | Open coronary endarterectomy |
| 33600 | C | Closure of valve |
| 33602 | C | Closure of valve |
| 33606 | C | Anastomosis/artery-aorta |
| 33608 | C | Repair anomaly w/conduit |
| 33610 | C | Repair by enlargement |
| 33611 | C | Repair double ventricle |
| 33612 | C | Repair double ventricle |
| 33615 | C | Repair, modified fontan |
| 33617 | C | Repair single ventricle |
| 33619 | C | Repair single ventricle |
| 33641 | C | Repair heart septum defect |
| 33645 | C | Revision of heart veins |
| 33647 | C | Repair heart septum defects |
| 33660 | C | Repair of heart defects |
| 33665 | C | Repair of heart defects |
| 33670 | C | Repair of heart chambers |
| 33681 | C | Repair heart septum defect |
| 33684 | C | Repair heart septum defect |
| 33688 | C | Repair heart septum defect |
| 33690 | C | Reinforce pulmonary artery |
| 33692 | C | Repair of heart defects |
| 33694 | C | Repair of heart defects |

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| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 33697 | C | Repair of heart defects |
| 33702 | C | Repair of heart defects |
| 33710 | C | Repair of heart defects |
| 33720 | C | Repair of heart defect |
| 33722 | C | Repair of heart defect |
| 33730 | C | Repair heart-vein defect(s) |
| 33732 | C | Repair heart-vein defect |
| 33735 | C | Revision of heart chamber |
| 33736 | C | Revision of heart chamber |
| 33737 | C | Revision of heart chamber |
| 33750 | C | Major vessel shunt |
| 33755 | C | Major vessel shunt |
| 33762 | C | Major vessel shunt |
| 33764 | C | Major vessel shunt & graft |
| 33766 | C | Major vessel shunt |
| 33767 | C | Major vessel shunt |
| 33770 | C | Repair great vessels defect |
| 33771 | C | Repair great vessels defect |
| 33774 | C | Repair great vessels defect |
| 33775 | C | Repair great vessels defect |
| 33776 | C | Repair great vessels defect |
| 33777 | C | Repair great vessels defect |
| 33778 | C | Repair great vessels defect |
| 33779 | C | Repair great vessels defect |
| 33780 | C | Repair great vessels defect |
| 33781 | C | Repair great vessels defect |
| 33786 | C | Repair arterial trunk |
| 33788 | C | Revision of pulmonary artery |
| 33800 | C | Aortic suspension |
| 33802 | C | Repair vessel defect |
| 33803 | C | Repair vessel defect |
| 33813 | C | Repair septal defect |
| 33814 | C | Repair septal defect |
| 33820 | C | Revise major vessel |
| 33822 | C | Revise major vessel |
| 33824 | C | Revise major vessel |
| 33840 | C | Remove aorta constriction |
| 33845 | C | Remove aorta constriction |
| 33851 | C | Remove aorta constriction |
| 33852 | C | Repair septal defect |
| 33853 | C | Repair septal defect |
| 33860 | C | Ascending aortic graft |
| 33861 | C | Ascending aortic graft |
| 33863 | C | Ascending aortic graft |
| 33870 | C | Transverse aortic arch graft |
| 33875 | C | Thoracic aortic graft |
| 33877 | C | Thoracoabdominal graft |
| 33910 | C | Remove lung artery emboli |
| 33915 | C | Remove lung artery emboli |
| 33916 | C | Surgery of great vessel |
| 33917 | C | Repair pulmonary artery |
| 33918 | C | Repair pulmonary atresia |
| 33919 | C | Repair pulmonary atresia |
| 33920 | C | Repair pulmonary atresia |
| 33922 | C | Transect pulmonary artery |
| 33924 | C | Remove pulmonary shunt |
| 33930 | C | Removal of donor heart/lung |
| 33935 | C | Transplantation, heart/lung |
| 33940 | C | Removal of donor heart |
| 33945 | C | Transplantation of heart |
| 33960 | C | External circulation assist |
| 33961 | C | External circulation assist |
| 33967 | C | Insert ia percut device |
| 33968 | C | Remove aortic assist device |
| 33970 | C | Aortic circulation assist |
| 33971 | C | Aortic circulation assist |

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| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 33973 | C | Insert balloon device |
| 33974 | C | Remove intra-aortic balloon |
| 33975 | C | Implant ventricular device |
| 33976 | C | Implant ventricular device |
| 33977 | C | Remove ventricular device |
| 33978 | C | Remove ventricular device |
| 33979 | C | Insert intracorporeal device |
| 33980 | C | Remove intracorporeal device |
| 34001 | C | Removal of artery clot |
| 34051 | C | Removal of artery clot |
| 34151 | C | Removal of artery clot |
| 34401 | C | Removal of vein clot |
| 34451 | C | Removal of vein clot |
| 34502 | C | Reconstruct vena cava |
| 34800 | C | Endovasc abdo repair w/tube |
| 34802 | C | Endovasc abdo repr w/device |
| 34804 | C | Endovasc abdo repr w/device |
| 34805 | C | Endovasc abdo repair w/pros |
| 34808 | C | Endovasc abdo occlud device |
| 34812 | C | Xpose for endoprosth, aortic |
| 34813 | C | Femoral endovas graft add-on |
| 34820 | C | Xpose for endoprosth, iliac |
| 34825 | C | Endovasc extend prosth, init |
| 34826 | C | Endovasc exten prosth, addl |
| 34830 | C | Open aortic tube prosth repr |
| 34831 | C | Open aortoiliac prosth repr |
| 34832 | C | Open aortofemor prosth repr |
| 34833 | C | Xpose for endoprosth, iliac |
| 34834 | C | Xpose, endoprosth, brachial |
| 34900 | C | Endovasc iliac repr w/graft |
| 35001 | C | Repair defect of artery |
| 35002 | C | Repair artery rupture, neck |
| 35005 | C | Repair defect of artery |
| 35013 | C | Repair artery rupture, arm |
| 35021 | C | Repair defect of artery |
| 35022 | C | Repair artery rupture, chest |
| 35045 | C | Repair defect of arm artery |
| 35081 | C | Repair defect of artery |
| 35082 | C | Repair artery rupture, aorta |
| 35091 | C | Repair defect of artery |
| 35092 | C | Repair artery rupture, aorta |
| 35102 | C | Repair defect of artery |
| 35103 | C | Repair artery rupture, groin |
| 35111 | C | Repair defect of artery |
| 35112 | C | Repair artery rupture,spleen |
| 35121 | C | Repair defect of artery |
| 35122 | C | Repair artery rupture, belly |
| 35131 | C | Repair defect of artery |
| 35132 | C | Repair artery rupture, groin |
| 35141 | C | Repair defect of artery |
| 35142 | C | Repair artery rupture, thigh |
| 35151 | C | Repair defect of artery |
| 35152 | C | Repair artery rupture, knee |
| 35161 | C | Repair defect of artery |
| 35162 | C | Repair artery rupture |
| 35182 | C | Repair blood vessel lesion |
| 35189 | C | Repair blood vessel lesion |
| 35211 | C | Repair blood vessel lesion |
| 35216 | C | Repair blood vessel lesion |
| 35221 | C | Repair blood vessel lesion |
| 35241 | C | Repair blood vessel lesion |
| 35246 | C | Repair blood vessel lesion |
| 35251 | C | Repair blood vessel lesion |
| 35271 | C | Repair blood vessel lesion |
| 35276 | C | Repair blood vessel lesion |
| 35281 | C | Repair blood vessel lesion |

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| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 35301 | C | Rechanneling of artery |
| 35311 | C | Rechanneling of artery |
| 35331 | C | Rechanneling of artery |
| 35341 | C | Rechanneling of artery |
| 35351 | C | Rechanneling of artery |
| 35355 | C | Rechanneling of artery |
| 35361 | C | Rechanneling of artery |
| 35363 | C | Rechanneling of artery |
| 35371 | C | Rechanneling of artery |
| 35372 | C | Rechanneling of artery |
| 35381 | C | Rechanneling of artery |
| 35390 | C | Reoperation, carotid add-on |
| 35400 | C | Angioscopy |
| 35450 | C | Repair arterial blockage |
| 35452 | C | Repair arterial blockage |
| 35454 | C | Repair arterial blockage |
| 35456 | C | Repair arterial blockage |
| 35480 | C | Atherectomy, open |
| 35481 | C | Atherectomy, open |
| 35482 | C | Atherectomy, open |
| 35483 | C | Atherectomy, open |
| 35501 | C | Artery bypass graft |
| 35506 | C | Artery bypass graft |
| 35507 | C | Artery bypass graft |
| 35508 | C | Artery bypass graft |
| 35509 | C | Artery bypass graft |
| 35510 | C | Artery bypass graft |
| 35511 | C | Artery bypass graft |
| 35512 | C | Artery bypass graft |
| 35515 | C | Artery bypass graft |
| 35516 | C | Artery bypass graft |
| 35518 | C | Artery bypass graft |
| 35521 | C | Artery bypass graft |
| 35522 | C | Artery bypass graft |
| 35525 | C | Artery bypass graft |
| 35526 | C | Artery bypass graft |
| 35531 | C | Artery bypass graft |
| 35533 | C | Artery bypass graft |
| 35536 | C | Artery bypass graft |
| 35541 | C | Artery bypass graft |
| 35546 | C | Artery bypass graft |
| 35548 | C | Artery bypass graft |
| 35549 | C | Artery bypass graft |
| 35551 | C | Artery bypass graft |
| 35556 | C | Artery bypass graft |
| 35558 | C | Artery bypass graft |
| 35560 | C | Artery bypass graft |
| 35563 | C | Artery bypass graft |
| 35565 | C | Artery bypass graft |
| 35566 | C | Artery bypass graft |
| 35571 | C | Artery bypass graft |
| 35582 | C | Vein bypass graft |
| 35583 | C | Vein bypass graft |
| 35585 | C | Vein bypass graft |
| 35587 | C | Vein bypass graft |
| 35600 | C | Harvest artery for cabg |
| 35601 | C | Artery bypass graft |
| 35606 | C | Artery bypass graft |
| 35612 | C | Artery bypass graft |
| 35616 | C | Artery bypass graft |
| 35621 | C | Artery bypass graft |
| 35623 | C | Bypass graft, not vein |
| 35626 | C | Artery bypass graft |
| 35631 | C | Artery bypass graft |
| 35636 | C | Artery bypass graft |
| 35641 | C | Artery bypass graft |

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| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 35642 | C | Artery bypass graft |
| 35645 | C | Artery bypass graft |
| 35646 | C | Artery bypass graft |
| 35647 | C | Artery bypass graft |
| 35650 | C | Artery bypass graft |
| 35651 | C | Artery bypass graft |
| 35654 | C | Artery bypass graft |
| 35656 | C | Artery bypass graft |
| 35661 | C | Artery bypass graft |
| 35663 | C | Artery bypass graft |
| 35665 | C | Artery bypass graft |
| 35666 | C | Artery bypass graft |
| 35671 | C | Artery bypass graft |
| 35681 | C | Composite bypass graft |
| 35682 | C | Composite bypass graft |
| 35683 | C | Composite bypass graft |
| 35691 | C | Arterial transposition |
| 35693 | C | Arterial transposition |
| 35694 | C | Arterial transposition |
| 35695 | C | Arterial transposition |
| 35697 | C | Reimplant artery each |
| 35700 | C | Reoperation, bypass graft |
| 35701 | C | Exploration, carotid artery |
| 35721 | C | Exploration, femoral artery |
| 35741 | C | Exploration popliteal artery |
| 35800 | C | Explore neck vessels |
| 35820 | C | Explore chest vessels |
| 35840 | C | Explore abdominal vessels |
| 35870 | C | Repair vessel graft defect |
| 35901 | C | Excision, graft, neck |
| 35905 | C | Excision, graft, thorax |
| 35907 | C | Excision, graft, abdomen |
| 36510 | C | Insertion of catheter, vein |
| 36660 | C | Insertion catheter, artery |
| 36822 | C | Insertion of cannula(s) |
| 36823 | C | Insertion of cannula(s) |
| 37140 | C | Revision of circulation |
| 37145 | C | Revision of circulation |
| 37160 | C | Revision of circulation |
| 37180 | C | Revision of circulation |
| 37181 | C | Splice spleen/kidney veins |
| 37182 | C | Insert hepatic shunt (tips) |
| 37183 | C | Remove hepatic shunt (tips) |
| 37195 | C | Thrombolytic therapy, stroke |
| 37616 | C | Ligation of chest artery |
| 37617 | C | Ligation of abdomen artery |
| 37618 | C | Ligation of extremity artery |
| 37660 | C | Revision of major vein |
| 37788 | C | Revascularization, penis |
| 38100 | C | Removal of spleen, total |
| 38101 | C | Removal of spleen, partial |
| 38102 | C | Removal of spleen, total |
| 38115 | C | Repair of ruptured spleen |
| 38380 | C | Thoracic duct procedure |
| 38381 | C | Thoracic duct procedure |
| 38382 | C | Thoracic duct procedure |
| 38562 | C | Removal, pelvic lymph nodes |
| 38564 | C | Removal, abdomen lymph nodes |
| 38724 | C | Removal of lymph nodes, neck |
| 38746 | C | Remove thoracic lymph nodes |
| 38747 | C | Remove abdominal lymph nodes |
| 38765 | C | Remove groin lymph nodes |
| 38770 | C | Remove pelvis lymph nodes |
| 38780 | C | Remove abdomen lymph nodes |
| 39000 | C | Exploration of chest |
| 39010 | C | Exploration of chest |

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| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 39200 | C | Removal chest lesion |
| 39220 | C | Removal chest lesion |
| 39499 | C | Chest procedure |
| 39501 | C | Repair diaphragm laceration |
| 39502 | C | Repair paraesophageal hernia |
| 39503 | C | Repair of diaphragm hernia |
| 39520 | C | Repair of diaphragm hernia |
| 39530 | C | Repair of diaphragm hernia |
| 39531 | C | Repair of diaphragm hernia |
| 39540 | C | Repair of diaphragm hernia |
| 39541 | C | Repair of diaphragm hernia |
| 39545 | C | Revision of diaphragm |
| 39560 | C | Resect diaphragm, simple |
| 39561 | C | Resect diaphragm, complex |
| 39599 | C | Diaphragm surgery procedure |
| 41130 | C | Partial removal of tongue |
| 41135 | C | Tongue and neck surgery |
| 41140 | C | Removal of tongue |
| 41145 | C | Tongue removal, neck surgery |
| 41150 | C | Tongue, mouth, jaw surgery |
| 41153 | C | Tongue, mouth, neck surgery |
| 41155 | C | Tongue, jaw, & neck surgery |
| 42426 | C | Excise parotid gland/lesion |
| 42845 | C | Extensive surgery of throat |
| 42894 | C | Revision of pharyngeal walls |
| 42953 | C | Repair throat, esophagus |
| 42961 | C | Control throat bleeding |
| 42971 | C | Control nose/throat bleeding |
| 43045 | C | Incision of esophagus |
| 43100 | C | Excision of esophagus lesion |
| 43101 | C | Excision of esophagus lesion |
| 43107 | C | Removal of esophagus |
| 43108 | C | Removal of esophagus |
| 43112 | C | Removal of esophagus |
| 43113 | C | Removal of esophagus |
| 43116 | C | Partial removal of esophagus |
| 43117 | C | Partial removal of esophagus |
| 43118 | C | Partial removal of esophagus |
| 43121 | C | Partial removal of esophagus |
| 43122 | C | Partial removal of esophagus |
| 43123 | C | Partial removal of esophagus |
| 43124 | C | Removal of esophagus |
| 43135 | C | Removal of esophagus pouch |
| 43300 | C | Repair of esophagus |
| 43305 | C | Repair esophagus and fistula |
| 43310 | C | Repair of esophagus |
| 43312 | C | Repair esophagus and fistula |
| 43313 | C | Esophagoplasty congenital |
| 43314 | C | Tracheo-esophagoplasty cong |
| 43320 | C | Fuse esophagus & stomach |
| 43324 | C | Revise esophagus & stomach |
| 43325 | C | Revise esophagus & stomach |
| 43326 | C | Revise esophagus & stomach |
| 43330 | C | Repair of esophagus |
| 43331 | C | Repair of esophagus |
| 43340 | C | Fuse esophagus & intestine |
| 43341 | C | Fuse esophagus & intestine |
| 43350 | C | Surgical opening, esophagus |
| 43351 | C | Surgical opening, esophagus |
| 43352 | C | Surgical opening, esophagus |
| 43360 | C | Gastrointestinal repair |
| 43361 | C | Gastrointestinal repair |
| 43400 | C | Ligate esophagus veins |
| 43401 | C | Esophagus surgery for veins |
| 43405 | C | Ligate/staple esophagus |
| 43410 | C | Repair esophagus wound |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 43415 | C | Repair esophagus wound |
| 43420 | C | Repair esophagus opening |
| 43425 | C | Repair esophagus opening |
| 43460 | C | Pressure treatment esophagus |
| 43496 | C | Free jejunum flap, microvasc |
| 43500 | C | Surgical opening of stomach |
| 43501 | C | Surgical repair of stomach |
| 43502 | C | Surgical repair of stomach |
| 43510 | C | Surgical opening of stomach |
| 43520 | C | Incision of pyloric muscle |
| 43605 | C | Biopsy of stomach |
| 43610 | C | Excision of stomach lesion |
| 43611 | C | Excision of stomach lesion |
| 43620 | C | Removal of stomach |
| 43621 | C | Removal of stomach |
| 43622 | C | Removal of stomach |
| 43631 | C | Removal of stomach, partial |
| 43632 | C | Removal of stomach, partial |
| 43633 | C | Removal of stomach, partial |
| 43634 | C | Removal of stomach, partial |
| 43635 | C | Removal of stomach, partial |
| 43638 | C | Removal of stomach, partial |
| 43639 | C | Removal of stomach, partial |
| 43640 | C | Vagotomy & pylorus repair |
| 43641 | C | Vagotomy & pylorus repair |
| 43800 | C | Reconstruction of pylorus |
| 43810 | C | Fusion of stomach and bowel |
| 43820 | C | Fusion of stomach and bowel |
| 43825 | C | Fusion of stomach and bowel |
| 43832 | C | Place gastrostomy tube |
| 43840 | C | Repair of stomach lesion |
| 43842 | C | Gastroplasty for obesity |
| 43843 | C | Gastroplasty for obesity |
| 43846 | C | Gastric bypass for obesity |
| 43847 | C | Gastric bypass for obesity |
| 43848 | C | Revision gastroplasty |
| 43850 | C | Revise stomach-bowel fusion |
| 43855 | C | Revise stomach-bowel fusion |
| 43860 | C | Revise stomach-bowel fusion |
| 43865 | C | Revise stomach-bowel fusion |
| 43880 | C | Repair stomach-bowel fistula |
| 44005 | C | Freeing of bowel adhesion |
| 44010 | C | Incision of small bowel |
| 44015 | C | Insert needle cath bowel |
| 44020 | C | Explore small intestine |
| 44021 | C | Decompress small bowel |
| 44025 | C | Incision of large bowel |
| 44050 | C | Reduce bowel obstruction |
| 44055 | C | Correct malrotation of bowel |
| 44110 | C | Excise intestine lesion(s) |
| 44111 | C | Excision of bowel lesion(s) |
| 44120 | C | Removal of small intestine |
| 44121 | C | Removal of small intestine |
| 44125 | C | Removal of small intestine |
| 44126 | C | Enterectomy w/o taper, cong |
| 44127 | C | Enterectomy w/taper, cong |
| 44128 | C | Enterectomy cong, add-on |
| 44130 | C | Bowel to bowel fusion |
| 44132 | C | Enterectomy, cadaver donor |
| 44133 | C | Enterectomy, live donor |
| 44135 | C | Intestine transplnt, cadaver |
| 44136 | C | Intestine transplant, live |
| 44139 | C | Mobilization of colon |
| 44140 | C | Partial removal of colon |
| 44141 | C | Partial removal of colon |
| 44143 | C | Partial removal of colon |

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| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 44144 | C | Partial removal of colon |
| 44145 | C | Partial removal of colon |
| 44146 | C | Partial removal of colon |
| 44147 | C | Partial removal of colon |
| 44150 | C | Removal of colon |
| 44151 | C | Removal of colon/ileostomy |
| 44152 | C | Removal of colon/ileostomy |
| 44153 | C | Removal of colon/ileostomy |
| 44155 | C | Removal of colon/ileostomy |
| 44156 | C | Removal of colon/ileostomy |
| 44160 | C | Removal of colon |
| 44202 | C | Lap resect s/intestine singl |
| 44203 | C | Lap resect s/intestine, addl |
| 44204 | C | Laparo partial colectomy |
| 44205 | C | Lap colectomy part w/ileum |
| 44210 | C | Laparo total proctocolectomy |
| 44211 | C | Laparo total proctocolectomy |
| 44212 | C | Laparo total proctocolectomy |
| 44300 | C | Open bowel to skin |
| 44310 | C | Ileostomy/jejunostomy |
| 44314 | C | Revision of ileostomy |
| 44316 | C | Devise bowel pouch |
| 44320 | C | Colostomy |
| 44322 | C | Colostomy with biopsies |
| 44345 | C | Revision of colostomy |
| 44346 | C | Revision of colostomy |
| 44602 | C | Suture, small intestine |
| 44603 | C | Suture, small intestine |
| 44604 | C | Suture, large intestine |
| 44605 | C | Repair of bowel lesion |
| 44615 | C | Intestinal stricturoplasty |
| 44620 | C | Repair bowel opening |
| 44625 | C | Repair bowel opening |
| 44626 | C | Repair bowel opening |
| 44640 | C | Repair bowel-skin fistula |
| 44650 | C | Repair bowel fistula |
| 44660 | C | Repair bowel-bladder fistula |
| 44661 | C | Repair bowel-bladder fistula |
| 44680 | C | Surgical revision, intestine |
| 44700 | C | Suspend bowel w/prosthesis |
| 44800 | C | Excision of bowel pouch |
| 44820 | C | Excision of mesentery lesion |
| 44850 | C | Repair of mesentery |
| 44899 | C | Bowel surgery procedure |
| 44900 | C | Drain app abscess, open |
| 44901 | C | Drain app abscess, percut |
| 44950 | C | Appendectomy |
| 44955 | C | Appendectomy add-on |
| 44960 | C | Appendectomy |
| 45110 | C | Removal of rectum |
| 45111 | C | Partial removal of rectum |
| 45112 | C | Removal of rectum |
| 45113 | C | Partial proctectomy |
| 45114 | C | Partial removal of rectum |
| 45116 | C | Partial removal of rectum |
| 45119 | C | Remove rectum w/reservoir |
| 45120 | C | Removal of rectum |
| 45121 | C | Removal of rectum and colon |
| 45123 | C | Partial proctectomy |
| 45126 | C | Pelvic exenteration |
| 45130 | C | Excision of rectal prolapse |
| 45135 | C | Excision of rectal prolapse |
| 45136 | C | Excise ileoanal reservior |
| 45540 | C | Correct rectal prolapse |
| 45541 | C | Correct rectal prolapse |
| 45550 | C | Repair rectum/remove sigmoid |

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| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 45562 | C | Exploration/repair of rectum |
| 45563 | C | Exploration/repair of rectum |
| 45800 | C | Repair rect/bladder fistula |
| 45805 | C | Repair fistula w/colostomy |
| 45820 | C | Repair rectourethral fistula |
| 45825 | C | Repair fistula w/colostomy |
| 46705 | C | Repair of anal stricture |
| 46715 | C | Repair of anovaginal fistula |
| 46716 | C | Repair of anovaginal fistula |
| 46730 | C | Construction of absent anus |
| 46735 | C | Construction of absent anus |
| 46740 | C | Construction of absent anus |
| 46742 | C | Repair of imperforated anus |
| 46744 | C | Repair of cloacal anomaly |
| 46746 | C | Repair of cloacal anomaly |
| 46748 | C | Repair of cloacal anomaly |
| 46751 | C | Repair of anal sphincter |
| 47010 | C | Open drainage, liver lesion |
| 47015 | C | Inject/aspirate liver cyst |
| 47100 | C | Wedge biopsy of liver |
| 47120 | C | Partial removal of liver |
| 47122 | C | Extensive removal of liver |
| 47125 | C | Partial removal of liver |
| 47130 | C | Partial removal of liver |
| 47133 | C | Removal of donor liver |
| 47140 | C | Partial removal, donor liver |
| 47141 | C | Partial removal, donor liver |
| 47142 | C | Partial removal, donor liver |
| 47360 | C | Repair liver wound |
| 47361 | C | Repair liver wound |
| 47362 | C | Repair liver wound |
| 47380 | C | Open ablate liver tumor rf |
| 47381 | C | Open ablate liver tumor cryo |
| 47400 | C | Incision of liver duct |
| 47420 | C | Incision of bile duct |
| 47425 | C | Incision of bile duct |
| 47460 | C | Incise bile duct sphincter |
| 47480 | C | Incision of gallbladder |
| 47550 | C | Bile duct endoscopy add-on |
| 47570 | C | Laparo cholecystoenterostomy |
| 47600 | C | Removal of gallbladder |
| 47605 | C | Removal of gallbladder |
| 47610 | C | Removal of gallbladder |
| 47612 | C | Removal of gallbladder |
| 47620 | C | Removal of gallbladder |
| 47700 | C | Exploration of bile ducts |
| 47701 | C | Bile duct revision |
| 47711 | C | Excision of bile duct tumor |
| 47712 | C | Excision of bile duct tumor |
| 47715 | C | Excision of bile duct cyst |
| 47716 | C | Fusion of bile duct cyst |
| 47720 | C | Fuse gallbladder & bowel |
| 47721 | C | Fuse upper gi structures |
| 47740 | C | Fuse gallbladder & bowel |
| 47741 | C | Fuse gallbladder & bowel |
| 47760 | C | Fuse bile ducts and bowel |
| 47765 | C | Fuse liver ducts & bowel |
| 47780 | C | Fuse bile ducts and bowel |
| 47785 | C | Fuse bile ducts and bowel |
| 47800 | C | Reconstruction of bile ducts |
| 47801 | C | Placement, bile duct support |
| 47802 | C | Fuse liver duct & intestine |
| 47900 | C | Suture bile duct injury |
| 48000 | C | Drainage of abdomen |
| 48001 | C | Placement of drain, pancreas |
| 48005 | C | Resect/debride pancreas |

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| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 48020 | C | Removal of pancreatic stone |
| 48100 | C | Biopsy of pancreas, open |
| 48120 | C | Removal of pancreas lesion |
| 48140 | C | Partial removal of pancreas |
| 48145 | C | Partial removal of pancreas |
| 48146 | C | Pancreatectomy |
| 48148 | C | Removal of pancreatic duct |
| 48150 | C | Partial removal of pancreas |
| 48152 | C | Pancreatectomy |
| 48153 | C | Pancreatectomy |
| 48154 | C | Pancreatectomy |
| 48155 | C | Removal of pancreas |
| 48180 | C | Fuse pancreas and bowel |
| 48400 | C | Injection, intraop add-on |
| 48500 | C | Surgery of pancreatic cyst |
| 48510 | C | Drain pancreatic pseudocyst |
| 48520 | C | Fuse pancreas cyst and bowel |
| 48540 | C | Fuse pancreas cyst and bowel |
| 48545 | C | Pancreatorrhaphy |
| 48547 | C | Duodenal exclusion |
| 48556 | C | Removal, allograft pancreas |
| 49000 | C | Exploration of abdomen |
| 49002 | C | Reopening of abdomen |
| 49010 | C | Exploration behind abdomen |
| 49020 | C | Drain abdominal abscess |
| 49021 | C | Drain abdominal abscess |
| 49040 | C | Drain, open, abdom abscess |
| 49041 | C | Drain, percut, abdom abscess |
| 49060 | C | Drain, open, retrop abscess |
| 49061 | C | Drain, percut, retroper absc |
| 49062 | C | Drain to peritoneal cavity |
| 49201 | C | Remove abdom lesion, complex |
| 49215 | C | Excise sacral spine tumor |
| 49220 | C | Multiple surgery, abdomen |
| 49255 | C | Removal of omentum |
| 49425 | C | Insert abdomen-venous drain |
| 49428 | C | Ligation of shunt |
| 49605 | C | Repair umbilical lesion |
| 49606 | C | Repair umbilical lesion |
| 49610 | C | Repair umbilical lesion |
| 49611 | C | Repair umbilical lesion |
| 49900 | C | Repair of abdominal wall |
| 49904 | C | Omental flap, extra-abdom |
| 49905 | C | Omental flap |
| 49906 | C | Free omental flap, microvasc |
| 50010 | C | Exploration of kidney |
| 50020 | C | Renal abscess, open drain |
| 50040 | C | Drainage of kidney |
| 50045 | C | Exploration of kidney |
| 50060 | C | Removal of kidney stone |
| 50065 | C | Incision of kidney |
| 50070 | C | Incision of kidney |
| 50075 | C | Removal of kidney stone |
| 50100 | C | Revise kidney blood vessels |
| 50120 | C | Exploration of kidney |
| 50125 | C | Explore and drain kidney |
| 50130 | C | Removal of kidney stone |
| 50135 | C | Exploration of kidney |
| 50205 | C | Biopsy of kidney |
| 50220 | C | Remove kidney, open |
| 50225 | C | Removal kidney open, complex |
| 50230 | C | Removal kidney open, radical |
| 50234 | C | Removal of kidney & ureter |
| 50236 | C | Removal of kidney & ureter |
| 50240 | C | Partial removal of kidney |
| 50280 | C | Removal of kidney lesion |

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| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 50290 | C | Removal of kidney lesion |
| 50300 | C | Removal of donor kidney |
| 50320 | C | Removal of donor kidney |
| 50340 | C | Removal of kidney |
| 50360 | C | Transplantation of kidney |
| 50365 | C | Transplantation of kidney |
| 50370 | C | Remove transplanted kidney |
| 50380 | C | Reimplantation of kidney |
| 50400 | C | Revision of kidney/ureter |
| 50405 | C | Revision of kidney/ureter |
| 50500 | C | Repair of kidney wound |
| 50520 | C | Close kidney-skin fistula |
| 50525 | C | Repair renal-abdomen fistula |
| 50526 | C | Repair renal-abdomen fistula |
| 50540 | C | Revision of horseshoe kidney |
| 50545 | C | Laparo radical nephrectomy |
| 50546 | C | Laparoscopic nephrectomy |
| 50547 | C | Laparo removal donor kidney |
| 50548 | C | Laparo remove k/ureter |
| 50570 | C | Kidney endoscopy |
| 50572 | C | Kidney endoscopy |
| 50574 | C | Kidney endoscopy & biopsy |
| 50575 | C | Kidney endoscopy |
| 50576 | C | Kidney endoscopy & treatment |
| 50578 | C | Renal endoscopy/radiotracer |
| 50580 | C | Kidney endoscopy & treatment |
| 50600 | C | Exploration of ureter |
| 50605 | C | Insert ureteral support |
| 50610 | C | Removal of ureter stone |
| 50620 | C | Removal of ureter stone |
| 50630 | C | Removal of ureter stone |
| 50650 | C | Removal of ureter |
| 50660 | C | Removal of ureter |
| 50700 | C | Revision of ureter |
| 50715 | C | Release of ureter |
| 50722 | C | Release of ureter |
| 50725 | C | Release/revise ureter |
| 50727 | C | Revise ureter |
| 50728 | C | Revise ureter |
| 50740 | C | Fusion of ureter & kidney |
| 50750 | C | Fusion of ureter & kidney |
| 50760 | C | Fusion of ureters |
| 50770 | C | Splicing of ureters |
| 50780 | C | Reimplant ureter in bladder |
| 50782 | C | Reimplant ureter in bladder |
| 50783 | C | Reimplant ureter in bladder |
| 50785 | C | Reimplant ureter in bladder |
| 50800 | C | Implant ureter in bowel |
| 50810 | C | Fusion of ureter & bowel |
| 50815 | C | Urine shunt to intestine |
| 50820 | C | Construct bowel bladder |
| 50825 | C | Construct bowel bladder |
| 50830 | C | Revise urine flow |
| 50840 | C | Replace ureter by bowel |
| 50845 | C | Appendico-vesicostomy |
| 50860 | C | Transplant ureter to skin |
| 50900 | C | Repair of ureter |
| 50920 | C | Closure ureter/skin fistula |
| 50930 | C | Closure ureter/bowel fistula |
| 50940 | C | Release of ureter |
| 51060 | C | Removal of ureter stone |
| 51525 | C | Removal of bladder lesion |
| 51530 | C | Removal of bladder lesion |
| 51535 | C | Repair of ureter lesion |
| 51550 | C | Partial removal of bladder |
| 51555 | C | Partial removal of bladder |

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| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 51565 | C | Revise bladder & ureter(s) |
| 51570 | C | Removal of bladder |
| 51575 | C | Removal of bladder & nodes |
| 51580 | C | Remove bladder/revise tract |
| 51585 | C | Removal of bladder & nodes |
| 51590 | C | Remove bladder/revise tract |
| 51595 | C | Remove bladder/revise tract |
| 51596 | C | Remove bladder/create pouch |
| 51597 | C | Removal of pelvic structures |
| 51800 | C | Revision of bladder/urethra |
| 51820 | C | Revision of urinary tract |
| 51840 | C | Attach bladder/urethra |
| 51841 | C | Attach bladder/urethra |
| 51845 | C | Repair bladder neck |
| 51860 | C | Repair of bladder wound |
| 51865 | C | Repair of bladder wound |
| 51900 | C | Repair bladder/vagina lesion |
| 51920 | C | Close bladder-uterus fistula |
| 51925 | C | Hysterectomy/bladder repair |
| 51940 | C | Correction of bladder defect |
| 51960 | C | Revision of bladder & bowel |
| 51980 | C | Construct bladder opening |
| 53085 | C | Drainage of urinary leakage |
| 53415 | C | Reconstruction of urethra |
| 53448 | C | Remov/replc ur sphinctr comp |
| 54125 | C | Removal of penis |
| 54130 | C | Remove penis & nodes |
| 54135 | C | Remove penis & nodes |
| 54332 | C | Revise penis/urethra |
| 54336 | C | Revise penis/urethra |
| 54390 | C | Repair penis and bladder |
| 54411 | C | Remov/replc penis pros, comp |
| 54417 | C | Remv/replc penis pros, compl |
| 54430 | C | Revision of penis |
| 54535 | C | Extensive testis surgery |
| 54560 | C | Exploration for testis |
| 54650 | C | Orchiopexy (Fowler-Stephens) |
| 55600 | C | Incise sperm duct pouch |
| 55605 | C | Incise sperm duct pouch |
| 55650 | C | Remove sperm duct pouch |
| 55801 | C | Removal of prostate |
| 55810 | C | Extensive prostate surgery |
| 55812 | C | Extensive prostate surgery |
| 55815 | C | Extensive prostate surgery |
| 55821 | C | Removal of prostate |
| 55831 | C | Removal of prostate |
| 55840 | C | Extensive prostate surgery |
| 55842 | C | Extensive prostate surgery |
| 55845 | C | Extensive prostate surgery |
| 55862 | C | Extensive prostate surgery |
| 55865 | C | Extensive prostate surgery |
| 55866 | C | Laparo radical prostatectomy |
| 56630 | C | Extensive vulva surgery |
| 56631 | C | Extensive vulva surgery |
| 56632 | C | Extensive vulva surgery |
| 56633 | C | Extensive vulva surgery |
| 56634 | C | Extensive vulva surgery |
| 56637 | C | Extensive vulva surgery |
| 56640 | C | Extensive vulva surgery |
| 57110 | C | Remove vagina wall, complete |
| 57111 | C | Remove vagina tissue, compl |
| 57112 | C | Vaginectomy w/nodes, compl |
| 57270 | C | Repair of bowel pouch |
| 57280 | C | Suspension of vagina |
| 57282 | C | Repair of vaginal prolapse |
| 57292 | C | Construct vagina with graft |

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| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 57305 | C | Repair rectum-vagina fistula |
| 57307 | C | Fistula repair & colostomy |
| 57308 | C | Fistula repair, transperine |
| 57311 | C | Repair urethrovaginal lesion |
| 57335 | C | Repair vagina |
| 57531 | C | Removal of cervix, radical |
| 57540 | C | Removal of residual cervix |
| 57545 | C | Remove cervix/repair pelvis |
| 58140 | C | Removal of uterus lesion |
| 58146 | C | Myomectomy abdom complex |
| 58150 | C | Total hysterectomy |
| 58152 | C | Total hysterectomy |
| 58180 | C | Partial hysterectomy |
| 58200 | C | Extensive hysterectomy |
| 58210 | C | Extensive hysterectomy |
| 58240 | C | Removal of pelvis contents |
| 58260 | C | Vaginal hysterectomy |
| 58262 | C | Vag hyst including t/o |
| 58263 | C | Vag hyst w/t/o & vag repair |
| 58267 | C | Vag hyst w/urinary repair |
| 58270 | C | Vag hyst w/enterocele repair |
| 58275 | C | Hysterectomy/revise vagina |
| 58280 | C | Hysterectomy/revise vagina |
| 58285 | C | Extensive hysterectomy |
| 58290 | C | Vag hyst complex |
| 58291 | C | Vag hyst incl t/o, complex |
| 58292 | C | Vag hyst t/o & repair, compl |
| 58293 | C | Vag hyst w/uro repair, compl |
| 58294 | C | Vag hyst w/enterocele, compl |
| 58400 | C | Suspension of uterus |
| 58410 | C | Suspension of uterus |
| 58520 | C | Repair of ruptured uterus |
| 58540 | C | Revision of uterus |
| 58605 | C | Division of fallopian tube |
| 58611 | C | Ligate oviduct(s) add-on |
| 58700 | C | Removal of fallopian tube |
| 58720 | C | Removal of ovary/tube(s) |
| 58740 | C | Revise fallopian tube(s) |
| 58750 | C | Repair oviduct |
| 58752 | C | Revise ovarian tube(s) |
| 58760 | C | Remove tubal obstruction |
| 58770 | C | Create new tubal opening |
| 58805 | C | Drainage of ovarian cyst(s) |
| 58822 | C | Drain ovary abscess, percut |
| 58825 | C | Transposition, ovary(s) |
| 58940 | C | Removal of ovary(s) |
| 58943 | C | Removal of ovary(s) |
| 58950 | C | Resect ovarian malignancy |
| 58951 | C | Resect ovarian malignancy |
| 58952 | C | Resect ovarian malignancy |
| 58953 | C | Tah, rad dissect for debulk |
| 58954 | C | Tah rad debulk/lymph remove |
| 58960 | C | Exploration of abdomen |
| 59100 | C | Remove uterus lesion |
| 59120 | C | Treat ectopic pregnancy |
| 59121 | C | Treat ectopic pregnancy |
| 59130 | C | Treat ectopic pregnancy |
| 59135 | C | Treat ectopic pregnancy |
| 59136 | C | Treat ectopic pregnancy |
| 59140 | C | Treat ectopic pregnancy |
| 59325 | C | Revision of cervix |
| 59350 | C | Repair of uterus |
| 59514 | C | Cesarean delivery only |
| 59525 | C | Remove uterus after cesarean |
| 59620 | C | Attempted vbac delivery only |
| 59830 | C | Treat uterus infection |

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| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 59850 | C | Abortion |
| 59851 | C | Abortion |
| 59852 | C | Abortion |
| 59855 | C | Abortion |
| 59856 | C | Abortion |
| 59857 | C | Abortion |
| 60254 | C | Extensive thyroid surgery |
| 60270 | C | Removal of thyroid |
| 60271 | C | Removal of thyroid |
| 60502 | C | Re-explore parathyroids |
| 60505 | C | Explore parathyroid glands |
| 60520 | C | Removal of thymus gland |
| 60521 | C | Removal of thymus gland |
| 60522 | C | Removal of thymus gland |
| 60540 | C | Explore adrenal gland |
| 60545 | C | Explore adrenal gland |
| 60600 | C | Remove carotid body lesion |
| 60605 | C | Remove carotid body lesion |
| 60650 | C | Laparoscopy adrenalectomy |
| 61105 | C | Twist drill hole |
| 61107 | C | Drill skull for implantation |
| 61108 | C | Drill skull for drainage |
| 61120 | C | Burr hole for puncture |
| 61140 | C | Pierce skull for biopsy |
| 61150 | C | Pierce skull for drainage |
| 61151 | C | Pierce skull for drainage |
| 61154 | C | Pierce skull & remove clot |
| 61156 | C | Pierce skull for drainage |
| 61210 | C | Pierce skull, implant device |
| 61250 | C | Pierce skull & explore |
| 61253 | C | Pierce skull & explore |
| 61304 | C | Open skull for exploration |
| 61305 | C | Open skull for exploration |
| 61312 | C | Open skull for drainage |
| 61313 | C | Open skull for drainage |
| 61314 | C | Open skull for drainage |
| 61315 | C | Open skull for drainage |
| 61316 | C | Implt cran bone flap to abdo |
| 61320 | C | Open skull for drainage |
| 61321 | C | Open skull for drainage |
| 61322 | C | Decompressive craniotomy |
| 61323 | C | Decompressive lobectomy |
| 61332 | C | Explore/biopsy eye socket |
| 61333 | C | Explore orbit/remove lesion |
| 61334 | C | Explore orbit/remove object |
| 61340 | C | Relieve cranial pressure |
| 61343 | C | Incise skull (press relief) |
| 61345 | C | Relieve cranial pressure |
| 61440 | C | Incise skull for surgery |
| 61450 | C | Incise skull for surgery |
| 61458 | C | Incise skull for brain wound |
| 61460 | C | Incise skull for surgery |
| 61470 | C | Incise skull for surgery |
| 61480 | C | Incise skull for surgery |
| 61490 | C | Incise skull for surgery |
| 61500 | C | Removal of skull lesion |
| 61501 | C | Remove infected skull bone |
| 61510 | C | Removal of brain lesion |
| 61512 | C | Remove brain lining lesion |
| 61514 | C | Removal of brain abscess |
| 61516 | C | Removal of brain lesion |
| 61517 | C | Implt brain chemotx add-on |
| 61518 | C | Removal of brain lesion |
| 61519 | C | Remove brain lining lesion |
| 61520 | C | Removal of brain lesion |
| 61521 | C | Removal of brain lesion |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 61522 | C | Removal of brain abscess |
| 61524 | C | Removal of brain lesion |
| 61526 | C | Removal of brain lesion |
| 61530 | C | Removal of brain lesion |
| 61531 | C | Implant brain electrodes |
| 61533 | C | Implant brain electrodes |
| 61534 | C | Removal of brain lesion |
| 61535 | C | Remove brain electrodes |
| 61536 | C | Removal of brain lesion |
| 61537 | C | Removal of brain tissue |
| 61538 | C | Removal of brain tissue |
| 61539 | C | Removal of brain tissue |
| 61540 | C | Removal of brain tissue |
| 61541 | C | Incision of brain tissue |
| 61542 | C | Removal of brain tissue |
| 61543 | C | Removal of brain tissue |
| 61544 | C | Remove & treat brain lesion |
| 61545 | C | Excision of brain tumor |
| 61546 | C | Removal of pituitary gland |
| 61548 | C | Removal of pituitary gland |
| 61550 | C | Release of skull seams |
| 61552 | C | Release of skull seams |
| 61556 | C | Incise skull/sutures |
| 61557 | C | Incise skull/sutures |
| 61558 | C | Excision of skull/sutures |
| 61559 | C | Excision of skull/sutures |
| 61563 | C | Excision of skull tumor |
| 61564 | C | Excision of skull tumor |
| 61566 | C | Removal of brain tissue |
| 61567 | C | Incision of brain tissue |
| 61570 | C | Remove foreign body, brain |
| 61571 | C | Incise skull for brain wound |
| 61575 | C | Skull base/brainstem surgery |
| 61576 | C | Skull base/brainstem surgery |
| 61580 | C | Craniofacial approach, skull |
| 61581 | C | Craniofacial approach, skull |
| 61582 | C | Craniofacial approach, skull |
| 61583 | C | Craniofacial approach, skull |
| 61584 | C | Orbitocranial approach/skull |
| 61585 | C | Orbitocranial approach/skull |
| 61586 | C | Resect nasopharynx, skull |
| 61590 | C | Infratemporal approach/skull |
| 61591 | C | Infratemporal approach/skull |
| 61592 | C | Orbitocranial approach/skull |
| 61595 | C | Transtemporal approach/skull |
| 61596 | C | Transcochlear approach/skull |
| 61597 | C | Transcondylar approach/skull |
| 61598 | C | Transpetrosal approach/skull |
| 61600 | C | Resect/excise cranial lesion |
| 61601 | C | Resect/excise cranial lesion |
| 61605 | C | Resect/excise cranial lesion |
| 61606 | C | Resect/excise cranial lesion |
| 61607 | C | Resect/excise cranial lesion |
| 61608 | C | Resect/excise cranial lesion |
| 61609 | C | Transect artery, sinus |
| 61610 | C | Transect artery, sinus |
| 61611 | C | Transect artery, sinus |
| 61612 | C | Transect artery, sinus |
| 61613 | C | Remove aneurysm, sinus |
| 61615 | C | Resect/excise lesion, skull |
| 61616 | C | Resect/excise lesion, skull |
| 61618 | C | Repair dura |
| 61619 | C | Repair dura |
| 61624 | C | Occlusion/embolization cath |
| 61680 | C | Intracranial vessel surgery |
| 61682 | C | Intracranial vessel surgery |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 61684 | C | Intracranial vessel surgery |
| 61686 | C | Intracranial vessel surgery |
| 61690 | C | Intracranial vessel surgery |
| 61692 | C | Intracranial vessel surgery |
| 61697 | C | Brain aneurysm repr, complx |
| 61698 | C | Brain aneurysm repr, complx |
| 61700 | C | Brain aneurysm repr, simple |
| 61702 | C | Inner skull vessel surgery |
| 61703 | C | Clamp neck artery |
| 61705 | C | Revise circulation to head |
| 61708 | C | Revise circulation to head |
| 61710 | C | Revise circulation to head |
| 61711 | C | Fusion of skull arteries |
| 61720 | C | Incise skull/brain surgery |
| 61735 | C | Incise skull/brain surgery |
| 61750 | C | Incise skull/brain biopsy |
| 61751 | C | Brain biopsy w/ ct/mr guide |
| 61760 | C | Implant brain electrodes |
| 61770 | C | Incise skull for treatment |
| 61850 | C | Implant neuroelectrodes |
| 61860 | C | Implant neuroelectrodes |
| 61863 | C | Implant neuroelectrode |
| 61864 | C | Implant neuroelectrde, add'l |
| 61867 | C | Implant neuroelectrode |
| 61868 | C | Implant neuroelectrde, add'l |
| 61870 | C | Implant neuroelectrodes |
| 61875 | C | Implant neuroelectrodes |
| 62000 | C | Treat skull fracture |
| 62005 | C | Treat skull fracture |
| 62010 | C | Treatment of head injury |
| 62100 | C | Repair brain fluid leakage |
| 62115 | C | Reduction of skull defect |
| 62116 | C | Reduction of skull defect |
| 62117 | C | Reduction of skull defect |
| 62120 | C | Repair skull cavity lesion |
| 62121 | C | Incise skull repair |
| 62140 | C | Repair of skull defect |
| 62141 | C | Repair of skull defect |
| 62142 | C | Remove skull plate/flap |
| 62143 | C | Replace skull plate/flap |
| 62145 | C | Repair of skull & brain |
| 62146 | C | Repair of skull with graft |
| 62147 | C | Repair of skull with graft |
| 62148 | C | Retr bone flap to fix skull |
| 62161 | C | Dissect brain w/scope |
| 62162 | C | Remove colloid cyst w/scope |
| 62163 | C | Neuroendoscopy w/fb removal |
| 62164 | C | Remove brain tumor w/scope |
| 62165 | C | Remove pituit tumor w/scope |
| 62180 | C | Establish brain cavity shunt |
| 62190 | C | Establish brain cavity shunt |
| 62192 | C | Establish brain cavity shunt |
| 62200 | C | Establish brain cavity shunt |
| 62201 | C | Establish brain cavity shunt |
| 62220 | C | Establish brain cavity shunt |
| 62223 | C | Establish brain cavity shunt |
| 62256 | C | Remove brain cavity shunt |
| 62258 | C | Replace brain cavity shunt |
| 63043 | C | Laminotomy, addl cervical |
| 63044 | C | Laminotomy, addl lumbar |
| 63075 | C | Neck spine disk surgery |
| 63076 | C | Neck spine disk surgery |
| 63077 | C | Spine disk surgery, thorax |
| 63078 | C | Spine disk surgery, thorax |
| 63081 | C | Removal of vertebral body |
| 63082 | C | Remove vertebral body add-on |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 63085 | C | Removal of vertebral body |
| 63086 | C | Remove vertebral body add-on |
| 63087 | C | Removal of vertebral body |
| 63088 | C | Remove vertebral body add-on |
| 63090 | C | Removal of vertebral body |
| 63091 | C | Remove vertebral body add-on |
| 63101 | C | Removal of vertebral body |
| 63102 | C | Removal of vertebral body |
| 63103 | C | Remove vertebral body add-on |
| 63170 | C | Incise spinal cord tract(s) |
| 63172 | C | Drainage of spinal cyst |
| 63173 | C | Drainage of spinal cyst |
| 63180 | C | Revise spinal cord ligaments |
| 63182 | C | Revise spinal cord ligaments |
| 63185 | C | Incise spinal column/nerves |
| 63190 | C | Incise spinal column/nerves |
| 63191 | C | Incise spinal column/nerves |
| 63194 | C | Incise spinal column & cord |
| 63195 | C | Incise spinal column & cord |
| 63196 | C | Incise spinal column & cord |
| 63197 | C | Incise spinal column & cord |
| 63198 | C | Incise spinal column & cord |
| 63199 | C | Incise spinal column & cord |
| 63200 | C | Release of spinal cord |
| 63250 | C | Revise spinal cord vessels |
| 63251 | C | Revise spinal cord vessels |
| 63252 | C | Revise spinal cord vessels |
| 63265 | C | Excise intraspinal lesion |
| 63266 | C | Excise intraspinal lesion |
| 63267 | C | Excise intraspinal lesion |
| 63268 | C | Excise intraspinal lesion |
| 63270 | C | Excise intraspinal lesion |
| 63271 | C | Excise intraspinal lesion |
| 63272 | C | Excise intraspinal lesion |
| 63273 | C | Excise intraspinal lesion |
| 63275 | C | Biopsy/excise spinal tumor |
| 63276 | C | Biopsy/excise spinal tumor |
| 63277 | C | Biopsy/excise spinal tumor |
| 63278 | C | Biopsy/excise spinal tumor |
| 63280 | C | Biopsy/excise spinal tumor |
| 63281 | C | Biopsy/excise spinal tumor |
| 63282 | C | Biopsy/excise spinal tumor |
| 63283 | C | Biopsy/excise spinal tumor |
| 63285 | C | Biopsy/excise spinal tumor |
| 63286 | C | Biopsy/excise spinal tumor |
| 63287 | C | Biopsy/excise spinal tumor |
| 63290 | C | Biopsy/excise spinal tumor |
| 63300 | C | Removal of vertebral body |
| 63301 | C | Removal of vertebral body |
| 63302 | C | Removal of vertebral body |
| 63303 | C | Removal of vertebral body |
| 63304 | C | Removal of vertebral body |
| 63305 | C | Removal of vertebral body |
| 63306 | C | Removal of vertebral body |
| 63307 | C | Removal of vertebral body |
| 63308 | C | Remove vertebral body add-on |
| 63700 | C | Repair of spinal herniation |
| 63702 | C | Repair of spinal herniation |
| 63704 | C | Repair of spinal herniation |
| 63706 | C | Repair of spinal herniation |
| 63707 | C | Repair spinal fluid leakage |
| 63709 | C | Repair spinal fluid leakage |
| 63710 | C | Graft repair of spine defect |
| 63740 | C | Install spinal shunt |
| 64752 | C | Incision of vagus nerve |
| 64755 | C | Incision of stomach nerves |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2004]

| CPT/HCPCS | NPRM SI | Description |
|---|---|---|
| 64760 | C | Incision of vagus nerve |
| 64763 | C | Incise hip/thigh nerve |
| 64766 | C | Incise hip/thigh nerve |
| 64804 | C | Remove sympathetic nerves |
| 64809 | C | Remove sympathetic nerves |
| 64818 | C | Remove sympathetic nerves |
| 64866 | C | Fusion of facial/other nerve |
| 64868 | C | Fusion of facial/other nerve |
| 65273 | C | Repair of eye wound |
| 69155 | C | Extensive ear/neck surgery |
| 69535 | C | Remove part of temporal bone |
| 69554 | C | Remove ear lesion |
| 69950 | C | Incise inner ear nerve |
| 69970 | C | Remove inner ear lesion |
| 75900 | C | Arterial catheter exchange |
| 75952 | C | Endovasc repair abdom aorta |
| 75953 | C | Abdom aneurysm endovas rpr |
| 75954 | C | Iliac aneurysm endovas rpr |
| 92970 | C | Cardioassist, internal |
| 92971 | C | Cardioassist, external |
| 92975 | C | Dissolve clot, heart vessel |
| 92992 | C | Revision of heart chamber |
| 92993 | C | Revision of heart chamber |
| 99190 | C | Special pump services |
| 99191 | C | Special pump services |
| 99192 | C | Special pump services |
| 99251 | C | Initial inpatient consult |
| 99252 | C | Initial inpatient consult |
| 99253 | C | Initial inpatient consult |
| 99254 | C | Initial inpatient consult |
| 99255 | C | Initial inpatient consult |
| 99261 | C | Follow-up inpatient consult |
| 99262 | C | Follow-up inpatient consult |
| 99263 | C | Follow-up inpatient consult |
| 99293 | C | Ped critical care, initial |
| 99294 | C | Ped critical care, subseq |
| 99295 | C | Neonatal critical care |
| 99296 | C | Neonatal critical care |
| 99298 | C | Neonatal critical care |
| 99299 | C | Ic, lbw infant 1500-2500 gm |
| 99356 | C | Prolonged service, inpatient |
| 99357 | C | Prolonged service, inpatient |
| 99433 | C | Normal newborn care/hospital |

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ADDENDUM H—WAGE INDEX FOR URBAN AREAS

| Urban area (constituent counties) | Wage index |
|---|---|
| 0040 [2] Abilene, TX | 0.7780 |
| Taylor, TX | |
| 0060 Aguadilla, PR | 0.4306 |
| Aguada, PR | |
| Aguadilla, PR | |
| Moca, PR | |
| 0080 Akron, OH | 0.9442 |
| Portage, OH | |
| Summit, OH | |
| 0120 Albany, GA | 1.0863 |
| Dougherty, GA | |
| Lee, GA | |
| 0160 [2] Albany-Schenectady-Troy, NY | 0.8526 |
| Albany, NY | |
| Montgomery, NY | |
| Rensselaer, NY | |
| Saratoga, NY | |
| Schenectady, NY | |
| Schoharie, NY | |
| 0200 Albuquerque, NM | 0.9300 |
| Bernalillo, NM | |
| Sandoval, NM | |
| Valencia, NM | |
| 0220 Alexandria, LA | 0.8037 |
| Rapides, LA | |
| 0240 Allentown-Bethlehem-Easton, PA | 0.9721 |
| Carbon, PA | |
| Lehigh, PA | |
| Northampton, PA | |
| 0280 Altoona, PA | 0.8827 |
| Blair, PA | |
| 0320 Amarillo, TX | 0.8986 |
| Potter, TX | |
| Randall, TX | |
| 0380 Anchorage, AK | 1.2351 |
| Anchorage, AK | |
| 0440 Ann Arbor, MI | 1.1074 |
| Lenawee, MI | |
| Livingston, MI | |
| Washtenaw, MI | |
| 0450 Anniston, AL | 0.8090 |
| Calhoun, AL | |
| 0460 [2] Appleton-Oshkosh-Neenah, WI | 0.9304 |
| Calumet, WI | |
| Outagamie, WI | |
| Winnebago, WI | |
| 0470 Arecibo, PR | 0.4155 |
| Arecibo, PR | |
| Camuy, PR | |

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| Hatillo, PR | |
| 0480 Asheville, NC | 0.9720 |
| Buncombe, NC | |
| Madison, NC | |
| 0500 Athens, GA | 0.9818 |
| Clarke, GA | |
| Madison, GA | |
| Oconee, GA | |
| 0520 [1] Atlanta, GA | 1.0130 |
| Barrow, GA | |
| Bartow, GA | |
| Carroll, GA | |
| Cherokee, GA | |
| Clayton, GA | |
| Cobb, GA | |
| Coweta, GA | |
| DeKalb, GA | |
| Douglas, GA | |
| Fayette, GA | |
| Forsyth, GA | |
| Fulton, GA | |
| Gwinnett, GA | |
| Henry, GA | |
| Newton, GA | |
| Paulding, GA | |
| Pickens, GA | |
| Rockdale, GA | |
| Spalding, GA | |
| Walton, GA | |
| 0560 Atlantic-Cape May, NJ | 1.0795 |
| Atlantic, NJ | |
| Cape May, NJ | |
| 0580 Auburn-Opelika, AL | 0.8494 |
| Lee, AL | |
| 0600 Augusta-Aiken, GA-SC | 0.9625 |
| Columbia, GA | |
| McDuffie, GA | |
| Richmond, GA | |
| Aiken, SC | |
| Edgefield, SC | |
| 0640 [1] Austin-San Marcos, TX | 0.9609 |
| Bastrop, TX | |
| Caldwell, TX | |
| Hays, TX | |
| Travis, TX | |
| Williamson, TX | |
| 0680 [2] Bakersfield, CA | 0.9967 |
| Kern, CA | |
| 0720 [1] Baltimore, MD | 0.9919 |
| Anne Arundel, MD | |
| Baltimore, MD | |
| Baltimore City, MD | |
| Carroll, MD | |
| Harford, MD | |
| Howard, MD | |
| Queen Anne's, MD | |
| 0733 Bangor, ME | 0.9904 |
| Penobscot, ME | |
| 0743 Barnstable-Yarmouth, MA | 1.2956 |
| Barnstable, MA | |
| 0760 Baton Rouge, LA | 0.8406 |
| Ascension, LA | |
| East Baton Rouge, LA | |
| Livingston, LA | |
| West Baton Rouge, LA | |
| 0840 Beaumont-Port Arthur, TX | 0.8424 |
| Hardin, TX | |
| Jefferson, TX | |
| Orange, TX | |
| 0860 Bellingham, WA | 1.1757 |
| Whatcom, WA | |
| 0870 Benton Harbor, MI | 0.8935 |
| Berrien, MI | |
| 0875 [1] Bergen-Passaic, NJ | 1.1731 |
| Bergen, NJ | |
| Passaic, NJ | |
| 0880 Billings, MT | 0.8961 |
| Yellowstone, MT | |
| 0920 Biloxi-Gulfport-Pascagoula, MS | 0.9029 |
| Hancock, MS | |
| Harrison, MS | |
| Jackson, MS | |
| 0960 [2] Binghamton, NY | 0.8526 |
| Broome, NY | |
| Tioga, NY1000 Birmingham, AL | 0.9212 |
| Blount, AL | |
| Jefferson, AL | |
| St. Clair, AL | |
| Shelby, AL1010 Bismarck, ND | 0.8033 |
| Burleigh, ND | |
| Morton, ND | |
| 1020 [2] Bloomington, IN | 0.8824 |
| Monroe, IN | |
| 1040 Bloomington-Normal, IL | 0.8832 |
| McLean, IL | |
| 1080 Boise City, ID | 0.9232 |
| Ada, ID | |
| Canyon, ID | |
| 1123 [1] Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH | 1.1233 |
| Bristol, MA | |
| Essex, MA | |
| Middlesex, MA | |
| Norfolk, MA | |
| Plymouth, MA | |
| Suffolk, MA | |
| Worcester, MA | |
| Hillsborough, NH | |
| Merrimack, NH | |
| Rockingham, NH | |
| Strafford, NH | |
| 1125 Boulder-Longmont, CO | 1.0049 |
| Boulder, CO | |
| 1145 Brazoria, TX | 0.8137 |
| Brazoria, TX | |
| 1150 Bremerton, WA | 1.0580 |
| Kitsap, WA | |
| 1240 Brownsville-Harlingen-San Benito, TX | 1.0303 |
| Cameron, TX | |
| 1260 Bryan-College Station, TX | 0.9019 |
| Brazos, TX | |
| 1280 [1] Buffalo-Niagara Falls, NY | 0.9604 |
| Erie, NY | |
| Niagara, NY | |
| 1303 Burlington, VT | 0.9704 |
| Chittenden, VT | |
| Franklin, VT | |
| Grand Isle, VT | |
| 1310 Caguas, PR | 0.4201 |
| Caguas, PR | |
| Cayey, PR | |
| Cidra, PR | |
| Gurabo, PR | |
| San Lorenzo, PR | |
| 1320 Canton-Massillon, OH | 0.9071 |
| Carroll, OH | |
| Stark, OH | |
| 1350 Casper, WY | 0.9209 |
| Natrona, WY | |
| 1360 Cedar Rapids, IA | 0.8874 |
| Linn, IA | |
| 1400 Champaign-Urbana, IL | 0.9907 |
| Champaign, IL | |
| 1440 Charleston-North Charleston, SC | 0.9332 |
| Berkeley, SC | |
| Charleston, SC | |
| Dorchester, SC | |
| 1480 Charleston, WV | 0.8880 |
| Kanawha, WV | |
| Putnam, WV | |
| 1520 [1] Charlotte-Gastonia-Rock Hill, NC-SC | 0.9730 |
| Cabarrus, NC | |
| Gaston, NC | |
| Lincoln, NC | |
| Mecklenburg, NC | |
| Rowan, NC | |
| Stanly, NC | |
| Union, NC | |
| York, SC | |
| 1540 Charlottesville, VA | 1.0025 |
| Albemarle, VA | |
| Charlottesville City, VA | |
| Fluvanna, VA | |
| Greene, VA | |
| 1560 Chattanooga, TN-GA | 0.9086 |
| Catoosa, GA | |
| Dade, GA | |
| Walker, GA | |
| Hamilton, TN | |
| Marion, TN | |
| 1580 [2] Cheyenne, WY | 0.9110 |
| Laramie, WY | |
| 1600 [1] Chicago, IL | 1.0892 |
| Cook, IL | |
| DeKalb, IL | |
| DuPage, IL | |
| Grundy, IL | |
| Kane, IL | |
| Kendall, IL | |
| Lake, IL | |
| McHenry, IL | |
| Will, IL | |
| 1620 Chico-Paradise, CA | 1.0193 |
| Butte, CA | |
| 1640 [1] Cincinnati, OH-KY-IN | 0.9413 |
| Dearborn, IN | |
| Ohio, IN | |
| Boone, KY | |
| Campbell, KY | |
| Gallatin, KY | |
| Grant, KY | |
| Kenton, KY | |
| Pendleton, KY | |
| Brown, OH | |
| Clermont, OH | |
| Hamilton, OH | |
| Warren, OH | |
| 1660 Clarksville-Hopkinsville, TN-KY | 0.8354 |
| Christian, KY | |
| Montgomery, TN | |
| 1680 [1] Cleveland-Lorain-Elyria, OH | 0.9671 |
| Ashtabula, OH | |
| Cuyahoga, OH | |
| Geauga, OH | |

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| Lake, OH | |
| Lorain, OH | |
| Medina, OH | |
| 1720 Colorado Springs, CO | 0.9833 |
| El Paso, CO | |
| 1740 Columbia, MO | 0.8695 |
| Boone, MO | |
| 1760 Columbia, SC | 0.8902 |
| Lexington, SC | |
| Richland, SC | |
| 1800 Columbus, GA-AL | 0.8694 |
| Russell, AL | |
| Chattahoochee, GA | |
| Harris, GA | |
| Muscogee, GA | |
| 1840 [1] Columbus, OH | 0.9648 |
| Delaware, OH | |
| Fairfield, OH | |
| Franklin, OH | |
| Licking, OH | |
| Madison, OH | |
| Pickaway, OH | |
| 1880 Corpus Christi, TX | 0.8521 |
| Nueces, TX | |
| San Patricio, TX | |
| 1890 Corvallis, OR | 1.1516 |
| Benton, OR | |
| 1900 [2] Cumberland, MD-WV (MD Hospitals) | 0.9125 |
| Allegany, MD | |
| Mineral, WV | |
| 1900 Cumberland, MD-WV (WV Hospitals) | 0.8200 |
| Allegany, MD | |
| Mineral, WV | |
| 1920 [1] Dallas, TX | 0.9974 |
| Collin, TX | |
| Dallas, TX | |
| Denton, TX | |
| Ellis, TX | |
| Henderson, TX | |
| Hunt, TX | |
| Kaufman, TX | |
| Rockwall, TX | |
| 1950 Danville, VA. | |
| Danville City, VA | |
| Pittsylvania, VA | 0.9035 |
| 1960 Davenport-Moline-Rock Island, IA-IL | 0.8985 |
| Scott, IA | |
| Henry, IL | |
| Rock Island, IL | |
| 2000 Dayton-Springfield, OH | 0.9529 |
| Clark, OH | |
| Greene, OH | |
| Miami, OH | |
| Montgomery, OH | |
| 2020 Daytona Beach, FL | 0.9060 |
| Flagler, FL | |
| Volusia, FL | |
| 2030 Decatur, AL | 0.8828 |
| Lawrence, AL | |
| Morgan, AL | |
| 2040 [2] Decatur, IL | 0.8254 |
| Macon, IL | |
| 2080 [1] Denver, CO | 1.0837 |
| Adams, CO | |
| Arapahoe, CO | |
| Broomfield, CO | |
| Denver, CO | |
| Douglas, CO | |
| Jefferson, CO | |
| 2120 Des Moines, IA | 0.9106 |
| Dallas, IA | |
| Polk, IA | |
| Warren, IA | |
| 2160 [1] Detroit, MI | 1.0101 |
| Lapeer, MI | |
| Macomb, MI | |
| Monroe, MI | |
| Oakland, MI | |
| St. Clair, MI | |
| Wayne, MI | |
| 2180 Dothan, AL | 0.7765 |
| Dale, AL | |
| Houston, AL | |
| 2190 Dover, DE | 0.9805 |
| Kent, DE | |
| 2200 Dubuque, IA | 0.8886 |
| Dubuque, IA | |
| 2240 Duluth-Superior, MN-WI | 1.0171 |
| St. Louis, MN | |
| Douglas, WI | |
| 2281 Dutchess County, NY | 1.0934 |
| Dutchess, NY | |
| 2290 [2] Eau Claire, WI | 0.9304 |
| Chippewa, WI | |
| Eau Claire, WI | |
| 2320 El Paso, TX | 0.9196 |
| El Paso, TX | |
| 2330 Elkhart-Goshen, IN | 0.9783 |
| Elkhart, IN | |
| 2335 [2] Elmira, NY | 0.8526 |
| Chemung, NY | |
| 2340 Enid, OK | 0.8559 |
| Garfield, OK | |
| 2360 Erie, PA | 0.8601 |
| Erie, PA | |
| 2400 Eugene-Springfield, OR | 1.1456 |
| Lane, OR | |
| 2440 [2] Evansville-Henderson, IN-KY (IN Hospitals) | 0.8824 |
| Posey, IN | |
| Vanderburgh, IN | |
| Warrick, IN | |
| Henderson, KY | |
| 2440 Evansville-Henderson, IN-KY (KY Hospitals) | 0.8429 |
| Posey, IN | |
| Vanderburgh, IN | |
| Warrick, IN | |
| Henderson, KY | |
| 2520 Fargo-Moorhead, ND-MN | 0.9797 |
| Clay, MN | |
| Cass, ND | |
| 2560 Fayetteville, NC | 0.8986 |
| Cumberland, NC | |
| 2580 Fayetteville-Springdale-Rogers, AR | 0.8396 |
| Benton, AR | |
| Washington, AR | |
| 2620 Flagstaff, AZ-UT | 1.1333 |
| Coconino, AZ | |
| Kane, UT | |
| 2640 Flint, MI | 1.0858 |
| Genesee, MI | |
| 2650 Florence, AL | 0.7797 |
| Colbert, AL | |
| Lauderdale, AL | |
| 2655 Florence, SC | 0.8709 |
| Florence, SC | |
| 2670 Fort Collins-Loveland, CO | 1.0148 |
| Larimer, CO | |
| 2680 [1] Ft. Lauderdale, FL | 1.0479 |
| Broward, FL | |
| 2700 Fort Myers-Cape Coral, FL | 0.9816 |
| Lee, FL | |
| 2710 Fort Pierce-Port St. Lucie, FL | 1.0124 |
| Martin, FL | |
| St. Lucie, FL | |
| 2720 Fort Smith, AR-OK | 0.8424 |
| Crawford, AR | |
| Sebastian, AR | |
| Sequoyah, OK | |
| 2750 Fort Walton Beach, FL | 0.8966 |
| Okaloosa, FL | |
| 2760 Fort Wayne, IN | 0.9585 |
| Adams, IN | |
| Allen, IN | |
| De Kalb, IN | |
| Huntington, IN | |
| Wells, IN | |
| Whitley, IN | |
| 2800 [1] Forth Worth-Arlington, TX | 0.9359 |
| Hood, TX | |
| Johnson, TX | |
| Parker, TX | |
| Tarrant, TX | |
| 2840 Fresno, CA | 1.0142 |
| Fresno, CA | |
| Madera, CA | |
| 2880 Gadsden, AL | 0.8229 |
| Etowah, AL | |
| 2900 Gainesville, FL | 0.9693 |
| Alachua, FL | |
| 2920 Galveston-Texas City, TX | 0.9279 |
| Galveston, TX | |
| 2960 Gary, IN | 0.9410 |
| Lake, IN | |
| Porter, IN | |
| 2975 [2] Glens Falls, NY | 0.8526 |
| Warren, NY | |
| Washington, NY | |
| 2980 Goldsboro, NC | 0.8622 |
| Wayne, NC | |
| 2985 Grand Forks, ND-MN (ND Hospitals) | 0.8636 |
| Polk, MN | |
| Grand Forks, ND | |
| 2985 [2] Grand Forks, ND-MN (MN Hospitals) | 0.9345 |
| Polk, MN | |
| Grand Forks, ND | |
| 2995 Grand Junction, CO | 0.9921 |
| Mesa, CO | |
| 3000 [1] Grand Rapids-Muskegon-Holland, MI | 0.9469 |
| Allegan, MI | |
| Kent, MI | |
| Muskegon, MI | |
| Ottawa, MI | |
| 3040 Great Falls, MT | 0.8918 |
| Cascade, MT | |
| 3060 Greeley, CO | 0.9453 |
| Weld, CO | |
| 3080 Green Bay, WI | 0.9518 |
| Brown, WI | |
| 3120 [1] Greensboro-Winston-Salem-High Point, NC | 0.9166 |

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| Alamance, NC | |
| Davidson, NC | |
| Davie, NC | |
| Forsyth, NC | |
| Guilford, NC | |
| Randolph, NC | |
| Stokes, NC | |
| Yadkin, NC | |
| 3150 Greenville, NC | 0.9167 |
| Pitt, NC | |
| 3160 Greenville-Spartanburg-Anderson, SC | 0.9335 |
| Anderson, SC | |
| Cherokee, SC | |
| Greenville, SC | |
| Pickens, SC | |
| Spartanburg, SC | |
| 3180 Hagerstown, MD | 0.9172 |
| Washington, MD | |
| 3200 Hamilton-Middletown, OH | 0.9214 |
| Butler, OH | |
| 3240 Harrisburg-Lebanon-Carlisle, PA | 0.9164 |
| Cumberland, PA | |
| Dauphin, PA | |
| Lebanon, PA | |
| Perry, PA | |
| 3283 [1 2] Hartford, CT | 1.2183 |
| Hartford, CT | |
| Litchfield, CT | |
| Middlesex, CT | |
| Tolland, CT | |
| 3285 [2] Hattiesburg, MS | 0.7778 |
| Forrest, MS | |
| Lamar, MS | |
| 3290 Hickory-Morganton-Lenoir, NC | 0.9242 |
| Alexander, NC | |
| Burke, NC | |
| Caldwell, NC | |
| Catawba, NC | |
| 3320 Honolulu, HI | 1.1116 |
| Honolulu, HI | |
| 3350 Houma, LA | 0.7771 |
| Lafourche, LA | |
| Terrebonne, LA | |
| 3360 [1] Houston, TX | 0.9834 |
| Chambers, TX | |
| Fort Bend, TX | |
| Harris, TX | |
| Liberty, TX | |
| Montgomery, TX | |
| Waller, TX | |
| 3400 Huntington-Ashland, WV-KY-OH | 0.9595 |
| Boyd, KY | |
| Carter, KY | |
| Greenup, KY | |
| Lawrence, OH | |
| Cabell, WV | |
| Wayne, WV | |
| 3440 Huntsville, AL | 0.9245 |
| Limestone, AL | |
| Madison, AL | |
| 3480 [1] Indianapolis, IN | 0.9916 |
| Boone, IN | |
| Hamilton, IN | |
| Hancock, IN | |
| Hendricks, IN | |
| Johnson, IN | |
| Madison, IN | |
| Marion, IN | |
| Morgan, IN | |
| Shelby, IN | |
| 3500 Iowa City, IA | 0.9548 |
| Johnson, IA | |
| 3520 Jackson, MI | 0.8986 |
| Jackson, MI | |
| 3560 Jackson, MS | 0.8399 |
| Hinds, MS | |
| Madison, MS | |
| Rankin, MS | |
| 3580 Jackson, TN | 0.8984 |
| Madison, TN | |
| Chester, TN | |
| 3600 [1] Jacksonville, FL | 0.9563 |
| Clay, FL | |
| Duval, FL | |
| Nassau, FL | |
| St. Johns, FL | |
| 3605 Jacksonville, NC | 0.8544 |
| Onslow, NC | |
| 3610 [2] Jamestown, NY | 0.8526 |
| Chautauqua, NY | |
| 3620 [2] Janesville-Beloit, WI | 0.9304 |
| Rock, WI | |
| 3640 Jersey City, NJ | 1.1115 |
| Hudson, NJ | |
| 3660 Johnson City-Kingsport-Bristol, TN-VA (TN Hospitals) | 0.8256 |
| Carter, TN | |
| Hawkins, TN | |
| Sullivan, TN | |
| Unicoi, TN | |
| Washington, TN | |
| Bristol City, VA | |
| Scott, VA | |
| Washington, VA | |
| 3660 [2] Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals) | 0.8498 |
| Carter, TN | |
| Hawkins, TN | |
| Sullivan, TN | |
| Unicoi, TN | |
| Washington, TN | |
| Bristol City, VA | |
| Scott, VA | |
| Washington, VA | |
| 3680 [2] Johnstown, PA | 0.8378 |
| Cambria, PA | |
| Somerset, PA | |
| 3700 Jonesboro, AR | 0.7809 |
| Craighead, AR | |
| 3710 Joplin, MO | 0.8681 |
| Jasper, MO | |
| Newton, MO | |
| 3720 Kalamazoo-Battlecreek, MI | 1.0500 |
| Calhoun, MI | |
| Kalamazoo, MI | |
| Van Buren, MI | |
| 3740 Kankakee, IL | 1.0419 |
| Kankakee, IL | |
| 3760 [1] Kansas City, KS-MO | 0.9715 |
| Johnson, KS | |
| Leavenworth, KS | |
| Miami, KS | |
| Wyandotte, KS | |
| Cass, MO | |
| Clay, MO | |
| Clinton, MO | |
| Jackson, MO | |
| Lafayette, MO | |
| Platte, MO | |
| Ray, MO | |
| 3800 Kenosha, WI | 0.9761 |
| Kenosha, WI | |
| 3810 Killeen-Temple, TX | 0.9159 |
| Bell, TX | |
| Coryell, TX | |
| 3840 Knoxville, TN | 0.8820 |
| Anderson, TN | |
| Blount, TN | |
| Knox, TN | |
| Loudon, TN | |
| Sevier, TN | |
| Union, TN | |
| 3850 Kokomo, IN | 0.9045 |
| Howard, IN | |
| Tipton, IN | |
| 3870 [2] La Crosse, WI-MN | 0.9304 |
| Houston, MN | |
| La Crosse, WI | |
| 3880 Lafayette, LA | 0.8225 |
| Acadia, LA | |
| Lafayette, LA | |
| St. Landry, LA | |
| St. Martin, LA | |
| 3920 [2] Lafayette, IN | 0.8824 |
| Clinton, IN | |
| Tippecanoe, IN | |
| 3960 Lake Charles, LA | 0.7841 |
| Calcasieu, LA | |
| 3980 [2] Lakeland-Winter Haven, FL | 0.8855 |
| Polk, FL | |
| 4000 Lancaster, PA | 0.9282 |
| Lancaster, PA | |
| 4040 Lansing-East Lansing, MI | 0.9714 |
| Clinton, MI | |
| Eaton, MI | |
| Ingham, MI | |
| 4080 Laredo, TX | 0.8091 |
| Webb, TX | |
| 4100 Las Cruces, NM | 0.8688 |
| Dona Ana, NM | |
| 4120 [1] Las Vegas, NV-AZ | 1.1528 |
| Mohave, AZ | |
| Clark, NV | |
| Nye, NV | |
| 4150 [2] Lawrence, KS | 0.8074 |
| Douglas, KS | |
| 4200 Lawton, OK | 0.8267 |
| Comanche, OK | |
| 4243 Lewiston-Auburn, ME | 0.9383 |
| Androscoggin, ME | |
| 4280 Lexington, KY | 0.8685 |
| Bourbon, KY | |
| Clark, KY | |
| Fayette, KY | |
| Jessamine, KY | |
| Madison, KY | |
| Scott, KY | |
| Woodford, KY | |
| 4320 Lima, OH | 0.9522 |
| Allen, OH | |
| Auglaize, OH | |
| 4360 Lincoln, NE | 1.0033 |
| Lancaster, NE | |
| 4400 Little Rock-North Little Rock, AR | 0.8923 |

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| Faulkner, AR | |
| Lonoke, AR | |
| Pulaski, AR | |
| Saline, AR | |
| 4420 Longview-Marshall, TX | 0.9113 |
| Gregg, TX | |
| Harrison, TX | |
| Upshur, TX | |
| 4480 [1] Los Angeles-Long Beach, CA | 1.1832 |
| Los Angeles, CA | |
| 4520 [1] Louisville, KY-IN | 0.9242 |
| Clark, IN | |
| Floyd, IN | |
| Harrison, IN | |
| Scott, IN | |
| Bullitt, KY | |
| Jefferson, KY | |
| Oldham, KY | |
| 4600 Lubbock, TX | 0.8272 |
| Lubbock, TX | |
| 4640 Lynchburg, VA | 0.9134 |
| Amherst, VA | |
| Bedford, VA | |
| Bedford City, VA | |
| Campbell, VA | |
| Lynchburg City, VA | |
| 4680 Macon, GA | 0.8975 |
| Bibb, GA | |
| Houston, GA | |
| Jones, GA | |
| Peach, GA | |
| Twiggs, GA | |
| 4720 Madison, WI | 1.0264 |
| Dane, WI | |
| 4800 Mansfield, OH | 0.9180 |
| Crawford, OH | |
| Richland, OH | |
| 4840 Mayaguez, PR | 0.4795 |
| Anasco, PR | |
| Cabo Rojo, PR | |
| Hormigueros, PR | |
| Mayaguez, PR | |
| Sabana Grande, PR | |
| San German, PR | |
| 4880 McAllen-Edinburg-Mission, TX | 0.8381 |
| Hidalgo, TX | |
| 4890 Medford-Ashland, OR | 1.0772 |
| Jackson, OR | |
| 4900 Melbourne-Titusville-Palm Bay, FL | 0.9776 |
| Brevard, Fl | |
| 4920 [1] Memphis, TN-AR-MS | 0.9009 |
| Crittenden, AR | |
| DeSoto, MS | |
| Fayette, TN | |
| Shelby, TN | |
| Tipton, TN | |
| 4940 [2] Merced, CA | 0.9967 |
| Merced, CA | |
| 5000 [1] Miami, FL | 0.9894 |
| Dade, FL | |
| 5015 [1] Middlesex-Somerset-Hunterdon, NJ | 1.1366 |
| Hunterdon, NJ | |
| Middlesex, NJ | |
| Somerset, NJ | |
| 5080 [1] Milwaukee-Waukesha, WI | 0.9988 |
| Milwaukee, WI | |
| Ozaukee, WI | |
| Washington, WI | |
| Waukesha, WI | |
| 5120 [1] Minneapolis-St. Paul, MN-WI | 1.1001 |
| Anoka, MN | |
| Carver, MN | |
| Chisago, MN | |
| Dakota, MN | |
| Hennepin, MN | |
| Isanti, MN | |
| Ramsey, MN | |
| Scott, MN | |
| Sherburne, MN | |
| Washington, MN | |
| Wright, MN | |
| Pierce, WI | |
| St. Croix, WI | |
| 5140 Missoula, MT | 0.8884 |
| Missoula, MT | |
| 5160 Mobile, AL | 0.7994 |
| Baldwin, AL | |
| Mobile, AL | |
| 5170 Modesto, CA | 1.1275 |
| Stanislaus, CA | |
| 5190 [1] Monmouth-Ocean, NJ | 1.1083 |
| Monmouth, NJ | |
| Ocean, NJ | |
| 5200 Monroe, LA | 0.7922 |
| Ouachita, LA | |
| 5240 Montgomery, AL | 0.7907 |
| Autauga, AL | |
| Elmore, AL | |
| Montgomery, AL | |
| 5280 [2] Muncie, IN | 0.8824 |
| Delaware, IN | |
| 5330 Myrtle Beach, SC | 0.9112 |
| Horry, SC | |
| 5345 Naples, FL | 0.9790 |
| Collier, FL | |
| 5360 [1] Nashville, TN | 0.9855 |
| Cheatham, TN | |
| Davidson, TN | |
| Dickson, TN | |
| Robertson, TN | |
| Rutherford TN | |
| Sumner, TN | |
| Williamson, TN | |
| Wilson, TN | |
| 5380 [1] Nassau-Suffolk, NY | 1.3140 |
| Nassau, NY | |
| Suffolk, NY | |
| 5483 [1] New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT | 1.2468 |
| Fairfield, CT | |
| New Haven, CT | |
| 5523 [2] New London-Norwich, CT | 1.2183 |
| New London, CT | |
| 5560 [1] New Orleans, LA | 0.9174 |
| Jefferson, LA | |
| Orleans, LA | |
| Plaquemines, LA | |
| St. Bernard, LA | |
| St. Charles, LA | |
| St. James, LA | |
| St. John The Baptist, LA | |
| St. Tammany, LA | |
| 5600 [1] New York, NY | 1.4018 |
| Bronx, NY | |
| Kings, NY | |
| New York, NY | |
| Putnam, NY | |
| Queens, NY | |
| Richmond, NY | |
| Rockland, NY | |
| Westchester, NY | |
| 5640 [1] Newark, NJ | 1.1518 |
| Essex, NJ | |
| Morris, NJ | |
| Sussex, NJ | |
| Union, NJ | |
| Warren, NJ | |
| 5660 Newburgh, NY-PA | 1.1509 |
| Orange, NY | |
| Pike, PA | |
| 5720 [1] Norfolk-Virginia Beach-Newport News, VA-NC | 0.8619 |
| Currituck, NC | |
| Chesapeake City, VA | |
| Gloucester, VA | |
| Hampton City, VA | |
| Isle of Wight, VA | |
| James City, VA | |
| Mathews, VA | |
| Newport News City, VA | |
| Norfolk City, VA | |
| Poquoson City, VA | |
| Portsmouth City, VA | |
| Suffolk City, VA | |
| Virginia Beach City VA | |
| Williamsburg City, VA | |
| York, VA | |
| 5775 [1] Oakland, CA | 1.5119 |
| Alameda, CA | |
| Contra Costa, CA | |
| 5790 Ocala, FL | 0.9728 |
| Marion, FL | |
| 5800 Odessa-Midland, TX | 0.9327 |
| Ector, TX | |
| Midland, TX | |
| 5880 [1] Oklahoma City, OK | 0.8984 |
| Canadian, OK | |
| Cleveland, OK | |
| Logan, OK | |
| McClain, OK | |
| Oklahoma, OK | |
| Pottawatomie, OK | |
| 5910 Olympia, WA | 1.0963 |
| Thurston, WA | |
| 5920 Omaha, NE-IA | 0.9745 |
| Pottawattamie, IA | |
| Cass, NE | |
| Douglas, NE | |
| Sarpy, NE | |
| Washington, NE | |
| 5945 [1] Orange County, CA | 1.1492 |
| Orange, CA | |
| 5960 [1] Orlando, FL | 0.9654 |
| Lake, FL | |
| Orange, FL | |
| Osceola, FL | |
| Seminole, FL | |
| 5990 Owensboro, KY | 0.8374 |
| Daviess, KY | |
| 6015 [2] Panama City, FL | 0.8855 |
| Bay, FL | |
| 6020 Parkersburg-Marietta, WV-OH (WV Hospitals) | 0.8039 |
| Washington, OH | |

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| Wood, WV | |
| 6020 [2] Parkersburg-Marietta, WV-OH (OH Hospitals) | 0.8820 |
| Washington, OH | |
| Wood, WV | |
| 6080 [2] Pensacola, FL | 0.8855 |
| Escambia, FL | |
| Santa Rosa, FL | |
| 6120 Peoria-Pekin, IL | 0.8734 |
| Peoria, IL | |
| Tazewell, IL | |
| Woodford, IL | |
| 6160 [1] Philadelphia, PA-NJ | 1.0883 |
| Burlington, NJ | |
| Camden, NJ | |
| Gloucester, NJ | |
| Salem, NJ | |
| Bucks, PA | |
| Chester, PA | |
| Delaware, PA | |
| Montgomery, PA | |
| Philadelphia, PA | |
| 6200 [1] Phoenix-Mesa, AZ | 1.0129 |
| Maricopa, AZ | |
| Pinal, AZ | |
| 6240 Pine Bluff, AR | 0.7865 |
| Jefferson, AR | |
| 6280 [1] Pittsburgh, PA | 0.8901 |
| Allegheny, PA | |
| Beaver, PA | |
| Butler, PA | |
| Fayette, PA | |
| Washington, PA | |
| Westmoreland, PA | |
| 6323 [2] Pittsfield, MA | 1.0432 |
| Berkshire, MA | |
| 6340 Pocatello, ID | 0.9249 |
| Bannock, ID | |
| 6360 Ponce, PR | 0.4708 |
| Guayanilla, PR | |
| Juana Diaz, PR | |
| Penuelas, PR | |
| Ponce, PR | |
| Villalba, PR | |
| Yauco, PR | |
| 6403 Portland, ME | 0.9949 |
| Cumberland, ME | |
| Sagadahoc, ME | |
| York, ME | |
| 6440 [1] Portland-Vancouver, OR-WA | 1.1213 |
| Clackamas, OR | |
| Columbia, OR | |
| Multnomah, OR | |
| Washington, OR | |
| Yamhill, OR | |
| Clark, WA | |
| 6483 [1] Providence-Warwick-Pawtucket, RI | 1.0977 |
| Bristol, RI | |
| Kent, RI | |
| Newport, RI | |
| Providence, RI | |
| Washington, RI | |
| 6520 Provo-Orem, UT | 0.9976 |
| Utah, UT | |
| 6560 [2] Pueblo, CO | 0.9328 |
| Pueblo, CO | |
| 6580 Punta Gorda, FL | 0.9510 |
| Charlotte, FL | |

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| 6600 [2] Racine, WI | 0.9304 |
| Racine, WI | |
| 6640 [1] Raleigh-Durham-Chapel Hill, NC | 0.9959 |
| Chatham, NC | |
| Durham, NC | |
| Franklin, NC | |
| Johnston, NC | |
| Orange, NC | |
| Wake, NC | |
| 6660 Rapid City, SD | 0.8806 |
| Pennington, SD | |
| 6680 Reading, PA | 0.9133 |
| Berks, PA | |
| 6690 Redding, CA | 1.1352 |
| Shasta, CA | |
| 6720 Reno, NV | 1.0682 |
| Washoe, NV | |
| 6740 Richland-Kennewick-Pasco, WA | 1.0609 |
| Benton, WA | |
| Franklin, WA | |
| 6760 Richmond-Petersburg, VA | 0.9349 |
| Charles City County, VA | |
| Chesterfield, VA | |
| Colonial Heights City, VA | |
| Dinwiddie, VA | |
| Goochland, VA | |
| Hanover, VA | |
| Henrico, VA | |
| Hopewell City, VA | |
| New Kent, VA | |
| Petersburg City, VA | |
| Powhatan, VA | |
| Prince George, VA | |
| Richmond City, VA | |
| 6780 [1] Riverside-San Bernardino, CA | 1.1348 |
| Riverside, CA | |
| San Bernardino, CA | |
| 6800 Roanoke, VA | 0.8700 |
| Botetourt, VA | |
| Roanoke, VA | |
| Roanoke City, VA | |
| Salem City, VA | |
| 6820 Rochester, MN | 1.1739 |
| Olmsted, MN | |
| 6840 [1] Rochester, NY | 0.9430 |
| Genesee, NY | |
| Livingston, NY | |
| Monroe, NY | |
| Ontario, NY | |
| Orleans, NY | |
| Wayne, NY | |
| 6880 Rockford, IL | 0.9666 |
| Boone, IL | |
| Ogle, IL | |
| Winnebago, IL | |
| 6895 Rocky Mount, NC | 0.9076 |
| Edgecombe, NC | |
| Nash, NC | |
| 6920 [1] Sacramento, CA | 1.1845 |
| El Dorado, CA | |
| Placer, CA | |
| Sacramento, CA | |
| 6960 Saginaw-Bay City-Midland, MI | 1.0032 |
| Bay, MI | |
| Midland, MI | |
| Saginaw, MI | |

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| 6980 St. Cloud, MN | 0.9679 |
| Benton, MN | |
| Stearns, MN | |
| 7000 [2] St. Joseph, MO | 0.8056 |
| Andrew, MO | |
| Buchanan, MO | |
| 7040 [1] St. Louis, MO-IL | 0.9033 |
| Clinton, IL | |
| Jersey, IL | |
| Madison, IL | |
| Monroe, IL | |
| St. Clair, IL | |
| Franklin, MO | |
| Jefferson, MO | |
| Lincoln, MO | |
| St. Charles, MO | |
| St. Louis, MO | |
| St. Louis City, MO | |
| Warren, MO | |
| 7080 Salem, OR | 1.0482 |
| Marion, OR | |
| Polk, OR | |
| 7120 Salinas, CA | 1.4339 |
| Monterey, CA | |
| 7160 [1] Salt Lake City-Ogden, UT | 0.9913 |
| Davis, UT | |
| Salt Lake, UT | |
| Weber, UT | |
| 7200 San Angelo, TX | 0.8535 |
| Tom Green, TX | |
| 7240 [1] San Antonio, TX | 0.8870 |
| Bexar, TX | |
| Comal, TX | |
| Guadalupe, TX | |
| Wilson, TX | |
| 7320 [1] San Diego, CA | 1.1147 |
| San Diego, CA | |
| 7360 [1] San Francisco, CA | 1.4514 |
| Marin, CA | |
| San Francisco, CA | |
| San Mateo, CA | |
| 7400 [1] San Jose, CA | 1.4626 |
| Santa Clara, CA | |
| 7440 [1] San Juan-Bayamon, PR | 0.4909 |
| Aguas Buenas, PR | |
| Barceloneta, PR | |
| Bayamon, PR | |
| Canovanas, PR | |
| Carolina, PR | |
| Catano, PR | |
| Ceiba, PR | |
| Comerio, PR | |
| Corozal, PR | |
| Dorado, PR | |
| Fajardo, PR | |
| Florida, PR | |
| Guaynabo, PR | |
| Humacao, PR | |
| Juncos, PR | |
| Los Piedras, PR | |
| Loiza, PR | |
| Luguillo, PR | |
| Manati, PR | |
| Morovis, PR | |
| Naguabo, PR | |
| Naranjito, PR | |
| Rio Grande, PR | |
| San Juan, PR | |
| Toa Alta, PR | |
| Toa Baja, PR | |

ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| Trujillo Alto, PR | |
| Vega Alta, PR | |
| Vega Baja, PR | |
| Yabucoa, PR | |
| 7460 San Luis Obispo-Atascadero-Paso Robles, CA | 1.1429 |
| San Luis Obispo, CA | |
| 7480 Santa Barbara-Santa Maria-Lompoc, CA | 1.0441 |
| Santa Barbara, CA | |
| 7485 Santa Cruz-Watsonville, CA | 1.2942 |
| Santa Cruz, CA | |
| 7490 Santa Fe, NM | 1.0653 |
| Los Alamos, NM | |
| Santa Fe, NM | |
| 7500 Santa Rosa, CA | 1.2877 |
| Sonoma, CA | |
| 7510 Sarasota-Bradenton, FL | 0.9971 |
| Manatee, FL | |
| Sarasota, FL | |
| 7520 Savannah, GA | 0.9488 |
| Bryan, GA | |
| Chatham, GA | |
| Effingham, GA | |
| 7560 Scranton—Wilkes-Barre—Hazleton, PA | 0.8412 |
| Columbia, PA | |
| Lackawanna, PA | |
| Luzerne, PA | |
| Wyoming, PA | |
| 7600 [1] Seattle-Bellevue-Everett, WA | 1.1562 |
| Island, WA | |
| King, WA | |
| Snohomish, WA | |
| 7610 [2] Sharon, PA | 0.8378 |
| Mercer, PA | |
| 7620 [2] Sheboygan, WI | 0.9304 |
| Sheboygan, WI | |
| 7640 Sherman-Denison, TX | 0.9700 |
| Grayson, TX | |
| 7680 Shreveport-Bossier City, LA | 0.9083 |
| Bossier, LA | |
| Caddo, LA | |
| Webster, LA | |
| 7720 Sioux City, IA-NE | 0.8993 |
| Woodbury, IA | |
| Dakota, NE | |
| 7760 Sioux Falls, SD | 0.9309 |
| Lincoln, SD | |
| Minnehaha, SD | |
| 7800 South Bend, IN | 0.9821 |
| St. Joseph, IN | |
| 7840 Spokane, WA | 1.0901 |
| Spokane, WA | |
| 7880 Springfield, IL | 0.8944 |
| Menard, IL | |
| Sangamon, IL | |
| 7920 Springfield, MO | 0.8457 |
| Christian, MO | |
| Greene, MO | |
| Webster, MO | |
| 8003 Springfield, MA | 1.0543 |
| Hampden, MA | |
| Hampshire, MA | |
| 8050 State College, PA | 0.8740 |
| Centre, PA | |
| 8080 [2] Steubenville-Weirton, OH-WV (OH Hospitals) | 0.8820 |
| Jefferson, OH | |
| Brooke, WV | |
| Hancock, WV | |
| 8080 Steubenville-Weirton, OH-WV (WV Hospitals) | 0.8398 |
| Jefferson, OH | |
| Brooke, WV | |
| Hancock, WV | |
| 8120 Stockton-Lodi, CA | 1.0404 |
| San Joaquin, CA | |
| 8140 [2] Sumter, SC | 0.8498 |
| Sumter, SC | |
| 8160 Syracuse, NY | 0.9412 |
| Cayuga, NY | |
| Madison, NY | |
| Onondaga, NY | |
| Oswego, NY | |
| 8200 Tacoma, WA | 1.1116 |
| Pierce, WA | |
| 8240 [2] Tallahassee, FL | 0.8855 |
| Gadsden, FL | |
| Leon, FL | |
| 8280 [1] Tampa-St. Petersburg-Clearwater, FL | 0.9103 |
| Hernando, FL | |
| Hillsborough, FL | |
| Pasco, FL | |
| Pinellas, FL | |
| 8320 [2] Terre Haute, IN | 0.8824 |
| Clay, IN | |
| Vermillion, IN | |
| Vigo, IN | |
| 8360 Texarkana, AR-Texarkana, TX | 0.8150 |
| Miller, AR | |
| Bowie, TX | |
| 8400 Toledo, OH | 0.9397 |
| Fulton, OH | |
| Lucas, OH | |
| Wood, OH | |
| 8440 Topeka, KS | 0.9108 |
| Shawnee, KS | |
| 8480 Trenton, NJ | 1.0517 |
| Mercer, NJ | |
| 8520 [2] Tucson, AZ | 0.9270 |
| Pima, AZ | |
| 8560 Tulsa, OK. | |
| Creek, OK | |
| Osage, OK | |
| Rogers, OK | |
| Tulsa, OK | |
| Wagoner, OK | 0.9185 |
| 8600 Tuscaloosa, AL | 0.8212 |
| Tuscaloosa, AL | |
| 8640 Tyler, TX | 0.9404 |
| Smith, TX | |
| 8680 [2] Utica-Rome, NY | 0.8526 |
| Herkimer, NY | |
| Oneida, NY | |
| 8720 Vallejo-Fairfield-Napa, CA | 1.3425 |
| Napa, CA | |
| Solano, CA | |
| 8735 Ventura, CA | 1.1064 |
| Ventura, CA | |
| 8750 Victoria, TX | 0.8184 |
| Victoria, TX | |
| 8760 Vineland-Millville-Bridgeton, NJ | 1.0405 |
| Cumberland, NJ | |
| 8780 [2] Visalia-Tulare-Porterville, CA | 0.9967 |
| Tulare, CA | |
| 8800 Waco, TX | 0.8394 |
| McLennan, TX | |
| 8840 [1] Washington, DC-MD-VA-WV | 1.0904 |
| District of Columbia, DC | |
| Calvert, MD | |
| Charles, MD | |
| Frederick, MD | |
| Montgomery, MD | |
| Prince Georges, MD | |
| Alexandria City, VA | |
| Arlington, VA | |
| Clarke, VA | |
| Culpeper, VA | |
| Fairfax, VA | |
| Fairfax City, VA | |
| Falls Church City, VA | |
| Fauquier, VA | |
| Fredericksburg City, VA | |
| King George, VA | |
| Loudoun, VA | |
| Manassas City, VA | |
| Manassas Park City, VA | |
| Prince William, VA | |
| Spotsylvania, VA | |
| Stafford, VA | |
| Warren, VA | |
| Berkeley, WV | |
| Jefferson, WV | |
| 8920 [2] Waterloo-Cedar Falls, IA | 0.8416 |
| Black Hawk, IA | |
| 8940 Wausau, WI | 0.9783 |
| Marathon, WI | |
| 8960 [1] West Palm Beach-Boca Raton, FL | 0.9798 |
| Palm Beach, FL | |
| 9000 [2] Wheeling, WV-OH (WV Hospitals) | 0.8018 |
| Belmont, OH | |
| Marshall, WV | |
| Ohio, WV | |
| 9000 [2] Wheeling, WV-OH (OH Hospitals) | 0.8820 |
| Belmont, OH | |
| Marshall, WV | |
| Ohio, WV | |
| 9040 Wichita, KS | 0.9238 |
| Butler, KS | |
| Harvey, KS | |
| Sedgwick, KS | |
| 9080 Wichita Falls, TX | 0.8341 |
| Archer, TX | |
| Wichita, TX | |
| 9140 [2] Williamsport, PA | 0.8378 |
| Lycoming, PA | |
| 9160 Wilmington-Newark, DE-MD | 1.0882 |
| New Castle, DE | |
| Cecil, MD | |
| 9200 Wilmington, NC | 0.9563 |
| New Hanover, NC | |
| Brunswick, NC | |
| 9260 [2] Yakima, WA | 1.0388 |
| Yakima, WA | |
| 9270 [2] Yolo, CA | 0.9967 |
| Yolo, CA | |
| 9280 York, PA | 0.9119 |
| York, PA | |
| 9320 Youngstown-Warren, OH | 0.9214 |
| Columbiana, OH | |

## ADDENDUM H—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| Mahoning, OH<br>Trumbull, OH | |
| 9340 Yuba City, CA<br>Sutter, CA<br>Yuba, CA | 1.0196 |
| 9360 [2] Yuma, AZ<br>Yuma, AZ | 0.9270 |

[1] Large Urban Area
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2004.

## ADDENDUM I.—WAGE INDEX FOR RURAL AREAS

| Nonurban area | Wage Index |
|---|---|
| Alabama | 0.7492 |
| Alaska | 1.1886 |
| Arizona | 0.9270 |
| Arkansas | 0.7734 |
| California | 0.9967 |
| Colorado | 0.9328 |
| Connecticut | 1.2183 |
| Delaware | 0.9595 |
| Florida | 0.8855 |
| Georgia | 0.8595 |
| Hawaii | 0.9958 |
| Idaho | 0.8974 |
| Illinois | 0.8254 |
| Indiana | 0.8824 |
| Iowa | 0.8416 |
| Kansas | 0.8074 |
| Kentucky | 0.7974 |
| Louisiana | 0.7467 |
| Maine | 0.8812 |
| Maryland | 0.9125 |
| Massachusetts | 1.0432 |
| Michigan | 0.8877 |
| Minnesota | 0.9345 |
| Mississippi | 0.7778 |
| Missouri | 0.8056 |
| Montana | 0.8800 |
| Nebraska | 0.8822 |
| Nevada | 0.9806 |
| New Hampshire | 1.0030 |
| New Jersey [1] | ..... |
| New Mexico | 0.8270 |
| New York | 0.8526 |
| North Carolina | 0.8456 |
| North Dakota | 0.7778 |
| Ohio | 0.8820 |
| Oklahoma | 0.7537 |
| Oregon | 0.9994 |
| Pennsylvania | 0.8378 |
| Puerto Rico | 0.4018 |
| Rhode Island [1] | ..... |
| South Carolina | 0.8498 |
| South Dakota | 0.8195 |
| Tennessee | 0.7886 |
| Texas | 0.7780 |
| Utah | 0.8974 |
| Vermont | 0.9534 |
| Virginia | 0.8498 |
| Washington | 1.0388 |
| West Virginia | 0.8018 |
| Wisconsin | 0.9304 |

## ADDENDUM I.—WAGE INDEX FOR RURAL AREAS—Continued

| Nonurban area | Wage Index |
|---|---|
| Wyoming | 0.9110 |

[1] All counties within the State are classified as urban.

## ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED

| Area | Wage index |
|---|---|
| Akron, OH | 0.9442 |
| Albany, GA | 1.0664 |
| Albuquerque, NM (NM hospitals) | 0.9300 |
| Albuquerque, NM (CO hospitals) | 0.9328 |
| Alexandria, LA | 0.8037 |
| Allentown-Bethlehem-Easton, PA | 0.9721 |
| Altoona, PA | 0.8827 |
| Amarillo, TX | 0.8858 |
| Anchorage, AK | 1.2351 |
| Ann Arbor, MI | 1.0846 |
| Anniston, AL | 0.7975 |
| Asheville, NC | 0.9477 |
| Athens, GA | 0.9564 |
| Atlanta, GA | 0.9990 |
| Atlantic-Cape May, NJ | 1.0531 |
| Augusta-Aiken, GA-SC | 0.9433 |
| Austin-San Marcos, TX | 0.9609 |
| Bangor, ME | 0.9904 |
| Barnstable-Yarmouth, MA | 1.2720 |
| Baton Rouge, LA | 0.8406 |
| Bellingham, WA | 1.1305 |
| Benton Harbor, MI | 0.8935 |
| Bergen-Passaic, NJ | 1.1731 |
| Billings, MT | 0.8961 |
| Biloxi-Gulfport-Pascagoula, MS | 0.8407 |
| Binghamton, NY | 0.8428 |
| Birmingham, AL | 0.9212 |
| Bismarck, ND | 0.8033 |
| Bloomington-Normal, IL | 0.8832 |
| Boise City, ID | 0.9232 |
| Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH | 1.1233 |
| Burlington, VT | 0.9332 |
| Caguas, PR | 0.4201 |
| Casper, WY | 0.9209 |
| Champaign-Urbana, IL | 0.9460 |
| Charleston-North Charleston, SC | 0.9332 |
| Charleston, WV (WV Hospitals) | 0.8568 |
| Charleston, WV (OH Hospitals) | 0.8820 |
| Charlotte-Gastonia-Rock Hill, NC-SC | 0.9730 |
| Charlottesville, VA | 0.9877 |
| Chattanooga, TN-GA | 0.9086 |
| Chicago, IL | 1.0752 |
| Cincinnati, OH-KY-IN | 0.9413 |
| Clarksville-Hopkinsville, TN-KY | 0.8354 |
| Cleveland-Lorain-Elyria, OH | 0.9671 |
| Columbia, MO | 0.8557 |
| Columbia, SC | 0.8902 |
| Columbus, GA-AL | 0.8595 |
| Columbus, OH | 0.9648 |
| Corpus Christi, TX | 0.8521 |
| Corvallis, OR | 1.1241 |
| Dallas, TX | 0.9974 |
| Davenport-Moline-Rock Island, IA-IL | 0.8985 |
| Dayton-Springfield, OH | 0.9529 |
| Decatur, AL | 0.8580 |
| Denver, CO | 1.0664 |

## ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

| Area | Wage index |
|---|---|
| Des Moines, IA | 0.9106 |
| Detroit, MI | 1.0101 |
| Dothan, AL | 0.7765 |
| Duluth-Superior, MN-WI | 1.0171 |
| Elkhart-Goshen, IN | 0.9554 |
| Erie, PA | 0.8526 |
| Eugene-Springfield, OR | 1.0977 |
| Fargo-Moorhead, ND-MN | 0.9501 |
| Fayetteville, NC | 0.8817 |
| Flagstaff, AZ-UT | 1.1079 |
| Flint, MI | 1.0703 |
| Florence, AL | 0.7797 |
| Fort Collins-Loveland, CO | 1.0148 |
| Ft. Lauderdale, FL | 1.0479 |
| Fort Pierce-Port St. Lucie, FL | 1.0124 |
| Fort Smith, AR-OK | 0.8077 |
| Fort Walton Beach, FL | 0.8804 |
| Forth Worth-Arlington, TX | 0.9359 |
| Gadsden, AL | 0.8229 |
| Gainesville, FL | 0.9693 |
| Grand Forks, ND-MN | 0.8636 |
| Grand Junction, CO | 0.9921 |
| Grand Rapids-Muskegon-Holland, MI | 0.9469 |
| Great Falls, MT | 0.8918 |
| Greeley, CO | 0.9453 |
| Green Bay, WI | 0.9518 |
| Greensboro-Winston-Salem-High Point, NC | 0.9058 |
| Greenville, NC | 0.9167 |
| Hamilton-Middletown, OH | 0.9214 |
| Harrisburg-Lebanon-Carlisle, PA | 0.9164 |
| Hartford, CT | 1.1359 |
| Hickory-Morganton-Lenoir, NC | 0.9113 |
| Honolulu, HI | 1.1116 |
| Houston, TX | 0.9834 |
| Huntington-Ashland, WV-KY-OH | 0.9076 |
| Huntsville, AL | 0.9120 |
| Indianapolis, IN | 0.9916 |
| Iowa City, IA | 0.9404 |
| Jackson, MS | 0.8399 |
| Jackson, TN | 0.8819 |
| Jacksonville, FL | 0.9563 |
| Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals) | 0.8498 |
| Johnson City-Kingsport-Bristol, TN-VA (KY Hospitals) | 0.8256 |
| Jonesboro, AR (AR Hospitals) | 0.7809 |
| Jonesboro, AR (MO Hospitals) | 0.8056 |
| Joplin, MO | 0.8558 |
| Kalamazoo-Battlecreek, MI | 1.0500 |
| Kansas City, KS-MO | 0.9715 |
| Knoxville, TN | 0.8820 |
| Kokomo, IN | 0.9045 |
| Lafayette, LA | 0.8225 |
| Lakeland-Winter Haven, FL | 0.8855 |
| Las Vegas, NV-AZ | 1.1401 |
| Lawton, OK | 0.8140 |
| Lexington, KY | 0.8475 |
| Lima, OH | 0.9522 |
| Lincoln, NE | 0.9597 |
| Little Rock-North Little Rock, AR | 0.8923 |
| Longview-Marshall, TX | 0.8943 |
| Los Angeles-Long Beach, CA | 1.1832 |
| Louisville, KY-IN | 0.9118 |
| Lubbock, TX | 0.8272 |
| Lynchburg, VA | 0.8941 |
| Macon, GA | 0.8975 |
| Madison, WI | 1.0117 |

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

| Area | Wage index |
|---|---|
| Medford-Ashland, OR | 1.0425 |
| Melbourne-Titusville-Palm Bay, FL | 0.9776 |
| Memphis, TN-AR-MS | 0.8786 |
| Miami, FL | 0.9894 |
| Milwaukee-Waukesha, WI | 0.9829 |
| Minneapolis-St. Paul, MN-WI | 1.1001 |
| Missoula, MT | 0.8884 |
| Mobile, AL | 0.7994 |
| Modesto, CA | 1.1148 |
| Monmouth-Ocean, NJ | 1.1083 |
| Monroe, LA | 0.7922 |
| Montgomery, AL | 0.7907 |
| Nashville, TN | 0.9591 |
| New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT | 1.2468 |
| New Orleans, LA | 0.9174 |
| New York, NY | 1.4018 |
| Newark, NJ | 1.1518 |
| Newburgh, NY-PA | 1.1048 |
| Oakland, CA | 1.5119 |
| Odessa-Midland, TX | 0.9076 |
| Oklahoma City, OK | 0.8984 |
| Olympia, WA | 1.0963 |
| Omaha, NE-IA | 0.9745 |
| Orange County, CA | 1.1492 |
| Orlando, FL | 0.9654 |
| Peoria-Pekin, IL | 0.8734 |
| Philadelphia, PA-NJ | 1.0883 |
| Phoenix-Mesa, AZ | 1.0129 |
| Pittsburgh, PA | 0.8901 |
| Pittsfield, MA | 0.9795 |
| Pocatello, ID | 0.9249 |
| Portland, ME | 0.9658 |
| Portland-Vancouver, OR-WA | 1.1213 |
| Provo-Orem, UT | 0.9976 |
| Raleigh-Durham-Chapel Hill, NC | 0.9725 |
| Rapid City, SD | 0.8806 |

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

| Area | Wage index |
|---|---|
| Reading, PA | 0.8998 |
| Redding, CA | 1.1352 |
| Reno, NV | 1.0682 |
| Richland-Kennewick-Pasco, WA (WA Hospitals) | 1.0388 |
| Richland-Kennewick-Pasco, WA (ID Hospitals) | 1.0215 |
| Richmond-Petersburg, VA | 0.9349 |
| Roanoke, VA | 0.8700 |
| Rochester, MN | 1.1739 |
| Rockford, IL | 0.9441 |
| Sacramento, CA | 1.1845 |
| Saginaw-Bay City-Midland, MI | 0.9751 |
| St. Cloud, MN | 0.9679 |
| St. Joseph, MO | 0.8578 |
| St. Louis, MO-IL | 0.9033 |
| Salinas, CA | 1.4339 |
| Salt Lake City-Ogden, UT | 0.9913 |
| San Antonio, TX | 0.8870 |
| Santa Fe, NM | 0.9524 |
| Santa Rosa, CA | 1.2877 |
| Sarasota-Bradenton, FL | 0.9971 |
| Savannah, GA | 0.9488 |
| Seattle-Bellevue-Everett, WA | 1.1562 |
| Sherman-Denison, TX | 0.9203 |
| Shreveport-Bossier City, LA | 0.8937 |
| Sioux City, IA-NE (NE Hospitals) | 0.8822 |
| Sioux City, IA-NE (SD Hospitals) | 0.8785 |
| Sioux Falls, SD | 0.9184 |
| South Bend, IN | 0.9715 |
| Spokane, WA | 1.0717 |
| Springfield, IL | 0.8944 |
| Springfield, MO | 0.8259 |
| Syracuse, NY | 0.9412 |
| Tampa-St. Petersburg-Clearwater, FL | 0.9103 |
| Texarkana, AR-Texarkana, TX | 0.7969 |

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

| Area | Wage index |
|---|---|
| Toledo, OH | 0.9397 |
| Topeka, KS | 0.9108 |
| Tucson, AZ | 0.9270 |
| Tulsa, OK | 0.8938 |
| Tuscaloosa, AL | 0.8101 |
| Tyler, TX | 0.9155 |
| Vallejo-Fairfield-Napa, CA | 1.3425 |
| Victoria, TX | 0.8184 |
| Waco, TX | 0.8394 |
| Washington, DC-MD-VA-WV | 1.0904 |
| Waterloo-Cedar Falls, IA | 0.8416 |
| Wausau, WI | 0.9783 |
| West Palm Beach-Boca Raton, FL | 0.9798 |
| Wichita, KS | 0.9004 |
| Wichita Falls, TX | 0.8341 |
| Wilmington-Newark, DE-MD | 1.0710 |
| Wilmington, NC | 0.9424 |
| Youngstown-Warren, OH | 0.9214 |
| Rural Florida | 0.8699 |
| Rural Illinois (IA Hospitals) | 0.8416 |
| Rural Illinois (MO Hospitals) | 0.8254 |
| Rural Kentucky | 0.7974 |
| Rural Louisiana | 0.7467 |
| Rural Minnesota | 0.9345 |
| Rural Missouri | 0.8056 |
| Rural Nebraska | 0.8822 |
| Rural Nevada | 0.9276 |
| Rural New Hampshire | 1.0030 |
| Rural Texas | 0.7780 |
| Rural Washington | 1.0388 |
| Rural Wyoming | 0.8984 |

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