**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR Parts 405 and 419**

**[CMS–1206–FC and CMS–1179–F]**

**RIN 0938–AL19 and 0938–AK59**

# Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2003 Payment Rates; and Changes to Payment Suspension for Unfiled Cost Reports

**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, 2003. This rule also allows the Secretary to suspend Medicare payments ''in whole or in part'' if a provider fails to file a timely and acceptable cost report.

In addition, this rule responds to public comments received on the November 2, 2001 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 payment under the Medicare's hospital outpatient prospective payment system. Finally, this rule responds to public comments received on the August 9, 2002 proposed rule for revisions to the hospital outpatient prospective payment system and payment rates (67 FR 52092). CMS finds good cause to waive proposed rulemaking for the assignment of new codes to Ambulatory Payment Classifications and for the payment of influenza and pneumococcal vaccines under reasonable cost; justification for the waiver will follow in a subsequent **Federal Register** notice.

**DATES:** *Effective date:* This final rule is effective January 1, 2003.

*Comment date:* We will consider comments on the ambulatory payment classification assignments of Healthcare Common Procedure Coding System codes identified in Addendum B with condition code NI, and on § 419.23(d)(3), if we receive them at the appropriate address, as provided below, no later than 5 pm on December 31, 2002.

**FOR FURTHER INFORMATION CONTACT:** Anita Heygster, (410) 786–0378—outpatient prospective payment issues; Lana Price, (410) 786–4533—partial hospitalization and end-stage renal disease issues; Gerald Walters, (410) 786–2070—payment suspension issues.

**SUPPLEMENTARY INFORMATION:**

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*Alphabetical List of Acronyms Appearing in the Final Rule*

ACEP—American College of Emergency Physicians
AMA—American Medical Association
APC—Ambulatory payment classification
AWP—Average wholesale price
BBA—Balanced Budget Act of 1997
BIPA—Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
BBRA—Balanced Budget Refinement Act of 1999
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 (Physician's) Current Procedural Terminology, Fourth Edition, 2002, copyrighted by the American Medical Association
CSW Clinical social worker
CY Calendar year
DRG Diagnosis-related group
DSH Disproportionate Share Hospital
EACH Essential Access Community Hospital
E/M Evaluation and management
ERCP Endoscopic retrograde cholangiopancreatography
ESRD End-stage renal disease
FACA Federal Advisory Committee Act
FY Federal fiscal year
HCPCS Healthcare Common Procedure Coding System
HIPAA Health Insurance Portability and Accountability Act of 1996
ICU Intensive care unit
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
IME Indirect Medical Education
IPPS (Hospital) inpatient prospective payment system
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
OT Occupational therapist
PHP Partial hospitalization program
PPS Prospective payment system
PPV Pneumococcal pneumonia (virus)
PRA Paperwork Reduction Act
RFA Regulatory Flexibility Act
RRC Rural Referral Center
RVUs Relative value units
SCH Sole Community Hospital
TEFRA Tax Equity and Fiscal Responsibility Act
USPDI United States Pharmacopoeia Drug Information

## I. Background

### *A. Authority for the Outpatient Prospective Payment System (OPPS)*

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

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

- On September 8, 1998, we published a proposed rule (63 FR 47552) to establish in regulations a PPS for hospital outpatient services, to eliminate the formula-driven overpayment for certain hospital outpatient services, and to extend reductions in payment for costs of hospital outpatient services. On June 30, 1999, we published a correction notice (64 FR 35258) to correct a number of technical and typographic errors in the September 1998 proposed rule including the proposed amounts and factors used to determine the payment rates.
- On April 7, 2000, we published a final rule with comment period (65 FR 18434) that addressed the provisions of the PPS for hospital outpatient services scheduled to be effective for services furnished on or after July 1, 2000. Under this system, Medicare payment for hospital outpatient services included in the PPS is made at a predetermined, specific rate. These outpatient services are classified according to a list of ambulatory payment classifications (APCs). The April 7, 2000 final rule with comment period also established requirements for provider departments and provider-based entities and prohibited Medicare payment for nonphysician services furnished to a hospital outpatient by a provider or supplier other than a hospital unless the services are furnished under arrangement. In addition, this rule extended reductions in payment for costs of hospital outpatient services as required by the BBA and amended by the BBRA. Medicare regulations governing the hospital OPPS are set forth at 42 CFR part 419.

• On June 30, 2000, we published a notice (65 FR 40535) announcing a delay in implementation of the OPPS from July 1, 2000 to August 1, 2000. We implemented the OPPS on August 1, 2000.

• On August 3, 2000, we published an interim final rule with comment period (65 FR 47670) that modified criteria that we use to determine which medical devices are eligible for transitional pass-through payments. The August 3, 2000 rule also corrected and clarified certain provider-based provisions included in the April 7, 2000 rule.

• On November 13, 2000, we published an interim final rule with comment period (65 FR 67798). This rule provided for the annual update to the amounts and factors for OPPS payment rates effective for services furnished on or after January 1, 2001. We implemented the 2001 OPPS on January 1, 2001. We also responded to public comments on those portions of the April 7, 2000 final rule that implemented related provisions of the BBRA and public comments on the August 3, 2000 rule.

• On August 24, 2001, we published a proposed rule (66 FR 44672) that would revise the OPPS to implement applicable statutory requirements, including relevant provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2002 (BIPA) and changes arising from our continuing experience with this system. It also described proposed changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the PPS. The changes applied to services furnished on or after January 1, 2002.

• On November 2, 2001, we published a final rule (66 FR 55857) that announced the Medicare OPPS conversion factor for calendar year 2002. In addition, it described the Secretary's estimate of the total amount of the transitional pass-through payments for CY 2002 and the implementation of a uniform reduction in each of the pass-through payments for that year.

• On November 2, 2001, we also published an interim final rule with comment period (66 FR 55850) that set forth the criteria the Secretary will use to establish new categories of medical devices eligible for transitional pass-through payments under Medicare's OPPS.

• On November 30, 2001, we published a final rule (66 FR 59856) that revised the Medicare OPPS to implement applicable statutory requirements, including relevant provisions of BIPA, and changes resulting from continuing experience with this system. It 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 August 9, 2002, we published a proposed rule (67 FR 52092) that would revise the OPPS to implement applicable statutory requirements and changes arising from our continuing experience with this system. The changes would be applicable to services furnished on or afterJanuary 1, 2003. This rule also proposed to allow the Secretary to suspend Medicare payments ''in whole or in part'' if a provider fails to file a timely and acceptable cost report.

*C. Authority for Payment Suspensions for Unfiled Cost Reports*

Authority for the provision regarding payment suspensions for unfiled cost reports is contained within the authority for subpart C of 42 CFR part 405, that is, sections 1102, 1815, 1833, 1842, 1866, 1870, 1871, 1879, and 1892 of the Social Security Act (42 U.S.C. 1302, 1395g, 1395l, 1395u, 1395cc, 1395gg, 1395hh, 1395pp, and 1395ccc) and 31 U.S.C. 3711.

*D. Summary of Changes in the August 9, 2002 Proposed Rule*

1. Changes Relating to the OPPS

On August 9, 2002, we published a proposed rule (67 FR 52092) that set forth proposed changes to the Medicare hospital OPPS and CY 2003 payment rates including 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 9, 2002 proposed rule.

a. *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 (including blood and blood products) and devices (including brachytherapy), that will, on January 1, 2003, have been paid under transitional pass-through methodology for at least 2 years.

b. *Additional Changes to OPPS*

We proposed the following additional changes to the OPPS and Payment Suspension Provisions:

• Creation of new evaluation and management service codes for outpatient clinic and emergency department encounters for implementation no earlier than January 1, 2004.

• Changes to the list of services that we do not pay in outpatient departments because we define them as inpatient only procedures.

• Changes to our policy of nonpayment for procedures on the inpatient only list in special cases involving death or transfer before inpatient admission.

• Changes to our policy governing observation in cases of direct admission to observation.

• Changes to status indicators for Healthcare Common Procedure Coding System (HCPCS) codes.

• Changes to our policies governing dialysis for end-stage renal disease (ESRD) patients and regarding partial hospitalization.

C. Changes to the Regulations Text

A. We proposed to make the following changes to our regulations:

Amend § 419.66(c)(1) to specify that we must establish a new category for a medical device if it is not described by any category previously in effect as well as an existing category.

2. Changes Relating to Payment Suspension for Unfiled Cost Reports

We proposed to revise § 405.371(c) to specify that we may suspend Medicare payments ''in whole or in part'' if a provider has failed to timely file an acceptable cost report. This provision is consistent with the existing provisions in § 405.371(a) governing the suspension of Medicare payments ''in whole or in part'' under certain conditions. We believe the Medicare program would benefit because immediate complete payment suspension can be disruptive to providers and may negatively affect the care of Medicare patients.

*E. Summary of the November 2, 2001 Interim Final Rule with Comment Period*

On November 2, 2001, we published an interim final rule with comment period in the **Federal Register** (66 FR 55850) that set forth the criteria for establishing new categories of medical devices eligible for transitional pass-through payments under Medicare's hospital OPPS as required by section 1833(t)(6)(B)(ii) of the Act, as amended by BIPA.

In the April 7, 2000 final rule with comment period (65 FR 18480), we defined new or innovative devices using eight criteria, three of which were revised in our August 3, 2000 interim final rule with comment period (65 FR 47673–74). These criteria remained applicable when defining a new category for devices, (that is, devices to be included in a category must meet all previously established applicable criteria for a device eligible for transitional pass-through payments) but we revised the definition of an eligible device to conform the requirements of amended section 1833(t)(6)(B)(ii) of the Act.

We also clarified our criterion that states that a device must be approved or cleared by the Food and Drug Administration (FDA).

In establishing the criteria for establishing additional categories, the Act mandates that new categories be established for devices that were not being paid for as an outpatient hospital service as of December 31, 1996 and for which no categories in effect (or previously in effect) are appropriate, in such a way that no device is described by more than one category and the average cost of devices to be included in the category is not insignificant in relation to the APC payment amount for the associated service. Based on these requirements, we used the following criteria to establish a category of devices:

- *Substantial clinical improvement.* The category describes devices that demonstrate a substantial improvement in medical benefits for Medicare beneficiaries compared to the benefits obtained by devices in previously established categories or other available treatments, as described in regulations at new § 419.66(c)(1).
- *Cost.* We determine that the estimated cost to hospitals of the devices in a new category (including any candidate devices and the other devices that we believe will be included in the category) is ''not insignificant'' relative to the payment rate for the applicable procedures.

We received five timely items of correspondence on the November 2, 2001 interim final rule with comment period. 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.

*F. Public Comments and Responses to the August 9, 2002 Proposed Rule*

We received approximately 1,000 timely items of correspondence containing multiple comments on the August 9, 2002 proposed rule. Of that total, we received eight comments relating to the payment suspension provision described in section I.D.2. Summaries of the public comments received on other provisions and our responses to those comments are provided below in section I.F.2 of this preamble.

1. OPPS

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 and incorporating the drugs and devices into payment for APCs. Pharmaceutial 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 data to support their assertions. The following are the major OPPS related issues addressed by the commenters:

- Expiration of pass-through payment for most devices and drugs/biologicals.
- Extent of reduction in payments for devices compared to payments in 2002.
- Potential impact on access to care of proposed payments.
- The proposal to package drugs with a per line cost less than $150 and to pay separately for others.
- Assignment and reassignment of codes to APCs (including assignments to procedural APCs from new tech APCs).
- Quality, quantity and content of claims data used to set payment weights.
- Continuation of a list of procedures that are not paid under OPPS because we believe that they should be performed as inpatient services.
- Policy on payment for outpatient observation care.
- Creation of evaluation and management codes for OPPS use.

Summaries of the public comments received and our responses to those comments are set forth below under the appropriate headings of this final rule with comment period.

2. Payment Suspension for Unfiled Cost Reports

Comments and Responses

*Comment:* All of the commenters stated that the rule provides for increased flexibility and a reduction in the financial impact of payment suspensions on providers. They indicated the increased flexibility would allow providers to receive partial payments from Medicare, which would lessen the financial impact of payment suspensions.

*Response:* We appreciate the hospital associations supporting this change.

*Comment:* One commenter suggested that payment suspension be limited to those payments directly determined by the cost report.

*Response:* We believe that immediate suspension of all payments when a cost report is not filed timely may not always be the appropriate response. However, if we require a provider to file a cost report, it is important for the cost report to be filed in a timely manner regardless of the amount of payment that is determined based on the cost report. We need flexibility in determining the amount of a provider's payments to suspend if its cost report is not filed timely. This could include the potential suspension of payments that are not determined by the cost report. Thus, we will retain § 405.371 of the regulation as set forth in the proposed 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 601, Mid-Level Clinic Visits. The APC weights are scaled to APC 601 because a mid-level clinic visit is one of the most frequently performed services in the outpatient setting.

Section 1833(t)(9)(A) of the Act requires the Secretary to review the components of the OPPS not less often than annually and to revise the groups and related payment adjustment factors to take into account changes in medical practice, changes in technology, and the addition of new services, new cost data, and other relevant information. Section 1833(t)(9)(A) of the Act requires the Secretary, beginning in 2001, to consult with an outside panel of experts when annually reviewing and updating 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 item or service in the group is more than 2 times greater than the lowest median cost 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 for this final rule with comment period, we analyzed the APC groups within this statutory framework.

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

1. Establishment of the Advisory Panel

Section 1833(t)(9)(A) of the Act, requires that we consult with an outside panel of experts when annually reviewing and updating the APC groups and the relative weights. The Act specifies that the panel will act in an advisory capacity. The expert panel, which is to be composed of representatives of providers, is to review and advise 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). 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). 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 themselves or a colleague. After carefully reviewing the applications, we chose 15 highly qualified individuals to serve on the Panel. The first APC Panel meeting was held on February 27, February 28, and March 1, 2001, to discuss the 2001 APCs in anticipation of the 2002 OPPS.

We published a notice in the **Federal Register** on December 14, 2001, to announce the location and time of the second Panel meeting, a list of agenda items, and that the meeting was open to the public. We also provided additional information through a press release and on our Web site. We convened the second meeting of the Panel on January 22 through January 24, 2002.

2. General Issues Considered by the Advisory Panel

In the proposed rule, we summarized the Panel's discussion of a recommendation by the Panel's Research Subcommittee concerning the format of written submissions and oral presentations to the Panel and of several general OPPS payment issues.

Content for Future Presentations to the Panel

During the 2001 meeting, the Panel members felt that requiring consistency for all presentations with regard to format, data submission, and general information would assist them in analyzing the submissions and presentations and making recommendations. Therefore, upon the Panel's recommendation, the Research Subcommittee was established during the 2001 meeting.

The Panel began its 2002 meeting by considering the Research Subcommittee's recommendation to the Panel on requirements for written submissions and oral presentations. The Research Subcommittee recommended that all future oral presentations and written submissions contain the following:

- Name, address, and telephone number of the proposed presenter.
- Financial relationship(s), if any, with any company whose products, services, or procedures are under consideration.
- CPT codes involved.
- APC(s) affected.
- Description of the issue.
- Clinical description of the service under discussion, with comparison to other services within the APC.
- Description of the resource inputs associated with the service under discussion, with a comparison to resource inputs for other services within the APC.
- Recommendations and rationale for change.
- Expected outcome of change and potential consequences of no change.

The Panel adopted the Subcommittee s recommendation. Presentations for the 2003 meeting must contain, at a minimum, this information.

Inpatient Only List

At its February 2001 meeting, the Panel discussed the existence of the inpatient list. The Panel favored its elimination. At the January 2002 meeting, Panel members noted that hospitals receive no payment for a service performed in an outpatient department that appears on the inpatient list, even though the physician performing that service will receive payment for his or her services. The Panel believes the physician should determine what procedure to perform and that both the hospital and the physician should receive payment for the procedure. We continue to disagree with the position taken by the Panel regarding the inpatient list for reasons that we discuss in detail in the April 7, 2000 final rule (65 FR 18456).

Prior to the 2002 Panel meeting, we received requests from hospital and surgical associations and societies to remove certain procedures from the inpatient list. We reviewed those requests and presented to the Panel the requests for which we were unable to make a determination based on the information submitted with the request.

The Panel considered removing the following procedures from the inpatient list:

| CPT | Description |
|---|---|
| 21390 | Treat eye socket fracture |
| 27216 | Treat pelvic ring fracture |
| 27235 | Treat thigh fracture |

| CPT | Description |
|---|---|
| 32201 | Drain, precut, lung lesion |
| 33967 | Insert a precut device |
| 47490 | Incision of gallbladder |
| 62351 | Implant spinal canal cath |
| 64820 | Remove sympathetic nerves |
| 92986 | Revision of aortic valve |
| 92987 | Revision of mitral valve |
| 92990 | Revision of pulmonary valve |
| 92997 | Pul art balloon repr, precut |
| 92998 | Pul art balloon repr, precut |

As the Panel recommended, we solicited comments and additional information from hospitals and medical specialty societies that have an interest in these procedures. At their 2003 meeting, the Panel also recommended that we present to them any such comments that we receive to assist in their evaluation of whether to recommend removing the codes from the inpatient list.

The Panel did recommend that we remove from the inpatient list CPT code 47001, Biopsy of liver, needle; when done for indicated purpose at time of other major procedure. We agreed with the Panel's recommendation and we proposed to remove 47001 from the inpatient list. We further proposed to assign it status indicator ''N'' so that costs associated withCPT code 47001 would be packaged into the APC payment for the primary procedure performed during the same operative session.

In section II.B.5 of the proposed rule, we discussed additional procedures, which were not considered by the Panel, that we proposed to remove from the inpatient list. We discussed in detail our reasons for proposing these additional changes, and we proposed two new criteria that we would adopt in the future when evaluating whether to make a procedure on the inpatient list payable under the OPPS. Table 6 in section II.B.5 of the proposed rule lists all the procedures we proposed to remove from the inpatient list, including those discussed by the Panel. We considered the removal of CPT code 33967, Insertion of intra-aortic balloon assist device, percutaneous from the inpatient list, but did not include it in Table 6. The Panel considered this code for removal from the inpatient list and had concerns about whether performing this procedure in an outpatient setting is appropriate. Further, we were not able to confirm that this procedure is being performed on Medicare beneficiaries in an outpatient setting. We solicited comments, including clinical data and specific case reports, which would support payment for CPT 33967 under the OPPS.

Our discussion of the comments we received on this issue, our response and the statement of final action regarding what services to remove from the inpatient list is contained in section II.B.5.

**Multiple Bills**

During its February 2001 meeting, the Panel received oral testimony identifying CMS exclusive use of single procedure claims to set relative weights for APCs as a potential problem in setting appropriate payment rates for APCs. Therefore, the panel asked its Research Subcommittee to work with CMS staff, using the Endoscopic Retrograde Cholangiopancreatography (ERCP) code family as a case study, to explore the use of multiple procedure claims data for setting relative weights.

The Subcommittee made the following recommendations to the Panel, which the Panel approved:

- We should continue to explore the use of multiple procedure claims data for setting payment rates but should continue to use only single procedure claims data to determine relative payment weights for CY 2003.
- We should work with the APC Panel to explore the use of multiple claims data drawn from OPPS claims for services such as radiation oncology in time for the next APC Panel meeting.
- We should educate hospitals on appropriate coding and billing practices to ensure that claims with multiple procedures are properly coded and that costs are properly allocated to each procedure.

One presenter to the panel suggested a method to increase the number of claims that could be considered as single claims. Currently, we consider any claim submitted with two or more primary codes (that is, a code assigned to an APC for separate payment) to be a multiple procedure claim. When these claims contain line items for revenue centers without an accompanying Healthcare Common Procedure Coding System (HCPCS) code there is no way to determine the appropriate primary code with which to package the revenue center. The presenter suggested that we consider all claims where every line contains a separately payable HCPCS code as a single procedure claim, reasoning that on such claims we do not have to determine how and where to ''package'' line items not identified by a separately payable HCPCS code. Where every line item contains a separately payable HCPCS code, every cost can easily be allocated to a separately payable HCPCS code on the line item and all costs for each HCPCS code can then be accurately and completely determined.

We agreed with that suggestion. In section II.B.4 of the proposed rule, we described how we determined the number of single claims used to set the APC relative weights proposed for 2003 using this methodology. We requested comments on our methodology.

Discussion of the comments we received on this issue, our responses, and the statement of final action are contained in section III.A.

Packaging

We sought the Panel's guidance on whether we should package the costs of HCPCS codes for radiologic guidance and radiologic supervision and interpretation services whose descriptors require that they only be performed in conjunction with a surgical procedure.

In the proposed rule, we discussed why we package the costs of certain procedures. We specified for example, that ''add-on'' procedures and radiologic guidance procedures should never be billed on a claim without the code for an associated procedure. A facility should not submit a claim for ultrasound guidance for a biopsy unless the claim also includes the biopsy procedure, because the guidance is necessary only when a biopsy is performed. A claim for a packaged guidance procedure (or a supervision and interpretation procedure whose descriptor requires it be performed in association with a surgical procedure)

would be returned to the provider for correction and resubmission.

Also, we explained that we use packaging because billing conventions allow hospitals to report costs for certain services using only revenue center codes (that is, hospitals are not required to specify HCPCS codes for certain services). Packaging allows these costs to be captured in the data used to calculate median costs for services with an APC.

After hearing the requests of several presenters, (details discussed at 66 FR 52098 of the proposed rule) the Panel concluded that, even though we could be setting relative weights based on error claims, we should not package additional radiologic guidance and supervision and interpretation procedures and should continue to explore methodologies that would allow these procedures to be recognized for separate payment. The Panel also recommended that radiology guidance codes that were in APC 268 for CY 2001 but that were designated with status indicator ''N'' as packaged services in 2002, be restored as separately payable services for CY 2003. The Panel requested that this topic be placed on the agenda for the next Panel meeting.

Our discussion of the comments we received on this issue, our responses and a statement of final action is contained in section III.B.

Add-On Codes

As discussed in the proposed rule (66 FR 52098), we presented for the Panel's consideration several options for payment of add-on codes, including assignment of status indicator ''N'' to package them into the payment for the base procedure. After thorough review, the Panel concluded that we should continue to pay for add-on codes separately, setting relative weights with the use of single procedure claims in spite of the fact that these were error claims. The Panel asked us to continue exploring ways to most appropriately pay for these services. They requested that this item also be placed on the agenda for the next Panel meeting.

We proposed to accept the recommendations of the APC Panel both for packaging radiology guidance and supervision and interpretation codes and for payment of add-on codes. We proposed to pay separately in 2003 for radiology guidance codes that were paid in APC 268 in CY 2001 but that were packaged in 2002.

3. Recommendations of the Advisory Panel and Our Responses

In the proposed rule, we summarized the issues considered by the Panel, the Panel's APC recommendations and our subsequent action with regard to the Panel's recommendations. The most recent data available for the Panel to review in considering specific APC groupings were the 1999–2000 pre-OPPS claims data that were the basis of the CY 2002 relative payment weights. In the proposed rule, we provided a detailed summary of the Panel discussion and recommendations (67 FR 52098–52102). See the proposed rule for more details regarding these discussions. The APC titles are shown in this discussion of the APC Panel recommendations as they existed when the APC Panel met in January 2002. In a few cases the APC titles were changed for the proposed 2003 OPPS and therefore some APCs do not have the same title in Addendum A as they have in this section.

As discussed below, the Panel sometimes declined to recommend a change in an APC even though the APC violated the 2 times rule. In section II.B.1 of this preamble, we discuss our proposals regarding the 2 times rule based on the CY 2001 data we are using to recalibrate the 2003 APC relative weights. Section II.B.1 also details the criteria we use in deciding to make an exception to the 2 times rule. We asked the Panel to review many of the exceptions we implemented in 2001 and 2002. We refer to the exceptions as ''violations of the 2 times'' rule in the following discussion.

APC 215: Level I Nerve and Muscle Tests
APC 216: Level III Nerve and Muscle Tests
APC 218: Level II Nerve and Muscle Tests

We presented this agenda item because APC 215 appeared to violate the 2 times rule. In order to remedy this violation, we asked the Panel to consider the following changes:

- Move CPT codes 95858, 95921, and 95922 from APC 215 to APC 218.
- Move CPT code 95930 from APC 216 to APC 218.
- Move CPT code 92275 from APC 216 to APC 231.
- Move CPT code 95920 from APC 218 to APC 216.

The Panel recommended that the changes we asked them to consider be made, that is, to move CPT codes 95921 and 95922 to APC 218. However, if the calendar year 2001 data support a move of 95921 to APC 216, the Panel recommended that we consider that move.

APC 600: Low Level Clinic Visits
APC 601: Mid Level Clinic Visits
APC 602: High Level Clinic Visits
APC 610: Low Level Emergency Visits
APC 611: Mid Level Emergency Visits
APC 612: High Level Emergency Visits

We discussed the Panel's recommendations related to facility coding for clinic and emergency department visits are discussed below, in (section X.A of this rule).

APC 296: Level I Therapeutic Radiologic Procedures
APC 297: Level II Therapeutic Radiologic Procedures
APC 263: Level I Miscellaneous Radiology Procedures
APC 264: Level II Miscellaneous Radiology Procedures

APCs 296, 263, and 264 appear to violate the 2 times rule. We asked the Panel to consider three options for reconfiguring these APCs so that they would conform with the 2 times rule.

*Option 1*: Create a new APC, Level III Therapeutic Radiology Procedures, by moving CPT code 75984 from APC 296 and 74475 from APC 297. Also, move CPT codes 76101, 70390, and 71060 from APC 263 to APC 264 and move CPT code 75980 from APC 297 to APC 296.

*Option 2:* Move CPT codes 76101, 703690, and 71060 from APC 263 to APC 264 and move CPT code 75984 from APC 296 to APC 264. Move CPT code 75980 from APC 297 to APC 296.

*Option 3:* Create a new APC, Level III Miscellaneous Radiology

Procedures, by moving CPT codes 76080, 7036736, 76101, 70390, 74190, and 71060 from APC 263. Move CPT code 74327 from APC 296 to APC 263 and move CPT code 75980 from APC 297 to APC 296. APC 264 remains unchanged.

The Panel noted that none of the options that we presented resolve all of the 2 times violations. However, the Panel agreed that Option 2 would create more clinically coherent APCs without creating a new APC based on anticipated device costs that would be billed in 2002. In addition, the Panel invited the American College of Radiology and other interested parties to proposed further changes for the Panel's consideration next year.

We proposed to accept the Panel's recommendations that option 2 be implemented.

APC 230: Level I Eye Tests and Treatments
APC 231: Level III Eye Tests and Treatments
APC 232: Level I Anterior Segment Eye Procedures
APC 233: Level II Anterior Segment Eye Procedures
APC 234: Level III Anterior Segment Eye Procedures

APC 235: Level I Posterior Segment Eye Procedures
APC 236: Level II Posterior Segment Eye Procedures
APC 237: Level III Posterior Segment Eye Procedures
APC 238: Level I Repair and Plastic Eye Procedures
APC 239: Level II Repair and Plastic Eye Procedures
APC 240: Level III Repair and Plastic Eye Procedures
APC 241: Level IV Repair and Plastic Eye Procedures
APC 242: Level V Repair and Plastic Eye Procedures
APC 247: Laser Eye Procedures Except Retinal
APC 248: Laser Retinal Procedures
APC 698: Level II Eye Tests and Treatments
APC 699: Level IV Eye Tests and Treatments

We asked the Panel to review these APCs to address clinical inconsistencies and violations of the 2 times rule. We suggested creating a new level for posterior segment eye procedures and other changes in order to make the groups more clinically coherent, as follows:

- Move CPT codes 65260 and 67218 from APC 237 to 236.
- Create a new APC (Level IV Posterior Segment Eye Procedures) by moving CPT codes 67107, 67112, 67040, and 67108 from APC 237.
- Move CPT codes 67145, 67105, and 67210 from APC 247 to APC 248.
- Move CPT code 66999 from APC 247 to APC 232.
- Move CPT code 67299 from APC 248 to APC 235.
- Move CPT codes 65855, 66761, and 66821 from APC 248 to APC 247.
- Move CPT code 67820 from APC 698 to APC 230.
- Move CPT code 67208 from APC 231 to APC 235.
- Move CPT codes 92226, 92284, 65205, 92140 from APC 231 to APC 698.
- Move CPT code 92235 from APC 231 to APC 699.
- Move CPT code 68100 from APC 233 to APC 232.
- Move CPT code 65180 from APC 233 to APC 234.
- Create a new APC (Level IV Anterior Segment Eye Procedures) by moving CPT codes 66172, 66185, 66180, 66225 from APC 234.
- Move CPT code 92275 from APC 216 to APC 231.

No presenters commented on these APCs, and, after brief discussion, the Panel recommended concurrence with our suggested changes. We proposed to accept the Panel's recommendations. We noted in the proposed rule that when we were able to use 2001 claims data to re-evaluate the changes recommended by the Panel for these APCs, we found violations of the 2 times rule in the reconfigured APCs. Nonetheless, we proposed to accept the Panel's recommendations because they result in more clinically coherent APCs. We solicited comments on further changes that would address the violations of the 2 times rule.

APC 110: Transfusion
APC 111: Blood Product Exchange
APC 112: Apheresis, Photopheresis, and Plasmapheresis

We presented these APCs to the Panel in 2001 because of their low payment rates and concern that our cost data were inaccurate. These APCs were on the 2002 agenda in order to obtain further comment on our cost data. We suggested no changes in the structure of these APCs.

The Panel recommended that plasma derivatives be placed in their own APCs and classified in the same manner as whole blood products. In addition, the Panel observed that hospitals incur additional costs with each unit of blood product transfused and, therefore, recommended that APC 110 be revised to allow for the costs of additional units of blood product and clinical services.

In section IV.D of this rule, we discussed our payment proposals for drugs and biologicals for which pass-through payments are scheduled to expire in 2003. Those proposals would affect payment for blood and blood products. We proposed not to accept the Panel's recommendation to change current OPPS payment policy for transfusions.

Panel Recommendations to Defer Changes Pending Availability of 2001 Claims Data

Regarding the remaining APC groups that are addressed below, the Panel recommended that we make no changes until data from claims billed in 2001 under the OPPS become available for analysis. The Panel further requested that we place the APC groups in this section on the agenda for consideration at its meeting in 2003. The changes that we proposed for the APCs in this section are based upon our review of the 2001 claims data, which did not become available until March 2002.

APC 203: Level V Nerve Injections
APC 204: Level VI Nerve Injections
APC 206: Level III Nerve Injections
APC 207: Level IV Nerve Injections

Several presenters to the Panel suggested changes in the configuration of these APCs 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 the APCs. Several of these APCs include procedures associated with drugs or with device categories for which pass-through payments are scheduled to expire in 2003. The Panel recommended that we not change the structure of these APCs at this time. Because the structure of these APCs was substantially changed for 2002, and 2002 cost data was not yet available, the Panel felt it would be appropriate to review 2002 cost data prior to making further structural changes to these APCs. We proposed to accept the Panel's recommendation.

We will place these APCs on the Panel's agenda when 2002 cost data becomes available.

APC 43: Closed Treatment Fracture Finger/Toe/Trunk
APC 44: Closed Treatment Fracture/Dislocation, Except Finger/Toe/Trunk

On the basis of 1999–2000 claims data, these APCs violate the 2 times rule. The Panel reviewed these APCs and recommended no changes.

Our subsequent review of 2001 OPPS cost data shows continuing violations of the 2 times rule and that costs within these APCs are virtually identical. Therefore, we proposed to combine APCs 43 and 44 into APC 43. The procedures in the consolidated APC are clinically homogeneous.

APC 58: Level I Strapping and Cast Application
APC 59: Level II Strapping and Cast Application

The Panel reviewed these APCs and recommended that no changes be made pending analysis of 2001 claims data. The Panel did recommend that billing instructions be developed on the appropriate use of the codes in these APCs. We agreed with the Panel's recommendation regarding the need for billing instructions, and we expect to develop such instructions for hospitals to use in 2003.

Our subsequent review of 2001 claims data reveals that, in some cases, costs for short casts and splints are greater than costs for long casts and splints. Moreover, the proposed payments for these two APCs, based on 2001 OPPS data, would not differ significantly from each other. Therefore, we proposed to combine the codes in APC 58 and APC 59 into a single APC, APC 58. Combining these APCs does not compromise clinical homogeneity. The relative weight of the proposed single APC is virtually identical to the relative weight of each of the two current APCs. We proposed to continue to work with hospitals to develop appropriate coding

for these services and will review the appropriate APC structure for these services next year.

APC 279: Level I Angiography and Venography Except Extremity
APC 280: Level II Angiography and Venography Except Extremity

Without the benefit of 2001 OPPS claims data, it was difficult for the Panel to determine whether the apparent violation of the 2 times rule in APCs 279 and 280 was attributable to underreporting of procedures or inaccurate coding. Therefore, the Panel recommended no changes pending the availability of the more recent claims data. After subsequently reviewing the 2001 claims data, we proposed to move CPT codes 75978, Transluminal balloon angioplasty, venous, radiological supervision and interpretation, and 75774, Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation, to new APC 0668. This would resolve violations of the 2 times rule and result in clinically coherent APCs.

APC 115: Cannula/Access Device Procedures

We proposed to move CPT code 36860, External Cannula Declotting; without balloon catheter, to APC 103, Miscellaneous Vascular Procedures. We believe this makes both APC 115 and APC 103 more clinically homogeneous and it resolves a violation of the 2 times rule in APC 115 that was caused by the presence of CPT code 36860.

APC 93: Vascular Repair/Fistula Construction
APC 140: Esophageal Dilation without Endoscopy
APC 141: Upper GI Procedures
APC 142: Small Intestine Endoscopy
APC 143: Lower GI Endoscopy
APC 144: Diagnostic Anoscopy
APC 145: Therapeutic Anoscopy
APC 146: Level I Sigmoidoscopy
APC 147: Level II Sigmoidoscopy
APC 148: Level I Anal/Rectal Procedure
APC 149: Level II Anal/Rectal Procedure

Our subsequent review of 2001 claims data suggests that the cost data for APCs 144 and 145 are aberrant. The cost data for these APCs yield relative weights and payments that are significantly higher than the relative weights for APCs 146 and 147, which consist of similar procedures performed through a sigmoidoscope rather than an anoscope. As currently arranged, the APC configuration for these services could provide a financial incentive for hospitals to perform unnecessary anoscopic procedures, either alone or with a sigmoidoscopy. To rectify this problem, we proposed to move the procedures in APCs 144 and 145 to APC 147 with the exception of CPT code 46600, Anoscopy; diagnostic, which we proposed to assign to APC 340, Minor Ancillary procedures. We believe these changes would result in clinically coherent APCs with appropriate relative weights and payment rates.

APC 363: Otorhinolaryngologic Function Tests

Based on 2001 claims data, we proposed to move CPT codes 92543, 92588, 92520, 92546, 92516, 92548, and 92584 to new APC 0660 (Level III Otorhinolaryngolgic Function Tests). This change would resolve a 2 times rule violation and create clinically coherent APCs.

APC 96: Non-Invasive Vascular Studies
APC 265: Level I Diagnostic Ultrasound Except Vascular
APC 266: Level II Diagnostic Ultrasound Except Vascular
APC 267: Vascular Ultrasound
APC 269: Level I Echocardiogram Except Transesophageal
APC 270: Transesophageal Echocardiogram

The APC Panel recommended making no changes in the configuration of these APCs. Based on 2001 claims data, we proposed to make several changes in order to resolve 2 times rule violations and to make these APCs more clinically coherent. Specifically, we proposed to move CPT code 43499 from APC 0140 to APC 141; CPT code 93721 from APC 0096 to APC 368; CPT code 93740 from APC 0096 to APC 367; CPT code 93888 from APC 0267 to APC 266; and CPT code 93931 from APC 0267 to APC 266. We also proposed to move CPT codes 78627, 76825, and 93320 from APC 0269 to new APC 0671 to achieve more clinical coherence. We also proposed to create new APC 0670 for intravascular ultrasound and intracardiac echocardiography consisting of CPT codes 37250, 37251, 92978, 92979, and 93662.

APC 291: Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans
APC 292: Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans

Subsequent to the APC Panel meeting, we received comments on these APCs from the Nuclear Medicine Task Force. After a thorough review of that proposal within the context of the 2001 claims data, we proposed to accept the recommendations of the Nuclear Medicine Task Force, which would result in a complete reconfiguration of APCs 290, 291, and 292. Although the reconfiguration would create violations of the 2 times rule, we agree with the Task Force that the reconfigured APCs are more clinically coherent. We note that APCs 290, 291, and 292 as currently configured would also violate the 2 times rule. Therefore, we solicited comments on the proposed reconfiguration of APCs 290, 291, and 292 and on alternative groupings that would achieve clinical coherence without violating the 2 times rule.

APC 274: Myleography
APC 179: Urinary Incontinence Procedures
APC 182: Insertion of Penile Prosthesis
APC 19: Level I Excision/Biopsy
APC 20: Level II Excision/Biopsy
APC 21: Level IV Excision/Biopsy
APC 22: Level V Excision/Biopsy
PC 694: Level III Excision/Biopsy

Based on 2001 claims data, we proposed to move several codes from APC 19 to APC 20 and several codes from ACP 20 to APC 21. Additionally, we proposed to move CPT codes 11770, 54105, and 60512 to APC 22. We also proposed to move CPT code 58999 to APC 191 and CPT code 37799 to APC 35. These changes would result in clinically coherent APCs that do not violate the 2 times rule.

APC 24: Level I Skin Repair
APC 25: Level II Skin Repair
APC 26: Level III Skin Repair
APC 27: Level IV Skin Repair
APC 686: Level V Skin Repair

Based on 2001 claims data, we proposed to move CPT code 43870 from APC 0025 to APC 141; and CPT codes with high costs from APC 26 to APC 27. We also proposed to move the codes remaining in APC 26 to APC 25. APC 26 would then be deleted. These changes would result in a more compact APC structure without compromising the clinical homogeneity of the reconfigured APCs and without violating the 2 times rule. See Table 1 for the final list of codes to be moved from APC 26 to APC 25 or APC 27.

TABLE 1.—HCPCS CODES TO BE MOVED FROM APC 26 INTO APC 25 OR APC 27

| 2002 APC 26 | 2003 APC 25 | 2003 APC 27 |
|---|---|---|
| 11960 | | 11960 |
| 11970 | | 11970 |
| 12037 | 12037 | |
| 12047 | 12047 | |
| 12057 | 12057 | |
| 13150 | 13150 | |
| 13160 | | 13160 |
| 14000 | | 14000 |
| 14001 | | 14001 |

TABLE 1.—HCPCS CODES TO BE MOVED FROM APC 26 INTO APC 25 OR APC 27—Continued

| 2002 APC 26 | 2003 APC 25 | 2003 APC 27 |
|---|---|---|
| 14020 | | 14020 |
| 14021 | | 14021 |
| 14040 | | 14040 |
| 14041 | | 14041 |
| 14060 | | 14060 |
| 14061 | | 14061 |
| 14300 | | 14300 |
| 14350 | | 14350 |
| 15000 | 15000 | |
| 15001 | 15001 | |
| 15050 | 15050 | |
| 15101 | | 15101 |
| 15120 | | 15120 |
| 15121 | | 15121 |
| 15200 | | 15200 |
| 15201 | 15201 | |
| 15220 | | 15220 |
| 15221 | 15221 | |
| 15240 | | 15240 |
| 15241 | 15241 | |
| 15260 | | 15260 |
| 15261 | 15261 | |
| 15351 | | 15351 |
| 15400 | 15400 | |
| 15401 | 15401 | |
| 15570 | | 15570 |
| 15572 | | 15572 |
| 15574 | | 15574 |
| 15576 | | 15576 |
| 15600 | | 15600 |
| 15610 | | 15610 |
| 15620 | | 15620 |
| 15630 | | 15630 |
| 15650 | | 15650 |
| 15775 | 15775 | |
| 15776 | 15776 | |
| 15819 | 15819 | |
| 15820 | | 15820 |
| 15821 | | 15821 |
| 15822 | | 15822 |
| 15823 | | 15823 |
| 15825 | | 15825 |
| 15826 | | 15826 |
| 15829 | | 15829 |
| 15835 | 15835 | |
| 20101 | | 20101 |
| 20102 | | 20102 |
| 20910 | | 20910 |
| 20912 | | 20912 |
| 20920 | | 20920 |
| 20922 | | 20922 |
| 20926 | | 20926 |
| 23921 | 23921 | |
| 25929 | | 25929 |
| 33222 | | 33222 |
| 33223 | | 33223 |
| 44312 | | 44312 |
| 44340 | | 44340 |
| 15580—Code Deleted | | |
| 15625—Code Deleted | | |

APC 77: Level I Pulmonary Treatment
APC 78: Level II Pulmonary Treatment
APC 251: Level I ENT Procedures
APC 252: Level II ENT Procedures
APC 253: Level III ENT Procedures
APC 254: Level IV ENT Procedures
APC 256: Level V ENT Procedures

Based on 2001 claims data, we proposed to address violations of the 2 times rule by moving CPT codes 40812, 42330, and 21015 from APC 0252 to APC 253 and by moving CPT codes 41120 and 30520 to APC 254.

We are adopting the changes discussed in the proposed rule as final except as noted in our discussion of specific APC changes in section II.B, below.

*B. Other Changes Affecting Ambulatory Payment Classification (APC) Assignments*

1. Limit on Variation of Costs of Services Classified Within a 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 a 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 group in unusual cases such as low-volume items and services. No exception may be made, however, 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 APC changes discussed in relation to the APC panel recommendations in this section of this preamble and the use of 2001 claims data to calculate the median cost of procedures classified to APCs, we reviewed all 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).

We received several comments on this proposal. A summary of these comments and our responses are provided below.

*Comment:* One commenter recommended that we move CPT code 47556 (Biliary endoscopy with dilation of biliary stricture with stent) from APC 0152 to APC 0153 because its placement in APC 0152 violated the 2 times rule.

*Response:* We will not make any changes at this time, but we will present this issue to the APC Advisory Panel. We do not use low-volume procedures in determining whether an APC violates the 2 times rule because there is a high potential for miscoding of such procedures and because our cost data is less reliable. The cost data that we do have for CPT 47556 indicates that APC 0152 is appropriate.

*Comment:* Several commenters thanked us for creating a separate APC for Computed Tomographic Angiography (CTA) but requested that we not use claims data to develop a payment rate. These commenters asserted that our claims data was faulty because hospitals had not developed specific charges for CTA and were using charges for other Computed Tomography (CT) when billing for CTA. They recommended that we use either the relative ratio of charges from hospitals that billed CTA at a higher rate than CT and use that ratio to determine a payment rate for CTA, or use a proxy model that the commenter had developed.

*Response:* Our payment rates for CT and CTA are different and our claims data indicates that CTA costs more than CT. Using claims data only from hospitals that charge more for CTA than CT is inappropriate, and the proxy model has not been validated. Therefore, we will update our payment for CTA next year based on 2002 claims data.

Table 2 contains the final list of APCs that we exempt from the 2 times rule based on the criteria cited above. In cases in which compliance with the 2 times rule appeared to conflict with a recommendation of the APC Advisory Panel, we generally accepted the Panel recommendation. This was 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 2.—TABLE OF APCS EXEMPTED FROM 2 TIMES RULE

| APC | Description |
|---|---|
| 0012 | Level I Debridement & Destruction |
| 0019 | Level I Excision/ Biopsy |
| 0020 | Level II Excision/ Biopsy |
| 0025 | Level II Skin Repair |
| 0032 | Insertion of Central Venous/Arterial Catheter |
| 0043 | Closed Treatment Fracture Finger/ Toe/Trunk |
| 0046 | Open/Percutaneous Treatment Fracture or Dislocation |

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

| APC | Description |
|---|---|
| 0058 ..... | Level I Strapping and Cast Application |
| 0074 ..... | Level IV Endoscopy Upper Airway |
| 0080 ..... | Diagnostic Cardiac Catheterization |
| 0081 ..... | Non-Coronary Angioplasty or Atherectomy |
| 0093 ..... | Vascular Repair/Fistula Construction |
| 0097 ..... | Cardiac and Ambulatory Blood Pressure Monitoring |
| 0099 ..... | Electrocardiograms |
| 0103 ..... | Miscellaneous Vascular Procedures |
| 0105 ..... | Revision/Removal of Pacemakers, AICD, or Vascular |
| 0121 ..... | Level I Tube changes and Repositioning |
| 0140 ..... | Esophageal Dilation without Endoscopy |
| 0147 ..... | Level II Sigmoidoscopy |
| 0148 ..... | Level I Anal/Rectal Procedure |
| 0155 ..... | Level II Anal/Rectal Procedure |
| 0165 ..... | Level III Urinary and Anal Procedures |
| 0170 ..... | Dialysis |
| 0179 ..... | Urinary Incontinence Procedures |
| 0191 ..... | Level I Female Reproductive Proc |
| 0192 ..... | Level IV Female Reproductive Proc |
| 0203 ..... | Level VI Nerve Injections |
| 0204 ..... | Level I Nerve Injections |
| 0207 ..... | Level III Nerve Injection |
| 0218 ..... | Level II Nerve and Muscle Tests |
| 0225 ..... | Implantation of Neurostimulator Electrodes |
| 0230 ..... | Level I Eye Tests & Treatments |
| 0231 ..... | Level III Eye Tests & Treatments |
| 0233 ..... | Level II Anterior Segment Eye Procedures |
| 0235 ..... | Level I Posterior Segment Eye Procedures |
| 0238 ..... | Level I Repair and Plastic Eye Procedures |
| 0239 ..... | Level II Repair and Plastic Eye Procedures |
| 0252 ..... | Level II ENT Procedures |
| 0260 ..... | Level I Plain Film Except Teeth |
| 0274 ..... | Myelography |
| 0286 ..... | Myocardial Scans |
| 0290 ..... | Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans |
| 0291 ..... | Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans |
| 0294 ..... | Level I Therapeutic Nuclear Medicine |
| 0297 ..... | Level II Therapeutic Radiologic Procedures |
| 0303 ..... | Treatment Device Construction |
| 0304 ..... | Level I Therapeutic Radiation Treatment Preparation |
| 0330 ..... | Dental Procedures |
| 0345 ..... | Level I Transfusion Laboratory Procedures |
| 0354 ..... | Administration of Influenza/Pneumonia Vaccine |
| 0356 ..... | Level II Immunizations |
| 0367 ..... | Level I Pulmonary Test |
| 0368 ..... | Level II Pulmonary Tests |
| 0370 ..... | Allergy Tests |
| 0373 ..... | Neuropsychological Testing |
| 0600 ..... | Low Level Clinic Visits |

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

| APC | Description |
|---|---|
| 0602 ..... | High Level Clinic Visits |
| 0660 ..... | Level III Otorhinolaryngologic Function Tests |
| 0692 ..... | Electronic Analysis of Neurostimulator Pulse Generators |
| 0694 ..... | Mohs Surgery |
| 0698 ..... | Level II Eye Tests & Treatments |

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

In the November 30, 2001 final rule, we made final our proposal to change the period of time during which a service may be paid under a new technology APC (66 FR 59903), initially established in the April 7, 2000 final rule. That is, beginning in 2002, we will 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.

Effective in 2003, we will move several procedures from new technology APCs to clinical APCs. Those procedures and the clinical APCs to which we are assigning the procedures for payment in 2003 are identified in Table 3. Based upon our review of the 2001 outpatient prospective payment system (OPPS) claims data, we believe that we have sufficient information upon which to base assignment of these procedures to clinical APCs. In making this determination, we reviewed both single and multiple procedure claims. In the proposed rule at 67 FR 52103, we discuss the procedures that we followed to make this determination. In some cases we proposed classification of a new technology procedure in an APC with procedures that are similar both clinically and in terms of resource consumption. In other cases, we proposed to create a new APC for a new technology procedure because we do not believe any of the existing APCs contain procedures that are clinically similar and similar in terms of resource consumption. We solicited comments on our proposed reassignment of the new technology procedures listed in Table 3 of the proposed rule (67 FR 52103–52104).

We received several comments on this proposal which are summarized below.

*Comment:* Several commenters brought to our attention that, as a result of moving codes for proton beam radiation therapy out of APC 0710 and APC 0712 (new technology codes) and into APC 0664 (Proton beam radiation therapy), simple treatments would receive a higher payment while intermediate and complex treatments would receive a lower payment. Commenters requested that these codes remain in APCs 0710 and 0712 or be split into separate APCs.

*Response:* We thank the commenters for bringing this to our attention, and we agree that codes for simple proton beam radiation therapy (CPT 77522 and CPT 77520) should be placed in a different APC than codes for intermediate (CPT 77523) and complex (CPT 77525) radiation therapy. However, it would be inappropriate to return these codes to their previous new technology APCs (0712 and 0712) due to our having sufficient claims data to place them in their own APCs. Therefore, we will place codes for simple radiation therapy (CPTs 77522 and 77520) in APC 0664 and codes for intermediate (CPT 77523) and complex (CPT 77525) therapy in the newly created APC 0650.

*Comment:* Numerous commenters expressed concern over the movement of HCPC G0173 (Stereo radiosurgery, complete) from APC 0721 (New Technology Level XV $5,000–$6,000) to APC 0663 (Stereotactic radiosurgery), resulting in lower payment. Commenters requested that HCPCS G0173 be returned to APC 0721 (New Technology Level XV $5,000–$6,000) because our current data includes both linear accelerator and multi source treatments.

*Response:* We agree with commenters and have returned HCPC G0173 (Stereotactic radiosurgery, complete) to APC 0721 (New Technology Level XV $5,000–$6,000). We will review our claims data for next year's proposed rule to determine appropriate placement for all stereotactic radiosurgery procedures.

*Comment:* Many commenters brought to our attention that G0251 (Stereotactic radiotherapy, multisession) was erroneously omitted from the proposed rule. Commenters asserted that G0251 differs substantially from G0173 and G0243, and they requested that G0251 be reinstated and placed in an APC that pays more than APC 0721 (New Technology Level XV $5,000–$6,000).

*Response:* We thank the commenters for bringing this to our attention, and we agree that the elimination of G0251 in the proposed rule was in error. However, we do not agree with the

placement of G0251 in an APC that pays more than APC 0721 (New Technology Level XV $5,000–$6,000). Although there are significant fixed costs for all stereotactic radiosurgery procedures, our review of cost data does not show that our current APC assignment for G0251 (APC 713) is inappropriate. We will review the APC assignments for all stereotactic radiosurgery procedures next year when we have 2002 claims data available.

*Comment:* A commenter expressed concern over the bundling of payments for CPT 77370 (Special medical radiation physics consultation) and CPT 77336 (Continuing medical physics consultation) into code G0242 (Multisource photon stereotactic plan) based on the understanding that G0242 is unrelated to CPT 77370 and CPT 77336. The commenter requested that CPT 77370 and CPT 77336 be unbundled from G0242.

*Response:* We want hospitals to bill all resources associated with G0242 in one code. G0242 includes the work of a physicist and other staff, therefore it is appropriate that the resources used for CPT 77370 and CPT 77336 remain bundled with G0242. Separate payment for 77370 and 77336 would result in duplicate payment.

*Comment:* Many commenters expressed concern that FDG PET procedures are moving to a new clinical APC 0667 (Nonmyocardial positron emission tomography) with a payment of $971—a reduction of $404. The commenters asserted that although the proposed rule would continue separate pass-through payment for FDG (in APC 1775), the proposed new payment would not cover the cost of the PET procedure and would undermine access to care.

*Response:* We agree that our claims data may not accurately reflect the cost of FDG PET procedures.

On June 29, 2001, CMS announced its intention to issue a national coverage determination (NCD) limiting the type of technology that can be used to perform Medicare-covered PET scans. This NCD became effective January 1, 2002. We believe that our claims data includes a significant number of PET scans performed on coincidence cameras that are no longer covered by Medicare. This could have the effect of lowering the median cost as compared to our future claims data that will reflect (due to the NCD) only the use of full-ring or partial-ring PET scanners. For this reason, until we are confident that our claims data reflects the predominant use of dedicated PET scanners, we will continue to pay for FDG PET in APC 714 (New Technology—Level IX $1250–$1500) until further review of claims data for the 2004 final rule.

*Comment:* A commenter expressed concern about our proposal to reassign digital mammography from New Technology APC 0707 to a clinical APC (0699). Commenters recommended that we retain the assignment to New Technology APC 0707 for 1 more year until further data analysis can be performed.

*Response:* We disagree with the commenter. Hospitals billed for approximately 7,000 occurrences of digital mammography in 2001, providing us with sufficient data upon which to calculate a median cost.

New Technology APC Issues

*Comment:* A manufacturer was pleased that we designated endometrial cryoablation as eligible for new technology service APC payment, but was displeased at the delay in reaching our decision as well as the specific new technology service APC in which the service was placed. We proposed to place endometrial cryoablation into new technology service APC 980, which has a payment rate of $1,875. The commenter contended that endometrial cryoablation has similar resource costs as cryoablation of the prostate and should be assigned to new technology service APC 984, at $4,250, which would cover the cost of a cryoablation probe also. It provided a brief cost analysis from a single major medical center.

*Response:* We assigned endometrial cryoablation into new technology service APC 980 based on cost data submitted.

New Technology APC for Preview Planning Software

*Comment:* A manufacturer commented on our proposal to reassign the procedure related to Preview Treatment Planning Software (C9708) from its current APC 975, which pays $625, to APC 973, which pays $250. The manufacturer of Preview asserted that its sales records, which it provided, demonstrate that the cost to hospitals of providing Preview support the assignment of APC 975. It contended that we must have based the new APC assignment on faulty claims data.

*Response:* For the final rule, we had access to a larger number of claims for C9708, and we have moved it back to APC 975.

*Comment:* A manufacturer was pleased that we designated endometrial cryoablation as eligible for new technology service APC payment, but was displeased at the delay in reaching our decision as well as the specific new technology service APC in which the service was placed. We proposed to place endometrial cryoablation into new technology service APC 980, which has a payment rate of $1,875. The commenter contended that endometrial cryoablation has similar resource costs as cryoablation of the prostate and should be assigned to new technology service APC 984, at $4,250, which would cover the cost of a cryoablation probe also. It provided a brief cost analysis from a single major medical center.

*Response:* We assigned endometrial cryoablation into new technology service APC 980 based on cost data submitted.

Table 3 below is the final list of Healthcare Common Procedure Coding System (HCPCS) reassignments of new technology procedures.

TABLE 3.—CHANGES IN HCPCS ASSIGNMENTS FROM NEW TECHNOLOGY APCS TO PROCEDURE APCS FOR 2003

| HCPCS | Description | 2002 SI | 2003 SI | 2002 APC | 2003 APC |
|---|---|---|---|---|---|
| 19103 | Bx breast precut w/device | S | T | 0710 | 0658 |
| 33282 | Implant pat-active ht record | S | S | 0710 | 0680 |
| 36550 | Declot vascular device | T | T | 0972 | 0677 |
| 53850 | Prostatic microwave thermotx | T | T | 0982 | 0675 |
| 53852 | Prostatic rf thermotx | T | T | 0982 | 0675 |
| 55873 | Cryoablate prostate | T | T | 0982 | 0674 |
| 76075 | Dual energy x-ray study | S | S | 0707 | 0288 |
| 76076 | Dual energy x-ray study | S | S | 0707 | 0665 |
| 77520 | Proton trmt, simple w/o comp | S | S | 0710 | 0664 |
| 77522 | Proton trmt, simple w/comp | S | S | 0710 | 0664 |

TABLE 3.—CHANGES IN HCPCS ASSIGNMENTS FROM NEW TECHNOLOGY APCS TO PROCEDURE APCS FOR 2003—Continued

| HCPCS | Description | 2002 SI | 2003 SI | 2002 APC | 2003 APC |
|---|---|---|---|---|---|
| 77523 | Proton trmt, intermediate | S | S | 0712 | 0664 |
| 77525 | Proton treatment, complex | S | S | 0712 | 0664 |
| 92586 | Auditor evoke potent, limit | S | S | 0707 | 0218 |
| 95965 | Meg, spontaneous | T | S | 0972 | 0717 |
| 95966 | Meg, evoked, single | T | S | 0972 | 0714 |
| 95967 | Meg, evoked, each addl | T | S | 0972 | 0712 |
| C1300 | Hyperbaric oxygen | S | S | 0707 | 0659 |
| C9708 | Preview Tx Planning Software | T | T | 0975 | 0973 |
| G0125 | PET img WhBD sgl pulm ring | T | S | 0976 | 0667 |
| G0166 | Extrnl counterpulse, per tx | T | T | 0972 | 0678 |
| G0168 | Wound closure by adhesive | T | X | 0970 | 0340 |
| G0173 | Stereo radoisurgery, complete | S | S | 0721 | 0663 |
| G0204 | Diagnostic mammography digital | S | S | 0707 | 0669 |
| G0206 | Diagnostic mammography digital | S | S | 0707 | 0669 |
| G0210 | PET img whbd ring dxlung ca | S | S | 0714 | 0667 |
| G0211 | PET img whbd ring init lung | S | S | 0714 | 0667 |
| G0212 | PET img whbd ring restag lun | S | S | 0714 | 0667 |
| G0213 | PET img whbd ring dx colorec | S | S | 0714 | 0667 |
| G0214 | PET img whbd ring init colre | S | S | 0714 | 0667 |
| G0215 | PET img whbd restag col | S | S | 0714 | 0667 |
| G0216 | PET img whbd ring dx melanom | S | S | 0714 | 0667 |
| G0217 | PET img whbd ring init melan | S | S | 0714 | 0667 |
| G0218 | PET img whbd ring restag mel | S | S | 0714 | 0667 |
| G0220 | PET img whbd ring dx lymphom | S | S | 0714 | 0667 |
| G0221 | PET img whbd ring init lymph | S | S | 0714 | 0667 |
| G0222 | PET img whbd ring resta lymp | S | S | 0714 | 0667 |
| G0223 | PET img whbd reg ring dx hea | S | S | 0714 | 0667 |
| G0224 | PET img whbd reg ring ini hea | S | S | 0714 | 0667 |
| G0225 | PET img whbd ring restag hea | S | S | 0714 | 0667 |
| G0226 | PET img whbd dx esophag | S | S | 0714 | 0667 |
| G0227 | PET img whbd ring ini esopha | S | S | 0714 | 0667 |
| G0228 | PET img whbd ring restg esop | S | S | 0714 | 0667 |
| G0229 | PET img metabolic brain ring | S | S | 0714 | 0667 |
| G0230 | PET myocard viability ring | S | S | 0714 | 0667 |
| G0231 | PET WhBD colorec; gamma cam | S | S | 0714 | 0667 |
| G0232 | PET WhBD lymphoma; gamma cam | S | S | 0714 | 0667 |
| G0233 | PET WhBD melanoma; gamma cam | S | S | 0714 | 0667 |
| G0234 | PET WhBD pulm nod, gamma cam | S | S | 0714 | 0667 |

3. APC Assignment for New Codes Created During Calendar Year (CY) 2002 and Selected Codes and APC Assignments for 2003

During CY 2002, we created several HCPCS codes to describe services newly covered by Medicare and payable under the hospital OPPS. While we have assigned these services to APCs for CY 2002, we opened the assignments to public comment in the proposed rule. In addition, in the proposed rule, we proposed to create several new HCPCS codes and APC assignments with an effective date of January 1, 2003 and we solicited comments on these proposed codes and proposed APC assignments. Table 4 below includes new procedural HCPCS codes either created for implementation in July 2002, which we intend to implement in October 2002, or which we will implement in January 2003.

Table 4 does not include new codes for drugs and devices for which we established or intend to establish pass-through payment eligibility in July or October 2002.

TABLE 4.—NEW G CODES FOR 2002 AND 2003 FOR WHICH THERE ARE FINAL APC ASSIGNMENTS

| Code | Long descriptor | Effective | Final APC | SI |
|---|---|---|---|---|
| G0245 | Initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include: 1. The diagnosis of LOPS, 2. A patient history, 3. A physical examination that consists of at least the following elements: (a) Visual inspection of the forefoot, hindfoot, and toe web spaces, (b) Evaluation of a protective sensation, (c) Evaluation of foot structure and biomechanics, (d) Evaluation of vascular status and skin integrity, and (e) Evaluation and recommendation of footwear. 4. Patient education. | 7/1/2002 | 0600 | V |

TABLE 4.—NEW G CODES FOR 2002 AND 2003 FOR WHICH THERE ARE FINAL APC ASSIGNMENTS—Continued

| Code | Long descriptor | Effective | Final APC | SI |
|---|---|---|---|---|
| G0246 ..... | Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a LOPS to include at least the following: 1. A patient history. 2. A physical examination that includes: (a) Visual inspection of the forefoot, hindfoot, and toe web spaces, (b) Evaluation of protective sensation, (c) Evaluation of foot structure and biomechanics, (d) Evaluation of vascular status and skin integrity, and (e) Evaluation and recommendation of footwear. 3. Patient education. | 7/1/2002 | 0600 | V |
| G0247 ..... | Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include if present, at least the following: (1) local care of superficial wounds, (2) debridement of corns and calluses, and (3) trimming and debridement of nails. | 7/1/2002 | 0009 | T |
| G0248 ..... | Demonstration, at initial use, of home INR monitoring for patient with mechanical heart valve(s) who meets Medicare coverage criteria, under the direction of a physician; includes: demonstrating use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient ability to perform testing. | 7/1/2002 | 0708 | S |
| G0249 ..... | Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valve(s) who meets Medicare coverage criteria. Includes provision of materials for use in the home and reporting of test results to physician; per 4 tests. | 7/1/2002 | 0708 | S |
| G0250 ..... | Physician review, interpretation and patient management of home INR testing for a patient with mechanical heart valve(s) who meets other coverage criteria; per 4 tests (does not require face-to-face service). | 7/1/2002 | N/A | E |
| G0252 ..... | PET imaging, full and partial-ring PET scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g., initial staging of axillary lymph nodes). | 10/1/2002 | 0714 | S |
| G0253 ..... | PET imaging for breast cancer, full and partial-ring PET scanners only, staging/restaging of local regional recurrence or distant metastases (i.e., staging/restaging after or prior to course of treatment). | 10/1/2002 | 0714 | S |
| G0254 ..... | PET imaging for breast cancer, full and partial-ring PET scanners only, evaluation of response to treatment, performed during course of treatment. | 10/1/2002 | 0714 | S |
| G0255 ..... | Current perception threshold/sensory nerve conduction test, (sNCT) per limb, any nerve ..... | 10/1/2002 | N/A | E |
| G0258 ..... | Intravenous infusion during separately payable observation stay, per observation stay (must be reported with G0244). | 1/1/2003 | 0340 Deleted with 90-day grace period | X |
| G0257 ..... | Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility. | 1/1/2003 | 0170 | S |
| G0259 ..... | Injection procedure for sacroiliac joint; arthrography ..... | 1/1/2003 | N/A | N |
| G0260 ..... | Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent and arthrography. | 1/1/2003 | 0204 | T |
| G0256 ..... | Prostate brachytherapy using permanently implanted palladium seeds, including transperitoneal placement of needles or catheters into the prostate, cystoscopy and application of permanent interstitial radiation source. | 1/1/2003 | 0649 | T |
| G0261 ..... | Prostate brachytherapy using permanently implanted iodine seeds, including transperitoneal placement of needles or catheters into the prostate, cystoscopy and application of permanent interstitial radiation source. | 1/1/2003 | 684 | T |
| G0263 ..... | Direct admission of patient with diagnosis of congestive heart failure, chest pain or asthma for observation. | 1/1/2003 | N/A | N |
| G0264 ..... | Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma. | 1/1/2003 | 0600 | S |
| G0290 ..... | Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel. | 1/1/2003 | 0656 | E |
| G0291 ..... | Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel. | 1/1/2003 | 0656 | E |

HCPCS Codes Created During CY 2002

The G codes G0245 through G0250 were created to implement payment for newly covered Medicare services due to national coverage determinations. The G codes G0252–G0255 were established October 1, 2002, as a result of national coverage policies that became effective October 1, 2002. These codes were created to accurately describe the services covered, to ensure that they were reported correctly, to track their utilization, and to establish payment.

We solicited comments on the APC assignment of these services. The codes describing evaluation and management services were assigned to clinic visit APCs containing similar services, and the codes describing procedural services were assigned to new technology APCs or to APCs containing procedures requiring similar resource consumption. Because G0250 is a professional service furnished by a physician, it is not payable under OPPS.

We did not receive any comments on the codes or APC assignments for G0245, G0246, G0247, G0248, G0249, G0250, or G0255. Therefore, we are finalizing them as shown.

We are also finalizing APC assignments for G0252, G0253, and G0254. The comments and responses for these services are discussed elsewhere in this preamble.

We implemented HCPCS code G0258 (Intravenous Infusion(s) During Separately Payable Observation Stay)

effective October 1, 2002, to describe infusion therapy given during a separately payable observation stay. We assigned it to APC 0340 because we believed APC 0340 appropriately accounts for the resources used for infusion during observation. As discussed in section X.B, we received many comments opposing creation of this code. Therefore, we will delete it effective January 1, 2003.

New HCPCS Codes for January 1, 2003, for Which We Proposed APC Assignments in the August 9, 2002 Proposed Rule

In the August 9, 2002, proposed rule, we proposed to create several new HCPCS codes for 2003 to address issues that have come to our attention, to describe new technology procedures, to implement policy proposals discussed in the rule, and to allow more appropriate reporting of procedures currently described by (physician's) current procedural terminology (CPT) (HCPCS Level I) codes. The codes we proposed are as follows:

(1) G0FFF—Bone Marrow Aspiration and Biopsy Services—we proposed to create this code to describe bone marrow aspiration and biopsy performed through the same incision. We proposed to place this code in APC 0003. This code also appears in the proposed rule for the physician fee schedule, published in the June 28, 2002, issue of the **Federal Register** (67 FR 43846). This code would facilitate proper reporting of this procedure.

As discussed under general comments and responses below, we received many comments that objected to the proliferation of G codes for the services for which the CPT or HCPCS level II process could be used to create a code. After review of the comments, we agree that this code should go through the CPT process. Therefore, we have not implemented the G code we proposed. We will instead, submit a code for ''Bone Marrow Biopsy and Aspiration Performed in the Same Bone'' to CPT in time for the 2004 CPT code cycle.

(2) G0257—Unscheduled and Emergency Treatment for ESRD Patients—we proposed this code to facilitate payment for dialysis provided to ESRD patients in the outpatient department of a hospital that does not have a certified ESRD facility. The comments, responses, and final action regarding these services are discussed in section X.F of this rule.

(3) G0259 and G0260—Sacroiliac Joint Injections—we proposed to create these two codes to replace CPT code 27096, Injection procedure for sacroiliac joint, arthrography and/or anesthetic steroid. CPT code 27096 describes two distinct procedures requiring different resource consumption. Moreover, our policy of packaging injection procedures for imaging required packaging of this procedure even when it was used to report injection of a steroid or anesthetic. In these cases, it was appropriately billed without another procedure and should have been payable. Therefore, in order to facilitate appropriate reporting and payment for the procedures described by CPT code 27096, we proposed to create G0259, Injection procedure for sacroiliac joint, arthrography, and G0260, Injection procedure for sacroiliac joint, provision of anesthetic and/or steroid. We proposed to give G0259 status indicator N, and we proposed to assign G0260 to APC 0204.

*Comment:* Many commenters raised concern over nonpayment for sacroiliac joint injections. The commenter brings to our attention that when a sacroiliac joint injection, CPT code 27096 (Injection procedure for sacroiliac joint, arthrography and/or anesthetic steroid), is performed for anesthetic/steroid purposes, the procedure is not being paid since the costs are only packaged into the arthrography imaging component.

*Response:* We appreciate this concern and agree with the commenter that payment should be made for sacroiliac joint injections when administered for anesthetic/steroid purposes. Therefore, in order to facilitate appropriate reporting and payment for the procedures described by CPT code 27096 (Injection procedure for sacroiliac joint, arthrography and/or anesthetic steroid), we have created the following new G-codes to replace CPT code 27096: G0259 (Injection procedure for sacroiliac joint, arthrography) and G0260 (Injection procedure for sacroiliac joint, provision of anesthetic and/or steroid). G0259 has been given status indicator N, and G0260 has been assigned to APC 0204.

(4) G0KKK—Prostate Brachytherapy—we proposed this code to implement our policy decision discussed in section III.C.3 of the proposed rule (section IV.E of this rule). As a result of comments we created two new codes G0256 and G0261. See section IV.E. for the discussion of prostate brachytherapy.

(5) G0263 and G0264—Observation Care—we proposed to create these codes to describe observation care provided to a patient who is directly admitted from a physician's office to a hospital for observation care. We discussed these codes in detail in section VIII.B of the proposed rule. Our discussion of the final action, comments, and responses is contained in section X.B of this rule.

(6) G0290, G0291; Drug Eluting Stents—We discuss these codes in the immediately following section.

Drug-Eluting Stents

In the August 9, 2002 proposed rule, we discussed the exceptional circumstances that led us to propose a departure from our standard OPPS payment methodology as we have done under the inpatient PPS for Federal fiscal year (FY) 2003 (67 FR 50003–50005). We made this unusual proposal to ensure consistent payment for drug-eluting stents in both the inpatient and outpatient settings; to ensure that hospital resources are not negatively affected by a sudden surge in demand for this new technology if FDA approval is received; and to ensure that Medicare payment does not impede beneficiary access to what appears to be a potentially landmark advance in the treatment of coronary disease. Consistent with the special approach we implemented in the inpatient PPS final rule, we proposed to create two new HCPCS codes and a new APC that may be used to pay for the insertion of coronary artery drug-eluting stents under the OPPS to be effective if these stents receive FDA approval for general use. Of course, as with other new procedures, FDA approval does not mean that Medicare will always cover the approved item. Medicare coverage depends upon whether an item or service is medically necessary to treat an illness or injury as determined by Medicare contractors based on the specifics of individual cases.

The new HCPCS codes that we proposed are as follows:

G0290—Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel

G0291—Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel

We proposed to assign G0290 and G0291 to new APC 0656, Transcatheter Placement of Drug-Eluting Coronary Stents, with a status indicator of T.

To establish a payment amount for the proposed new APC, we proposed to apply the same assumptions that we used in establishing the weights for diagnosis-related group (DRG) 526 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with AMI) and DRG 527 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent Without AMI) as described in the final

rule implementing the FY 2003 inpatient PPS. That is, we assume a price differential of approximately $1,200 when drug-eluting stents are used. We assumed an average of 1.5 stents per procedure, and we proposed to add $1,200 to the median costs established for APC 0104 based on 2001 claims data to determine the payment rate for APC 656. We proposed to calculate a relative payment weight and payment rate for APC 0656 in accordance with the methodology that we discuss in section III.B. of this preamble.

We proposed to implement payment under APC 0656 effective April 1, 2003, consistent with the effective date for implementation of the drug-eluting DRGs under the OPPS and contingent upon FDA approval by that date. If the FDA grants approval prior to April 1, 2003, hospitals would be paid for insertion of coronary artery drug-eluting stents under APC 104. Such claims may qualify for outlier payments.

We proposed to establish the new HCPCS codes and APC group for coronary artery drug-eluting stents to allow close tracking of the utilization and costs associated with these services. In the proposed rule, we invited comments on this proposed methodology for recognizing the additional costs of drug-eluting stents under the OPPS.

*Comment:* All of the commenters who addressed our payment proposal for drug-eluting stents supported our taking proactive steps to create an APC for this new technology in anticipation of FDA approval by April 2003. However, most of the commenters expressed concern about the level of payment proposed for APC 656, stating that $1,200 significantly understates the added cost of the drug-eluting stents. One commenter suggested that indications from the market are projecting a cost of $2,000 per stent. Another commenter cited vendors who indicate that drug-eluting stents will cost 3 times the cost of the current stent for an approximate cost of $3,360 each. Several commenters stated that the incremental cost between a bare metal and a drug-eluting stent is expected to be $2,000. Two commenters urged us to set the rate for APC 656 based on the actual price difference between the current and drug-eluting stents, and one commenter recommended setting the initial payment amount at a level that is 60 percent above the probable hospital acquisition cost. One commenter asked why we added $1,200 to APC 656 rather than $1,800. The basis for this request was that the incremental payment for inpatient care was $1,800 for an average of 1.5 stents per procedure.

*Response:* To establish a payment rate for APC 656, we proposed to add $1,200 to the median cost of stent insertion procedures in APC 104, based on assumptions that we applied to establish the weights for DRGs involving drug-eluting stents under the inpatient PPS. Based on the median cost established for APC 104 using the 2001 claims data that were reflected in the August 9, 2002 proposed rates, we determined that an additional $1,200 would offset the incremental cost of an average of 1.5 drug-eluting stents per procedure.

We do not agree that the incremental payment should be $1,800. Although it is true that 1.5 stents are typically placed per procedure, it is rare for two stents to be placed in one coronary artery in an outpatient setting. Furthermore, hospitals can bill under the OPPS a separate code for each vessel in which a stent is placed, unlike the inpatient PPS. Because hospitals will in most cases be able to report each stent placement separately in the outpatient setting, making an incremental payment of $1800 would significantly overpay for each stent.

As we explain elsewhere in this preamble, the payment rates that this final rule implements are based on more current data than those that were available when we set the rates proposed in the August 9, 2002 rule. The rates in this final rule also reflect adjustments intended to level the transition from rates based on pre-OPPS data and estimated pass-through device and drug costs to rates based entirely on OPPS data that reflect actual device and drug costs reported by hospitals.

*Comment:* One commenter expressed concern about our expectation that a new technology must ''transform'' medical care and be the object of substantial demand in order to justify making an exception to our standard OPPS payment methodology. The commenter believes that our rationale for making an exception for drug-eluting stents establishes an almost unattainable threshold for other technologies to reach in order to receive similar treatment in the future. Conversely, another commenter expressed concern that by establishing codes and payment rates for drug-eluting stents, we are setting a precedent that will likely increase the pressure to create new temporary codes for non-breakthrough technologies. This commenter encouraged us to maintain highly selective criteria when creating new codes for new technologies in the future.

*Response:* As we explain at length in the August 9, 2002 proposed rule, we believe that drug-eluting stents are potentially a revolutionary approach to the treatment of coronary disease. Ordinarily, we would expect a new technology like the drug-eluting stent to qualify for a pass-through payment or for payment under a new technology APC.

However, because the drug-eluting stent does not meet the criteria established for these two methods of payment for new technology under the OPPS, we were compelled to seek an alternative approach in order to ensure beneficiary access to this extraordinary new treatment, once it receives FDA approval, without placing an extraordinary burden on hospital resources. We expect that either a pass-through payment or assignment to a new technology APC will, in the overwhelming preponderance of cases, provide adequate and timely payment under the OPPS for new technology. We agree with the commenter who supported maintaining highly selective standards when establishing codes for new technology. The threshold for such an approach must be exceptionally high and applicable only in the most extraordinary and unusual cases.

*Comment:* One commenter asked that we clarify how we will adjust the 2003 OPPS payment rates if FDA approval is not given for drug-eluting stents by April 1, 2003. The commenter is concerned about the adverse effect on the rates for other services that would result from our having recalibrated and scaled the relative payment weights for all services, taking into account additional payment for drug-eluting stents that turns out not to be an expenditure.

*Response:* We have reviewed the impact of the drug-eluting stents on the total recalibration exercise and determined that excluding the additional allowance for the drug-eluting stents would not result in a significant redistribution of funds for other services if FDA approval were not issued by April 1, 2003, triggering payment under the OPPS. We estimated that slightly fewer than one-third of the cases paid under APC 104 (approximately 5,400 procedures) would be performed using drug-eluting stents during the three quarters of 2003 when payment would be made for APC 656, assuming FDA approval is issued by April 1, 2003. Payment for the use of drug-eluting stents represents approximately 0.17 percent of the total APC weights. Restoration of these payments to the pool of weights for other services would not measurably

change the weights of the other APCs. Therefore, we would not revise the 2003 APC weights if payment for drug-eluting stents were not allowed beginning April 1, 2003.

*Comment:* One commenter expressed concern that the general use of data from other countries to set the national payment rate for a new device in the absence of hospital claims and cost data raises long term issues regarding the impact this approach would have on manufacturers' investment and pricing strategies, both abroad and in the United States. The commenter recommended that we consider these issues in more depth.

*Response:* We respond to this issue in our discussion of MedPAC comments in section XI.

*Comment:* One commenter recommended that we carefully monitor the use of APCs for which the national payment rate is established based on pricing in countries other than the United States and the costs reported by hospitals for those APCs. Another commenter stated that the new HCPCS codes for the drug-eluting stent procedures should be temporary and that we should ask the CPT Editorial Board to develop national CPT codes as soon as possible.

*Response:* As we indicated in the August 9, 2002 proposed rule, we intend to closely track the utilization and costs associated with the drug-eluting stents. We established the G-codes for the use of drug-eluting stents precisely in order to permit us to collect these data. However, the cost data taken from hospital claims associated with the use of the drug-eluting stents will ultimately be incorporated into the current CPT codes for coronary stent placement. We believe that the current CPT codes describe the procedure adequately and that separate permanent codes specific to the use of drug-eluting stents are not necessary based on the expectation that drug-eluting stents will eventually become the standard of care.

Effective for services furnished on or after April 1, 2003, contingent upon FDA approval of the drug-eluting stents, we are implementing payment under APC 656, Transcatheter Placement of Drug-Eluting Coronary Stents, for two temporary HCPCS codes:

G0290 Transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel.

G0291 Transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel.

Note that Table 6 and Addendum B show status indicator E for HCPCS codes G0290 and G0291 since payment under these codes will not be effective before April 1, 2001. However, we include the APC for drug eluting stent procedures (APC 0656) in Addendum A with the payment rate and status indicator of T to identify how these new codes will be paid once they are implemented.

If the FDA grants approval before April 1, 2003, hospitals will be paid for placement of drug-eluting stents under APC 104. If the FDA does not grant approval by April 1, 2003, we will announce a new effective date for APC 0656 and for HCPCS codes G0290 and G0291 by Program Memorandum.

G codes for Outpatient Services Under National Clinical Trials

We have created three new G codes for use in reporting services furnished in hospital outpatient departments under national clinical trials: G0292 Administration(s) of experimental drug(s) only in a Medicare qualifying clinical trial (includes administration for chemotherapy and other types of therapy via infusion and/or other than infusion), per day.

G0293 Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a Medicare qualifying clinical trial, per day.

G0294 Noncovered surgical procedure(s) using either no anesthesia or local anesthesia only, in a Medicare qualifying clinical trial, per day.

On September 19, 2000, Medicare issued a national coverage decision stating that Medicare will pay for the routine costs of clinical trials. This policy is published as section 30–1 of Medicare's Coverage Issues Manual. Because the experimental intervention is not covered but items and services required solely because of the intervention are covered, we needed to identify ways to properly code for and pay for the routine costs when delivered in a hospital outpatient department.

We believe that to accurately pay for the covered services associated with the administration of drugs as part of a clinical trial, we need to create a new code to allow for correct billing and payment for routine costs, as defined by the national coverage determination. Therefore, the code G0292, ''Administration(s) of experimental drug(s) only in a Medicare qualifying clinical trial (includes administration for chemotherapy and other types of therapy via infusion and/or other than infusion), per day,'' should be billed when only experimental drugs are administered as part of a Medicare qualifying clinical trial. When an experimental drug is being administered in conjunction with payable drugs or on the same day as payable drugs, G0292 should not be used. Instead, the appropriate drug administration code should be billed.

There are also procedures that may be performed in the hospital outpatient department as part of a qualifying clinical trial. Because the intervention is not covered under Medicare's clinical trial policy, we need a mechanism to pay the hospital for its covered fixed costs associated with providing the service under the clinical trial. We have created two codes to allow for correct billing of procedures performed as the focus of qualifying clinical trials, G0293 and G0294. G0293 is defined as ''Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a Medicare qualifying clinical trial, per day,'' and G0294 is defined as ''Noncovered surgical procedure(s) using either no anesthesia or local anesthesia only, in a Medicare qualifying clinical trial, per day.''

All three of these codes are for OPPS use only. Other provider types may not bill these codes.

The interim APC assignments for G0292, G0293, and G0294 are APC 0708, 0710, and 0707, respectively. The status indicator for these three codes is S. As discussed below, this APC assignment is subject to comment during the comment period discussed in section I of this rule.

General comments on creation and use of G codes

*Comment:* Several commenters were concerned about the creation of G codes with long descriptors that appear complex and specific to OPPS rules. In addition, we received comments indicating that the hospital coding community was less familiar with G codes and requesting that CMS consider other existing code sets.

*Response:* Prior to the creation of any G code, we examine alternative mechanisms for implementing coverage and payment policy in a timely fashion. In the event no other appropriate mechanism exists, we create a G code to allow accurate payment given applicable statutory and regulatory requirements. After the creation of a G code, we work with the American Medical Association's Current Procedural Terminology (CPT) Editorial Panel whenever possible to create a replacement CPT code. We are deleting 25 G codes this year as a result of this process. However, there are instances

where G codes cannot be converted to CPT codes due to the unique nature of the statutory and regulatory requirements. In these situations, we work to educate the provider community as to the appropriate use of these codes. Part of this educational effort includes the development of comprehensive descriptors at the time the G code is created.

*Comment:* Two commenters indicated they would like to see a shorter timeframe between the FDA approval for a new drug and the development of a HCPCS code for that drug.

*Response:* The FDA approval process is one source of information we use in reviewing new drugs. However, the FDA process does not address the statutory and regulatory requirements of the Medicare program. We perform our review of new drugs as expeditiously as possible given these requirements. We are conscious of the need to streamline this process and we will continue to seek ways to do so.

Public Comments on Interim APC Assignments for Codes New for 2003

As discussed in section I, we are accepting public comment on the interim APC assignments for the new codes shown in Addendum A with the indicator NI. These codes are new for 2003 and the APC assignment was not subjected to public comment in the August 9, 2002 proposed rule. We are not accepting comment on APC assignments that were proposed in the August 9, 2002 proposed rule and are being shown as NF in Addendum B since they have already been subjected to public comment and are made final in this rule.

*Comment:* Several commenters expressed concern about the increasing frequency of G codes issued by CMS. Commenters asserted that, in the interest of coding standardization, clarity, and accuracy, G codes should be developed only as a last resort. Commenters also stated that G codes sometimes overlap or duplicate other code sets. One commenter recommended a single, standardized process for establishment of temporary HCPCS Level II codes, ensuring that a duplicate or overlapping code is not anticipated in another coding set (for example, CPT).

*Response:* We agree that, where appropriate, G codes should be temporary. Unfortunately, it is sometimes necessary to develop G codes to accommodate changes in legislation, regulation, coverage, and payment policy. Not only is the timetable for such changes inconsistent with the timetable for CPT publication, but frequently these changes must be made on a quarterly basis.

In 2002, CMS and CPT staff, working together, reviewed all existing G codes and agreed to transition over 20 of them to CPT codes. Therefore, for 2003 many G codes will be deleted in favor of newly created CPT codes. We believe that an annual review of G codes by CMS and CPT staff is the best way to determine which G codes should be transitioned to CPT codes and the process to use for such a transition. Therefore, we plan to continue working with CPT staff on an annual basis to continue transitioning existing G codes to CPT codes. We believe such an annual, comprehensive review will address the commenters' concerns. However, we do wish to emphasize that CMS, where appropriate, does consult with interested providers prior to the creation of G codes in order to facilitate coding clarity and minimize the coding burden on hospitals.

4. Other Public Comments on APC Assignments and Payment Rates

*Comment:* One commenter asked us to create three new tech APCs for cardiac resynchronization therapy, or, alternatively, to establish a new tech APC payment for placement of the left ventricular lead used in cardiac resynchronization therapy.

*Response:* We have placed the CPT codes for left ventricular lead placement in new tech APCs. We believe the APC placement accounts for the cost of the procedure and for the lead. The cost of the guidewires and catheters used in the procedure will be captured in the code used to report placement of the pacemaker or cardioverter defibrillator and other leads.

*Comment:* Several commenters were concerned about bundling payment of radiopharmaceuticals into procedures and about payment reductions for myocardial perfusion scanning.

*Response:* Payment for most myocardial perfusion scans will increase in 2003 and the payment reduction for scans in APC 666 is commensurate with the costs of performing those procedures. The issue of packaging radiopharmaceuticals is discussed elsewhere in this preamble.

*Comment:* A commenter expressed concern about CMS's decision to discontinue the pass-through category C1780 (New Technology Intraocular Lens (IOLs)). The commenter stated that the proposal to eliminate this code from pass through status and separate payment contradicts existing regulations.

*Response:* We do not agree that our proposal contradicts existing regulations. We believe the commenter is referring to § 141 (b) of the Social Security Act Amendments of 1994 (Public Law 103–432) that requires us to implement a process under which interested parties may request a review of the appropriateness of payment for IOLs furnished by ambulatory surgical centers (ASCs). In compliance with this statutory change, we published regulations concerning payment for IOLs in ASCs (42 CFR 416). Those regulations do not apply to the payment for such lenses furnished to patients of hospital outpatient departments. As described elsewhere in the final rule, the cost of IOLs, along with the costs of other sunsetting pass through devices, is reflected in the median cost and thus the payment for the procedures with which IOLs are used.

*Comment:* A commenter asserted that the current description of HCPCS code J2790 is flawed. According to the commenter, the description of ''1 dose package'' does not accurately describe the two sizes of dosage units available in the marketplace for different indications (50 mcg and 300 mcg). The commenter expressed hope that an application for new HCPCS codes would be approved, and the commenter also requested that we establish separate payment rates for this product based upon the distinction between the two dosages. The commenter noted that current ''Redbook'' average wholesale price (AWP) for the 50 mcg dose is $53.90; for the 300 mcg dose, it is $126.14.

*Response:* We reviewed the hospital charge data upon which the payment amount for this code must be based. In the absence of separate codes for two different product sizes, we are unable to determine a separate median cost per encounter for the two sizes. We can only base our determination about this product on existing data that represents the current descriptor of this code. We note that, in using the latest set of OPPS claims data available for the final rule, the median cost per encounter of this code was below the $150 threshold. Therefore, this code will be packaged in 2003.

*Comment:* A commenter requested that we create new HCPCS codes, one for digital-based computer-aided detection (CAD) with screening mammography and one for digital-based CAD with diagnostic mammography.

*Response:* When the computer-aided detection codes were originally assigned, there was minimal use of CAD in conjunction with direct digital mammography. The current descriptors of both HCPCS G0236 and CPT code 76085 do not explicitly state that these

services can be billed in conjunction with either direct digital images or standard film images converted to digital images for this reason. We agree with the commenter that use of CAD with direct digital images should be reportable. Therefore, we have revised the descriptor of HCPCS code G0236 to include conversion of both direct digital images and standard film images converted to digital images. Additionally, we will request that the CPT editorial panel review the current definition associated with the screening computer-aided detection code (CPT code 76085) for future revision. Until any such revision is made to CPT code 76085, hospitals should use CPT code 76085 for reporting application of CAD to both direct digital screening images and standard film images.

The descriptor for G0236 has been revised to read as follows: digitalization of film radiographic images with computer analysis for lesion detection, or computer analysis of digital mammogram for lesion detection, and further physician review for interpretation, diagnostic mammography (list separately in addition to code for primary procedure). We believe that we have sufficient claims data to use in assigning digital mammography to an APC.

*Comment:* Several commenters expressed concern over the payment rate reduction for CPT 52353 (Cystoureteroscopy with lithotripsy) in APC 0163 (Level IV Cystourethroscopy and other genitourinary procedures). Commenters also requested that we place CPT 52353 in APC 0169 (Lithotripsy).

*Response:* Movement of CPT 52353 to APC 0169 would result in APC 0169 no longer being clinically homogenous, therefore CPT 52353 (Cystoureteroscopy with lithotripsy) will remain in APC 0163 (Lithotripsy) with other similar procedures.

*Comment:* Several commenters brought to our attention that placing CPT 52234 (removal of small tumors) and CPT 52235 (removal of medium tumors) in APC 163 (Level IV Cystourethroscopy) instead of APC 0162 (Level III Cystourethroscopy) would adversely affect the payment rate for APC 0163, which contains several more costly procedures. Furthermore, commenters stated that it seemed illogical for CPT 52234 (removal of small tumors) and CPT 52235 (removal of medium tumors) to be placed in APC 0163 while CPT 52224 (removal of minor tumors) and CPT 52240 (removal of large tumors) were placed in APC 0162 (Level III Cystourethroscopy). These commenters requested that these four codes be placed together in APC 0162 (Level III Cystourethroscopy).

*Response:* We agree with commenters and have placed CPT codes 52234 and 52235 in APC 0162 (Level III Cystourethroscopy). This result is a significant increase in payment for APC 0163 while maintaining an appropriate payment rate for CPT codes 52234 and 52235.

*Comment:* A commenter stated that APC 0100 (Cardiac stress tests) carries a proposed payment rate of $69.69, which the commenter believes does not sufficiently cover the cost of CPT 93025 (Microvolt t-wave alternans). The commenter requested that CPT 93025 be assigned to an APC that pays in the $250 range.

*Response:* CPT 93025 (Microvolt t-wave assessment) is frequently performed simultaneously with CPT 93017 (Cardiovascular stress test) (that is, the patient is placed on a treadmill once and data for the stress test and Microvolt t-wave alternans are obtained simultaneously), achieving significant economies of scale. Therefore we will keep CPT 93025 (Microvolt t-wave assessment) in APC 0100 (Cardiac stress tests). However, we will review this request again next year when we have more claims data for 93025.

*Comment:* We received several comments urging that CPT 52647 (Laser surgery of prostate) be placed in a higher paying APC than APC 0163 (Level IV Cystourethroscopy and other genitourinary procedures) in order to cover the cost of a new laser source involved in this procedure.

*Response:* We have significant claims for this procedure. Any costs associated with new technology developed to perform this procedure should be reflected in future claims data, insofar as the new technology is used, and will be reflected in our updated payment rates. Because we have sufficient claims data indicating the appropriate placement of this service is in APC 0163, CPT 52647 (Laser surgery of prostate) will remain in APC 0163.

*Comment:* A commenter urged that we maintain a separate APC for items currently billed under C1784 (Ocular device, intraoperative, detached retina). The commenter stated that separate coding and payment would ensure that the procedure groupings maintain their clinical homogeneity and remain similar with respect to resource consumption.

*Response:* We do not agree that a separate APC for items currently billed under C1784 (Ocular device, intraoperative, detached retina) is necessary to maintain clinical homogeneity or to remain similar with respect to resource consumption. Therefore, items currently billed under C1784 will not remain in a separate APC. However, we will present this issue to the Advisory Panel on Ambulatory Payment Classification Groups (the APC Advisory Panel) next year for further review.

*Comment:* A commenter expressed concern over the movement of CPT 15000 (surgical debridement) from APC 0026 (Level III Skin repair) to APC 0025 (Level II Skin repair) due to the consolidation of these APCs. The commenter believed that if CPT 15000 and CPT 15342 (Cultured skin graft, 25 cm) were placed in the same APC that separate payment would not be made for both procedures.

*Response:* The commenter is incorrect. Separate payment will be made for both procedures even if they are in the same APC. Because this APC has a status indicator of ''T,'' payment of the full APC amount will be made for the first procedure and 50 percent of the APC amount will be paid for the second procedure. Furthermore, we believe that the codes within APC 0025 are clinically homogeneous and do not violate the 2 times rule. Therefore, we will not move either of these procedures into a different APC.

*Comment:* Several commenters stated that autonomic nervous system (ANS) services (HCPCS 95921 and 95922) are incongruent with the services grouped in APC 0218. The commenter asserted that ANS tests are more appropriately grouped in APC 0216 when evaluated on the basis of complexity and resources used.

*Response:* The APC Advisory Panel reviewed this issue and recommended that we move HCPCS 95921 and 95922 to APC 0216 only if our claims data supported such a move. Since our claims data did not support such a move, HCPCS 95921 and 95922 will remain in APC 0218. However, we will present this concern to the APC Advisory Panel again next year.

*Comment:* A commenter expressed concern over the combination of skin tests and miscellaneous red blood cell tests in APC 0341. The commenter asserted that the services within this group cannot be considered comparable with respect to the resources used. The commenter recommended the creation of a new APC titled, ''Miscellaneous Red Blood Cell Tests'' and suggested that the new APC contain the following HCPCS codes: 86880, 86885, 86886, 86900, and 86901.

*Response:* We do not agree with the commenter's assertion that the skin tests and miscellaneous red blood cell tests in APC 0341 are not comparable with respect to the resources used. However,

we will present this issue to the APC Advisory Panel.

*Comment:* A commenter asserts that HCPCS 86915 (Bone marrow/stem cell prep) does not fit within APC 346 (Level II Transfusion Laboratory Procedures) and should be moved to the highest paying Transfusion Laboratory Procedures APC 347(Level III Transfusion Laboratory Procedures). Similarly HCPCS 86932 (Frozen blood freeze/thaw) is more properly categorized with its sister codes (HCPCS 86930 and 86931) in APC 347.

*Response:* We thank the commenter and agree that CPT code 86915 (Bone marrow/stem cell prep) is not appropriately placed in APC 0346 (Level II Transfusion Laboratory Procedures). Therefore, we have moved HCPC 86915 to APC 0110 (Transfusion). This change maintains the clinical homogeneity of APC 110 and allows a more appropriate payment for CPT code 86915. We also agree with the commenter that CPT code 86932 is more appropriately assigned to APC 0347 based on resource consumption; therefore, we have assigned HCPC 86932 to APC 0347.

*Comment:* Several commenters asserted that the placement of all prosthetic urological procedures and devices in APC 0182 (Insertion of penile prosthesis) does not adequately reflect the difference in cost between inflatable and non-inflatable penile prostheses. These commenters suggested that CPTs 54401, 54405, and 54410 (codes for inflatable penile prosthesis) be separated from CPTs 54400, 54402, and 54416 (codes for insertion of penile prosthesis) and that the status indicator for APCs 0182 (Insertion of penile prosthesis) and 0179 (Insertion of artificial urinary sphincters) be changed from ''T'' to ''S.''

*Response:* To the extent that no facility specializes in implanting inflatable penile prostheses, the APC payment should, on average, be appropriate. Therefore, we will not make any changes in APC 182 at this time. However, we will present this issue to the APC Advisory Panel next year. In addition, the status indicator for APCs 0182 (Insertion of penile prosthesis) and 0179 (Insertion of artificial urinary sphincters) will remain a ''T.'' These APCs will rarely, if ever, be reported with a higher paying APC and thus rarely subject to reduction.

*Comment:* Several commenters were concerned about the large reduction in payment for APC 0222 (Implantation of Neurological Device) and APC 0225 (Implantation of Neurostimulator). They suggested that we continue the use of pass through codes or use manufacturer submitted device cost data, or hospital invoice data, to determine payment rates for these procedures. One commenter also suggested creating a new APC specifically to capture the costs of one brand of devices.

*Response:* We are also concerned about the payment reduction to these APCs (and other APCs) and have taken steps to address these reductions. Such steps are discussed elsewhere in this rule. For these APCs, we developed relative weights using only claims that contained C codes for devices and in addition we limited the absolute payment reduction. Furthermore, because APCs 0022 and 0225 may be billed together, we have changed the status indicator of APC 0225 to ''S.'' This means that APC 0225 will not be subject to a 50 percent reduction in payment when billed with APC 0222. We believe that the measures we have taken should address the concerns of the commenters.

*Comment:* Several commenters agreed with our proposal to make separate payment for radiological guidance procedures.

*Response:* We thank these commenters and are finalizing our proposal.

*Comment:* One commenter, who performs digital reconstruction of computed tomographic angiography images, stated that the claims data upon which we based our proposed payment rate for C9708 was flawed and that we should use other data sources in determining a payment rate for this code.

*Response:* In developing the final rule, we had access to a larger number of claims for C9708 and have concluded our proposed payment rate was inappropriate. Accordingly, we will not finalize our proposal, and C9708 will continue to be paid in APC 0975.

*Comment:* One commenter requested that guidance be provided on proper use of codes for strapping and casting (APCs 58 and 59).

*Response:* We agree with the commenter and will work with appropriate experts to provide such guidance. In view of the similar costs for all of these procedures in our current data, we will combine these two APCs (as we proposed), as this is administratively easier for hospitals.

*Comment:* One commenter disagreed with our proposal to combine APCs 0043 and 0044, as more work is involved in treating a fractured leg than a fractured toe.

*Response:* Our claims data indicates that the hospital resources involved in all of these procedures are very similar. Therefore, we are finalizing our proposal.

*Comment:* One commenter agreed with our moving all procedures in APCs 0144 and 0145 into APC 0147 but disagreed with our moving CPT code 46600 (diagnostic anoscopy) into APC 0340.

*Response:* We disagree. We had a substantial number of single procedure claims for CPT 46600, and the median cost for CPT 46600 makes it appropriate for placement in APC 0340. We are finalizing our proposal.

*Comment:* One commenter objected to our placement of impedence cardiography in APC 0099. The commenter stated that even though APC 0099 was clinically homogeneous, the resources required for impedence cardiography were greater than the resources required to perform other procedures in the APC.

*Response:* We disagree. The resources used for the procedures in this APC are similar, and it is clinically homogeneous. We are not making any changes in this APC at this time.

*Comment:* One commenter requested that we move CPT code 95955 (EEG during non intracranial surgery) to APC 213 and that we move CPT code 95904 (Sensory nerve conduction) to APC 0218.

*Response:* We are not making any changes at this time because our claims data indicates that these procedures are appropriately placed. However, we will present these concerns to the APC Advisory Panel.

*Comment:* One commenter requested that we move CPT code 0009T (Endometrial cryoablation) to APC 0984 because it should have a payment rate similar to prostate cryoablation (CPT code 55873).

*Response:* We have placed CPT code 0009T in APC 0980. Based on the information that we have reviewed, we believe that is an appropriate assignment. CPT 0009T is a significantly shorter procedure than CPT 55873 and requires the use of fewer resources. The main cost of CPT 0009T is a disposable probe, the cost of which is appropriately accounted for in APC 0980.

*Comment:* One commenter requested that we change the status indicator for CPT code 92974 (Coronary brachytherapy) to S.

*Response:* We are not making any changes at this time, but we will present this to the APC Advisory Panel next year to obtain its input.

*Comment:* A commenter requested that we move CPT code 57288 (Sling operation for stress incontinence) from APC 202 into its own APC. This is because it is the only procedure in the

APC that requires use of a device. The commenter also believed our claims data was flawed and did not reflect the true cost of the sling used for the procedure. The commenter also asked us to create a special APC payment for the sling.

*Response:* We are not making any changes at this time but will present this to the APC Advisory Panel. We note that we had many single procedure claims for 57288 and that 57288 was by far the most common procedure performed in APC 202. This means that 57288 determined the payment rate for the APC. Therefore, moving 57288 into its own APC would not change its payment rate. Furthermore, we do not create APCs for devices.

*Comment:* Two commenters were concerned about reduced payment for echocardiography.

*Response:* Review of payment rates for echocardiography does not show a significant decrease in payment from 2002 for the most commonly performed echocardiograms. The reduction in payment for echocardiograms in APC 671 appropriately reflects the costs of performing those procedures.

*Comment:* One commenter asked us to clarify the payment rate for Zevalin.

*Response:* As discussed elsewhere in this rule we have created G codes that describe the diagnostic and therapeutic administration of Zevalin. These two G codes are placed in APCs with payment rates that account for the procedure and the cost of Zevalin. We will use claims data to update the payment rates of these services when such data becomes available.

*Comment:* One manufacturer of medical devices submitted comments on a large number of APCs (76, 81, 83, 85, 86, 87, 93, 109, 141, 147, 151, 163, 229, 656, and 670). In general the commenter was concerned about seeming violations of the two times rule, use of improperly coded claims, lack of use of multiple procedure claims, and our use of medians to determine payment rates. The commenter also asked us to use outside cost data in setting payment rates and made some specific requests to move codes to differentAPCs.

*Response:* Many of this commenter's concerns have been addressed in other responses to APC issues. We did use properly coded claims where appropriate. Specifically, for procedures that required use of a device we only used claims that contained C codes. We also took other measures to mitigate steep reductions in payment for device related APCs and we increased the number of claims we used to set payment rates (as discussed in the proposed rule). We believe that many of the commenter's concerns have been addressed by these measures. However, we will review these comments and present several of the specific requests concerning APC changes to the APC Advisory Panel.

*Comment:* We received many comments from physicians, freestanding breast imaging centers, and others who believed that the proposed OPPS payment amounts for percutaneous breast biopsy (CPT codes 19102 and 19103) would affect the payments made for physician services and in freestanding breast imaging centers and who objected to reduced payments to physicians and to freestanding breast imaging centers.

*Response:* These commenters are mistaken. The proposed rates affect only hospital outpatient department payment. Payment to physicians and to freestanding facilities is addressed in the Physician Fee Schedule.

*Comment:* We received comments from hospitals and others who understood that the proposed payments would be limited to hospital outpatient department services. Some of these commenters indicated that the proposed payments for percutaneous breast biopsy (CPT codes 19102 and 19103) would be substantially below payments to hospitals for open breast biopsy (CPT code 19101) and that the proposed rule proposed reductions in payment for percutaneous breast biopsy while it proposed increases in payment for open breast biopsy. They believe that the proposed payment changes would create incentives for performing open breast biopsies instead of less invasive procedures such as percutaneous biopsies. This may result, they asserted, in an increased frequency of open breast biopsies and a decreased frequency of percutaneous breast biopsies, resulting in poorer quality of care and increased costs to Medicare and to beneficiaries. One commenter believed that our claims data do not appropriately account for the costs of CPT code 19103 because CPT code 19103 was a new CPT code in 2001 and hospitals were slow to transition from using CPT code 19101 for these procedures.

*Response:* We thank the commenters for their comments. We note that CPT codes 19102 and 19103 are never performed alone. They are always performed, at minimum, in conjunction with an imaging guidance procedure. Therefore, the true payment rate for CPT codes 19102 and 19103 is the sum of the APC payments for CPT codes 19102 or 19103 and of the APC payments for procedures billed with CPT codes 19102 and 19103. In order to determine the true payments for these procedures, we examined our claims data and determined the most common combination of CPT codes billed when CPT codes 19102 and 19103 were on the claim. Our claims data verified that CPT codes 19102 and 19103 are rarely performed alone.

Furthermore, we looked at the 10 most frequent combinations of codes billed with CPT codes 19102 and 19103 and summed the proposed APC payments that would be made for these combinations of codes. This represents the true Medicare payment for CPT codes 19102 and 19103. For CPT code 19102 (for which the proposed rule proposed payment under APC 0005 of $157.01), total payment by Medicare would range from $181.45 to $549.16 when the 10 most common combinations of services are provided. Similarly for CPT code 19103 (for which the proposed rule proposed payment under APC 0658 of $289.69), total payment by Medicare would range from $532.05 to $681.84. These combination totals are less than the proposed payment for open breast biopsy (APC 0028, CPT codes 19105, 19120 and 19125, for which we proposed to pay $908.04); however, as the commenters themselves asserted, the resources required for an open surgical procedure are greater than those used for a percutaneous procedure. We agree with the commenters that the costs to the Medicare program of an open breast biopsy are greater than the cost of a percutaneous biopsy. We also believe that the relative total payment rates, as discussed above, for open and percutaneous procedures are appropriate.

With regard to hospital miscoding, even if hospitals took time to transition from using CPT code 19101 to CPT codes 19102 and 19103, the cost data for CPT codes 19102 and 19103 should be accurate. While it is possible that the cost data for CPT code 19101 could be high as it may include some percutaneous procedures, this would not be true for cost data from CPT codes 19102 and 19103. Further, we would note that each of CPT codes 19102 and 19103 were reported over 20,000 times by hospital outpatient departments and that we had several thousand single claims for each code upon which to base relative weights.

We do not believe that the proposed payments will create incentives to perform inappropriate open breast biopsies. We believe that physicians will select the procedure that best meets the needs of the patient and that the hospital will provide the services

needed to support the procedure that the physician provides.

5. Procedures That Will Be Paid Only as Inpatient Procedures

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. 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 we have already moved off the inpatient list.

We last updated the inpatient list in the November 30, 2001 final rule. As we discuss in section II.A.2 above, the APC Panel at its January 2002 meeting reviewed certain procedures on the inpatient list for which we had received requests that they be made payable under the OPPS. As the Panel members recommended, we solicited comments and further information about all of these procedures except for CPT code 47001, which they recommended to be removed from the inpatient list.

In addition to considering the comments of the APC Panel, we compared procedures with status indicator ''C'' (status indicator ''C'' is assigned to inpatient procedures that are not payable under the OPPS) to the list of procedures that are currently on the ambulatory surgical center (ASC) list of approved procedures, to procedures that we proposed to add to the ASC list in a proposed rule published in the **Federal Register** on June 12, 1998 (63 FR 32291), and to procedures recommended for addition to the ASC list by commenters in response to the June 12, 1998, proposed rule. We concluded that it was appropriate to propose removal of procedures from the OPPS inpatient list that are being performed on an outpatient basis and/or that we had determined could be safely and appropriately performed on a Medicare beneficiary in an ASC under the applicable ASC rules, which are set forth in 42 CFR 416.22. Therefore, we proposed to add 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 numerous 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 ASC procedures or proposed by us for addition to the ASC list.

In addition to the procedures considered by the APC Panel for removal from the inpatient list, Table 6 in the proposed rule includes other procedures that we proposed to remove from the inpatient list for payment under the OPPS for 2003. We applied the criteria discussed above in order to be consistent with the ASC list of approved procedures and with utilization data that indicate the procedures are being performed on an outpatient basis. We solicited comments on whether the procedures listed in Table 6 of the proposed rule should be paid under the OPPS. We also solicited comments on the APC assignment that we proposed for these procedures in the event we determine in the final rule, based on comments, that these procedures would be payable under the OPPS in 2003. We asked that commenters recommending reclassification of a procedure to an APC include evidence (preferably from peer-reviewed medical literature) that the procedure is being performed on an outpatient basis in a safe and appropriate manner.

Following our review of the comments, we either assigned a CPT code for a service formerly on the inpatient list 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, we chose to keep the service on the inpatient list for 2003 and to present the comments to the APC Panel at its 2003 meeting. Table 6 identifies codes that were on the inpatient list in 2002 but are not on the inpatient list in 2003 and which, therefore, will be payable under the OPPS on and after January 1, 2003.

We received numerous comments on this proposal, which we summarize below.

*Comment:* In addition to the APC Advisory Panel, numerous hospital associations, hospitals, and other organizations recommended that we eliminate the inpatient list. They asserted that the inpatient list interferes with the practice of medicine and is unnecessarily intrusive. Most of these commenters argued that it is the physician, not the hospital, who determines what procedures should be performed and whether a patient's condition warrants an inpatient admission. Numerous commenters asserted that if CMS insists on retaining the inpatient list, then the same payment rules should apply to physicians as well as to hospitals. These commenters argued that if CMS believes Medicare beneficiaries are at risk for safety and quality issues, then Medicare should not pay for the professional services of the physician who performs a procedure on the inpatient list when payment for the hospital services is denied. In addition, several commenters noted that because the physician receives payment when a procedure on the inpatient list is performed on an outpatient basis, there is no incentive for the physician to heed whether Medicare will pay the hospital for the procedure. A few commenters noted that the inpatient list sometimes conflicts with the policy of private payers, creating confusion among physicians, patients, and hospitals. One commenter recommended that it should be left to medical review to monitor site of service. Several commenters viewed the inpatient list as an attempt to punish hospitals for a decision over which they have no real control. One commenter objected to the inpatient list because it places an unfair financial burden on beneficiaries, who are liable for payment if a procedure on the inpatient list is performed in the outpatient setting, and because the beneficiary normally relies on the physician to determine where a procedure is to be performed.

*Response:* Since implementation of the OPPS in August 2000, we have engaged in an ongoing review of the procedures on the inpatient list. In the August 9, 2002 proposed rule (67 FR 52092), we proposed APC assignments for 41 procedures that have a current status indicator designation of ''C''. We continue to move procedures from the inpatient list to an APC for payment under the OPPS in response to comments and recommendations from hospitals, surgeons, professional societies, and hospital associations which demonstrate that a procedure on the inpatient list meets our criteria for determining that a procedure can be performed on an outpatient basis in a

safe and effective manner. In spite of the assertions made by commenters, we have received very few requests since publication of the November 30, 2001 final rule.

Hospitals or associations representing hospitals submitted the overwhelming majority of comments recommending elimination of the inpatient list. Their comments expressed considerable frustration resulting from apparent conflicts with physicians over which procedures Medicare will pay for under the OPPS. Although we understand the frustration that exists in the hospital community about the inpatient list, we believe that appropriate education of physicians and other hospital staff by CMS, hospitals, and organizations representing hospitals is the best way to minimize any existing confusion. We are prepared to remove procedures from the inpatient list as part of the quarterly OPPS updates. If a physician believes that a procedure should be payable under the OPPS, we urge the hospital and physician to provide operative reports about specific procedures on the inpatient list are being performed on Medicare beneficiaries who are outpatients. In the meantime, we are reviewing with CMS provider education staff ways that we can support carrier and fiscal intermediary efforts to clarify the reasons for the OPPS inpatient list and its billing and payment implications. Also, in section X.C. of this preamble, we explain how hospitals can receive payment under certain conditions for procedures on the inpatient list that are performed on an emergency basis when the status of a patient is that of an outpatient.

*Comment:* We received a number of comments regarding the criteria that we 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, including the two new criteria that we proposed in the August 2002 proposed rule to add to the current criteria. One commenter asked what we meant by ''numerous'' hospitals. Several commenters commended CMS for recognizing that surgical procedures payable in the ambulatory surgical center (ASC) setting should also be payable in an outpatient hospital setting and for removing a number of codes from the inpatient list that are currently payable in an ASC. Several commenters urged CMS to closely monitor and coordinate the OPPS inpatient list and the ASC list for consistency and to ensure that changes in medical practice are reflected within both lists as expeditiously as possible. Commenters expressed concern that more than 60 CPT codes remain on the inpatient list in Addendum E even though they are currently on the approved ASC list and urged CMS to reconcile the disparity between the two lists.

*Response:* The criterion that a procedure is being performed in ''numerous'' hospitals on outpatients means that the procedure is being performed nationally in hospitals other than a few large teaching hospitals that specialize in innovative surgery. We intend to continue monitoring for consistency the procedures that Medicare pays for in a hospital outpatient setting with those that are payable in an ASC as we prepare a final rule to update the ASC list based on the additions and deletions that we proposed in the June 12, 1998 **Federal Register** (63 FR 32290).

*Comment:* One commenter recommended that CMS remove from the inpatient list those procedures that routinely show a one-day inpatient stay.

*Response:* We believe this recommendation has merit and we will endeavor to conduct a study to explore the issue in preparation for the 2004 OPPS update.

*Comment:* One commenter stated that CMS should have a formal process to solicit and act on suggestions to remove procedures where community medical standards and practice can demonstrate the safety and efficacy of performing the procedure in an outpatient setting. Another commenter stated that physician comments, outcome data, post-procedure care data, and medical literature would be better criteria for determining which procedures are outpatient.

*Response:* As we stated above, anyone interested in having a particular code or group of codes on the inpatient list reviewed for payment under the OPPS need only submit a request to the Director, Division of Outpatient Care, Centers for Medicare & Medicaid Services, Mailstop C4–05–17, 7500 Security Boulevard, Baltimore, MD 21244–1850. The request should include supporting information and data to demonstrate that the code meets the five criteria discussed above. 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. We agree with the commenters suggestions, and encourage, in addition to medical literature, the submission of community medical standards and practice as well physician comments, outcome data, and post-procedure care data to reinforce the point.

When this information is received, it is thoroughly reviewed by our medical advisors within the context of the criteria we have established. Further information or clarification may be requested. If, following this review, we determine that there is sufficient evidence to confirm that the code can be safely and appropriately performed on an outpatient basis, we will assign the procedure to an APC and include it as a payable procedure in the next OPPS quarterly update. The change in payment status will be subject to public comment as part of the subsequent annual OPPS update.

Interested parties may also submit a request to change the payment status of a code on the inpatient list for consideration as an agenda item at the next meeting of the APC Advisory Panel.

*Comment:* One commenter expressed concern about the inpatient list becoming a ''self-fulfilling prophecy'' because hospitals cannot be paid for procedures on the list, therefore no data become available to show that the procedure is safely done on an outpatient basis.

*Response:* Information may be available on non-Medicare patients receiving a procedure on the list. Further, this is not the sole criterion upon which a change is based, as we note above.

*Comment:* One commenter recommended that CMS establish a transitional methodology for estimating appropriate hospital costs for CPT codes on the inpatient list that are proposed for payment under the OPPS. The commenter expressed particular concern about payment for CPT codes 92986, 92987, and 92990.

*Response:* The APC assignments for the CPT codes in Table 6 of the August 2002 proposed rule (67 FR 52115) for which we propose to make payment under the OPPS take into account the expectation that the simplest procedure described by the codes, and therefore, relatively, the least resource intensive, would be performed on an outpatient basis. Also, we identify APCs that consist of procedures that are similar both in terms of clinical characteristics and in terms of resource consumption. Finally, we invited comments on the proposed APC assignment. Over time, claims data for the newly assigned codes will confirm either that the procedures belong in the designated APC or that they should be moved to different APC.

*Comment:* Two commenters supported our proposal to remove CPT

code 47001, Biopsy of liver, needle; when done for indicated purpose at time of other major procedure, from the inpatient list. Several commenters supported generally our proposal to pay under the OPPS for the procedures in Table 6 of the proposed rule, but did not comment on our proposed APC assignments. One commenter urged that CPT code 92986, Percutaneous balloon valvuloplasty; aortic valve, not be assigned to APC 0083, asserting that this procedure cannot be performed safely in an outpatient setting. We received no other comments opposing payment under the OPPS for the procedures listed in Table 6 of the August 9 proposed rule.

*Response:* We agree with the commenters and with the APC Panel's recommendations that CPT code 47001 be payable under the OPPS beginning in 2003. Because this is an add-on code, payment will be packaged with the payment for the surgical procedure with which it is billed.

We are making final our proposal to remove this code from the inpatient list, but we will consider presenting this concern to the APC Panel. In the absence of comments disagreeing with our proposal to pay under the OPPS for the 41 CPT codes listed in Table 6 of the August 2002 proposed rule (67 FR 52115), we are making these proposed changes final.

*Comment:* One commenter favored removing CPT 33967, insertion of intra-aortic balloon assist device, percutaneous, from the inpatient list, but did not submit any information to support this position.

*Response:* We discussed in the proposed rule our uncertainty, and that of the APC Advisory Panel, about whether or not this procedure should be removed from the inpatient list. We also indicated that we were having difficulty finding data to confirm that the procedure is being performed on Medicare beneficiaries in an outpatient setting. We asked for comments and clinical data and case reports that would support payment for CPT 33967 under the OPPS. No commenters submitted data in any form to support removing the procedure from the inpatient list. Therefore, we have decided not to remove CPT 33967 from the inpatient list in 2003.

*Comment:* One commenter recommended payment for CPT codes 22612, 22614, 33243, 49000, and 49062 under the OPPS.

*Response:* Our medical advisors reviewed these codes and have determined that CPT 22612, Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique), and CPT 22614, Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (list separately in addition to code for primary procedure), are safely and appropriately being performed on an outpatient basis. We are assigning these codes to APC 0208.

We did not propose to remove the other codes suggested by the commenter from the inpatient list, and the commenter submitted no evidence to support payment for these codes under the OPPS. Nor could we find any information to indicate that these codes meet the criteria for moving them off the inpatient list. Therefore, we will continue to designate these CPT codes with status indicator ''C'' in 2003.

- We are adopting two additional criteria to guide our determination of whether a procedure should be removed from the inpatient list:
- The procedure is being performed in numerous hospitals on an outpatient basis; or
- The procedure can be appropriately and safely performed in an ASC and is on the list of approved ASC procedures or proposed by us for addition to the ASC list.
- We are adding CPT codes 22612 and 22614 to APC 0208 effective for services furnished on or after January 1, 2003.
- We are making final our proposal in the August 2002 rule to pay under the OPPS for the CPT codes listed in Table 5, below.

TABLE 5.—PROCEDURES ON THE 2002 INPATIENT LIST WHICH ARE PAYABLE UNDER THE OPPS IN CY 2003

| CPT Code | Status Indicator | APC | Description |
|---|---|---|---|
| 21390 | T | 0256 | OPEN TREATMENT OF ORBITAL FLOOR BLOWOUT FRACTURE; PERIORBITAL APPROACH, WITH ALLOPLASTIC OR OTHER IMPLANT. |
| 22100 | T | 0208 | PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG, SPINOUS PROCESS, LAMINA OR FACET) FOR INTRINSIC BONY LESION, SINGLE VERTEBRAL SEGMENT; CERVICAL. |
| 22101 | T | 0208 | PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG, SPINOUS PROCESS, LAMINA OR FACET) FOR INTRINSIC BONY LESION, SINGLE VERTEBRAL SEGMENT; THORACIC. |
| 22102 | T | 0208 | PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG, SPINOUS PROCESS, LAMINA OR FACET) FOR INTRINSIC BONY LESION, SINGLE VERTEBRAL SEGMENT; LUMBAR. |
| 22103 | T | 0208 | PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT (EG, SPINOUS PROCESS, LAMINA OR FACET) FOR INTRINSIC BONY LESION, SINGLE VERTEBRAL SEGMENT; EACH ADDITIONAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE). |
| 22612 | T | 0208 | ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE, SINGLE LEVEL; LUMBAR (WITH OR WITHOUT LATERAL) TRANSVERSE TECHNIQUE). |
| 22614 | T | 0208 | ARTHODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE, SINGLE LEVEL; EACH, ADDITIONAL VERTEBRAL SEGMENT (LIST, SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE). |
| 23035 | T | 0049 | INCISION, BONE CORTEX (EG, OSTEOMYELITIS OR BONE ABSCESS), SHOULDER AREA. |
| 23125 | T | 0051 | CLAVICULECTOMY; TOTAL. |
| 23195 | T | 0050 | RESECTION, HUMERAL HEAD. |
| 23395 | T | 0051 | MUSCLE TRANSFER, ANY TYPE, SHOULDER OR UPPER ARM; SINGLE. |
| 23397 | T | 0052 | MUSCLE TRANSFER, ANY TYPE, SHOULDER OR UPPER ARM; MULTIPLE. |
| 23400 | T | 0050 | SCAPULOPEXY (EG, SPRENGELS DEFORMITY OR FOR PARALYSIS). |
| 24150 | T | 0052 | RADICAL RESECTION FOR TUMOR, SHAFT OR DISTAL HUMERUS; |
| 24151 | T | 0052 | RADICAL RESECTION FOR TUMOR, SHAFT OR DISTAL HUMERUS; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT). |
| 24152 | T | 0052 | RADICAL RESECTION FOR TUMOR, RADIAL HEAD OR NECK; |
| 24153 | T | 0052 | RADICAL RESECTION FOR TUMOR, RADIAL HEAD OR NECK; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT). |
| 25170 | T | 0052 | RADICAL RESECTION FOR TUMOR, RADIUS OR ULNA. |

TABLE 5.—PROCEDURES ON THE 2002 INPATIENT LIST WHICH ARE PAYABLE UNDER THE OPPS IN CY 2003—Continued

| CPT Code | Status Indicator | APC | Description |
|---|---|---|---|
| 25390 | T | 0050 | OSTEOPLASTY, RADIUS OR ULNA; SHORTENING. |
| 25391 | T | 0051 | OSTEOPLASTY, RADIUS OR ULNA; LENGTHENING WITH AUTOGRAFT. |
| 25392 | T | 0050 | OSTEOPLASTY, RADIUS AND ULNA; SHORTENING (EXCLUDING 64876). |
| 25393 | T | 0051 | OSTEOPLASTY, RADIUS AND ULNA; LENGTHENING WITH AUTOGRAFT. |
| 25420 | T | 0051 | REPAIR OF NONUNION OR MALUNION, RADIUS AND ULNA; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT). |
| 27035 | T | 0052 | DENERVATION, HIP JOINT, INTRAPELVIC OR EXTRAPELVIC INTRA-ARTICULAR BRANCHES OF SCIATIC, FEMORAL, OR OBTURATOR NERVES. |
| 27216 | T | 0050 | PERCUTANEOUS SKELETAL FIXATION OF POSTERIOR PELVIC RING FRACTURE AND/OR DISLOCATION (INCLUDES ILIUM, SACROILIAC JOINT AND/OR SACRUM). |
| 27235 | T | 0050 | PERCUTANEOUS SKELETAL FIXATION OF FEMORAL FRACTURE, PROXIMAL END, NECK, UNDISPLACED, MILDLY DISPLACED, OR IMPACTED FRACTURE. |
| 31582 | T | 0256 | LARYNGOPLASTY; FOR LARYNGEAL STENOSIS, WITH GRAFT OR CORE MOLD, INCLUDING TRACHEOTOMY. |
| 31785 | T | 0254 | EXCISION OF TRACHEAL TUMOR OR CARCINOMA; CERVICAL. |
| 32201 | T | 0070 | PNEUMONOSTOMY; WITH PERCUTANEOUS DRAINAGE OF ABSCESS OR CYST. |
| 38700 | T | 0113 | SUPRAHYOID LYMPHADENECTOMY. |
| 42842 | T | 0254 | RADICAL RESECTION OF TONSIL, TONSILLAR PILLARS, AND/OR RETROMOLAR TRIGONE; WITHOUT CLOSURE. |
| 43030 | T | 0253 | CRICOPHARYNGEAL MYOTOMY. |
| 47490 | T | 0152 | PERCUTANEOUS CHOLECYSTOSTOMY. |
| 47001 | N | ..... | BIOPSY OF LIVER, NEEDLE; WHEN DONE FOR INDICATED PURPOSE AT TIME OF OTHER MAJOR PROCEDURE. |
| 62351 | T | 0208 | IMPLANTATION, REVISION OR REPOSITIONING OF TUNNELED INTRATHECAL OR EPIDURAL CATHETER, FOR LONG-TERM MEDICATION ADMINISTRATION VIA AN EXTERNAL PUMP OR IMPLANTABLE RESERVOIR/INFUSION PUMP; WITH LAMINECTOMY. |
| 64820 | T | 0220 | SYMPATHECTOMY; DIGITAL ARTERIES, EACH DIGIT. |
| 69150 | T | 0252 | RADICAL EXCISION EXTERNAL AUDITORY CANAL LESION; WITHOUT NECK DISSECTION. |
| 69502 | T | 0254 | MASTOIDECTOMY; COMPLETE. |
| 92986 | T | 0083 | PERCUTANEOUS BALLOON VALVULOPLASTY; AORTIC VALVE. |
| 92987 | T | 0083 | PERCUTANEOUS BALLOON VALVULOPLASTY; MITRAL VALVE. |
| 92990 | T | 0083 | PERCUTANEOUS BALLOON VALVULOPLASTY; PULMONARY VALVE. |
| 92997 | T | 0081 | PERCUTANEOUS TRANSLUMINAL PULMONARY ARTERY BALLOON ANGIOPLASTY; SINGLE VESSEL. |
| 92998 | T | 0081 | PERCUTANEOUS TRANSLUMINAL PULMONARY ARTERY BALLOON ANGIOPLASTY; EACH ADDITIONAL VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE). |

*C. Partial Hospitalization*

Payment Methodology

As we discussed in the proposed rule, partial hospitalization is an intensive outpatient program of psychiatric services provided to patients in the place of inpatient 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). In the August 1, 2000 final rule (65 FR 18452), we established a per diem payment methodology for the PHP APC based on hospital data. The current per diem payment amount is $212.27. This amount represents the hospital or CMHC overhead costs associated with the program.

In the August 9, 2002 OPPS proposed rule, we proposed to revise the PHP APC using 2001 claims data from hospitals and CMHCs and computed a median per diem using the same methodology as that used for all other APCs. As we explained in the August 9, 2002 proposed rule, we adjusted the CMHC costs to account for the difference between settled and as-filed cost reports. We proposed that the resulting per diem is $256.96, of which $51.39 is the beneficiary's coinsurance.

In addition, to facilitate proper billing and ensure comparable reporting of costs by hospitals and CMHCs, we proposed to revise § 410.43 (Partial hospitalization services: Conditions and exclusions) to add CSW services that meet the requirements of section 1861(hh)(2) of the Act to the list of professional services not considered to be PHP services. Such revision would mean that hospitals and CMHCs could bill the carrier for CSW services furnished to PHP patients.

*Comment:* One commenter indicated that the proposed methodology for ratesetting is appropriate.

*Response:* As we indicated in the April 7, 2000 OPPS final rule, payment to providers under OPPS represents the facility costs, that is, overhead, support staff, equipment, and supplies. The physician and nonphysician practitioner services excluded from the definition of PHP services are those professional services paid through the physician fee schedule. The facility continues to incur the overhead costs associated with provision of the professional service, for example, room, heat, lights, mental health technicians, and nurses. The OPPS is intended to pay providers for the resource costs associated with their outpatient programs, including outpatient psychiatric programs and PHPs.

As part of our analysis of current billing instructions for PHP, we discovered that Addendum B of the November 30, 2001, CY 2002 OPPS final rule does not clearly identify all the HCPCS codes that may be billed for PHP patients. We plan to revise this addendum in the 2004 update so that all PHP services are identified. However, in order to avoid billing errors, we are providing the following list of the current HCPCS codes for PHPs:

| Revenue codes | Description | HCPCS codes |
|---|---|---|
| 43X | Occupational Therapy | G0129. |
| 904 | Activity Therapy | G0176. |
| 910 | Psychiatric General Services | 90801, 90802, 90875, 90876, 90899. |
| 914 | Individual Psychotherapy | 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829. |
| 915 | Group Therapy | 90849, 90853, 90857. |
| 916 | Family Psychotherapy | 90846, 90847, 90849. |
| 918 | Psychiatric Testing | 96100, 96115, 96117. |
| 942 | Education/Training | G0177. |

*Comment:* Two national behavioral health care organizations commented that the proposed PHP rate for CY 2003 more adequately represents the resources needed to provide PHP; however, they expressed concern that providers continue to have difficulty in receiving reimbursement for PHP services as a result of intermediary medical review (MR) of claims.

*Response:* As noted in the comment, we have issued a program memorandum to intermediaries regarding medical review of PHP claims. While we recognize that MR can have a financial impact on PHP claims, there is no direct relationship between MR and the level of reimbursement for individual claims.

**III. Recalibration of APC Weights for 2003**

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 for application in 2002. 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 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, 2003, and before January 1, 2004, we proposed to use the same basic methodology that we described in the April 7, 2000 final rule. That is, we would recalibrate the weights based on claims and cost report data for outpatient services. We proposed to use the most recent available data to construct the database for calculating APC group weights. For the purpose of recalibrating APC relative weights for CY 2003, the most recent available claims data are more than 90 million final action claims for hospital outpatient department services furnished on or after April 1, 2001, and before March 31, 2002, and processed through July 2002. In the proposed rule, we proposed to base the 2003 OPPS on claims for services furnished January 1, 2001 through December 31, 2001. However, after issuance of the proposed rule we determined that coding and charges for the period of April 1, 2001 thru March 31, 2002 would be a better base for recalculation of weights.

We believe that using claims data from this period is consistent with section 1833(t)(9)(A) of the Act, which directs us to take into account ''new cost data'' in our annual review and adjustment of components of the OPPS. This is also consistent with our proposal in the August 9, 2002 proposed rule (67 FR 52108) to use the most recent available claims data to set the weights. We had several reasons for using claims from this period: claims from this period provide the most recent charge data available to us. Since we did not implement the 2002 OPPS until April 1, 2002, we can use the claims for the period from January 1, 2002, through and including March 31, 2002, together with claims data from the period of April 1, 2001 to December 31, 2001 to set weights. Using claims data for services furnished during this period of time also provides the most reliable charge data for devices and services that use medical devices because the device category codes were in effect for the entire period. Hence, we believe that claims from this period are the most reliable basis for setting relative weights for CY 2003 OPPS.

Many of the claims from hospitals were for services that are not paid under OPPS (such as clinical laboratory tests). We matched the claims that are paid under OPPS to the most recent cost report filed by the individual hospitals represented in our claims data. The APC relative weights would continue to be based on the median hospital costs for services in the APC groups.

*A. Data Issues*

1. Treatment of ''Multiple Procedure'' Claims

In the August 9, 2002 proposed rule, we discussed in detail the circumstances in which we had difficulty with using the data from claims that had multiple procedures (67 FR 52108). We solicited public comment on the methods we considered for apportioning the total charges to individual HCPCS codes as described above. These possible methods included: dividing the total charges in a revenue center, or for a packaged HCPCS code, by the number of payable HCPCS codes for the multiple procedures on the claim; apportioning the charges among the codes based on physician work relative value units (RVUs); apportioning the charges among the codes based on physician nonfacility practice expense RVUs; or requiring the hospital to apportion all charges currently shown in revenue centers to the HCPCS codes billed so that we could use all multiple services claims in the calculation of relative weights. We also invited suggestions of other alternative means of apportioning the total costs on multiple procedure claims to the HCPCS codes for the procedures so that we can use more data from multiple procedure claims in the 2004 update of the OPPS.

We also solicited information on existing studies that would provide comparative hospital outpatient resource inputs by HCPCS code. In addition, we welcomed suggestions for studies that we might undertake either to determine the relative value of OPD resources by HCPCS code or to provide a valid means of apportioning the charges among HCPCS codes when multiple surgical procedures are billed on the same claim with a single total charge for all services.

Finally, we solicited information regarding the extent to which efficiencies are realized when multiple services are furnished during the same visit or operative session.

The discussion of recalibration of relative weights in section III.B of this final rule summarizes the process that we used to determine the claims that could be used to set the weights.

Comments and our responses are summarized below:

Low Numbers of Services Used To Set Weights and Failure To Use Multiple Procedure Claims

*Comment:* Many commenters indicated that we used very few of the claims that were submitted for a particular service and that using so few claims resulted in lower weights than would have occurred if we had used all claims. Some commenters indicated that by using only single procedure claims and data from multiple procedure claims that met the criteria we set (see section III.A.I. of this final rule), we significantly reduced the validity of the cost data. Some commenters stated that by using median costs for procedures that can only be done as an add-on to other procedures, we had based the payment for the add-on procedure on data which, by definition, were faulty. Some commenters suggested that we needed to develop an allocation strategy that would enable us to use all multiple procedure claims, either based on a study of relative resource allocation or an arbitrary allocation that could be refined over the years. Some commenters asked that we reconsider our data trimming strategy to examine each claim that is eliminated by trimming for validity and to determine if it should be used. They asked that any claim that represents new technology be returned to the data set and used, notwithstanding its aberrancy.

*Response:* For 2003, we made great strides by increasing the number of claims used to set the OPPS weights from 39.9 million (66 FR 59885) for the 2002 OPPS to 62.2 million for the 2003 OPPS. We intend to review other means of using data from multiple claims for 2004. We recognize that it would be preferable to use data from all claims, including those with multiple procedures, in development of the weights, as long as we can ensure that the data recovered from those claims are valid. We were not able to develop and test a strategy for allocating undifferentiated charges to multiple HCPCS codes on a claim for the 2003 final rule. Therefore, in some cases, we continued to use data from small numbers of claims because many claims did not meet the tests for inclusion in the data set. As discussed in section II, the APC Panel recommended that we continue to rely on data from single procedure claims until we were able to validly allocate charges to multiple procedures, even in establishing payments for add-on codes. In addition, as requested by some commenters, we excluded claims for procedures that could not be performed without a device when the claim did not contain the device. This gave us a more valid base of claims on which to set the weight for that service but reduced the number of claims used for these APCs. It became clear from this activity that basing the weights on more claims does not necessarily result in more valid data because in the cases of these APCs, deleting claims from the set was necessary to arrive at a more valid relative weight.

With regard to the trimming methodology, it is a routine and accepted statistical practice that is well established in inpatient PPS data examination and has served well in the past to eliminate anomalies that could further skew the data. We will consider whether it is useful and to what extent it is practical to examine all trimmed claims to determine if they represent the first claims for a new technology and should remain in the body of claims.

Recommendations for Including More Multiple Procedure Claims

*Comment:* We received a number of comments that contained ideas for allocating charges to multiple procedures where they exist on the claim. Some commenters recommended that we allocate the charges to HCPCS codes in proportion to the relative weight of the HCPCS codes or the relative charges for the HCPCS codes. Some commenters suggested that we survey hospitals with regard to the most common combinations of procedures that appear on claims to determine which services and, therefore, which charges go with which HCPCS code. Some commenters suggested that we research the relative resources for each HCPCS code individually and then create an algorithm by which we would allocate charges to HCPCS codes on multiple procedure claims. One commenter provided a study that addressed the efficiency of resource usage when multiple procedures are performed on the same day that the commenter recommended could be useful in allocating charges for the second and subsequent procedures on a claim. One commenter also suggested that we ensure that the claim assesses services on the same date of service, since in many cases, the claim can have services that are spread over a period of time and, therefore, are not really multiple procedures provided at the same time. Several commenters submitted detailed descriptions of ways by which we could allocate charges to HCPCS codes. Many hospitals objected to any requirement that hospitals do the allocation of all charges to HCPCS codes to show the charges that go with each HCPCS code; they noted that doing so would require massive accounting and cost report changes and thus impose a burden and cost on hospitals, which would exist for no purpose other than to improve the Medicare OPPS claims data.

*Response:* We expect to explore a number of strategies for allocating charges to HCPCS codes on multiple procedure claims for the development of the 2004 OPPS and beyond.

Impact on Data of a Visit and Drug Administration the Same Day

*Comment:* Several commenters applauded our attempt to include some multiple procedure claims in the calculation of OPPS payment rates. They were, however, concerned whether some properly coded claims, which included both an administration code and a J code or claims that included an evaluation and management visit in addition to an administration code and a J code, were eliminated as multiple procedure claims.

*Response:* Where an evaluation and management visit and an administration code and J code were billed on the same claim, they would have been considered to be a multiple procedure claim and would not be used because there would be no way of knowing how to allocate the charges in revenue centers to the visit versus the administration code. As we explained in detail in the August 9, 2002 proposed rule, there would be no way to know to what extent charges in revenue centers, such as sterile supplies, were associated with the visit versus the administration code. We are concerned about this problem and are exploring ways to do an allocation of charges that would enable us to use all multiple procedure claims. However, we were not able to do it for this final rule.

2. Calendar Year 2002 Charge Data for Transitional Pass-Through Device Categories

In the August 9, 2002 proposed rule, we discussed our concerns with the claims data for the devices losing eligible for transitional pass-through status in CY 2003 (67 FR 52110). We had been advised that during the period in which the 2001 OPPS was in effect, hospitals may not have billed properly for devices eligible for transitional pass-through payments. We acknowledged in the 2002 proposed rule that changes in billing format and systems for implementation of the OPPS may have compounded the problems of billing using the device-specific codes during the first 9 months of the OPPS. We had been informed that these problems were

further compounded by the creation and requirement to use category codes on and after April 1, 2001. In general, we had been advised that hospitals may have been underpaid for transitional pass-through devices (because they did not bill separately for them and, therefore, did not get the pass-through payment) and that our data will not correctly show the charges associated with the devices (because the devices were not coded with device-category codes on the claim).

We proposed to package payment for devices into payment for the procedure in which they were furnished because doing so is consistent with the concept of a prospective payment system and because we believed that it would give us the best data on which to pay devices once they ceased to be paid at cost via the pass-through methodology. We thought that by packaging the cost of the devices into the cost of the procedure with which they were used, we would capture the charges for the devices whether billed in revenue centers or with the HCPCS code for the device.

Our subsequent review of the data for the period of April 1, 2001, through March 31, 2002, indicated that there was a notable absence of hospital billing for devices category codes, even when the procedure billed could not be done without a pass-through device. We calculated the median costs for the APCs containing procedures that we believed required use of devices (including both claims with and claims without device C codes on the claim) and compared them to the median costs for the procedures from only claims that were billed with devices. We found that the median costs on claims billed with devices were more consistent with the median costs that we would expect to see for these APCs. Hence, for these APCs, we used the median costs calculated from claims that reported a device C code in place of the median costs calculated from all claims (claims billed both with devices and without device C codes). We did not eliminate claims that did not contain a device C code where HCPCS codes within an APC indicated that the procedure did not require a pass-through device. In such cases, HCPCS codes were, appropriately, rarely reported with C codes. The APCs for which we used the medians from claims with device C codes billed are listed in Table 6. This methodology resulted in higher median costs and, therefore, higher weights for these APCs than would have occurred had we included claims that did not contain coding for a device. The medians we used for all APCs are contained in Addendum C, which is on our Web site at *http://www.cms.hhs.gov.*

TABLE 6.—APC RATES WHICH ARE SET BASED ONLY ON CLAIMS THAT CONTAINED CODES FOR DEVICES

| APC | Description |
|---|---|
| 0032 | Insertion of Central Venous/Arterial Catheter. |
| 0048 | Arthroplasty with Prosthesis. |
| 0080 | Diagnostic Cardiac Catheterization. |
| 0081 | Non-Coronary Angioplasty or Atherectomy. |
| 0082 | Coronary Atherectomy. |
| 0083 | Coronary Angioplasty and Percutaneous Valvuloplasty. |
| 0085 | Level II Electrophysiologic Evaluation. |
| 0086 | Ablate Heart Dysrhythm Focus. |
| 0087 | Cardiac Electrophysiologic Recording/Mapping. |
| 0089 | Insertion/Replacement of Permanent Pacemaker and Electrodes. |
| 0655 | Insertion/Replacement of Permanent Dual Chamber Pacemaker. |
| 0090 | Insertion/Replacement of Pacemaker Pulse Generator. |
| 0680 | Insertion of Patient Activated Event Recorders. |
| 0653 | Vascular Reconstruction/Fistula Repair with Device. |
| 0104 | Transcatheter Placement of Intracoronary Stents. |
| 0106 | Insertion/Replacement/Repair of Pacemaker and/or Electrodes. |
| 0107 | Insertion of Cardioverter-Defibrillator. |
| 0108 | Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads. |
| 0115 | Cannula/Access Device Procedures. |
| 0119 | Implantation of Devices. |
| 0122 | Level II Tube changes and Repositioning. |
| 0652 | Insertion of Intraperitoneal Catheters. |
| 0167 | Level III Urethral Procedures. |
| 0179 | Urinary Incontinence Procedures. |
| 0182 | Insertion of Penile Prosthesis. |
| 0202 | Level VIII Female Reproductive Proc. |
| 0222 | Implantation of Neurological Device. |
| 0225 | Implantation of Neurostimulator Electrodes. |
| 0226 | Implantation of Drug Infusion Reservoir. |
| 0227 | Implantation of Drug Infusion Device. |
| 0229 | Transcatherter Placement of Intravascular Shunts. |
| 0259 | Level VI ENT Procedures. |
| 0670 | Intravenous and Intracardiac Ultrasound. |
| 0680 | Insertion of Patient Activated Event Recorders. |
| 0681 | Knee Arthroplasty. |
| 0693A | Breast Reconstruction with Prosthesis. |

Application of Cost-to-Charge Ratio to Charges Not Resulting in Costs

*Comment:* Many commenters stated that the application of a departmental cost-to-charge ratio to the high cost of devices would not result in the true cost of the device because hospitals would have to mark up the cost by 300 percent or more for that to be the result.

*Response:* See the discussion of the comments on cost to charge ratios and charge compression in section III.B of this final rule.

Absence of Devices on Claims

*Comment:* Many commenters indicated that hospitals did not bill for the devices that were paid under the pass-through mechanism in 2001, and therefore the median costs for the APCs for which most of the cost is a device are grossly understated.

*Response:* As discussed previously, we believe the commenters have a point. For the APCs for which the service cannot be furnished without a pass-through device, we eliminated claims that were not billed with a device C code from the claims used to calculate the median cost for those APCs. By taking these steps as well as packaging the device cost billed with both revenue centers and device category codes, we believe our final rates for these procedures are more appropriate. The APCs for which we used only claims with devices are identified in Table 6 above.

*B. Description of How Weights Were Calculated for CY 2003*

As discussed previously in this section, we first selected claims for services provided from April 1, 2001 through March 31, 2002. The methodology we followed to calculate the final APC relative payment weights for CY 2003 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 ESRD).
- We eliminated 1.6 million 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 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 301 hospitals that we identified as having reported charges on their cost reports, which were not actual charges (for example, a uniform charge applied to all services).
- We calculated the geometric mean of the total operating CCRs of hospitals remaining in the CCR data. We removed from the CCR data 67 hospitals whose total operating CCR exceeded the geometric mean by more than 3 standard deviations.
- We excluded from our data approximately 3.6 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 approximately 92.9 million claims to CCRs for remaining hospitals.
- We separated the 92.9 million claims that we had matched with a cost report into the following three distinct groups:

(1) Single-procedure claims.

(2) Multiple-procedure claims.

(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), which 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 in this manner yielded approximately 30.7 million single-procedure claims and 20.4 million multiple-procedure claims. Approximately 41.8 million claims without at least one covered OPPS service were set aside.

We converted 10.8 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 chest X-rays (HCPCS codes 71010 and/or 71020) and/or EKGs (HCPCS code 93005) on these claims. If only one procedure (other than HCPCS codes 71010, 71020, and 93005) 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 claim if the line item was billed as a single unit.

(4) If the claim had no packaged HCPCS codes on the claim but had packaged revenue centers for the procedure, we ignored the line item for chest X-rays and/or EKG codes (as identified above) and if only one HCPCS code remained, we treated the claim as a single procedure claim. We created an additional 31.5 million single-procedure bills through this process, which enabled us to use these data from multiple-procedure claims in calculation of the APC relative payment weights.

- To calculate median costs for services within an APC, we used only single-procedure bills and those multiple procedure bills that we converted into single claims. 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.1 of this final rule, we did not use multiple-procedure claims that included 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 other multiple-procedure bills to recalibrate APC weights that minimizes the risk of improperly assigning charges to the wrong procedure or visit.
- 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 departmental CCR. 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 we used the hospital's overall cost-to-charge ratio 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 the service. We observed the packaging provisions set forth in the April 7, 2000 final rule with comment period that were in effect during 2001 (65 FR 18484). For instance, in calculating the cost of a surgical procedure, we included charges for the operating room; treatment rooms; recovery; observation; medical and surgical supplies; pharmacy; anesthesia; casts and splints; and donor tissue, bone, and organs. To determine medical visit costs, we included charges for items such as medical and surgical supplies, drugs, and observation in those instances where they are still packaged. Table 7 lists packaged services by revenue center that we proposed to use to calculate per-service

costs for outpatient services furnished in CY 2003.

TABLE 7.—PACKAGED SERVICES BY REVENUE CODE

| Revenue code | Description |
|---|---|
| | **SURGERY** |
| 250 | PHARMACY. |
| 251 | GENERIC. |
| 252 | NONGENERIC. |
| 257 | NONPRESCRIPTION DRUGS. |
| 258 | IV SOLUTIONS. |
| 259 | OTHER PHARMACY. |
| 260 | IV THERAPY, GENERAL CLASS. |
| 262 | IV THERAPY/PHARMACY SERVICES. |
| 263 | IV THERAPY/DRUG 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. |
| 379 | OTHER ANESTHESIA. |
| 390 | BLOOD STORAGE AND PROCESSING. |
| 399 | OTHER BLOOD STORAGE AND PROCESSING. |
| 560 | MEDICAL SOCIAL SERVICES. |
| 569 | OTHER MEDICAL SOCIAL SERVICES. |
| 624 | INVESTIGATIONAL DEVICE (IDE). |
| 630 | DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS. |
| 631 | SINGLE SOURCE. |
| 632 | MULTIPLE. |
| 633 | RESTRICTIVE PRESCRIPTION. |
| 700 | CAST ROOM. |
| 709 | OTHER CAST ROOM. |
| 710 | RECOVERY ROOM. |
| 719 | OTHER RECOVERY ROOM. |
| 720 | LABOR ROOM. |
| 721 | LABOR. |
| 762 | OBSERVATION ROOM. |
| 810 | ORGAN ACQUISITION. |
| 819 | OTHER ORGAN ACQUISITION. |
| | **MEDICAL VISIT** |
| 250 | PHARMACY. |
| 251 | GENERIC. |
| 252 | NONGENERIC. |
| 257 | NONPRESCRIPTION DRUGS. |
| 258 | IV SOLUTIONS. |
| 259 | OTHER PHARMACY. |
| 270 | M&S SUPPLIES. |
| 271 | NONSTERILE SUPPLIES. |
| 272 | STERILE SUPPLIES. |
| 279 | OTHER M&S SUPPLIES. |
| 560 | MEDICAL SOCIAL SERVICES. |
| 569 | OTHER MEDICAL SOCIAL SERVICES. |
| 630 | DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS. |
| 631 | SINGLE SOURCE DRUG. |
| 632 | MULTIPLE SOURCE DRUG. |
| 633 | RESTRICTIVE PRESCRIPTION. |
| 637 | SELF-ADMINISTERED DRUG (INSULIN ADMIN. IN EMERGENCY DIABETIC COMA. |
| 700 | CAST ROOM. |
| 709 | OTHER CAST ROOM. |
| 762 | OBSERVATION ROOM |
| 942 | EDUCATION/TRAINING. |

TABLE 7.—PACKAGED SERVICES BY REVENUE CODE—Continued

| Revenue code | Description |
|---|---|
| | **OTHER DIAGNOSTIC** |
| 254 | PHARMACY INCIDENT TO OTHER DIAGNOSTIC. |
| 280 | ONCOLOGY. |
| 289 | OTHER ONCOLOGY. |
| 372 | ANESTHESIA INCIDENT TO OTHER DIAGNOSTIC. |
| 560 | MEDICAL SOCIAL SERVICES. |
| 569 | OTHER MEDICAL SOCIAL SERVICES. |
| 622 | SUPPLIES INCIDENT TO OTHER DIAGNOSTIC. |
| 624 | INVESTIGATIONAL DEVICE (IDE). . |
| 710 | RECOVERY ROOM. |
| 719 | OTHER RECOVERY ROOM. |
| 762 | OBSERVATION ROOM. |
| | **RADIOLOGY** |
| 255 | PHARMACY INCIDENT TO RADIOLOGY. |
| 280 | ONCOLOGY. |
| 289 | OTHER ONCOLOGY. |
| 371 | ANESTHESIA INCIDENT TO RADIOLOGY. |
| 560 | MEDICAL SOCIAL SERVICES. |
| 569 | OTHER MEDICAL SOCIAL SERVICES. |
| 621 | SUPPLIES INCIDENT TO RADIOLOGY. |
| 624 | INVESTIGATIONAL DEVICE (IDE). |
| 710 | RECOVERY ROOM. |
| 719 | OTHER RECOVERY ROOM. |
| 762 | OBSERVATION ROOM. |
| | **ALL OTHER APC GROUPS** |
| 250 | PHARMACY. |
| 251 | GENERIC. |
| 252 | NONGENERIC. |
| 257 | NONPRESCRIPTION DRUGS. |
| 258 | IV SOLUTIONS. |
| 259 | OTHER PHARMACY. |
| 260 | IV THERAPY, GENERAL CLASS. |
| 262 | IV THERAPY PHARMACY SERVICES. |
| 263 | IV THERAPY DRUG/SUPPLY/DELIVERY. |
| 264 | IV THERAPY SUPPLIES. |
| 269 | OTHER IV THERAPY. |
| 270 | M&S SUPPLIES. |
| 271 | NONSTERILE SUPPLIES. |
| 272 | STERILE SUPPLIES. |
| 279 | OTHER M&S SUPPLIES. |
| 560 | MEDICAL SOCIAL SERVICES. |
| 569 | OTHER MEDICAL SOCIAL SERVICES. |
| 630 | DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS. |
| 631 | SINGLE SOURCE DRUG. |
| 632 | MULTIPLE SOURCE DRUG. |
| 633 | RESTRICTIVE PRESCRIPTION. |
| 762 | OBSERVATION ROOM. |
| 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 FY 2003 hospital inpatient prospective payment system (IPPS) wage index published in the **Federal Register** on August 1, 2002 (67 FR 49982). 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 the proposed APC changes described in section II.A of this final rule.

• We calculated the median cost for each APC by using the claims for services included in the APC. In the case of APCs for which we eliminated the claims that did not contain device

C codes, we used only the claims that contained device codes to set the median cost for the APC. See section III.A.2 of this final rule for a complete discussion of why we used the device code medians for these codes (which are identified in Table 6).

• Using these 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. This approach is consistent with that used in developing RVUs for the Medicare physician fee schedule. 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 the 2001 through 2002 data, the median cost for APC 0601 is $57.56.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes and wage index changes be made in a manner that ensures that aggregate payments under the OPPS for 2003 are neither greater than nor less than, the aggregate payments that would have been made without the changes. To comply with this requirement concerning the APC changes, we compared aggregate payments using the CY 2002 relative weights to aggregate payments using the CY 2003 final weights. Based on this comparison, in this final rule, we are making an adjustment of .969 to the weights. The final weights for CY 2003, which incorporate the recalibration adjustments explained in this section, are listed in Addendum A and Addendum B of this final rule with comment period. The final weights are rounded to 4 decimals for greater precision.

We received many comments on the issues related to calculation of the OPPS payment weights, which we summarize and address below:

Changes in Payment Rates from 2002 to 2003

*Comment:* We received many comments expressing concern with the amount of decreases in payments for many services, in particular those that will include drugs and devices that will cease to be eligible for pass-through payment in 2003. Many commenters said that the costs for drugs and devices derived from claims data, on which we based weights for these APCs, were considerably below the acquisition price hospitals pay for the drugs and devices. Many commenters said that the proposed payments would result in hospitals ceasing to provide services that require expensive devices and drugs because they could no longer afford to furnish them under the proposed rates.

*Response:* We are concerned that our payments not compromise access of Medicare beneficiaries to high quality services involving new technologies. Accordingly, we have adopted a number of changes in our estimating procedures, as described in more detail below and elsewhere in this final rule, designed to better ensure that the payment rates we establish in this rule are as accurate and reasonable as possible.

*Comment:* Many commenters, in particular hospital organizations, supported the significant increases in payments for primary care and preventive services that were proposed. They strongly stated that we should rely only on Medicare claims data to ensure that these services would not be reduced in payment by increases to payments for device and drug related services, as happened in 2002 when external price data were used in the absence of Medicare claims data. They noted that the services that received increases in payments using 2001 claims data are furnished by all hospitals and that rural hospitals and small urban hospitals in particular are heavily dependent on adequate payment for these services to be able to continue to offer services to Medicare patients in their communities.

*Response:* We also are concerned that our payments not compromise access of Medicare beneficiaries to high quality services that may not involve new technologies; these services in fact represent the bulk of services in all hospitals. Accordingly, we have been mindful that increases in the payment on some services will result in decreases in others.

*Comment:* Many commenters shared with us data from various sources outside our claims data (for example, manufacturers' prices, prices reported by group purchasing organizations, and amounts from invoices as proof of acquisition price). Many of these commenters suggested we use these data as a substitute for or supplement to claims data for particular APCs or where particular drugs or devices are used.

*Response:* We appreciate the data that these commenters provided to us. We carefully reviewed all the data that were furnished to us and used the data to guide us in analysis of claims data and in making decisions regarding how to generate the final payment weights.

We note that the OPPS is not designed to pay hospitals their full accounting costs for delivery of particular services. The system was set up to be budget neutral to the prior system, which, under several provisions of the statute, paid approximately 82 percent of reported hospital outpatient department costs as shown on the cost reports. Payment rates for individual services are set, in essence, to reflect relative resource use within a payment system that pays at what was a discount of approximately 18 percent. Thus, for us to make changes to ensure that a particular service receives what observers believe is its ''full'' cost is difficult, partly because determination of ''full'' cost for a particular service is an uncertain exercise and partly because such a service could only be paid ''full'' cost at the expense of all other services, which in principle would be paid at an even greater discount than that already implied by the operation of the system. Accordingly, while we have used data from external sources to evaluate the reasonableness of our payment rates and to guide us in choice of methods that would achieve results as reasonable as possible, we have not directly substituted such data into our estimates.

*Comment:* Many commenters suggested that we use only claims on which pass-through devices had been coded to set medians for APCs containing procedures that required devices to be furnished.

*Response:* We agree that this suggestion presents a useful way to edit our data, and adopted it in calculating the rates presented in this rule. We calculated medians from our most current set of claims data using all claims, (that is, using claims with no device C code, and using claims with device C code) and compared the medians. We found that, in many APCs because the procedures require use of a pass-through device, the medians that resulted from using any claims on which device C codes were billed were more similar to the device and procedure costs provided by external data than were the medians calculated using all claims. For these APCs, shown in Table 6, we used the median calculated using only claims on which a device had been coded.

*Comment:* Many of the commenters asked that we adjust the weights so that no service, or at least no service for which a commenter had objected to a decrease, would receive a decrease in payment of more than 10 percent from 2002 to 2003.

*Response:* We agree that the substantial fall in payment rates for some APCs suggests the need for some approach to moderate the changes.

Many of these decreases appear to be linked to one or more of the following:

- Changes in the payment methodology for those drugs and devices that will no longer be eligible for pass-through payments,
- Miscoding,
- Restructuring of APCs (in which movement of a single code from one APC to another may change the median cost of both APCs), or
- Use of data from the period following implementation of the OPPS.

In the interest of using a method that could be employed simply and that could ensure that all APCs were treated similarly regardless of whether interested parties had identified them as sources of concern, we adopted a method that we applied to all APCs except new technology APCs, and APCs for drugs and devices that will receive pass-through payments in 2003.

We considered a number of different ways of moderating the reductions in payment that would have occurred under the August 9, 2002 proposed rule. We considered options that would have limited both significant increases and significant decreases in some fashion. However, we rejected these options because they would have reduced payments for those services that would otherwise have significant increases. Inspection of APCs that would have significant increases suggested that many of these increases were reasonable, and we did not want to reduce them more than necessary.

We considered options that would have created a fixed corridor that would have limited any reduction to some fixed value, such as 10 or 15 percent, as suggested by some commenters. However, we rejected this option, because it would have reduced the role of the claims data to a minimum, even though these data do reflect hospital charging behavior and are likely to have some degree of accuracy. In addition, setting an absolute floor on reductions would have shifted significant resources away from all other APCs.

We considered targeting those APCs that would experience a reduction in median costs beyond a threshold and limiting the reduction in median costs to half of the difference between the threshold level and the total reduction. Because of budget neutrality constraints, the costs of this approach must be met by reductions in other services. We concluded that setting a threshold at a 15 percent reduction and decreasing the reduction in median costs by half of the difference between the total proposed reduction and the threshold provided an appropriate balance, reflecting our assessment of the relative quality of claims data, other information from commenters, and the effects on services overall.

Thus, we adopt the following procedure. For any APC where the median cost would have fallen by 15 percent or more from between 2002 to 2003 from the values that would be otherwise applicable for 2003, after the data and method improvements noted above, we first decreased the reduction in median cost by one half of the difference between the value derived from the claims data and 15 percent. This methodology was applied to all APCs, not just those involving drugs or devices losing pass-through eligibility. We then assessed the results of this procedure with information from comments and concluded that several additional but more targeted steps were appropriate.

We examined further those APCs containing procedures involving devices where the device represented a very large portion of the overall costs. Noting that the overall reduction from cost discussed elsewhere in this section would mean that services where devices represented 80 percent or more of the total costs would leave virtually no margin to cover hospital costs in performing the procedure, we limited our attention to those APCs with device costs of 80 percent of more. We then calculated adjusted APC median costs for these APCs by determining the portion of the cost that was attributable to the procedure and summing it with a weighted average of the cost of the device. We determined the weighted average of the cost of the device by giving a weight of 3 to the median acquisition cost of the device as provided by external data and a weight of 1 to the median cost from our claims data. We then added the adjusted cost of the device to the unadjusted cost of the procedure to calculate the total cost of the procedure. Our dampening policy was then applied to the adjusted total cost of the procedure.

We believe that this process gave us credible adjusted medians for APCs 107, 108, 222 and 259. We gave external acquisition cost data a weight 3 times that of the adjusted claims median data because these APCs are disproportionately highly weighted with device costs and we recognize that our device data have weaknesses that would otherwise result in payments that are so low as to limit beneficiary access to these services.

We also examined further those APCs involving blood and blood products, and vaccines. Information from comments raised significant concerns about the payment reductions that would result, even after improvements in data and methods and the adjustments described above were applied, on blood and certain blood products (including antihemophilia factors). Considering the importance of these products to ongoing operation of hospitals, the short shelf life of many of them, other peculiarities of their distribution, and possible adverse effects on public health, we concluded that these products should be further protected from decreases. Accordingly, we limited the reduction in the median cost from 2002 to 2003 for these products to 11 percent, which resulted in limiting the reduction in payment from 2002 to 2003 to about 15 percent. We did this for the APCs listed in Table 8.

We also adopted specific changes relating to vaccines and certain orphan drugs, as described elsewhere in this final rule.

We created unscaled weights for all APCs by dividing the adjusted medians by the median cost for APC 601 (mid level visit). We then scaled the weights for budget neutrality. The budget neutrality scaler that we applied to the weights was .968969.

TABLE 8.—BLOOD AND BLOOD PRODUCTS WITH SPECIAL LIMITS

| APC | Description |
|---|---|
| 0949 | Plasma, Pooled Multiple Donor, Solvent/Detergent T. |
| 0950 | Blood (Whole) For Transfusion. |
| 0952 | Cryoprecipitate. |
| 0954 | RBC leukocytes reduced. |
| 0955 | Plasma, Fresh Frozen. |
| 0956 | Plasma Protein Fraction. |
| 0957 | Platelet Concentrate. |
| 0958 | Platelet Rich Plasma. |

TABLE 8.—BLOOD AND BLOOD PRODUCTS WITH SPECIAL LIMITS—Continued

| APC | Description |
|---|---|
| 0959 | Red Blood Cells. |
| 0960 | Washed Red Blood Cells. |
| 0966 | Plasmaprotein fract,5%,250ml. |
| 1009 | Cryoprecip reduced plasma. |
| 1010 | Blood, L/R, CMV-neg. |
| 1011 | Platelets, HLA-m, L/R, unit. |
| 1013 | Platelet concentrate, L/R, unit. |
| 1016 | Blood, L/R, froz/deglycerol/washed. |
| 1017 | Platelets, aph/pher, L/R, CMV-neg, unit. |
| 1018 | Blood, L/R, irradiated. |
| 1019 | Platelets, aph/pher, L/R, irradiated, unit. |
| 9500 | Platelets, irradiated. |
| 9501 | Platelets, pheresis. |
| 9502 | Platelet pheresis irradiated. |
| 9503 | Fresh frozen plasma, ea unit. |
| 9504 | RBC deglycerolized. |
| 9505 | RBC irradiated. |
| 9506 | Granulocytes, pheresis. |
| 0925 | Factor viii per iu. |
| 0926 | Factor VIII (porcine) per iu. |
| 0927 | Factor viii recombinant per iu. |
| 0928 | Factor ix complex per iu. |
| 0929 | Anti-inhibitor per iu. |
| 0931 | Factor IX non-recombinant, per iu. |
| 0932 | Factor IX recombinant, per iu. |
| 1409 | Factor viia recombinant, per 1.2 mg. |
| 1618 | Vonwillebrandfactrcmplx, per iu |

*Comment:* Many commenters, while indicating appreciation for our efforts to use data from multiple claims in determining relative weights as described in the August 9, 2002 proposed rule, believe that we have not done enough. Although we have significantly increased the number and proportion of claims that enter the calculation for relative weights, commenters asserted that, in particular, clinical areas, our mobility to draw on multiple claims distorts the relative weights assigned to services, because in normal circumstances certain services would always be performed with other particular services. If packaged services also appear on such claims, the claims would not be used in our current methodology, and relative weight calculations may not be as accurate as desired as a result. These commenters urged us to do more to include data from multiple claims.

*Response:* We appreciate the recognition of the methodological improvements that we have been able to accomplish this year. Although intend to continue the gains achieved for 2003, the development of appropriate methods is difficult. Further methodological development may be very detailed and involve clinical review of particular areas of services. We have been unable to develop any further methodological changes at present, so for 2003, we are adopting the same methods we proposed. We wish to develop further methods of allocation that will permit use of more multiple claims in the future, particularly in problem areas identified by commenters, and we hope to be able to make further progress in this area in time for the 2004 update.

*Comment:* Several commenters raised questions about our editing procedures relating to which claims were used in analysis. On one hand, some questioned whether our standard method of trimming claims with values over three standard deviations above the median was appropriate, or whether it might leave out reasonable claims involving newly disseminating, high cost technologies. Other commenters suggested that we edit the claims more restrictively, removing from analysis claims with values outside a clinically relevant range (of drug dosages, for instance).

*Response:* While we think the suggestions made by these commenters deserve further consideration, we have made no changes in developing the estimates for the final rule. Our procedure for trimming claims with values above three standard deviations, an exceedingly small proportion of claims, is a standard procedure we use in estimates for several payment systems. This procedure prevents undue influence on the estimates by claims that have a high probability of coding errors, and we have no particular indication that this procedure is inappropriately applied in this system. Establishing clinically relevant ranges would be difficult. The most obvious method would involve establishment of norms of particular services based on the judgment of clinicians, but these judgments might not be validated by actual experience in the field. We would have to develop this idea more thoroughly before adopting it. Accordingly, for 2003 we are using the trimming and editing procedures rules described in the August 9, 2002 proposed rule.

*Comment:* Several commenters noted that hospital coding appeared to improve over the course of 2001, based on quarter-by-quarter examination of claims data.

*Response:* We agree that hospital coding practices appear to have improved during the early months of the implementation of the OPPS. Because accurate coding now has definite implications for payment that it lacked in the past, this change was expected and comports with our experience in implementing other payment systems. To improve the quality of estimates for this final rule, we changed the reference period of the data used for the final rule by one quarter. The August 9, 2002 proposed rule was based on data from calendar year 2001; for the final rule, we dropped data from the first quarter of 2001 and added data from the first quarter of 2002. We were thus able to draw on data from a more recent period

while maintaining approximately the same number of claims for analysis. This change was possible in this instance because the implementation of the 2002 update on April 1, 2002 meant that the coding during the first quarter of calendar year 2002 was unchanged from the prior year. We believe that this change has improved the quality of our estimates.

*Comment:* Commenters asked a number of very detailed questions about our data and methods of calculation.

*Response:* Within a few weeks of the publication of this rule, we expect to invite interested parties to a meeting at our headquarters in Baltimore to discuss these and other questions regarding methods and estimates with our technical staff.

Use of Cost-to-Charge Ratios and Charge Compression

*Comment:* A number of commenters raised concerns about our use of cost-to-charge ratios in determining median costs of items and services. Of particular concern is the effect of our procedure on the costs we calculate for high-cost drugs and devices. These commenters asserted that hospitals markup their acquisition costs of drugs and devices by different percentages depending on the cost of the item. If so, application of cost-to-charge ratios that do not take this effect into account would result in a relative weight (and hence payment) for a high-cost item that was inappropriately low. Commenters asserted that differential mark-up behavior, sometimes referred to as ''charge compression,'' is common among hospitals, at least on purchased inputs such as implantable devices.

To illustrate, assume cost-to-charge ratios are about generally 50 percent. That would imply that an item that cost, for example, $100, would be marked up by 100 percent to $200. ($100/$200 = .5) If the hospital decided to mark up the cost of a high cost item by only 50 percent, the charge for an item that cost $1,000 would be $1,500, and the cost-to-charge ratio would be 67 percent. ($1,000/$1,500 = .67) On the other hand, the hospital might choose to mark up a low cost item by 150 percent: The charge for an item that cost $10 would be $25, and the cost-to-charge ratio would be 40 percent ($10/$25 = .4).

Commenters did not provide any useful empirical information on issues such as those above. One commenter presented results of a statistical analysis of the relation of average wholesale price (AWP) of some drugs to our proposed payments, but we do not know if average wholesale prices vary uniformly in proportion to the acquisition costs of hospitals and consequently do not find this analysis particularly informative.

*Response:* We calculate OPPS payment rates based on the charges made by the hospitals on OPD claims, reduced to costs by application of a cost-to-charge ratio that is either specific to each of the various departments of each hospital or, in cases where data are inadequate, to the individual hospital as a whole. Costs are not available on a service-specific basis, but are reported on each hospital's cost report by revenue center, which can in turn be grouped by department. Thus, the service-specific amount claimed is multiplied by the departmental cost-to-charge ratio to convert it into a measure of the cost on a service-specific basis. We then use these costs to adjust the relative weights for the various APCs as part of the annual update process.

In making this calculation, we are assuming that the ratio of cost to charges is constant across all services to which it is applied. This assumption has proved workable in the inpatient setting for almost 20 years. The calculations may not perfectly capture the costs identified for particular services, but as long as we use them in a set of relative calculations, any deviations should largely cancel out. However, if hospitals do not mark-up services in a uniform fashion within departments, the payment rates resulting from application of this assumption would be too low for some services (and too high for others), and the rates would create incentives for hospitals to avoid (or favor) particular services.

This postulated behavior of hospitals is not implausible, as they may attempt to avoid adverse reactions to high prices among consumers and to reduce coinsurance burden on high cost items used infrequently. However, the possibility of differential mark-up behavior is not well documented empirically. We do not know if differential mark-ups are common across many hospitals or across many services. Further, we do not know the size of any differential that may exist. Do hospitals apply differential mark-ups to all services or only to certain purchased inputs? Do they apply differential mark-ups only above some threshold (such as $1,000), or does the mark-up vary in some uniform fashion with the cost of the service?

In the face of the paucity of reliable empirical information on this issue, we find that we cannot move quickly to revise our current methodology. We are adopting our proposed methodology for calculating cost-to-charge ratios for 2003. We believe this issue merits further study, and we expect to address it further in the future.

Use of Means Rather Than Medians To Set Weights

*Comment:* Some commenters suggested that CMS use means rather than medians to set rates because means will result in higher values for device-related APCs than using medians. Some commenters noted that means are a better measure of central tendency because medians are so sensitive to the atypical distribution of new technology services within an APC. Some commenters recommended that if we use medians, we should revise the data set by deleting claims for services that require a device if the device was not billed.

*Response:* We will explore the possibility and potential impact of using means rather than medians for the 2004 OPPS. We lacked the resources and time to explore the impact of this change for the final rule with comment. However, since the purpose of these measures is to create relative payment weights, it does not necessarily follow that basing the relative weights of services on means will cause a change to the weights in a manner that would satisfy the commenter. We did, however, revise the data set by deleting claims for procedures that required a device if the device was not billed.

Collect at Least 3 Years' Data for Pass-Through Devices Before Setting Rates Based on Claims Data

*Comment:* Commenters recommended that we not use claims data to set weights for pass-through devices unless they have at least 3 years of claims data for the device. They argued that this was the minimum amount of time needed to allow stability in the hospitals' coding and charges for the items.

*Response:* We cannot ensure that we will wait for 3 years to pass before we will set payments based on data for new devices. The statute provides for no less than 2 years and no more than 3 years payment under pass-through for items that do not fit a previously existing device category. Hence, in most cases, items will not have received 3 years of transitional pass-through payment before they are priced based on costs. Moreover, many new devices do not receive pass-through status because they fit in a category that previously met the criteria and, once pass-through payment is no longer permitted for the category, these devices will be paid through payment for the procedure in which they are used from their first use.

In general, the statute requires us to use costs as the basis for the weights.

Claims data are the single national uniform basis of cost data for all OPD items and services. Other data sources are fragmented and are not national in scope, and may be biased in various ways. We believe that 2 years provides a sufficient time for hospitals to establish coding practices and to determine what charges to impose for items and services paid under the OPPS and that this will be even more true in the future as hospital coders and billers become more accustomed to HCPCS coding and the impact of charges on future payments.

Continue 2002 Weights for 2003 and Train Hospital Staff Coders and Billers Because Claims Data Are Flawed

*Comment:* Some commenters asserted that Medicare 2001 claims data are so badly flawed that the weights should be left untouched for 2003. They requested that we should initiate training of hospital staff billers and coders to ensure that future data accurately reflect the codes of the services furnished and that the charges accurately reflect the costs of drugs and devices.

*Response:* We have decided to revise the weights for 2003 based on the best available information. We believe that the adjustments and moderations we have made to the median costs for the services that would have been most adversely affected under the methodology used in the August 9, 2002 proposed rule have enabled us to establish a valid set of relative weights for the 2003 OPPS. This comports with the requirement of section 1833(t)(9)(A) of the Act that we review and revise the relative weights annually to take into account new cost data and other relevant information, and factors. Regarding training of hospital staff, we have greatly expanded our efforts to assist providers in complying with all Medicare rules, including creation of the Medlearn Web site, issuance of specialized articles and provider seminars. However, the fundamental responsibility for correct coding and billing for services lies with the hospitals who are paid under the OPPS system and who have every incentive to bill correctly to ensure that they are paid for all the services they furnish to Medicare beneficiaries.

Release of Crosswalk for Packaging Costs to Specific APCs

*Comment:* Some commenters asked that we release the crosswalk used to assign pass-through device costs to specific APCs. They indicated that without this crosswalk, they are unable to make specific comments and they urged the Congress to fund an additional activity to correct APCs they determine to be severely underfunded after they perform this analysis.

*Response:* There is no CMS-generated crosswalk that was used to assign pass-through device costs to APCs. We relied upon the coding of hospitals in their packaging of devices, drugs, and other items and services into the payment for the procedure in which they were used. We will make a public use file available that containing the claims data used to set the final payment weights. By examination of these data, interested parties can determine what was packaged into the medians for the APCs. While we recognize that the claims may contain errors, we believe that the probability of making errors in crosswalking services to procedures is reduced by accepting what providers bill as the items and services furnished with the procedure.

Impact of Medical Education on OPPS Payment Adequacy

*Comment:* Several commenters noted that payment under OPPS does not take into account the time and cost components associated with providing teaching services in teaching hospitals and thereby puts teaching hospitals at a disadvantage. Moreover, teaching hospitals are typically on the cutting edge of development and implementation of new innovations, technological and otherwise and would therefore be underpaid by the low payments proposed for APCs that use expensive devices. The commenters asked that Medicare provide an indirect medical education (IME) payment percentage add-on for all outpatient APCs similar to the IME factor used to adjust DRG payments for inpatient services.

*Response:* We have not developed an IME add-on for payments made under the OPPS because the statute does not provide for this adjustment, and we are not unconvinced that it would be appropriate in a budget-neutral system in which such changes would result in reduced payments to all other hospitals. Moreover, in the final rule, we have developed payment weights that we believe resolve many of the issues with payments for devices for which payment is packaged into the payment for the procedure in which the device is used. These and other payment changes should help ensure equitable payment for all hospitals as provided within the constraints of the statute.

Elimination of Payment for Cochlear Implants and Vagus Nerve Stimulators

*Comments:* A number of commenters objected to what they believed was a proposal to eliminate payment for cochlear implants and vagus nerve stimulators. Those who had the implant indicated that these devices had greatly improved their lives, or others who were expected to have the device implanted objected to what they believed was a proposal to no longer pay for them.

*Response:* We did not propose to cease payment for these devices under Medicare or to cease payment for services needed to implant them. We did propose payment amounts for 2003, and, in this final rule, we provide the payment rates that will determine payments under the OPPS in 2003. The establishment of payment amounts does not constitute a Medicare determination that these items and services are or are not covered in any particular case.

Underfunding of OPPS in General

*Comment:* Some commenters stated that OPPS was severely underfunded when it was established and it will never result in adequate payment of costs under its current budget neutrality requirements. They asked that we support their efforts to seek increased funding for outpatient services since hospital care is increasingly furnished in the outpatient setting and because continued absence of adequate funding will result in reduced access to services. Some commenters indicated that since the budget neutrality scaler is determined on the basis of estimates, we have considerable latitude to ensure that payments are as close to costs as possible, notwithstanding that the base was set at 82 percent of cost when the system was established.

*Response:* We do not believe that the OPPS system is severely underfunded, nor do we believe that the statute gives us flexibility in the determination of budget neutrality. Congress set the OPPS system to be budget neutral to the total payments under prior payment methods; those methods, as result of several statutory provisions dating back to FY 1990 and FY 1991, paid for hospital outpatient department services at approximately 82 percent of costs. We understand that observers at the time believed that hospitals had shifted accounting costs that might otherwise have been attributed to inpatient cost centers to the outpatient setting because the inpatient PPS limited hospital payment on the inpatient side while the outpatient side was not similarly constrained. Congress had thus reduced payments for outpatient department services below nominal costs, and the OPPS was set to be budget neutral relative to total payments under the prior system. Whether this situation

implies that hospital outpatient departments are underfunded under the OPPS is hard to judge.

With respect to budget neutrality, section 1833(t)(9)(B) of the Act makes clear that any adjustments to the OPPS made by the Secretary may not cause estimated expenditures to increase or decrease. We do not believe the statute provides us authority to depart from budget neutrality simply because it uses the word ''estimated.''

Data Issues Peculiar to Radiopharmaceuticals

*Comment:* Commenters stated various reasons why it would be inappropriate to use the 2001 claims data to calculate the median cost of radiopharmaceuticals. They claimed that additional costs unique to radiopharmaceuticals, such as overhead costs for nuclear pharmacies and safety/regulatory costs, were not reported in the 2001 claims. Also, they believe not all hospitals billed for their costs, particularly costs for overhead items, to the appropriate revenue codes. Therefore, they argue this misallocation of charges resulted in an underestimate of the cost-to-charge ratios that were used to set the payment rates. The low volume of claims for radiopharmaceuticals in the 2001 dataset may be attributed to the use of HCPCS A4641, which many hospitals used for radiopharmaceutical billing, instead of more specific coding. Also, they suggested that we did not receive reliable reporting data from the hospitals because of significant descriptor and payment rate changes in 2001. Thus, they recommended that we not implement the proposed changes until more accurate data on hospital costs could be collected.

*Response:* As discussed elsewhere in this section, we believe that we have satisfactorily resolved the data issues in the claims data for 2001 to enable us to create an appropriate set of relative weights for OPPS services for 2003. We find no justification for delaying the update of the 2003 OPPS. Moreover, we see nothing unique in the issues raised in the context of data for radiopharmaceuticals. As with other services, the costs in revenue centers and for A4641 were packaged into the procedure with which the items were billed. Similarly, we do not believe that the problem with multiple procedure claims is more of a problem for radiopharmaceuticals than for other services that are commonly provided in combinations. Lastly, there were significant descriptor and payment rate changes for all services paid under OPPS in 2001, and the extent of the changes for radiopharmaceuticals did not differ significantly from the extent of changes for other items and services.

Methodological Reasons That the Data for Drugs Are Flawed

*Comment:* Many commenters asserted that there are significant methodological problems in the 2001 claims data for drugs and biologicals, especially the high cost items. They said that the 2001 claims data do not reflect appropriate codes and charges for separately paid drugs and biologicals and that the proposed payment rate does not take into account additional pharmacy overhead costs. They indicated that when we process a claim, we reject the second and subsequent line if it is identical to a previously billed line as a duplicate claim and that, therefore, the subsequent lines are not included in the claims data. They maintained that the methodology of analyzing single line-items on drug claims is not consistent with how hospitals bill for particular drugs and biologicals. They stated that claims reported by hospitals for certain drugs and biologicals showed unit amounts that fell outside a therapeutic range and therefore should have been excluded from the body of claims used to set the rates. They said that many drugs and biologicals have a low HCPCS code dose that skews the computation of the relative weights, and thus the payment rates for these products.

*Response:* We recognize that not all hospitals billed properly for drugs and biologicals in 2001. However, since most payment for drugs and biologicals was made on a pass-through basis at 95 percent of AWP in 2001, hospitals had a significant incentive to bill properly and we believe that in most cases they billed properly for the services they furnished so as to receive payment for them. We recognize that if a claim was submitted in a manner that caused it to be rejected by duplicate claims edits, it would not appear in the data. However, we expect that in those cases, hospitals would submit an adjustment bill to secure payment for the full service and that the costs for the drugs or biologicals as shown in the adjustment bill would be reflected in the data. We also recognize that some claims reflect that the drugs were furnished in amounts that were outside of therapeutic ranges. However, we have no reason to believe that those claims do not represent what actually was furnished to the patient. Should a physician deviate from standard therapeutic ranges in particular a case, it is reasonable to expect the claim to reflect what was administered. With regard to the low dose of the HCPCS code, the payment is set based on the definition of the code and so to the extent that the drug or biological is correctly coded on the claim, the claims data would reflect the cost of the drug or biological.

Elimination of Data for Hospitals Without Actual Charges

*Comment:* Several commenters raised concerns regarding the elimination of about 3 million claims from 301 hospitals because their reported charges were not actual charges. The commenters requested the following information from us on the effect of eliminating these claims: Did the elimination of this information create more bias against higher cost drugs and biologicals? Were the claims from certain specialty hospitals?

*Response:* There is no way for us to determine what effect would have taken place if these hospitals had reported charges as other hospitals did. However, because we know that the reported charges for these hospitals are not actual charges, we know that the information provided by these hospitals is meaningless for the purpose of calculating payment rates under OPPS.

Impact of Rounding of Relative Weights for Drugs

*Comment:* Commenters stated that the rounding of relative weights down to only two decimal places causes a significant reduction in payment. For example, rounding a unit down to a relative weight of 0.01 from a greater amount (for example, 0.01433) can substantially decrease the payment amount of a therapeutic dose.

*Response:* We rounded relative weights to 4 decimal places in the final rule.

*Comment:* A commenter indicated that we included data from the 11 PPS-exempt cancer hospitals that should have been excluded from the rate-setting calculations.

*Response:* We disagree with the commenter's concern. According to 42 CFR 412.23(f), cancer hospitals that meet specific criteria are excluded from the inpatient PPS; however, these hospitals are not excluded from OPPS. Rather, under OPPS, cancer hospitals are held harmless. The hold harmless provision is set forth in our existing regulations at 42 CFR 419.70(d)(2). Therefore, we do not exclude claims for services furnished in these hospitals in our rate setting calculations.

Need for a Special Exceptions Process

*Comment:* Some commenters said that CMS should have a process by which hospitals should be able to submit special documentation to indicate that

unusual conditions exist and be paid an additional amount set by the contractor for the unusual conditions or costs that the hospital is incurring. They suggested this as a means of being assured of recouping costs where the APC payment would not otherwise reimbursement for full costs.

*Response:* We did not accept the comment because the OPPS already has an outlier system that provides for an additional payment when costs are incurred that meet the outlier criteria.

Claims Process

*Comment:* One commenter said that the implementation of OPPS was extremely daunting to providers because it was so different from prior billing and coding for these services and because CMS processes and rules changed so frequently. They indicated that software vendors often lagged behind CMS requirements and that errors in either provider billing or intermediary processing often required a hospital to detect a problem and resubmit claims. Moreover, the volume of claims can cause a small problem to become a large problem in very little time. They ask that CMS do whatever it can to simplify the processes they must undertake to achieve submission of a ''clean'' claim.

*Response:* We recognize that implementation of CMS was difficult for providers and we have tried to do all that we can to simplify billing and payment rules and to respond to problems as they arise. Most recently, the hospital open door forum calls have provided a means for hospitals to bring problems to the attention of the CMS staff as quickly as possible so that they can be resolved.

Reduced Quality of Care for Gamma Knife Services

*Comment:* A commenter said that reducing payment for hospital services for G0242 will force hospitals to reduce the hours of work for medical physicists in the hospital and will therefore decrease quality by increasing the opportunity for errors in the calculations that must be done before treatment.

*Response:* We believe that hospitals would not jeopardize themselves by decreasing the extent to which they ensure that errors are not made.

We are finalizing our rate methodology for PHP, including data from hospital outpatient and CMHC programs. The national unadjusted rate for CY 2003 will be $240.03, of which $48.17 is the beneficiary's national unadjusted coinsurance. Upon further review we have determined that we will not include the issue of separate billing for clinical social worker services provided to PHP patients in this final rule but will address it in future rulemaking.

## 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 biologicals.

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

Transitional pass-through payments are also required for certain ''new'' medical devices, drugs, and biological agents that could not be described as current, 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 are to 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. On March 22, 2001, we issued two Program Memoranda, Transmittals A–01–40 and A–01–41 that established the initial categories. We posted them on our Web site at *http://cms.hhs.gov.*

Transmittal A–01–41 includes a list of the initial device categories and a crosswalk of all the item-specific codes for individual devices that were approved for transitional pass-through payments as of January 21, 2001 to the initial category code by which the device is 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 biologicals are identified by status indicator ''G.'' Subsequently, we added two additional categories and made clarifications to some of the categories' long descriptors found in transmittal A–01–73. A current list of device category codes in effect as of July 1, 2002 can be found in Transmittal A–02–050, which was issued on June 17, 2002. This Program Memorandum can be accessed on our Web site at *http://cms.hhs.gov.* The list is also included in this preamble in Table 7.

Section 1833(t)(6)(B)(ii) of the Act also requires us to establish, through rulemaking, criteria that will be used to create additional device categories. The criteria for new categories are the subject of a separate interim final rule with comment period that we published in the **Federal Register** on November 2, 2001 (66 FR 55850). We respond to public comments on that interim final rule in this final rule with comment that implements the 2003 OPPS update.

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

The processes 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://cms.hhs.gov*. If we revise the application instructions in any way, we will post the revisions on our Web site and submit the changes for approval by the Office of Management and Budget (OMB) under the Paperwork Reduction Act (PRA). Notification of new drug, biological, or device category application processes are generally posted on the OPPS Web site at *http://cms.hhs.gov/Medicare/hopps/default.asp.*

As we indicated in the NPRM (67FR52130), Determining that a drug or biological is eligible for a pass-through payment or making a decision to pay a drug or biological on a separate APC basis (rather than packaging payment into payment for a procedure) does not represent a determination that the drug or biological is covered by the Medicare program.

CMS and its contractors make coverage determinations and the FDA makes premarket approval decisions under different statutory standards. Whereas the FDA must determine that a product is safe and effective as a condition of approval, CMS must determine that the product is reasonable and necessary as a condition of coverage under section 1862(a)(1)(A) of the Social Security Act. Under a premarket approval review, the FDA determines whether or not the product is safe and effective for its intended use that is

stated in its proposed labeling. Medicare evidence-based NCD reviews consider the medical benefit and clinical utility of an item or service in determining whether the item or service and its expenses are reasonable and necessary under the Medicare program. Unlike the FDA safety and effectiveness evaluation, CMS determines whether or not the product is clinically effective, that is, does the item or service improve net health outcomes in the Medicare population as compared to other covered technologies or procedures. CMS and its contractors do require that a drug or biological first be approved by the FDA, although not necessarily for the indication for which coverage is sought. CMS and its contractors also strongly consider the FDA's evaluation when making a coverage determination for a product and do not substitute their judgment for that of the FDA's regarding safety and effectiveness. Instead, we focus our review on the issues that are unique to Medicare's reasonable and necessary determination. (We note that approval of a product by the FDA as a drug or biological does not automatically assure that Medicare payment for the product will be as a drug or biological. The product must still be placed into the most appropriate Medicare benefit category before Medicare can make appropriate payments.)

In the case of an FDA-approved indication for drugs and biologicals, CMS and its contractors have generally considered that use to be reasonable and necessary, without performing a separate review, although Medicare has always retained the right to perform a separate evaluation. (See, for example, 54 FR 4302, 4306, January 30, 1989) (Proposed Rule-Coverage Criteria) (''Questions regarding coverage of drugs and biologicals are rarely referred to PHS since we have determined as a matter of national policy that drugs or biologicals approved for marketing by FDA are safe and effective when used for indications specified in their labeling.'') (emphasis added); Medicare Carriers Manual section 2049.4 (''Use of the drug or biological must be safe and effective *and otherwise reasonable and necessary*. Drugs or biologicals approved for marketing by the Food and Drug Administration are considered safe and effective for purposes of this requirement when used for indications specified on the labeling.'' (emphasis added). Under section 2049.4, our contractors ''*may* pay for the use of an FDA approved drug or biological, if: (1) It was injected on or after the date of the FDA's approval; (2) It is reasonable and necessary for the individual patient; and (3) All other applicable coverage requirements are met.'' (emphasis added).

CMS developed this approach, because, in the past, it was a more efficient mechanism for coverage and the impact of drugs and biologicals on the Medicare program was relatively small. Now, as a result of the increasing number of novel therapies on the market and the impact of new drugs and biologicals on the Medicare program, it is prudent for Medicare to perform its traditional coverage analysis for appropriate drugs and biologicals as it does for all other items and services to ensure that it only pays for those products that are clinically effective. For drugs and biologicals, Medicare will continue to use FDA approval as a default for a reasonable and necessary determination of an FDA-approved indication unless CMS decides otherwise. CMS may choose to perform a reasonable and necessary determination in several circumstances, including, but not limited to the following: the drug or biological in question represents a novel, complex or controversial treatment, may be costly to the Medicare program, may be subject to overutilization or misuse, or received marketing approval based on the use of surrogate outcomes.

*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 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. 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 pass-through payments will exceed the applicable percentage but also to determine the appropriate reduction to the conversion factor.

In the August 9, 2002 proposed rule, we describe in detail the methodology we would use to make an estimate of pass-through spending in 2003 (67 FR 52117 through 52118). Very generally, after projecting 2003 pass-through spending for the groups of devices, drugs, biologicals, and radiopharmaceuticals as described in the proposed rule, we would calculate total projected 2003 pass-through spending as a percentage of the total (that is, Medicare and beneficiary payments) projected payments under OPPS to determine if the pro rata reduction would be required.

Below is a table showing our current estimate of 2003 pass-through spending based on information available at the time the table was developed. In the August 9, 2002 proposed rule we indicated that we were uncertain whether pass-through spending in 2003 will exceed $467 million or 2.5 percent of total estimated OPPS spending because we had not yet completed the estimate of pass-through spending for a number of drugs. We invited comments on the methodology we proposed to use to determine if a pro rata reduction would be necessary as well as the assumptions shown in Table X of the August 9, 2002 proposed rule that included anticipated utilization and utilization not yet determined.

We received several comments on this proposal, which are summarized below.

Estimates of Pass-Through Spending

*Comment:* A device manufacturer stated that it would be premature to impose pro rata reductions before we accurately account for an APC's device offset amount.

*Response:* Where applicable we have applied offset amounts to APCs with device categories for determining the final estimate of 2003 pass-through spending.

*Comment:* Many commenters said that there should be no pro rata reduction because we did not present the cost and utilization data that would be used to determine if the criteria for a reduction were met. Some commenters said that the pro rata reduction is discretionary and that we should not impose one because of the magnitude of the decreases for APCs that require expensive devices and the decreases in APCs for drugs (as compared to the pass-through payment). Some commenters said that our proposed projections overestimated the volumes that could be expected to occur in 2003.

*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 2003,

the statutory limit is 2.5 percent of total estimated program payments. In the August 9, 2002 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 2003, 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 2003.

We have refined and finalized our estimate of pass-through spending in 2003 and, for the reasons discussed below, we have determined that no pro rata reduction will be required in 2003. Moreover, as discussed below the estimate falls under the statutory limit of 2.5 percent. Therefore, the conversion factor has been increased.

*Comment:* A commenter disagreed with the 2003 payment estimates in Table X of the August 9, 2002 proposed rule for the diagnostic and therapeutic radiopharmaceutical agents, IN–111 Zevalin and Y–90 Zevalin. The commenter estimated the number of patients receiving this therapy in the outpatient department setting in 2003 at approximately 2,500 for both the diagnostic and therapeutic portions, instead of the 9,000 that we projected in our August 9, 2002 proposed rule. The commenter further stated that the payment per patient for the Y–90 Zevalin therapy should be based on 40 mCi, the amount required in the preparation of the dose.

*Response:* Since publication of the August 9, 2002 proposed rule, we have determined that the appropriate payment mechanism for IN–111 Zevalin and Y–90 Zevalin is through the new technology APCs, rather than through the transitional pass-through payment methodology. Zevalin began receiving pass-through payment as a hospital outpatient service in 2002 as a radiopharmaceutical drug. After careful reexamination of Zevalin, we have determined that Zevalin is not a drug and therefore does not qualify for a pass-through payment.

Section 1861(t)(1) provides that the terms drugs and biologicals ''include only such drugs (including contrast agents) and biologicals, respectively, as are included (or approved for inclusion) in [one of several pharmacopoeias] (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.'' A careful reading of this statutory language convinces us that inclusion of an item in, for example, the USPDI (as Zevalin is included, as a biological), does not necessarily mean that the item is a drug or biological. Inclusion in such 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. Rather, if we are to call a product a drug or a biological for our purposes, CMS must still make its own determination that the product is a drug or biological. In the case of Zevalin, we have determined that Zevalin is not a drug or a biological.

Zevalin consists of a radioactive isotope that is delivered to its target tissue by a monoclonal antibody. Because of the specific requirements associated with delivery of radioactive isotope therapy, any product containing a therapeutic radioisotope, including Y–90 Zevalin, will be considered to be in the category of benefits described under section 1861(s)(4) of the Act. Similarly, the appropriate benefit category for all diagnostic radiopharmaceuticals, including IN–111 Zevalin, is 1861(s)(3). We will consider neither diagnostic nor theraputic radiopharmaceuticals to be drugs as described in section 1861(t).

Thus, we have determined that the most appropriate Medicare benefit categories for IN–111 Zevalin and Y–90 Zevalin are as provided in sections 1861(s)(3) and (4) of the Act because they are a new diagnostic test and new radioactive isotope therapy, respectively. We will pay for IN–111 Zevalin under the New Technology APC 718 and for Y–90 Zevalin under the New Technology APC 725 until we have sufficient hospital charge data upon which to use in assigning these services to clinical APCs. Because we have decided that Zevalin does not qualify for transitional pass-through payments, we have not included the estimated payments for Zevalin in our revised estimates of total 2003 transitional pass-through payments.

We have based the determination of New Technology APCs for IN–111 Zevalin and Y–90 Zevalin on information received from the manufacturer and invoices made available to us, and we believe the resulting payment rates to hospitals should be adequate. We note that had we found it necessary to pay for these products as drugs, the average wholesale price alone could have exceeded $28,000 per treatment. We believe his pricing is excessive and that it would have placed an unnecessarily large burden on the Medicare Trust Funds. Had we found it necessary to treat these products as drugs, however, we could have invoked the authority of section 1833(t)(2)(E) to establish a more equitable payment rate.

A hospital may bill for the number of millicuries billed to them by a radiopharmacy or, if the hospital prepares Zevalin itself, the number of millicuries prepared for administration to the patient but, in either case, no more than 40 millicuries.

CMS has also undertaken a national coverage determination (NCD) for Zevalin, which has been approved by the Food and Drug Administration (FDA) to treat certain types of non-Hodgkin's lymphoma, to assure that the product is appropriately used in the Medicare program. A decision memorandum addressing the clinical uses of Zevalin to be covered by Medicare will appear on the CMS coverage Web site (*http://www.cms.hhs.gov/coverage*) soon after publication of this rule.

*Comment:* A drug company raised concerns about the relationship of epoetin alpha and darbepoetin alpha, two competing biologicals used for treatment of anemia. The commenter urged that CMS determine that the two products are substitutes with the same clinical effects and argued that the two should be paid, subject to an appropriate conversion ratio, 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 treat their anemia.

In the late 1980's, scientists used recombinant DNA technology to produce an erythropoietin-like protein called epoetin alpha. Epoetin alpha 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-alpha 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 FDA for marketing for the following conditions: (1) Treatment of anemia of 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 has recently developed a new erythropoietin-like product, darbepoetin alpha, which it markets as Aranesp™. Also produced by recombinant DNA technology, darbepoetin alpha differs from epoetin alpha by the addition of two carbohydrate chains. The addition of these two carbohydrate chains affects the biologic half-life. This change, in turn, affects how often the biological can be administered, which yields a decreased dosing schedule for darbepoetin alpha by comparison to epoetin alpha. 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 alpha has two additional carbohydrate side-chains, it is not structurally identical to epoetin alpha. However, the two products are functionally equivalent: In this case, both products use the same biological mechanism to produce the same clinical result, stimulation of the bone marrow to produce red blood cells. Thus, Epogen™, Procrit™, and Aranesp™ are all functionally equivalent.

These biologicals are dosed in different units. Epoetin alpha is dosed in Units per kilogram (U/kg) of patient weight and darbepoetin alpha 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 alpha was developed, biologicals (such as those developed through recombinant DNA) were typically dosed in International Units (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 clinical practice, CMS recognizes that no strict method of converting an epoetin alpha dose to a darbepoetin alpha dose exists. There are general guidelines for conversion, and clinicians modify the dose based on the patient's hematopoietic response. For developing a payment policy, however, it is feasible to establish a method of converting the dose of each of these drugs to the other.

As part of the process to define a conversion ratio between these biologicals, CMS held a series of meetings with both Amgen and Ortho Biotech. Both companies provided substantial written and published information. We reviewed the Food and Drug Administration labeling for each product (Epogen™, Procrit™, and Aranesp™). We also hired an independent contractor to review the available clinical evidence, and we performed an internal review of this evidence as well. The body of literature reviewed included 40 scientific articles culled from references submitted by the companies as well as a Medline literature search. CMS took into consideration both published and unpublished studies as well as abstracts, conference reports, and materials provided by the two companies.

In selecting articles for review, CMS sought studies that (1) provided a ''head-to-head'' comparison of epoetin alpha to darbepoetin alpha either in patients with chronic kidney disease (on or not on dialysis) or in cancer patients with chemotherapy-induced anemia, and (2) in which an appropriate outcome measure was used. In the absence of such data, we 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.

CMS's identification of a conversion ratio between the dosages of these two products, darbepoetin alpha and epoetin alpha, is solely for the purpose of developing a Medicare payment policy. It is not meant to imply or suggest 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 the needs of individual patients. In terms of payment, however, CMS considers these biologicals to be functionally equivalent (even if structurally different), and, therefore, will establish an equitable payment policy that relates dosage of the agents to each other.

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 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 to 260 International Units of epoetin alpha to one microgram of darbepoetin alpha (260:1).

We think that improved information from clinical trials involving ''head-to-head'' comparisons of these two products could help us insure our policy is correct and if necessary update this policy in the future. In this vein, the National Cancer Institute has been directed to work with CMS to quickly develop and sponsor a trial or trials to evaluate the appropriate conversion ratio between these products for the purpose of Medicare pricing. We expect this project to be completed during the cycle for development of the 2004 OPPS update regulation. If we can estimate a more accurate conversion ratio based on this study or from our review of our own payment data, we will make a change to reflect this ratio so as soon as practicable.

We proposed that transitional pass-through payments for epoetin alpha end at the end of this calendar year, and that payment be made in calendar year 2003 in a separate, unpackaged APC. We are adopting these policies for the final rule.

We had proposed to continue transitional pass-through payments for darbepoetin alpha. We accept, however, the comment suggesting that these two biologicals should be paid at the same rate. As noted above, the products are almost identical; nevertheless there is a great disparity in their costs. In this situation, we believe it is appropriate for us to rely on our authority in section 1833(t)(2)(E) of the Social Security Act to make an adjustment we determine ''necessary to ensure equitable payments.'' We do not believe it would be equitable or an efficient use of Medicare funds to pay for these two functionally equivalent products at greatly different rates. We would package these two biologicals into the same APC, but the difference in dosage metrics makes this step technically impossible if we are to maintain the ability to pay on the basis of the actual dose used. Consequently, they will be in separate APCs but paid at equivalent rates. The 2003 payment rate for non-ESRD epoetin alpha is established as $9.10 per 1000 Units elsewhere in this

rule. We employ the conversion ratio of 260:1 to establish the 2003 payment rate for darbepoetin alpha as $2.37 per 1 microgram. Because this payment rate equals the payment rate for epoetin alpha (albeit expressed in different units), we reduce the transitional pass-through payment for darbepoetin alpha to zero.

An alternative line of reasoning would produce the same result. Section 1833(t)(6)(A) of the Social Security Act distinguishes between ''current'' and ''new'' biologicals. Epoetin alpha is a ''current'' biological. Since April 2002, we have treated darbepoetin alpha as a ''new'' biological. However, section 1833(t)(6)(A)(iv) sets forth the criteria that must be met for a biological to be considered ''new.'' One criterion is that the biological is not described by any item described in clauses (i), (ii) or (iii) of section 1833(t)(6)(A) of the Act, which define ''current'' drugs, biologicals, and devices. Given the determination stated above that these products are functionally equivalent, we believe that darbepoetin alpha is already described by epoetin alpha, a ''current'' biological. Because darbepoetin alpha is functionally equivalent to epoetin alpha, we believe we could conclude that it would be most appropriate to consider darbepoetin alpha a ''current'' biological. In that event, it would not qualify for a pass-through payment as a ''new'' biological. Accordingly, under this analysis, we would terminate the duration of transitional pass-through payment eligibility for darbepoetin alpha on December 31, 2002, and pay for it in a fashion comparable to other products that lose eligibility for transitional pass-through status on that date. More particularly, we would pay it equivalently to epoetin alpha.

Beneficiary copayments are unchanged as a result of the change in payment for darbepoetin alpha, because under this rule the copayment amount for both biologicals would have equaled that calculated for epoetin alpha in any case.

This change is budget neutral. As a result of this change, our estimate of total transitional pass-through payments is smaller than it would otherwise have been. The percentage we have reduced the conversion factor to compensate for transitional pass-through spending is accordingly smaller, and in a budget neutral fashion payment rates for other services are correspondingly higher.

We do not expect to make nationally-applicable determinations of similarity of drugs or biologicals, such as that discussed above, on a routine basis. We regard this situation as unusual, distinguished by the very strong similarity of the two products and by the size of the potential effects on the Medicare program. We thus believe that making this determination and insuring comparable payment is justified in this particular instance.

*Comment:* Commenters from pharmaceutical manufacturers, trade associations, and a provider of oncology services raised concern over the methods used to estimate 2003 pass-through payments for drugs. The primary concern was that we overestimated pass-through spending for 2003, and as a result would trigger pro rata reductions in pass-through payments for drugs appearing on Table X.

Some commenters suggested that we refine our estimation procedures by utilizing alternative modeling techniques and by using data from claims experience. Several of the comments included, in depth, data analysis along with models used to predict pass-through drug spending for calendar year 2003. Spending estimates ranged from $213 million to $441 million dollars.

Other commenters objected to the techniques used to estimate pass-through spending for future products, those items first eligible for pass-though payments in April 2003 or later. A manufacturer's association objected to the use of drugs eligible for pass-through payment beginning in January 1, 2003 as the basis of a forecast of drugs likely to acquire pass-through statusthroughout the remainder of the year. This objection stems from what the association views as the lack of similarities between drugs first eligible for pass-through payments on January 1, 2003 and those eligible later in the year. Further, they object to estimating any additional pass-through payments when it is not clear whether or not a product will be added to the list during 2003.

Another commenter proposed the use of a more sophisticated model based on drugs currently in the FDA pipeline to be used to project spending of drugs first eligible for pass-through payment between April and December 2003.

Other commenters objected to our estimates for specific drugs.

*Response:* We have made a number of changes in response to these comments and in the course of our efforts to complete and refine our preliminary estimates. We have removed several items from the list of 2003 pass-through items that appeared in our August 9, 2002 proposed rule and thus from our final estimates of 2003 pass-through payments. These include IN–111 Zevalin and Y–90 Zevalin, as noted above. FDG (HCPCS C1775; APC 1775) meets the statutory definition of a current radiopharmaceutical and has been receiving pass-through payments. Because we have decided that the pass-through status of current radiopharmaceuticals will not continue past December 31, 2002, pass-through payment status for FDG will end on January 1, 2003. Because a separate code for FDG did not exist until April 2002, we do not have discrete hospital charge data upon which to calculate a median cost for FDG. For transition purposes in 2003, we will pay separately for this supply based on an estimated acquisition cost of 71 percent applied to the 2002 payment rate.

We address below several other issues that arose during our refinement of Table X in the proposed rule. We proposed to continue pass-through payment status for TC 99M oxidronate under HCPCS C1058. However, following publication of the August 9, 2002 proposed rule, we determined that this drug was also represented by HCPCS code Q3009. Under HCPCS code Q3009, this radiopharmaceutical agent has received pass-through payment status for at least 2 years, and will no longer be eligible for pass-through payment under either HCPCS code Q3009 or C1058 beginning on January 1, 2003. As proposed, we are packaging the cost of Q3009 into the procedures with which the code was billed.

Two other HCPCS codes representing radiopharmaceutical agents were inadvertently included in the list of 2003 pass-through drugs in the proposed rule. HCPCS codes C1064 and C1065 were add-on codes used to bill for an additional mCi of I–131. These codes, along with the related HCPCS code C1188 and C1348, which are used to report an initial 1–5 or 1–6 mCi, respectively, will no longer be eligible for pass-through payment on January 1, 2003.

Table 9 contains the final list of items that are eligible for pass-through payments in 2002 and will remain eligible in 2003. Table 9 also contains items that have been approved for pass-through payments beginning in 2003.

It does not contain categories of devices or drugs for which pass-through applications are still pending at the time of issuance of this final rule or for which applications have yet to be received.

We used the following methodology to estimate the pass-through payments for 2003.

1. Devices eligible in 2002 [Device categories beginning July 1, 2002 (C1783, C1888, C1900)] that will continue in 2003: We used manufacturers' retail prices along with

claims utilization estimated for 2003 by our clinical staff, based on our claims data and coding and projected utilization information supplied in the applications. No device offsets were applicable.

2. Drugs eligible in 2002 that will continue in 2003: We used the July 2002 Redbook prices to determine the AWP, which we used in combination with our ratios for establishing estimated acquisition costs to derive pass-through payments for drugs in 2003. We determined the volume for pass-through drugs by soliciting manufacturer estimates of volume for the Medicare population where possible and relying upon a commenter's estimates for the volumes of other drugs.

3. Devices eligible in January 2003: We used manufacturers' retail prices along with claims utilization estimated for 2003 by our clinical staff, based on our claims data and coding and projected utilization information supplied in the applications. We applied offsets to procedures associated with devices that mapped to APCs with offsets.

4. Drugs eligible in January 2003: We used the July 2002 Redbook prices to determine the AWP which we used in combination with our ratios for establishing estimated acquisition costs to derive pass-through payments for drugs in 2003. We determined the volume for pass-through drugs by soliciting manufacturer estimates of volume for the Medicare population where possible and relying upon a commenter's estimates for the volumes of other drugs.

5. Devices eligible in 2001 and will continue in 2003: We used manufacturers' retail prices along with claims utilization for the 12 months that ended March 31, 2002, increased to 2003 by the growth rate provided by our actuary.

Our final estimate of transitional pass-through spending for 2003 also includes projected spending for items that have not yet been approved for 2003. We had proposed to base our estimate of spending for such items on items that have been newly approved for January 1, 2003. In response to comments, we have based our projection for items that will be approved later in 2003 on items that were newly approved for October 1, 2002 and January 1, 2003. We have based our estimate on the two most recent quarters of approval because we anticipate a higher volume of pass-through approvals compared to early 2002 for two reasons. First, we began paying for categories of devices on April 1, 2001. The vast majority of items in use at that time, as well as newly FDA approved items, could receive pass-through payments under a category code. We received, and subsequently approved, a relatively small number of pass-through applications in the first half of 2002. Consequently, we based our projection of spending for items that will be determined eligible for pass-through status in 2003 based on items determined eligible for October 1, 2002 and items determined eligible or expected to be determined eligible for January 1, 2003.

In summary, we estimate that pass-through spending in 2003 will approximate $427.4 million. We believe that pass-through spending in 2003 will break out into the following categories for 2003:

TABLE 9.—ESTIMATE OF PASS-THROUGH SPENDING IN 2003

| HCPC | APC | Drug Biological | 2003 Pass-through payment portion | 2003 Estimated utilization | 2003 Anticipated pass-through payment |
|---|---|---|---|---|---|
| **Existing Pass-through Drugs/biologicals** | | | | | |
| A9700 | 9016 | Echocardiography Contrast | $30.00 | 423,220 | 12,696,607 |
| J9017 | 9012 | Arsenic Trioxide | $7.92 | 4,047 | 32,054 |
| J0587 | 9018 | Botulinum toxin type B | $2.22 | 350,000 | 777,000 |
| J0637 | 9019 | Caspofugen acetate, 5 mg | $8.64 | 98,950 | 854,928 |
| J9010 | 9110 | Alemtuzumab, per 10mg/ml | $129.15 | 11249.19861 | 1,452,834 |
| C9111 | 9111 | Injectin Bivalrudin, 250 mg vial | $100.50 | 38,549 | 3,874,219 |
| C9112 | 9112 | Perflutren lipid micro, 2 ml | $1.25 | 12,676,293 | 15,845,366 |
| C9113 | 9113 | Inj Pantoprazole sodium, vial | $5.76 | 20,000 | 115,200 |
| J2324 | 9114 | Nesiritide, per 1.5 mg vial | $36.48 | 48,000 | 1,751,040 |
| J3487 | 9115 | Zoledronic acid, 2 mg | $102.77 | 228,000 | 23,431,560 |
| C9200 | 9200 | Orcel, per 36 cm2 | $286.80 | 1,000 | 286,800 |
| C9201 | 9201 | Dermagraft, per 37.5 sq cm | $145.92 | 4,770 | 696,038 |
| C9116 | 9116 | Ertapenum sodium | $11.45 | 8,902 | 101,928 |
| C9119 | 9119 | Pegfilgrastim | $708.00 | 102,645 | 72,672,864 |
| J9219 | 7051 | Leuprolide acetate implant | $1,364.16 | 373 | 508,493 |
| **Pass-through Drugs/Biologicals Effective January 2003** | | | | | |
| C9120 | 9120 | Faslodex | $22.13 | 9,690 | 214,440 |
| C9121 | 9121 | Argatroban | $3.60 | 50,000 | 180,000 |
| **Existing Pass-through Devices** | | | | | |
| C1765 | 1765 | Adhesior barrier | | 224 | 110,880 |
| C2618 | 2618 | Probe, cryoablation | | 752 | 150,400 |
| C1783 | 1783 | Ocular implant, aqueous drainage dev | | 2,042 | 1,327,300 |
| C1888 | 1888 | Endovascular non-cardiac ablation catheter | | 208 | 150,800 |
| C1900 | 1900 | Lead, left ventricular coronary venous | | 2,042 | 4,084,000 |
| **Pass-through Devices Effective January 2003** | | | | | |
| C2614 | 2614 | Brachytherapy solution/liquid,I–125 | | 100 | 840,000 |
| C2632 | 2632 | Percutaneous Lumbar Discectomy Probe | | 612 | 1,190,340 |

TABLE 9.—ESTIMATE OF PASS-THROUGH SPENDING IN 2003—Continued

| HCPC | APC | Drug Biological | 2003 Pass-through payment portion | 2003 Estimated utilization | 2003 Anticipated pass-through payment |
|---|---|---|---|---|---|
| **Other Items Expected to Be Determined Eligible for 2003** | | | | | |
| ..... | ..... | Spending for future approved drugs | ..... | ..... | 234,581,267 |
| ..... | ..... | Spending for future approved devices | ..... | ..... | 49,519,559 |
| ..... | ..... | Total Spending for Pass-through Drugs/biologicals, and devices 2003. | ..... | ..... | 427,445,917 |

Our total 2003 estimate of $427.4 million is 2.3 percent of total estimated program payment. We proposed to reduce the conversion factor by 2.5 percent to account for pass-through spending. Since our estimate is now below 2.5 percent, we have adopted a reduction of 2.3 percent to the conversion factor in accord with our estimate of pass-through payments. Our final assumptions used to create the estimate are shown in Table 9 above.

*C. Expiration of Transitional Pass-Through Payments in Calendar Year 2003 for 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 95 device categories currently in effect will expire effective January 1, 2003. Our proposed payment methodology for devices that have been paid by means of pass-through categories, but for which pass-through status will expire effective January 1, 2003, is discussed in the section below.

Although the device category codes became effective on April 1, 2001, many 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, or 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,) To establish the expiration date for the category codes listed in Table 10, we determined when item-specific devices that are described by the categories were first made effective for pass-through payment before the implementation of device categories. These dates are listed in Table 7 in the column entitled ''Date First Populated.'' We proposed to base the expiration date for a device category on the earliest effective date of pass-through status for any device that populates that category. Thus, the 95 categories for devices that will have been eligible for pass-through payments for at least 2 years as of December 31, 2002 would not be eligible for pass-through payments effective January 1, 2003.

Below is Table 7, which includes a comprehensive list of all pass-through device categories effective on or before July 1, 2002 with the date that devices described by the category first became effective for payment under the pass-through provisions and their respective proposed expiration dates.

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

| | HCPCS codes | Category long descriptor | Date first populated | Expiration date |
|---|---|---|---|---|
| 1 | C1883 | Adaptor/extension, pacing lead or neurostimulator lead (implantable). | 8/1/00 | 12/31/02 |
| 2 | C1765 | Adhesion barrier | 10/01/00–3/31/01; 7/1/01 | 12/31/03 |
| 3 | C1713 | Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable). | 8/1/00 | 12/31/02 |
| 4 | C1715 | Brachytherapy needle | 8/1/00 | 12/31/02 |
| 5 | C1716 | Brachytherapy seed, Gold 198 | 10/1/00 | 12/31/02 |
| 6 | C1717 | Brachytherapy seed, High Dose Rate Iridium 192 | 1/1/01 | 12/31/02 |
| 7 | C1718 | Brachytherapy seed, Iodine 125 | 8/1/00 | 12/31/02 |
| 8 | C1719 | Brachytherapy seed, Non-High Dose Rate Iridium 192 | 10/1/00 | 12/31/02 |
| 9 | C1720 | Brachytherapy seed, Palladium 103 | 8/1/00 | 12/31/02 |
| 10 | C2616 | Brachytherapy seed, Yttrium-90 | 1/1/01 | 12/31/02 |
| 11 | C1721 | Cardioverter-defibrillator, dual chamber (implantable) | 8/1/00 | 12/31/02 |
| 12 | C1882 | Cardioverter-defibrillator, other than single or dual chamber (implantable). | 8/1/00 | 12/31/02 |
| 13 | C1722 | Cardioverter-defibrillator, single chamber (implantable) | 8/1/00 | 12/31/02 |
| 14 | C1888 | Catheter, ablation, non-cardiac, endovascular (implantable) | 7/1/02 | 12/31/04 |
| 15 | C1726 | Catheter, balloon dilatation, non-vascular | 8/1/00 | 12/31/02 |
| 16 | C1727 | Catheter, balloon tissue dissector, non-vascular (insertable) | 8/1/00 | 12/31/02 |
| 17 | C1728 | Catheter, brachytherapy seed administration | 1/1/01 | 12/31/02 |
| 18 | C1729 | Catheter, drainage | 10/1/00 | 12/31/02 |
| 19 | C1730 | Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes). | 8/1/00 | 12/31/02 |
| 20 | C1731 | Catheter, electrophysiology, diagnostic, other than 3D mapping (20 or more electrodes). | 8/1/00 | 12/31/02 |
| 21 | C1732 | Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping. | 8/1/00 | 12/31/02 |
| 22 | C1733 | Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip. | 8/1/00 | 12/31/02 |

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

| | HCPCS codes | Category long descriptor | Date first populated | Expiration date |
|---|---|---|---|---|
| 23 | C2630 | Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip. | 10/1/00 | 12/31/02 |
| 24 | C1887 | Catheter, guiding (may include infusion/perfusion capability) | 8/1/00 | 12/31/02 |
| 25 | C1750 | Catheter, hemodialysis/peritoneal, long-term | 8/1/00 | 12/31/02 |
| 26 | C1752 | Catheter, hemodialysis/peritoneal, short-term | 8/1/00 | 12/31/02 |
| 27 | C1751 | Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis). | 8/1/00 | 12/31/02 |
| 28 | C1759 | Catheter, intracardiac echocardiography | 8/1/00 | 12/31/02 |
| 29 | C1754 | Catheter, intradiscal | 10/1/00 | 12/31/02 |
| 30 | C1755 | Catheter, intraspinal | 8/1/00 | 12/31/02 |
| 31 | C1753 | Catheter, intravascular ultrasound | 8/1/00 | 12/31/02 |
| 32 | C2628 | Catheter, occlusion | 10/1/00 | 12/31/02 |
| 33 | C1756 | Catheter, pacing, transesophageal | 10/1/00 | 12/31/02 |
| 34 | C2627 | Catheter, suprapubic/cystoscopic | 10/1/00 | 12/31/02 |
| 35 | C1757 | Catheter, thrombectomy/embolectomy | 8/1/00 | 12/31/02 |
| 36 | C1885 | Catheter, transluminal angioplasty, laser | 10/1/00 | 12/31/02 |
| 37 | C1725 | Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability). | 8/1/00 | 12/31/02 |
| 38 | C1714 | Catheter, transluminal atherectomy, directional | 8/1/00 | 12/31/02 |
| 39 | C1724 | Catheter, transluminal atherectomy, rotational | 8/1/00 | 12/31/02 |
| 40 | C1758 | Catheter, ureteral | 10/1/00 | 12/31/02 |
| 41 | C1760 | Closure device, vascular (implantable/insertable) | 8/1/00 | 12/31/02 |
| 42 | L8614 | Cochlear implant system | 8/1/00 | 12/31/02 |
| 43 | C1762 | Connective tissue, human (includes fascia lata) | 8/1/00 | 12/31/02 |
| 44 | C1763 | Connective tissue, non-human (includes synthetic) | 10/1/00 | 12/31/02 |
| 45 | C1881 | Dialysis access system (implantable) | 8/1/00 | 12/31/02 |
| 46 | C1764 | Event recorder, cardiac (implantable) | 8/1/00 | 12/31/02 |
| 47 | C1767 | Generator, neurostimulator (implantable) | 8/1/00 | 12/31/02 |
| 48 | C1768 | Graft, vascular | 1/1/01 | 12/31/02 |
| 49 | C1769 | Guide wire | 8/1/00 | 12/31/02 |
| 50 | C1770 | Imaging coil, magnetic resonance (insertable) | 1/1/01 | 12/31/02 |
| 51 | C1891 | Infusion pump, non-programmable, permanent (implantable) | 8/1/00 | 12/31/02 |
| 52 | C2626 | Infusion pump, non-programmable, temporary (implantable) | 1/1/01 | 12/31/02 |
| 53 | C1772 | Infusion pump, programmable (implantable) | 10/1/00 | 12/31/02 |
| 54 | C1893 | Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away. | 10/1/00 | 12/31/02 |
| 55 | C1766 | Introducer/sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away. | 1/1/01 | 12/31/02 |
| 56 | C1892 | Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel- away. | 1/1/01 | 12/31/02 |
| 57 | C1894 | Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser. | 8/1/00 | 12/31/02 |
| 58 | C2629 | Introducer/sheath, other than guiding, other than intracardiac electrophysiological, laser. | 1/1/01 | 12/31/02 |
| 59 | C1776 | Joint device (implantable) | 10/1/00 | 12/31/02 |
| 60 | C1895 | Lead, cardioverter-defibrillator, endocardial dual coil (implantable). | 8/1/00 | 12/31/02 |
| 61 | C1777 | Lead, cardioverter-defibrillator, endocardial single coil (implantable). | 8/1/00 | 12/31/02 |
| 62 | C1896 | Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable). | 8/1/00 | 12/31/02 |
| 63 | C1900 | Lead, left ventricular coronary venous system | 7/1/02 | 12/31/04 |
| 64 | C1778 | Lead, neurostimulator (implantable) | 8/1/00 | 12/31/02 |
| 65 | C1897 | Lead, neurostimulator test kit (implantable) | 8/1/00 | 12/31/02 |
| 66 | C1898 | Lead, pacemaker, other than transvenous VDD single pass | 8/1/00 | 12/31/02 |
| 67 | C1779 | Lead, pacemaker, transvenous VDD single pass | 8/1/00 | 12/31/02 |
| 68 | C1899 | Lead, pacemaker/cardioverter-defibrillator combination (implantable). | 1/1/01 | 12/31/02 |
| 69 | C1780 | Lens, intraocular (new technology) | 8/1/00 | 12/31/02 |
| 70 | C1878 | Material for vocal cord medialization, synthetic (implantable) | 10/1/00 | 12/31/02 |
| 71 | C1781 | Mesh (implantable) | 8/1/00 | 12/31/02 |
| 72 | C1782 | Morcellator | 8/1/00 | 12/31/02 |
| 73 | C1784 | Ocular device, intraoperative, detached retina | 1/1/01 | 12/31/02 |
| 74 | C1783 | Ocular implant, aqueous drainage assist device | 7/1/02 | 12/31/04 |
| 75 | C2619 | Pacemaker, dual chamber, non rate-responsive (implantable) | 8/1/00 | 12/31/02 |
| 76 | C1785 | Pacemaker, dual chamber, rate-responsive (implantable) | 8/1/00 | 12/31/02 |
| 77 | C2621 | Pacemaker, other than single or dual chamber (implantable) | 1/1/01 | 12/31/02 |
| 78 | C2620 | Pacemaker, single chamber, non rate-responsive (implantable). | 8/1/00 | 12/31/02 |
| 79 | C1786 | Pacemaker, single chamber, rate-responsive (implantable) | 8/1/00 | 12/31/02 |
| 80 | C1787 | Patient programmer, neurostimulator | 8/1/00 | 12/31/02 |
| 81 | C1788 | Port, indwelling (implantable) | 8/1/00 | 12/31/02 |

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

| | HCPCS codes | Category long descriptor | Date first populated | Expiration date |
|---|---|---|---|---|
| 82 | C2618 | Probe, cryoablation | 4/1/01 | 12/31/03 |
| 83 | C1789 | Prosthesis, breast (implantable) | 10/1/00 | 12/31/02 |
| 84 | C1813 | Prosthesis, penile, inflatable | 8/1/00 | 12/31/02 |
| 85 | C2622 | Prosthesis, penile, non-inflatable | 10/1/01 | 12/31/02 |
| 86 | C1815 | Prosthesis, urinary sphincter (implantable) | 10/1/00 | 12/31/02 |
| 87 | C1816 | Receiver and/or transmitter, neurostimulator (implantable) | 8/1/00 | 12/31/02 |
| 88 | C1771 | Repair device, urinary, incontinence, with sling graft | 10/1/00 | 12/31/02 |
| 89 | C2631 | Repair device, urinary, incontinence, without sling graft | 8/1/00 | 12/31/02 |
| 90 | C1773 | Retrieval device, insertable | 1/1/01 | 12/31/02 |
| 91 | C2615 | Sealant, pulmonary, liquid (Implantable) | 1/1/01 | 12/31/02 |
| 92 | C1817 | Septal defect implant system, intracardiac | 8/1/00 | 12/31/02 |
| 93 | C1874 | Stent, coated/covered, with delivery system | 8/1/00 | 12/31/02 |
| 94 | C1875 | Stent, coated/covered, without delivery system | 8/1/00 | 12/31/02 |
| 95 | C2625 | Stent, non-coronary, temporary, with delivery system | 10/1/00 | 12/31/02 |
| 96 | C2617 | Stent, non-coronary, temporary, without delivery system | 10/1/00 | 12/31/02 |
| 97 | C1876 | Stent, non-coated/non-covered, with delivery system | 8/1/00 | 12/31/02 |
| 98 | C1877 | Stent, non-coated/non-covered, without delivery system | 8/1/00 | 12/31/02 |
| 99 | C1879 | Tissue marker (implantable) | 8/1/00 | 12/31/02 |
| 100 | C1880 | Vena cava filter | 1/1/01 | 12/31/02 |

We considered a number of options on how to pay for devices after their pass-through payment status expires effective January 1, 2003. We held a Town Hall Meeting on April 5, 2002, to solicit recommendations on how to pay for drugs, biologicals, and devices once their eligibility for transitional pass-through payments expires in accordance with the time limits set by the statute. Interested parties representing hospitals, physician specialty groups, device and drug manufacturers and trade associations, and other organizations presented their views on these issues.

After carefully considering all the comments, concerns, and recommendations submitted to us regarding payment for devices and drugs and biologicals that would no longer be eligible for pass-through payments in 2003, we proposed to package the costs of medical devices no longer eligible for pass-through payment in 2003 into the costs of the procedures with which the devices were billed in 2001. (Our proposal to pay for pass-through drugs and biologicals whose pass-through status expires in 2003 is discussed below, in section IV.D.)

The methodology that we proposed to use to package pass-through device costs is consistent with the methodology for packaging that we describe in section III.B of this preamble. That is, 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 2001 charges for devices that will cease to be eligible for pass-through payment in 2003 into the changes for the HCPCS codes with which the devices were billed. We relied on the hospitals to correctly code their bills for all costs, including pass-through devices, using HCPCS codes and revenue centers as appropriate to describe the services that they furnished.

To prevent the loss of the device costs billed by hospitals through revenue centers in developing our relative weights for APCs, we proposed to package the costs of both the device ''C'' codes and the billed revenue centers, whichever appeared on the claim. At the time, we believed that this method would allow us to capture all device related costs billed by hospitals. See our discussion of charges for devices in section III.A.2 of the preamble for this issue.

We customarily allow a grace period for HCPCS codes that are scheduled for deletion. When we allow a grace period for deleted codes, we permit deleted codes to continue to be billed and paid for 90 days after the effective date of the changes that require their deletion. However, we proposed to not allow a grace period for expiring pass-through codes because permitting a grace period would result in pass-through payment for the items for which we proposed to cease pass-through payment effective with services furnished on or after January 1, 2003. Effective for services furnished on or after January 1, 2003, hospitals would submit charges for all surgically inserted devices in the supply, implant, or device revenue center that most appropriately describes the implant. Device costs will thus be packaged into and reflected in the costs for the procedure with which they are associated. Therefore, effective for services furnished on or after January 1, 2003, we proposed to reject line items containing a ''C'' code for a device category scheduled to expire effective January 1, 2003.

We received several comments on this proposal, which are summarized below.

General

*Comment:* A number of hospital organizations indicated they were pleased with our handling of the transitional pass-through payment provisions. The commenters supported our proposal to package into procedural APCs the costs of devices that are no longer eligible for pass-through payment. The commenters asserted that packaging of device costs into base APC payments minimized the confusion and complication of identifying pass-through codes for certain devices and eliminates special payment incentives to use pass-through devices. Provider organizations emphasized the difficult and complicated task of appropriate coding of pass-through items, especially during the transition from a brand-specific to device category system. These commenters also supported our proposal to include device costs from revenue centers in packaging device costs into APCs, to include all device costs.

*Response:* We appreciate these comments. We are adopting our proposed policy in this area as final for 2003.

*Comment:* A hospital organization proposed that we release the crosswalk we used to assign pass-through device costs to specific APCs, so that it can study the assignments made, out of concern that some APCs may receive inadequate payment rates.

*Response:* Our methodology did not involve a cross-walk, so we do not have

one available. Claims files we have made publicly available may be used to analyze where device costs were allocated.

*Comment:* A device manufacturer stated it conceptually agreed that costs of devices should be packaged into ''base'' APC rates of related procedures. However, it viewed as critical that 2003 payment rates appropriately and adequately capture device costs.

*Response:* We agree. As described elsewhere, we are adopting a number of changes in our methodology to help insure appropriate payments for procedures whose payment rates would otherwise have fallen significantly from 2002.

*Comment:* A hospital provider organization urged us to remain committed to the averaging process inherent in a prospective payment system, rather than seek to pay actual cost for elements of total costs, such as new technology. It opposed the imposition of additional administrative costs, for example, any required reporting of acquisition costs on claims, in order to ''fine tune'' pass-through payments or relative weights. It preferred a sample survey to any reporting of acquisition costs. It also preferred that hospitals be permitted to establish their charge structures separately from our payment policies. It recommended that we avoid overriding the hospital-specific cost-to-charge ratio in order to alter the ratios for new technology devices and not distort the PPS to pay for selected items.

*Response:* We appreciate this comment. We have no plans to require reporting of acquisition costs on claims. Although we intend to consider further improvements in our methods for determining OPPS payment rates in the future, we recognize that the importance of maintaining a well developed and coherent methodology.

*Comment:* A hospital provider organization recommended that we furnish a regulatory impact analysis that reflects the total change in payments that are estimated to occur that include outlier, pass-through and corridor payments and each of these items should be separately identifiable.

*Response:* We regret that we are unable to provide the level of detail the commenter requests in the impact analysis. We discuss the extent of our knowledge of accuracy of the pro rata reduction and fold in impact in 2002 in section VIII.

*Comment:* A commenter requested that we disclose how much the ''fold-in'' of device costs into procedure APC payments for 2002 and the pro rata reduction imposed during 2002 over or under compensated hospitals for the new technology devices and drugs. This organization contended that we overestimated the amount of pass-through payments in 2002, when compared to actual payments, and thus arbitrarily removed some $400 million from an already underfunded OPPS.

*Response:* We do not have a revised estimate of transitional pass-through spending for 2002 available at this time. We note that the lack of a pro rata reduction in 2001 may have resulted in higher than expected spending in that year. In either case, the statute does not provide for any retrospective adjustments, either up or down, if the Secretary's estimate of transitional pass-through spending made in advance of the start of the relevant calendar year, and which is used to determine whether a pro rata reduction is necessary and if so how large it must be, later proves too high or too low.

Expiration of Device Categories

*Comment:* A large number of commenters questioned the adequacy of rates proposed for 2003 for APCs involving devices now paid transitional pass-through payments in instances where the device categories expire. Many of these commenters provided information about manufacturers' prices for these devices.

*Response:* We are also concerned about the adequacy of these payment rates. We have reviewed the information provided, and it has helped guide us in determining our final policies for 2003. As discussed elsewhere in this preamble, we have used more recent data, carefully selected appropriate claims for use in relative weight calculations, and adopted dampening provisions to mitigate the reduction in payment rates that might otherwise have occurred.

*Comment:* Some commenters recommended that we delay expiration of transitional pass-through device categories until we collect more accurate data. A device manufacturer suggested that we extend the pass-through payment period for another year to allow time to study ways of capturing hospital costs, to improve accuracy of APC rates.

*Response:* For devices that have been paid in 2000, we cannot extend the pass-through payment as suggested, because this would violate the statutory provision that limits pass-through payments for at least 2 but not more than 3 years. Section 1833(t)(6)(B)(iii)(II) states that a category of devices shall be in effect for a period of at least 2 but not more than 3 years, which begins in the case of the categories initially implemented on April 1, 2001, ''on the first date on which payment was made * * * for any device described by such category (including payments made during the period before April 1, 2001.'' We cannot extend the transitional pass-through payments in order to collect more data.

*Comment:* A number of organizations recommended that we continue transitional pass-through payment status for an additional year for one or more of several categories that were first populated with devices on January 1, 2001. One commenter recommended that we continue pass-through payments for all current device categories until July 31, 2003 and through December 31, 2003 for items in categories first populated as of January 1, 2001, stating that we make mid-year changes to billing requirements and HCPCS codes. The commenter acknowledged that this may be burdensome, but stated that the benefit of paying appropriately outweighs the cost of revising rates in mid-year.

*Response:* We have reviewed these categories and do not see a marked difference between these categories and the other categories the eligibility of which is expiring. As a result, we do not believe it would be appropriate to continue transitional pass-through payment status for them beyond December 31, 2002.

Revising rates in mid-year is not generally part of Medicare rate-making policy and is not appropriate in this instance either. It is not only burdensome for this agency, it also burdens the providers and fiscal intermediaries, and it would add confusion to an already complex system.

*Comment:* Organizations recommended that we continue pass-through payment status for cardiac resynchronization ICDs devices through category C1882. We indicated that this category contains devices that first received transitional pass-through payments as of August 1, 2000. The commenter is concerned that this category, which is described as ''cardioverter-defibrillator, other than single or dual chamber,'' also includes a cardiac resynchronization ICD that was first eligible for transitional pass-through payments on January 1, 2001. The commenter suggested that in order to avoid any unfair competitive advantage among categories with competing technologies, we should extend pass-through payments for both C1882 and C2621, ''pacemaker, other than single or dual chamber,'' which includes cardiac pacemakers.

*Response:* We cannot extend the pass-through payment status for C1882. We believe the most appropriate step is to end these categories in tandem. Therefore, we will terminate transitional pass-through payments for these 2 categories simultaneously as of January 1, 2003.

*Comment:* A hospital organization requested clarification regarding the expiration of transitional pass-through device categories effective January 1, 2003. This commenter was confused by our stated proposal to delete 95 pass-through category codes as of January 1, 2003, yet Addendum B of the proposed rule shows these 95 codes as active codes with an OPPS status indicator of ''N'' (packaged). A number of commenters recommended that hospitals retain the option to code them and have the ''N'' status drive the payment, or in order to continue to report and track those devices.

*Response:* We intend on deleting these codes, with the line item use of the codes rejected. We clarify the status indicator in this final rule.

*Comment:* A hospital provider organization requested clarification on our proposal that hospitals submit charges for all surgically inserted devices in the supply, implant, or device revenue center that most appropriately describes the implant and that the device costs will then be packaged into and reflected in the costs for the procedure with which they are associated. It noted that we published clear requirements on what revenue codes were appropriate for reporting medical devices that had been granted pass-through status in Program Memorandum A–01–50. The organization stated that that this would constitute the appropriate revenue center list to use for these devices even though they are now packaged.

*Response:* In the proposed rule we indicated that effective for services furnished on or after January 1, 2003, hospitals would not bill a ''C'' code for devices that no longer qualify for pass-through payment, but would submit charges for surgically inserted devices in the supply, implant or device revenue center that most appropriately describes the implant. We agree with the commenter that the revenue codes listed in Program Memorandum A–01–50 will continue to constitute the appropriate revenue codes under which such devices must be billed, even when the devices are no longer eligible for pass-through payments.

Use of Codes for Expiring Categories After January 1, 2003

*Comment:* A commenter asked us to clarify the use of device HCPCS codes after their expiration dates. Commenters expressed concern that our proposed deletion of the pass-through codes of drugs and devices as of January 1, 2003 without a grace period would place a burden on hospitals. One commenter recommends that we change the status indicator to ''N'', that is, packaged with other services. One commenter stated that we should keep all C-codes in effect permanently, even without reimbursement. The commenter argues that this step would provide better tracking for providers and payers and eliminates the coding burden caused by deletion of codes.

*Response:* We proposed to delete the pass-through category codes for devices when the eligibility of the category for pass-through payments expires. Therefore, any claims that use these codes will be returned to providers. We proposed to reject the line item in the proposed rule. However, on further consideration and discussion within CMS, we decided that we must return the claim to the provider so that the provider may correctly place the charges for the device in a revenue center. This is important to ensure that the hospital receives any hold harmless, corridor or outlier payments that it is due. If we were to line item reject the deleted code and process the rest of the claim, then the hospital could be underpaid by the absence of payments that would result if the charges for the device were correctly reported. Given the frequency with which our data shows that providers fail to bill for the device (even when they could receive pass-through payment for it as discussed in section III.A.2 of the preamble), we believe that it is important that the claim be returned to the provider so that it can be corrected and resubmitted for payment.

*Comment:* A hospital organization agreed with our proposal not to have a 90-day grace period for C-codes scheduled for deletion, to prevent additions to the pass-through payment pool, which could then contribute to a pro rata reduction to other services.

*Response:* We agree. We believe it is necessary in this instance to forgo a grace period to prevent incorrect payments.

New Device Categories

*Comment:* A number of commentersprovided both supportive and critical comments to the August 9, 2002 proposed rule on our criteria for establishing new device categories for transitional pass-through payment. One commenter indicated that we have been reviewing and evaluating applications for new device categories even though we have not issued a final rule on this subject.

*Response:* We have summarized comments that we received timely in response to the November 2, 2001 interim final rule on the criteria, and these are addressed in section V of this final rule. We will take note of all comments as we evaluate the new device category process and any modifications to the process we might propose in the future. Our review of applications for device categories has been done under authority of the November 2, 2001 interim final rule.

Stent Categories C1874 and C1875

*Comment:* A number of commenters took issue with our interpretation of existing category limitation in evaluating applications for new pass-through device categories. They cited our discussion on drug-eluting stents, that is, that this new technology was described by existing categories C1874, stent, coated/covered with delivery system, and C1875, stent, coated/covered without delivery system. These commenters asserted that neither of the existing categories appropriately describes the drug-eluting stent technology. While they indicated that creating a new APC for drug-eluting stents is appropriate, they expressed concern that many existing categories are described in broad terms, thus potentially excluding other new technologies from additional categories. Examples of applications for ICDs and total joint implants were provided.

*Response:* We are making final our proposal for separate, procedure APCs for procedures involving drug-eluting stents. These stents will not be in a transitional pass-through category nor receive transitional pass-through payments. In the case of breakthrough therapies that may quickly achieve widespread distribution and that are sufficiently expensive to have a significant effect on hospitals, we may propose to create appropriate APCs, as we have done in this instance. The existing transitional pass-through device categories were deliberately specified in fairly broad terms in order to provide an appropriate balance between specificity and the reporting burden on hospitals.

DME Payment for Implantable Devices

*Comment:* One commenter, concerned about reduced payments for implantable devices, suggested that we define certain implantable devices as durable

medical equipment and/or prosthetics, for payment under the durable medical equipment fee schedule instead of the OPPS.

*Response:* The BBRA of 1999 changed the OPPS and durable medical equipment fee schedule (see sections 1833(t)(1)(B)(iii) and 1834(h)(4)(B) of the Act) so that implantable prosthetic devices delivered in the hospital outpatient setting must be paid through the OPPS, rather than on the durable medical equipment fee schedule.

Category C1765, Adhesion Barrier

*Comment:* A commenter claimed that one of our categories that we propose to continue pass-through payment in 2003, Adhesion Barrier (C1765), contains a product that was manufactured by a single company. The FDA asked the company to recall the product, and it has been off the market for more than a year. This commenter suggested that C1765 be removed from the APC system for 2003, since neither this nor equivalent products are on the market. If and when this or another similar product is reintroduced to the market, it should be considered for pass-through payment at that time.

*Response:* We will not remove category C1765 from active pass-through payment, which is scheduled to continue through December 31, 2003. C1765 is open to any product that fits the category description of adhesion barrier in accordance with the definition in Program Memorandum A–02–050, not only the product of the stated manufacturer.

Cochlear Implants

*Comment:* Numerous providers, including hospitals, ENT clinics, physicians, clinical audiologists and other commenters, protested our proposed payment rates for cochlear implant services. They questioned our data for 2001, saying insufficient claims data appear to be reported for the procedure or that the charges appear inappropriately low. Some providers requested an average payment of $3,000 for the surgery, plus the invoice cost of the device, some offering to include the manufacturer's invoice with their claims. Comments also included recommendations that we continue to pay for cochlear implants as pass-through payments for another year or more to develop more accurate claims data . A group of manufacturers also recommended that we issue written guidance to hospitals regarding the correct billing procedures for cochlear implants.

*Response:* We have attempted to mitigate the proposed reductions in payment rates resulting from the expiration of transitional pass-through device categories, of which cochlear implant is one . Transitional pass-through payments were first made for cochlear implants on August 1, 2000, before pass-through category L8614 was established. Therefore, we cannot provide another year or more of pass-through payments, because the statute limits pass-through payments to a period of at least 2 years but not more than 3 years. We feel the recommendation that we issue guidance to hospitals regarding the correct billing procedures for device related procedures, such as cochlear implants, may have merit, and we will consider providing further guidance in this area.

IOLs

*Comment:* A number of commenters expressed concern that the expiration of the transitional pass-through device category for new technology intraocular lenses (IOLs) on January 1, 2003 would result in inadequate payment for new technology lenses. These commenters recommended that a new APC be created to pay for the provision of these lenses, even though the incremental cost is low. These commenters also recommended that we create new categories of new technology IOL ''for additional payment similar to the provision applicable in ambulatory surgical centers. One commenter was concerned that we not allow the broad description of the current category C1780, ''lens, intraocular (new technology)'' to interfere with future intraocular lenses being eligible for pass-through payment.

*Response:* Regarding the adequacy of payment after the new technology IOL category expires, no specific data were provided by any commenters. However, we believe that the incremental cost of such lenses is low. We do not believe a change the APC for implanting new technology IOLs is warranted at this time.

**Implantation of Neurostimulator (APC 222) and Electrode (APC 225)**

*Comment:* A manufacturer and a number of medical centers commented that the proposed payments for implantation of a neurostimulator generator (APC 222) and electrode (APC 225) are inadequate. One of these commenters recommended that we delay the expiration of these pass-through categories for another year or two.

*Response:* The implantations of a neurostimulator generator and electrode have been paid via pass-through payment for devices since August 2000, and we proposed to retire the pass-through categories as of January 1, 2003. For devices that have been paid since August 2000, we cannot extend the pass-through payment for another year or two, as suggested, because this would violate the statutory provision that limits pass-through payments for at least 2 but not more than 3 years. Therefore, we are moving to prospective payment for these devices from the charge-based pass-through payments.

Dialysis Access Systems

*Comment:* A manufacturer of a dialysis access system asserted that the 2003 proposed reduction in payment rates for dialysis access would curtail patient access.

The commenter provided two suggestions regarding the expiring category code for dialysis access systems, C1881. One option suggested is for us to assign a unique HCPCS code for placement of the manufacturer's brand specific dialysis system and place it in a new or existing APC that has appropriate payment. This commenter contended that bundling C1881 within APC 115 will result in inadequate payment, because the device will be bundled with standard hemodialysis catheters and chemotherapy ports. The second option suggested is to extend pass-through payment status for category C1881. This commenter stated its dialysis system was approved for pass-through payment in August 2000, and there were limited sales and therefore claims in 2000 and the first half of 2001. Thus, this commenter expressed the opinion that there is approximately 1 year of data for this category, not the 2 to 3 years required.

*Response:* Regarding the option proposed by this commenter for assignment of a unique product-specific HCPCS code, we do not assign unique HCPCS codes for brand-specific devices. Section 1833(t)(6)(B) of the Act indicates that transitional pass-through status of devices is to be determined based on categories. HCPCS codes are generally assigned for procedures that are not adequately described by existing HCPCS codes. This device has had a temporary category code for roughly two and one-half years, and we believe there are sufficient data to measure its utilization and cost. Regarding this commenter's proposal to extend pass-through payment status for category C1881, we cannot, by law, extend the pass-through payment period beyond the 2 to 3 year period. Although the commenter asserted that there were only limited claims for pass-through payment for the device in 2000 and the first half of 2001, section 1833(t)(6)(B)(iii) of the

Act explicitly indicates that the 2 to 3 year period for which categories of devices may be in effect applies from the first date on which payment was made under the OPPS for any device described by the category, which was August 2000.

**Specific Category Applications**

*Comment:* Several commenters commented on specific pass-through device category applications which we had open as of the time of the comment or applications which we had previously denied as eligible for pass-through payment.

*Response:* We evaluate all pass-through device category applications individually and respond to applicants directly.

*D. Expiration of Transitional Pass-Through Payments in Calendar Year 2003 for Drugs and Biologicals (Including Radiopharmaceutical Agents, Blood, and Blood Products)*

Under the OPPS, we currently pay for drugs and biologicals, including radiopharmaceutical agents, blood, and blood products, in one of three ways: packaged payment, separate APCs and transitional pass-through payment.

Drugs as Packaged Supplies

As we explained in the April 7, 2000 final rule, we generally package the cost of drugs and biologicals into the APC payment rate for the primary procedure or treatment with which the drugs are usually furnished (65 FR 18450). 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.) Hospitals bill for costs directly related and integral to performing a procedure or furnishing a service using a revenue center or packaged HCPCS code (status indicator ''N''). As discussed earlier in section III.A.2 of the preamble, we list the packaged services, by revenue center, that we use to calculate per-service costs.

As specified in the regulations at § 419.2(b), costs directly related and integral to performing a procedure or furnishing a service on an outpatient basis are included in the determination of OPPS payment rates for the procedure or service. In the August 9, 2002 proposed rule, we provided some illustrations of situations in which drugs are considered to be supplies. For example, sedatives administered to patients while they are in the preoperative area being prepared for a procedure are supplies that are integral to being able to perform the procedure. Similarly, mydriatic drops instilled into the eye to dilate the pupils, anti-inflammatory drops, antibiotic ointments, and ocular hypotensives that are administered to the patient immediately before, during, or immediately following an ophthalmic procedure are considered an integral part of the procedure without which the procedure could not be performed. The costs of these items are packaged into and reflected within the OPPS payment rate for the procedure. Likewise, barium or low osmolar contrast media are supplies that are integral to a diagnostic imaging procedure as is the topical solution used with photodynamic therapy furnished at the hospital to treat non-hyperkeratotic actinic keratosis lesions of the face or scalp. Local anesthetics such as marcaine, lidocaine (with or without epinephrine) and antibiotic ointments such as bacitracin, placed on a wound or surgical incision at the completion of a procedure, are other examples we cited in the proposed rule. The hospital furnishes these items while the patient is in the hospital and registered as an outpatient for the purpose of receiving a therapy, treatment, procedure, or service. These and other such supplies may be furnished pre-operatively, while the patient is being prepared for a procedure; intra-operatively, while the procedure is being performed; or post-operatively, while the patient is in the recovery area prior to discharge. Or, these items may be part of an E/M service furnished during a clinic visit or in the emergency department. All of these supplies are directly related and integral to the performance of a separately payable therapy, treatment, procedure, or service with which they are furnished. Therefore, we do not generally recognize them as separately payable services. We package their cost into the cost of the primary procedure, and we pay for them as part of the APC payment.

We received several comments concerning the treatment of drugs as supplies, which are summarized below, along with our responses.

*Comment:* Several commenters asked for clarification of CMS's policy with respect to self-administered drugs, claiming the discussion in the preamble which lists examples of drugs, including self-administered drugs, that are packaged and paid as integral to an outpatient service conflicts with section 1861(s)(2) of the Act and CMS manuals which consider self-administered drugs to be non-covered.

*Response:* Our policy is based on the premise that certain drugs are so integral to a treatment or procedure that the treatment or procedure could not be performed without them. Because such drugs are so clearly a component part of the procedure or treatment, we believe that they are more appropriately considered as supplies and should be packaged as supplies into the APC payment for the procedure or treatment. Moreover, the payment for packaged supplies is included in the APC payment for the procedure or treatment, so beneficiaries should not be separately billed for them.

*Comment:* A commenter stated that virtually all drugs furnished in the outpatient setting are integral to an outpatient service and asked that CMS clarify those circumstances when usually self-administered drugs would not be considered integral to a service and therefore, non-covered.

*Response:* A drug would be treated as a packaged supply in cases where, although the drug is not separately payable, it is directly related and integral to a procedure or treatment and is required to be provided to a patient in order for a hospital to perform the procedure or treatment during a hospital outpatient encounter. A drug would not be treated as a packaged supply if it failed to meet these conditions. For example, we would not treat as packaged supplies any drugs that are given to a patient for their continued use at home after leaving the hospital. Another example would be a situation where a patient who is receiving an outpatient chemotherapy treatment develops a headache. Any medication given the patient for the headache would not meet the conditions necessary to be treated as a packaged supply. Similarly, if a patient who is undergoing surgery needs his or her daily insulin or hypertension medication, the medication would not be treated as a packaged supply.

*Comment:* A commenter from a teaching hospital indicated that revenue code 819, which is required for the acquisition of bone marrow or blood-derived peripheral stem cells, is bundled into the charge for the transplantation procedure, CPT 38240. The commenter noted that the transplant CPT code pays approximately $350–$400; however, charges for acquiring stem cells are generally $25,000–$35,000 each. Therefore, the commenter recommended that we create

a new biological pass-through code for the stem cells until we can build the cost of the acquisition into the procedure, and the code should be retroactive to January 1, 2002.

*Comment:* A commenter from a teaching hospital indicated that revenue code 819, which is required for the acquisition of bone marrow or blood-derived peripheral stem cells, is bundled into the charge for the transplantation procedure, CPT 38240. The commenter noted that the transplant CPT code pays approximately $350–$400; however, charges for acquiring stem cells are generally $25,000–$35,000 each. Therefore, the commenter recommended that we create a new biological pass-through code for the stem cells until we can build the cost of the acquisition into the procedure, and the code should be retroactive to January 1, 2002.

*Response:* We understand the commenter's concern. Pass-through payments, after December 31, 2002, will only be made for medical devices, drugs, or biologicals in accordance with section 1833(t)(6)(A)(iv) of the Act. Stems cells are not medical devices nor do they meet the statutory prerequisite for calling these items ''drugs and biologicals,'' as stated in sections 1861(t)(A) and (B) of the Act. For example, stems cells do not receive FDA approval and are not listed in the United States Pharmacopoeia.

The commenter indicates that the hospital is not being paid adequately for stem cell acquisition costs. However, the commenter should note that hospitals should be reporting all charges associated with the purchase of stem cells under Revenue Code 819. Therefore, to the extent that hospitals are billing a charge for the cost of acquiring stem cells under Revenue Code 819, those costs would be packaged into the median cost of CPT 38240 and be reflected in the APC payment rate. These services may also qualify for outlier payments.

Separate APCs for Drugs Not Eligible for Transitional Pass-Through Payment

There are certain new technology drugs and biologicals that are not eligible for transitional pass-through payments but for which we have made separate payment. Beginning with the April 7, 2000 rule (65 FR 18476), we created separate APCs for these drugs and biologicals as well as devices. We proposed to create temporary individual APC groups for the various drugs classified as tissue plasminogen activators and other thromobolytic agents that are used to treat patients with myocardial infarctions as well as certain vaccines to allow separate payment so as not to discourage their use where appropriate. In the case of blood and blood products, wide variations in patient requirements convinced us that we should pay for these items separately rather than packaging their costs into the procedural APCs. Moreover, the Secretary's Advisory Council on Blood Safety and Access recommended that blood and blood products be paid separately to ensure that to minimize incentives that would be inconsistent with the promotion of blood safety and access.

In the case of the other drugs and vaccines that we proposed not package into payment for visits or procedures, we paid separately for them because we wanted to avoid creating an incentive to cease providing these drugs when they were medically indicated.

We based the payment rate for the APCs for these drugs and biologicals on median hospital acquisition costs using 2001 claims data. We set beneficiary copayment amounts for these drug and biological APCs at 20 percent of the payment amount. In 2003 we will use status indicator ''K'' to denote the APCs for drugs and biologicals (including blood and blood products) and certain brachytherapy seeds that are paid separately from and in addition to the procedure or treatment with which they are associated but that are not eligible for transitional pass-through payment.

General

BBRA provided for special transitional pass-through payments for a period of 2 to 3 years for the following drugs and biologicals (pass-through payments for devices are addressed in section IV.C. of the preamble):

- Current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act.
- Current drugs and biologic agents used for treatment of cancer.
- Current radiopharmaceutical drugs and biological products.
- New drugs and biological agents.

In this context, ''current'' refers to those items for which hospital outpatient payment was being made on August 1, 2000, the date on which the OPPS was implemented. A ''new'' drug or biological is a product that is not paid under the OPPS as a ''current'' drug or biological, was not paid as a hospital outpatient service before January 1, 1997, and for which the cost is not insignificant in relation to the payment for the APC with which it is associated.

Section 1833(t)(6)(D)(i) of the Act sets the payment rate for pass-through eligible drugs as the amount by which the amount determined under section 1842(o) of the Act, that is, 95 percent of the applicable average wholesale price (AWP), exceeds the difference between 95 percent of the applicable AWP and the portion of the otherwise applicable fee schedule amount (that is, the APC payment rate) that the Secretary determines is associated with the drug or biological. Therefore, in order to determine the pass-through payment amount, we first had to determine the cost that was packaged for the drug or biological within its related APC. In order to determine this amount, we used data on hospital acquisition costs for drugs from a survey that is described more fully in the April 7, 2000 and the November 30, 2001 final rules. The ratio of hospital acquisition cost, on average, to AWP that we used is as follows:

- For sole-source drugs, the ratio of acquisition cost to AWP equals 0.68.
- For multisource drugs, the ratio of acquisition cost to AWP equals 0.61.
- For multisource drugs with generic competitors, the ratio of acquisition cost to AWP equals 0.43.

Section 1833(t)(6)(C)(i) of the Act specifies that the duration of transitional pass-through payments for current drugs and biologicals must be no less than 2 years nor any longer than 3 years beginning on the date that the OPPS is implemented. Therefore, the latest date for which current drugs that have been in transitional pass-through status since August 1, 2000 will be eligible for transitional pass-through payments is July 31, 2003. We proposed to remove these drugs from transitional pass-through status effective January 1, 2003 because the statute gives us the discretion to do so and because we generally implement annual OPPS updates on January 1 of each year. We would be in violation of the law if we were to not remove these drugs and biologicals from transitional pass-through status by August 1, 2003. The next update of the OPPS that will go into place will not be effective until January 1, 2004, at which time the statute's 3-year limit on pass-through payments for these drugs would have been exceeded. We further proposed to remove from transitional pass-through status, beginning January 1, 2003, those drugs for which transitional pass-through payments were made effective on or prior to January 1, 2001 because the law gives us the discretion to do so and we believe that, to the extent possible, payments should be made under the OPPS, without pass-through payment, when the law permits, as it does in this case.

As explained above, our policy has been to package payment for drugs and

biologicals into the payment for the procedure or service to which the drug is integral and directly related. In general, packaging the costs of items and services into the payment for the primary procedure or service with which it is associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility. Packaging costs into a single aggregate payment for a service procedure or episode of care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. Our proposal to package the costs of devices that we discuss in section IV.C of this preamble is based on this principle. As we refine the OPPS in the future, we intend to continue to package, to the maximum possible extent, the costs of any items and services that are furnished with an outpatient procedure or service into the APC payment for services with which it is billed.

In spite of our commitment to package as many costs as possible, we are aware of concerns that were presented at the April 5, 2002 Town Hall meeting and that have been brought to our attention by various interested parties, that packaging payments for certain drugs, especially those that are particularly expensive or rarely used, might result in insufficient payments to hospitals, which could adversely affect beneficiary access to medically necessary services.

The options that we considered included packaging the costs of all drugs and biologicals, both those with status indicator ''K'' in 2002 and those that would no longer receive pass-through payments in 2003, or continuing to make separate payment for both categories of drugs and biologicals through separate APCs. After careful consideration of the various options for 2003, we proposed to package the cost of many drugs for which separate payment is made currently. But we also proposed to continue making separate payment for certain orphan drugs (as discussed below), blood and blood products, vaccines that are paid under a benefit separate from the outpatient hospital benefit (that is, influenza, pneumococcal pneumonia, and hepatitis B), and certain higher cost drugs as explained below. The payment rates for those drugs for which we would make separate payment in 2003 would be an APC payment rate based on a relative weight calculated in the same way that relative weights for procedural APCs are calculated.

Comments on this proposal and our responses are summarized below:

*Comment:* We received many comments regarding the significant reduction in the payment rates for numerous drugs and biologicals that are sunsetting from their transitional pass-through status. The commenters asserted that proposed payment rates are significantly lower than the costs hospitals incur in acquiring and dispensing these products. As a result, inadequate payment may drive hospitals to discontinue stocking these products, and thus threaten beneficiary access to important drugs and biologicals. The commenters attributed the dramatic reduction in payment rates on the flaws in the 2001 claims data and deficiencies in the methodology that was used to derive the APC median costs. Commenters suggested numerous ways to correct the payment rates until reliable and sufficient claims data became available. Commenters proposed the following suggestions: maintain separate pass-through payments for APCs whose proposed payment rates decreased; pay a flat amount per item on a per patient basis; develop a rate setting methodology that does not depend upon the hospital's ability to record the proper number of units of a drug utilized; use information provided by commenters to set the 2003 payment rates; revise payment rates to include payment for the drug and related pharmacy overhead costs; pay 90 to 100 percent of AWP for non-pass-through drugs; use an appropriate ratio of acquisition cost to AWP as estimated in the proposed rule; conduct a new external survey of hospitals' drug acquisition costs to obtain more current data; or pay according to the median hospital cost for the item.

*Response:* As discussed elsewhere in this rule, in order to lessen the impact of the dramatic reduction in the proposed payment rates for many of the drugs and biologicals from 2002 to 2003, we decided that the most appropriate mechanism is to apply a dampening option to all of the APCs that decreased in median costs by more than 15 percent. For these APCs, we limited the reduction in median costs from 2002 median costs to half of the difference between the total proposed reduction and 15 percent. However, budget neutrality adjustments needed to compensate for the effects of this dampening subsequently reduced payment rates of all APCs by an additional percentage. Also, we applied a special dampening option to all blood and blood products and hemophilia clotting factors that limited the decrease in their payment rates to about 15 percent. These adjustments yielded significant moderation in the reduction of the final 2003 payment rates. These adjustments are described in detail in section III.B of the preamble.

After carefully reviewing all of the comments, a dampening option seemed most plausible and practical for us to undertake. Most of the recommendations proposed by the commenters were not feasible or not suitable for the purposes of OPPS.

*Comment:* Many commenters indicated that the median costs derived from the claims data was not reflective of the hospitals' true costs for acquiring and dispensing these drugs and biologicals.

*Response:* We agree with this point; however, the commenters should note that we intend to pay only for the cost of acquiring the drug under a drug APC and not for costs associated with the administration of the drug. Costs associated with administering the drug and with other pharmacy overhead are captured in pharmacy revenue cost centers and reflected in the median cost of APCs involving drug administration. Therefore, we believe that it is not appropriate for us to duplicate these costs in both the administration and drug APCs.

*Comment:* Several commenters noted that many drugs and biologicals were packaged into administration APCs; however, they were surprised to see decreases in the proposed payment rates for several of the administration APCs. The commenters stated that the addition of the costs of the packaged products should have caused the APC median cost levels to increase, thus their payment rates should have also increased compared to 2002. However, the commenters assert that the proposed payment rates for several administration APCs in which the drugs were packaged does not adequately cover the acquisition cost of the drugs themselves. Thus, they recommended that we reevaluate our data to ensure that costs of the packaged drug were included with the data for the applicable administration APCs, or otherwise explain how we plan to reimburse hospitals for the costs of the packaged drugs; retain the 2002 payment rates for administration services and pay for the drugs separately; or use our authority to limit any payment reductions for certain services. One commenter suggested that we conduct a survey of cancer centers to determine the true cost of infusion procedures and make an adjustment to the APC rates based on our finding.

*Response:* After reanalyzing our data, we were able to verify that the median costs of the drugs were indeed packaged into the median costs of the

administration APCs. We acknowledge that the median costs of several administration APCs before we packaged drug costs declined between those median costs used to set the 2002 rates and those median costs developed from the 2001 claims for the 2003 rates. This decline occurred because, in setting the 2002 rates, we packaged in 75 percent of the cost of pass through devices we projected would be billed with the administration codes, based on manufacturer prices. The 2001 claims data, however, did not reflect the charges that we predicted would be billed for such devices. An increase in the median cost of a service does not guarantee that the payment rate for the service will increase because payment rates under the OPPS are based on relative costs and the budget neutrality adjustment. If the relative cost of a service increases at a lower rate than other services, the payment rate may actually decline. In addition, all rates are affected by the budget neutrality adjustment that has lowered rates over the past several years. (We note that it is possible for the budget neutrality adjustment to increase rates as occurred in the proposed rates.) As noted elsewhere, for APCs whose median costs decreased by more than 15 percent from 2002 to 2003, the dampening option described elsewhere in this rule limits the decreases in their payment rates.

*Comment:* A commenter requested that we describe the methodology used to calculate the payment rates for sunsetting pass-through drugs that are being assigned to separate APCs.

*Response:* We have provided a detailed description of the methodology we used in the calculation of the APC payment rates for sunsetting drugs and biologicals in section III.B of the preamble.

*Comment:* A major hospital association supported our proposal to incorporate pass-through drugs into APC rates. However, the commenter was concerned that many of these same drugs would continue to receive 95 percent of AWP in other settings, and differential payments may result in patient care being directed out of the hospital outpatient setting and into physician offices for non-clinical reasons.

*Response:* We believe that the payment rates for sunsetting pass-through drugs and biologicals reflect hospital acquisition cost to a sufficient extent so that hospitals will not, in general, stop furnishing these products to beneficiaries. While Medicare payment in other settings will be higher, the extent of response that may be expected to these payment differentials is unclear. We note that the same differentials prevailed for years prior to the introduction of the outpatient prospective payment system. We believe that the appropriate policy response is to address the use of AWP as a basis for payment in non-hospital sites.

*Comment:* A state hospital association indicated that confusion exists among hospitals over which drugs can be self-administered and that instructions from fiscal intermediaries are inconsistent and/or confusing. The commenter requested that we publish a definitive list of drugs that are to be considered to be self-administrable, and thus is not part of covered services. Another commenter from a hospital urged us to clarify whether self-administrable drugs (both those that are integral and non-integral to the patient's procedure) in outpatient and observation settings are the patient's responsibility or should be packaged under procedure APCs. Another commenter from a hospital organization suggested that we exempt hospitals from determining which drugs should be classified as self-administered or allow hospitals to classify drugs based on the dosing form and pursue payment from the beneficiary.

*Response:* On May 15, 2002, we issued Transmittal AB–02–072 entitled ''Medicare Payment for Drugs and Biologicals Furnished Incident to a Physician's Service.'' The program memorandum gives instructions to the fiscal intermediaries for applying the exclusion to drugs that are usually self-administered by the patient. Each fiscal intermediary makes its determination on each drug based on whether the drug meets all of the program requirements for coverage. The payment rates that we are finalizing in this rule only indicate the Medicare payment amounts under OPPS when a drug is covered by Medicare; therefore, determination of a payment amount does not represent a determination that the Medicare program covers the drug. We discuss elsewhere in this preamble how Medicare makes payments for drugs that are considered to be supplies.

*Comment:* Several commenters suggested that we publish various sorts of additional information about the methodology we used to calculate the payment rates, including technical details of the methodology used in analysis of the 2001 claims.

*Response:* We do not believe the final rule is the appropriate vehicle for conveying the extensive background technical detail that may be of interest to the analytical community. However, we plan to hold a meeting in December 2002 or January 2003 to address the questions these commenters or other interested parties may have about our methodology.

*Comment:* Several commenters were concerned that fiscal intermediaries have addressed the issue of drug units of service with respect to billing and waste differently, and requested that we provide clear and consistent guidance to the fiscal intermediaries as well to providers on how to define ''waste.''

*Response:* In the fall of 1996, we issued a memorandum to our regional offices with guidance regarding our current policy on drug and biological product wastage. Although this memorandum focused on guidance for carriers, it overall reflects our current policy for drug and biological product wastage.

We recognize that some drugs may be available only in packaged amounts that exceed the needs of an individual patient. Once the drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life. Since an individual patient may receive less than the fully reconstituted amount, we encourage hospitals to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a Medicare patient, the provider may bill for the amount of drug discarded along with the amount administered.

*Example 1:* Drug X is available only in a 100-unit size. A hospital schedules three Medicare patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to Medicare on the account of the last patient. Therefore, 30 units are billed on behalf of the first patient seen and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

*Example 2:* An appropriate hospital staff must administer 30 units of drug X to a Medicare patient, and it is not practical to schedule another patient who requires the same drug. For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and did not know the patient's condition. The hospital bills for 100 units on behalf of the patient, and Medicare pays for 100 units.

*Comment:* A few commenters urged us to provide a crosswalk identifying which drugs are being associated with which APCs and in what amounts, to help ensure that costs are being appropriately transferred to and allocated among APCs.

*Response:* Our methodology did not rely on a crosswalk, and we do not have one available. In our methodology, we

packaged drugs and biologicals that fell below the $150 median cost per line threshold into the procedure APCs they were billed from April 1, 2001 to March 31, 2002. Interested parties may analyze the claims data that is available to the public to determine the extent to which the costs of specific drugs and biologicals were included in payment rates of the procedure APCs.

*Comment:* A commenter expressed concern related to the adenosine products J0150 and J0151. The commenter stated that although these two codes reflect different uses and doses of the adenosine products, OPPS only recognizes billing only under the lowest dose of J0150 and J0151 is assigned a status indicator of E. Consequently, the hospitals have been billing for both products under code J0150. The commenter requested that we clear the confusion that exists among hospitals when billing for these products by reinstating J0151 under a separately paid APC with an adequate payment rate and revising J0150 so that the code is specific to its actual use.

*Response:* After reviewing the comment, we assigned a status indicator of N to J0150 to indicate that J0150 will be packaged in 2003; and changed the status indicator for J0151 from E to K and assigned it to APC 0917.

*Comment:* One commenter requested that we update the HCPCS description for all drugs to accurately report all medications in the way manufacturers currently package them. The commenter claimed that our current use of codes causes confusion and has the potential to create reimbursement problems for providers and the Medicare program.

*Response:* To the extent possible, when creating the ''C'' codes used to report drugs and biologicals eligible for transitional pass-through payment under OPPS, we employ the lowest common measurement of dosage for each drug so that hospitals can bill the number of units that are required to treat the patient by using multiple units of a single code. As drugs and biologicals retire from pass-through status, we expect to retire the ''C'' codes for these items. We expect these items will receive appropriate ''non-C'' HCPCS codes.

*Comment:* Several commenters claimed that our proposal to package many of the non-pass-through, lower cost drugs and biologicals with HCPCS codes for therapeutic administration is a violation of the ''two-times'' rule. Therefore, they recommended that we continue to pay for all drugs and biologicals separately or by revising the APCs in which the drugs are packaged.

*Response:* We do not agree with the commenters' assertion that packaging of drugs and biologicals results in violations of the two-times rule, stated in section 1833(t)(2) of the Act. We understand the commenters' confusion and attempt to provide a clarification on how we apply the ''two-times'' rule to determine APC structures. Most APC's consist of one or more services, which reported with CPT or HCPCS G codes, that are similar clinically and in terms of resource use. Many individual items (for example, sterile supplies or pharmaceuticals such as anesthetic agents) are integral to the procedure, and thus we have packaged them with the procedure. In some instances, such as APCs for transitional pass-through drugs and devices, the APC includes no procedure, and the APC is used only to pay for a specific item.

The ''two times'' rule requires that the highest median cost of a service or item within an APC cannot be more than two times greater than the lowest median cost of a service or item within that APC. We apply the ''two-times'' rule to the total cost of each procedure (which includes items that are packaged within that procedure). In the case of APCs containing only items, we apply the rule to the cost of each item that is grouped in the APC. We do not apply the two times rule to the variation in cost of individual items or ancillary services we attribute to a single HCPCS code.

If we were to attempt to apply the rule to all items within the various procedures, accounting for the variation in cost of supplies such as bandages, reusable instruments, and other medical supplies would be a practical impossibility. It would lead to a highly fragmented set of payment cells and a greatly more complex payment system that would reduce the incentives for effective management by hospitals. We do not believe the Congress would have intended such a result.

Consistent with the principles of prospective payment, we package the cost of as many items as possible into the median cost of a procedure. Therefore, our payment methodology for 2003 includes packaging the costs of drugs and biologicals with median costs below $150 per line into the costs of the procedures with which they were billed. We reviewed the median cost of the procedures used for administration of drugs and biologicals, before and after we packaged the costs of drugs and biologicals. Our review indicates that the final median cost appropriately accounts for the administration procedure and the cost of the administered drug and/or biologic.

*Comment:* Numerous commenters were concerned about the proposed reduction in payment rates for several radiopharmaceutical products. They asserted that hospitals would not be reimbursed adequately for these products, and thus, beneficiary access could be negatively impacted. They recommended that we should not base payments on the 2001 claims data and use a different methodology instead. They suggested that we estimate acquisitions costs using the proposed ratios for acquisition cost to AWP based on analysis conducted by the agency; maintain the 2002 payment levels; or create new APCs using cost ranges and assign radiopharmaceuticals to APCs based on their costs, as determined by AWP plus overhead fees, or another proxy for actual hospital costs.

*Response:* We are concerned about the possible effects of payment reductions on beneficiary access, and accordingly, we have included radiopharmaceuticals in the dampening policy described section III.B. of the Preamble.

*Comment:* Several commenters were concerned with our proposal to package numerous radiopharmaceutical products. They claimed that given the problems with the claims data and the great variation in the cost and use of radiopharmaceuticals for the same procedure, all radiopharmaceuticals should be paid under their own APCs, in addition to their associated nuclear medicine procedures. This would assure appropriate reimbursement for both the product and procedure, and would be the best way to capture hospital costs for radiopharmaceuticals in future claims data.

*Response:* While we acknowledge the commenters' concerns, we believe that the most appropriate payment structure is one that packages services together to the extent it is reasonable to do so, and thus presents hospitals with bundled payments that permit them to effectively manage resource allocation in the treatment of particular patients. Accordingly, we have not adopted this suggestion.

*Comment:* A manufacturer and a trade association suggested that we could improve the accuracy of the APC payment rates by establishing new revenue codes to accurately capture data and calculate costs for radiophamaceuticals in future years.

*Response:* While we do want to improve the accuracy of APC payment rates, we are reluctant to impose new requirements on hospital cost reports. In addition, the creation of new revenue centers must be made through a process that includes other payers as well as representatives of various providers.

Therefore, we will not adopt this suggestion for 2003. As discussed in section III. B of this final rule, we expect to address the issue of improving the accuracy of our data further in the future.

*Comment:* A hospital organization indicated that there is a competitive disadvantage between different types of providers (clinic, Independent Diagnostic Testing Facilities (IDTF), and outpatient hospital) and their payment policies for Low Osmolar Contrast Media (LOCM). The commenter stated that in a clinic or IDTF, LOMC receives separate payment when clinical conditions are met. However, when LOCM is administered in an outpatient hospital without an intrathecal procedure or if one of the Medicare coverage conditions is non-covered, hospitals are expected to issue an ABN to the patient. The commenter recommended that we allow hospitals to bill for LOCM even when the patient does not meet conditions, or instruct the clinics and IDTFs to seek ABNs for LOCM in non-covered circumstances. A state hospital association suggested that we eliminate the medical necessity requirement for LOCM since it is not applicable to hospital outpatient services.

*Response:* These suggestions involve several different Medicare payment systems, and appropriate resolution of this concern will require further analysis. We will consider this issue further in the future.

*Comment:* One commenter requested clarification on whether there will be any more changes to the payment calculation for HCPCS C1775 (FDG, per dose) other than what is proposed in Table X of the proposed rule.

*Response:* According to our new policy for radiopharmaceuticals, as described elsewhere in this final rule, FDG will no longer be granted pass-through status in 2003. It will instead be paid separately under its own APC and be assigned to a status indicator of K.

*Comment:* Another commenter requested that we describe our waste policy on whether a hospital may bill for a medication that is ordered and mixed, but not administered to the patient due to a change in patient status or a no-show by the patient for that day's visit. If the drug cannot be used later or on another patient, the hospital would still incur the costs.

*Response:* If the drug is not administered to a Medicare beneficiary, then payment may not be made by the Medicare Program.

Packaging Issue

*Comment:* Several commenters indicated that our methodology of analyzing single line-items on drug claims is not consistent with how hospitals bill for certain particular drugs and biologicals. This inconsistency particularly affects whether a drug or biological falls below the $150 median cost per line threshold or not. They claimed that we incorrectly assumed ''that a single administration of a drug was billed as a single line item on a claim and that the correct number of units was placed in the 'units' field of the claim form.'' Commenters noted that this was not always true because hospitals often bill for certain drugs using multiple lines in a claim that represents one patient encounter. They indicated that in our calculation of the median cost per line for a drug, we multiplied the median cost per unit of the drug by the average number of units billed per line. Thus, our methodology does not take into account all of the units of a drug administered during one encounter if the units were billed in multiple lines on the claim, and consequently, may not reflect the full cost of delivering the drug.

*Response:* For 2003, we chose to use the $150 median cost per line threshold level to determine whether to package a drug, as opposed to another packaging criterion, for the reasons of administrative simplicity, administrability, and responsiveness. However, in our analysis of the data, we observed that instances where a drug was billed on multiple lines in a claim were rare (less than 1 percent of total billings for drugs). We reiterate that our intent is to review and refine the packaging methodology in the future and will take the commenters' concern into account.

Orphan Drugs

We recognize that orphan drugs that are used solely for an orphan condition or conditions are generally expensive and, by definition, are rarely used. We believe that if the cost of these drugs were packaged into the payment for an associated procedure or visit, the payment for the procedure might be insufficient to compensate a hospital for the typically high cost of this special type of drug. Therefore, we proposed to establish separate APCs to pay for those orphan drugs that are used solely for orphan conditions.

To identify the orphan drugs for which we would continue to make separate payment, we applied the following criteria:

- The drug must be designated as an orphan drug by FDA and approved by FDA for the orphan condition.
- The current United States Pharmacopoeia Drug Information (USPDI) shows that the drug had neither an approved use for other than an orphan condition nor an off label use for conditions other than the orphan condition. There are three orphan drugs that are used solely for orphan conditions for which we proposed to make separate payment: J0205 Alglucerase injection; J0256 Alpha 1 proteinase inhibitor; and J09300 Gemtuzumab ozogamicin.

*Comment:* Several commenters stated that the proposed payment rates for the orphan drugs would grossly underpay hospitals for providing these drugs to patients. They recommended that we pay for orphan drugs according to current year acquisition and actual total costs of providing the products; maintain the 2002 payment levels; or remove from them from the OPPS system and set payment according to the methodology used in the physician office and other non-inpatient settings.

*Response:* After reviewing the comments, we have decided to remove the three orphan drugs that do not have any other non-orphan indications from the OPPS system and will pay for them on a reasonable cost basis. Other drugs that have orphan status according to the FDA will be partly protected by the dampening options described in section III.B of this final rule.

*Comment:* Several commenters objected to what they characterized as our definition of ''orphan drug.'' These commenters believe we should treat comparably all drugs and biologicals that have been designated as under section 526 of the Federal Food, Drug, and Cosmetic Act.

*Response:* We emphasize that we are not creating a new definition of orphan drugs; instead, we continued to rely on the definition stated in the Federal Food, Drug, and Cosmetic Act. However, within the set of drugs that the FDA has identified as orphan drugs, we have identified a subset of three drugs that have only orphan indications and decided to remove them from the outpatient prospective payment system. We have distinguished these drugs from other orphan drugs because of their low volume of patient use and their lack of other indications, which means they can rely on no other source of payment. Many orphan drugs are approved for multiple indications, including non-orphan indications that have significant patient use that provide the drugs with financial support. For example, epoetin alfa was originally identified as an

orphan drug for use in ESRD patients; however, currently it is being used extensively in patients with chemotherapy-induced anemia. Once a drug is granted orphan status, no further effort is made to update this status, even though indications for use may change substantially with experience. After consulting with our clinical advisors, we have decided to remove from OPPS the three orphan drugs that have no other non-orphan indications. We recognize the importance of all orphan drugs, however, and accordingly we have applied the dampening policies described in section III.B of the preamble to the other orphan drugs.

Blood and Blood Products

From the onset of the OPPS, we have made separate payment for blood and blood products either in APCs with status indicator ''K'' or as pass-through drugs and biologicals with status indicator ''G'' rather than packaging them into payment for the procedures with which they were administered. As we explained in the April 7, 2000 final rule (65 FR 18449), the high degree of variability in blood use among patients could result in payment inequities if the costs of blood and blood products were packaged with their administration. We also want to ensure that costs associated with blood safety testing are fully recognized. The safety of the nation's blood supply continues to be among the highest priorities of the Secretary's council on Blood Safety and Access. Therefore, we proposed to continue to pay separately for blood and blood products.

*Comment:* Several major blood collection organizations, specialty physician groups, a large trade association, hospital associations, and individual hospitals supported our decision to maintain separate APCs for blood and blood products; however, the commenters were concerned with the reduction in payment rates for these products in the proposed rule.

The commenters provided several suggestions. They recommended that we base the payment rates for blood products on current year acquisition costs and actual total costs rather than on hospital claims from previous years, and use industry data on the current hospital costs of blood and blood products that have been submitted to us; consider costs related to additional costs that hospitals incur in storing and preparing units for transfusion when assigning APC relative weights to blood and blood products; continue the 2002 payment rates until more accurate information on the actual costs of blood and blood products are gathered; or reimburse hospitals on a reasonable cost basis for blood and blood products.

*Response:* After carefully reviewing the comments and comparing the industry data against our data, we were convinced that the proposed reduction in payment rates for many of the blood and blood products would result in payment that is significantly lower than hospital acquisition costs. Thus, inadequate reimbursement may compromise access to beneficiaries and the safety of these products. We continue to be aware of the variability in the use of blood and blood products in various procedures, and by our desire to recognize costs of new tests being performed on blood, we have decided to apply a special dampening option to blood and blood products that had significant reductions in payment rates from 2002 to 2003. For these products, as described in section III.B of the preamble, we limited the decrease in their median costs by 11 percent, which limited the decrease in payment rates to approximately 15 percent. We note that the APCs for these products are intended to cover product costs; costs for storage, etc., are packaged into the APCs for the procedures with which the products are used.

*Comment:* A commenter from an individual hospital disagreed with our proposal to not change the current OPPS payment policy for transfusions. The commenter stated that their hospital has more than the average number of cases that require more than one unit of blood, and thus, averaging the payment would adversely affect specialty hospitals.

*Response:* For transfusion services that are paid under OPPS, hospitals can bill for the administration of the transfusion and the number of units of blood transfused. With the payment rates for transfusion and blood and blood products that are in the final rule, we believe that hospitals, including those that specialize in the transfusion of multiple units of blood, will receive adequate payment for transfusion services. The hospitals will receive separate payment for the blood in addition to the APC payment for the transfusion service. Even though we will not change our payment policy for transfusions for 2003, this is an issue that we will continue to monitor in the future.

*Comment:* Two commenters requested that we provide special comprehensive billing and coding guidelines in the area of blood, blood processing, and transfusion medicine, and the proper use or non-use of the transfusion medicine codes. They stated that Transmittal A–01–50 does not clarify all of the confusing issues that hospitals currently experience in billing and coding for blood-related services.

*Response:* We acknowledge that need for comprehensive billing and coding guidelines in the areas mentioned by the commenters and agree that the program memorandum that was issued previously may require further clarification. Therefore, this is an area that we expect to focus on during the upcoming year.

*Comment:* Several hospitals, advocacy organizations, manufacturers, and beneficiaries were concerned that the proposed decrease in reimbursement for certain clotting factors would not enable hospitals to recover the acquisition costs of the products. They indicated that inadequate reimbursement would create incentives for hospitals to not provide these products at all or to provide only those clotting factors that limit financial loss. Commenters also indicated that given the high cost of the clotting factors, the average cost to charge ratio methodology that might apply to other drugs does not apply to clotting factors, and the proposal would shift patients to the inpatient setting where costs of care are higher. Their recommendations were that we adjust the proposed payment with a rate consistent with the average acquisition cost of the drugs; maintain the 2002 payment rates; use current hospital inpatient payment rates in place of the proposed rates; or remove from the OPPS system and set payment according to the methodology used in the physician office and other non-inpatient settings.

*Response:* We recognize the importance of insuring adequate reimbursement and access to hemophilia clotting factors for our beneficiaries, as did the Congress when it created a separate benefit category for clotting factors in section 1861(s)(2)(I) of the Act. Accordingly, we have adopted a provision to insure that the payment rates for these products does not decrease by more than approximately 15 percent from 2002 to 2003.

*Comment:* Several commenters were very concerned with the proposed payment rates for plasma products and their recombinant analogs therapies. They argued that reduction in payments would create significant patient access problems since the hospitals will be unable to recoup costs incurred in acquiring and dispensing such therapies. They recommended that we pay for these products on a reasonable cost basis; revise the payment rates significantly to allow hospitals to recover their acquisition and dispensing costs; base payment on current acquisition costs and actual total costs

of the products in outpatient settings; maintain payment at the 2002 level; or establish an add-on payment to be based on a national formula derived outside of OPPS.

*Response:* We recognize the importance of these drugs, and consequently included them in the dampening procedure described section III.B of the preamble.

*Comment:* Several commenters urged us to clarify the category of ''blood and blood products'' to include drugs and biologicals that are derived from plasma fractionation and their biotechnology analogs. They stated that the rationale for creating separate APCs for blood and blood products also equally apply to plasma-based products and their recombinant therapies. These commenters recommended that we continue to pay for all plasma-derived and recombinant analog therapies in separate APCs and include them in the category of ''blood and blood products'' as it is done under the FDA's definition of ''blood and blood products.''

*Response:* We acknowledge that plasma-based products and their recombinant therapies are derived from blood however, these products are highly processed and not manufactured by local blood banks. Upon consultation with our clinical advisors, we have determined that these products do not have the same access and safety concerns as other blood and blood products. Thus, it is reasonable for us to distinguish these products from other blood and blood products. For the purposes of OPPS, we will not consider any plasma-derived products and their recombinant analogs, including albumin and immune globulins and except for hemophilia clotting factors, to fall under the category of ''blood and blood products''. Accordingly, we apply to these products the same packaging procedures applicable to other drugs and biologicals.

Vaccines Covered Under a Benefit Other Than OPPS

Outpatient hospital departments administer large numbers of the vaccines for influenza (flu), pneumococcal pneumonia (PPV), and hepatitis B, typically by participating in immunization programs encouraged by the Secretary because these vaccinations greatly reduce death and illness in vulnerable populations. In recent years, the availability and cost of the vaccines (particularly the flu vaccine) have varied considerably. We want to avoid creating any disincentives to provide these important preventative services that might result from packaging their costs into those of primary procedures, visits, or administration codes. Therefore, we proposed to pay for these vaccines under OPPS through the establishment of separate APCs.

We received no comments on our proposal to pay for these vaccines under separate APCs. However, we have had considerable discussion with providers in the past about the cost to hospitals of influenza and pneumococcal pneumonia vaccines in particular. In particular, we have had many discussions in which we were advised by providers that OPPS payment was insufficient for them to be able to guarantee that they would be able to offer these important vaccines to Medicare patients they treat. They cited the timing of updates to OPPS rates as well as volatility of costs as a result of irregular supplies of these vaccines as their major concern. Public health officials encourage high risk individuals, including Medicare beneficiaries, to receive flu immunitions beginning each September. Each flu season, a new vaccine is produced; the cost of the vaccine is also typically higher than the previous year's vaccine cost. Thus, from September through December, providers paid under the OPPS for administering flu vaccines do not receive the benefit of the update that occurs in January. In recent years, the cost of the vaccine has been volatile because of irregular supplies.

Therefore, we have decided to pay hospitals for influenza and pneumococcal pneumonia vaccines under reasonable cost methodology. Section 1833(t)(2)(A)(i) of the Act gives the Secretary discretion to define outpatient hospital services for purposes of payment under the OPPS. Until now we have defined it to include influenza and pneumococcal pneumonia vaccines. However, in view of the importance of these vaccines to the public health and our strong desire to ensure that hospitals are paid appropriately for these vaccines, we have decided to exclude them from OPPS.

We are therefore revising regulations at § 419.21(d)(3) to remove the words ''influenza'' and ''pneumococcal pneumonia.'' As a result of this change, hospitals, HHAs and hospices which were paid for these vaccines under OPPS will be paid reasonable cost for these vaccines. We will issue further instructions regarding how CORFs will be paid for these vaccines in 2003 and will issue implementation instructions for hospitals, HHAs and hospices.

Higher Cost Drugs

While our preferred policy is to package the cost of drugs and other items into the cost of the procedures with which they are associated, we are concerned that beneficiary access to care may be affected by packaging certain higher cost drugs. For this reason, we proposed to allow payment under separate APCs for high cost drugs for an additional year while we further study various payment options. Specifically, we proposed to pay separately for drugs for which the median cost per line (cost per unit multiplied by the number of units billed on the claim) exceeded $150, as we briefly describe below. We provide more detail in the proposed rule regarding the methodology we used to determine this threshold (67 FR 52124–52125).

To establish a reasonable threshold for determining which drugs we would pay under separate APCs rather than through packaging, we calculated the median cost per unit using 2001 claims data for each of the drugs for which transitional pass-through payment ceases January 1, 2003 and for those additional drugs that we have paid separately (status indicator ''K'') since the outset of OPPS.

We excluded from these calculations the orphan drugs, vaccines, and blood and blood products discussed above. Because many drugs are used and billed in multiple unit doses, we then multiplied the median cost per unit for the drug by the average number of units that were billed per line. Once we calculated an approximate median cost per line for the drug, we then arrayed the median cost per line in ascending order and examined the distribution. A natural break occurs at $150 per line, the midpoint of a $10 span between the drug immediately above and below the $150 point. Within the array, approximately 61 percent of the drugs fall below the $150 point and 39 percent of the array are above the point. Among the drugs that we proposed to package are some radiopharmaceuticals, vaccines, anesthetics, and anticancer agents. After including the costs of packaged drugs in the services with which they were provided, we noted that the median costs of those services increased. We solicited comments that address specific alternative protocols we might use when several packaged drugs whose total cost significantly exceeds the applicable APC payment amount may be administered to a patient on the same day (for example, multiple agent cancer chemotherapy).

We requested comments on the factors we considered in determining which drugs to package in 2003. We were particularly interested in comments for the exclusion of high cost drugs from packaging. We added that we would continue to analyze the effect

of our drug-packaging proposal to assess whether the $150 threshold should be adjusted to avoid significant overpayments or underpayments for the base APCs relative to the median costs of the individual drugs packaged into the APCs. Depending on this analysis, we stated that we may revise our threshold or criteria for packaging in the final rule for 2003. We expect to further consider each of these exclusions for packaging when we develop our proposals for the 2004 OPPS.

Although we expect to expand packaging of drugs to package payment for more drugs into the APC for the services with which they are billed, we nonetheless, requested comments on alternatives to packaging. One example of an alternative approach is to use different criteria from those we propose in this proposed rule to identify the drugs to package into procedure APCs and the drugs to pay separately. Another alternative approach would be to create APCs for groups of drugs based on their costs. Still another approach would be to create separate APCs for each drug. We emphasized in the proposed rule that we welcomed a full discussion of the alternatives as we determine the best way to ensure that hospitals are paid appropriately for the drugs they administer to the Medicare beneficiaries whom they treat in their outpatient departments.

Drugs that we pay for separately in 2003 are designated in Addendum B by status indicator ''K'' or ''G.''

A summary of the comments we received on this proposal and our responses to them are summarized below.

*Comment:* Numerous national trade associations, drug manufacturers, consultants, and other commenters opposed our proposal to package sunsetting drugs and biologicals that fell below a threshold of $150 median cost per line into procedure APCs. These commenters urged us to continue to pay separately for drugs and biologicals that were paid separately in 2002, including those for which pass-through status has expired. Some recommended that we maintain the 2002 payment levels until more accurate data could be obtained.

In contrast, one national hospital organization recommended that we adopt a much higher threshold of $1,000 for a drug to warrant separate payment and package all other drugs that fall below the threshold. Furthermore, another national hospital association encouraged us to expeditiously incorporate into APCs both low and high cost drugs that will lose their eligibility for transitional pass-through payments, while limiting separate APC payment only to orphan drugs, blood and blood products, certain vaccines and extremely costly drugs. The commenter also stated that integrating payments for packaged services will be less burdensome for hospitals and will eliminate incentives for higher costs that might be created by special additional reimbursement. As noted in section XI, the Medicare Payment Advisory Committee also urged CMS to incorporate more drugs into the base APCs.

*Response:* We appreciate all of the comments regarding the various aspects we should consider in making our decision to package lower-cost drugs and biologicals into procedure APCs. After carefully considering all recommendations submitted by the commenters regarding how we should treat these drugs and biologicals, we concluded that the packaging methodology we proposed is appropriate. We believe that we have sufficient data on drugs and biologicals to allow us to make a reasonable decision on whether to package individual items. We further believe that our decision to package these costs is consistent with the concept of a prospective payment system and we expect to continue incorporating additional drugs into the base APCs in future years.

*Comment:* Several commenters stated that the $150 threshold established for separate APC payment is arbitrary and such a packaging rule would create confusion among hospitals. One national hospital association was concerned that the policy would create incentives for pharmaceutical companies to increase their prices so their drugs will receive separate payment, and, potentially, for physicians to choose one drug over a clinically appropriate substitute.

*Response:* We acknowledge the concerns for using a median cost per line threshold level when the cost of a particular drug may fluctuate over time. However, we must set the rates prospectively. We will consider these issues further as we determine our policy for the criteria for packaging as we develop our proposed rule for the 2004 update.

*Comment:* Several commenters supported our decision to pay separately for higher-cost drugs, clotting factors, and orphan drugs in 2003, but recommended that we delay packaging higher-cost drugs until more accurate data is available. Other commenters suggested that we collect at least 2 more years of data on all drugs and biologicals before contemplating bundling them with other APCs. They stated that once a drug or biological is bundled, hospitals will have no incentive to code for it, and there will be no means of collecting data on the product in the future. Thus, by not packaging, we would be able to determine appropriate payment rates that reflect variations in hospital expenses for these products and continue to collect product-specific information.

*Response:* We agree with the commenters who stated that we should not package higher cost drugs until we have more data on those products; however, we disagree with the other commenters who suggested that we should not consider packaging any drugs and biologicals until we have collected data for two more years. We believe that at this time we have sufficient data to determine which drugs and biologicals should be packaged and which products we will pay separately for in 2003. While some hospitals may fail to separately report codes that represent packaged items, we have repeatedly instructed hospitals to submit all charges related to covered outpatient services, including those for packaged items. The total charges submitted by hospitals for each service will be used to set future rates. For that reason, and because of the possible impact on their ability to receive outlier payments for which they might qualify, it is extremely important that hospitals report all appropriate charges for their covered outpatient services.

*Comment:* Several commenters suggested that, at minimum, we should continue to pay separately for drugs and biologicals that typically cost more than $150 per administration, regardless of whether the median cost per line exceeds $150 using the 2001 claims data. In addition, a trade association suggested that we reflect the common practice of combining radiopharmaceuticals and others drugs used in performing nuclear medicine procedures by qualifying for separate payment those drug combinations which exceed the agency's $150 threshold.

*Response:* We appreciate the commenters' suggestions regarding methodologies that would refine the $150 threshold level used in making packaging determinations for 2003. We believe our proposed policy strikes a reasonable balance of simplicity, administrability, and responsiveness. We intend to review and refine our methodology in the future, and the proposals submitted by commenters will be taken into consideration at that time.

*Comment:* Several commenters claimed that our proposal to package many of the non-pass-through, lower cost drugs and biologicals with HCPCS codes for therapeutic administration is a violation of the ''two-times'' rule. Therefore, they recommended that we continue to pay for all drugs and biologicals separately or by revising the APCs in which the drugs are packaged.

*Response:* We do not agree with the commenters' assertion that packaging of drugs and biologicals results in violations of the two-times rule, stated in section 1833(t)(2) of the Act. We understand the commenters' confusion and attempt to provide a clarification on how we apply the ''two-times'' rule to determine APC structures. Most APC's consist of one or more services, which we refer to as ''procedures'' and code with CPT or HCPCS G codes, that are similar clinically and in terms of resource use. Many individual items (for example, sterile supplies or pharmaceuticals such as anesthetic agents) or ancillary services (for example, nursing or recovery room services) are integral to the procedure, and thus we have packaged them with the procedure. In some instances, such as APCs for transitional pass-through drugs and devices, the APC includes no procedure, and the APC is used only to pay for a specific item.

The ''two times'' rule requires that the highest median cost of a within an APC cannot be more than two times greater than the lowest median cost of a procedure within that APC. We apply the ''two-times'' rule to the total cost of each procedure (which includes items and services that are packaged within that procedure). In the case of APCs containing only items, we apply the rule to the cost of each item that is grouped in the APC. We do not apply the two times rule to the variation in cost of individual items or ancillary services we attribute to a single HCPCS code.

If we were to attempt to apply the rule to all items and ancillary services within the various procedures, accounting for the variation in cost of supplies such as bandages, reusable instruments, and other medical supplies would be a practical impossibility. It would lead to a highly fragmented set of payment cells and a greatly more complex payment system that would reduce the incentives for effective management by hospitals. We do not believe Congress would have intended such a result.

Consistent with the principles of prospective payment, we package the cost of as many items and ancillary services as possible into the median cost of a procedure. Therefore, our payment methodology for 2003, includes packaging the costs of drugs and biologicals with median costs below $150 per line into the costs of the procedures with which they were billed. We reviewed the median cost of the procedures used for administration of drugs and biologicals, before and after we packaged the costs of drugs and biologicals. Our review indicates that the final median cost appropriately accounts for the administration procedure and the cost of the administered drug and/or biologic.

*Comment:* A commenter requested that we include a statement in the final rule that was included in the preamble of the September 8, 1998 proposed rule (63 FR 47563–47564) that stated ''We propose to allow hospitals to provide drugs to patients without requiring that the hospital bill the patient, and without Medicare paying the hospital. Normally, hospitals are not allowed to waive such billing, since not charging a patient could be seen as an inducement to the patient to use other services at the hospital, for which the hospital would be paid. However, if the benefit is not advertised, we believe that provision of the self-administered drugs at no charge to the beneficiary need not constitute an inducement in violation of the anti-kickback rules. The hospital may not advertise this to the public or in any other way induce patients to use the hospital's service in return for forgoing payment.''

*Response:* We are not making final the proposal in the September 8, 1998 rule (63 FR 47563–64) that the commenter quotes. Medicare policy affecting how payment is made under the OPPS has evolved considerably since that rule. In the intervening years, CMS, providers, contractors, and beneficiaries all have acquired considerable experience under the OPPS that has added perspective and substance to a broad range of policy issues, including what is and is not payable under the OPPS. The following points summarize our current policy related to the issue posed by the commenter:

- In accordance with the in section 1861(s)(2)(B) of the Act and related Medicare regulations and program issuances, drugs and biologicals that are not usually self-administered by the patient are payable under the OPPS. As we explain elsewhere in this final rule, Medicare makes separate payment for certain drugs and biologicals and packages payment for others into the procedure with which they are billed.
- The fact that a drug has a HCPCS code and a payment rate under the OPPS does not imply that the drug is covered by the Medicare program, but only indicates how the drug may be paid if it is covered by the program.
- A code and payment amount does not represent a determination that the Medicare program covers a drug. Contractors must determine whether the drug meets all program requirements for coverage; for example, that the drug is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment because it is usually self-administered.
- Certain drugs are so integral to a treatment or procedure that the treatment or procedure could not be performed without them. Because such drugs are so clearly an integral component part of the procedure or treatment, they are packaged as supplies under the OPPS into the APC for the procedure or treatment. Consequently, payment for them is included in the APC payment for the procedure or treatment of which they are an integral part.
- Under the OPPS, hospitals may not separately bill beneficiaries for items whose costs are packaged into the APC payment for the procedure with which they are used (except for the copayment that applies to the APC).

In short, neither the OPPS nor other Medicare reimbursement rules regulate the provision or billing by hospitals of non-covered drugs to Medicare beneficiaries. Accordingly, it would be inappropriate to include the statement in the 1998 rule. However, in some circumstances, such practices potentially implicate other statutory and regulatory provisions, including the prohibition on inducements to beneficiaries, section 1128A(a)(5) of the Act, or the anti-kickback statute, section 1128B(b) of the Act.

### *E. Expiration of Transitional Pass-Through Payments in Calendar Year 2003 for Brachytherapy*

Section 1833(t)(6) of the Act requires us to establish transitional pass-through payments for devices of brachytherapy. As of August 1, 2000, we established item-specific device codes including codes for brachytherapy seeds, needles, and catheters. Effective April 1, 2001, we established category codes for brachytherapy seeds on a per seed basis (one for each isotope), brachytherapy needles on a per needle basis, and brachytherapy catheters on a per catheter basis. Because initial payment was made for a device in each of these categories in August 2000, we proposed that these categories (and the transitional pass-through payments) will be discontinued as of January 1, 2003. Furthermore, as discussed above, we

proposed that there will be no grace period for billing these category codes.

We received comments, both in writing and at the April 2002 Town Hall meeting, recommending that we continue to make separate payment for brachytherapy seeds. The basis for this recommendation is that the number of brachytherapy seeds implanted per procedure is variable. These commenters stated that the number and type of seeds implanted in a given patient depends on the type of tumor, its size, extent, and biology, and the amount of radioactivity contained in each seed. To further complicate the matter, the HCPCS codes used to report implantation of brachytherapy seeds are not tumor-specific. Instead, they are defined based on the number of sources, that is, the number of seeds or ribbons used in the procedure. This means that the treatment of many different tumors requiring implantation of widely varying numbers of seeds is described by a single HCPCS code. Therefore, it has been argued that given the costs of seeds and the variety of treatments described by a single HCPCS code, the cost of brachytherapy billed under a single HCPCS code could vary by as much as $3,000.

In determining whether to package seeds into their associated procedures, we considered all these factors as well as our claims data. Consistent with our proposed policy for other device costs and the cost of many drugs, as well as with the principles of a prospective payment system, our preferred policy is to package the cost of brachytherapy devices into their associated procedures. For 2003, in the case of remote afterloading high intensity brachytherapy and prostate brachytherapy, which we discuss below, weproposed to package the costs into payment for the procedures with which they are billed.

For other uses of brachytherapy, we proposed to defer packaging of brachytherapy seeds for at least 1 year. In those cases, when paying separately in 2003 for brachytherapy seeds, we proposed to continue payment on a per seed basis. The payment amount would be based on the median cost of brachytherapy seeds, per seed, as determined from our claims data.

We solicited comments on methodologies we might use to package all brachytherapy seeds beginning in CY 2004. For example, creation of tumor-specific brachytherapy HCPCS codes would reduce the variability in seed implantation costs associated with the current HCPCS codes used for seed implantation.

As stated above, beginning January 1, 2003, we proposed to package payment for brachytherapy seeds into the payment for the following two types of brachytherapy services:

Remote Afterloading High Intensity Brachytherapy

Participants in the April 5, 2002 Town Hall meeting expressed concern about packaging single use brachytherapy seeds into payment for procedures.

Remote afterloading high intensity brachytherapy treatment does not involve implantation of seeds. Instead, it utilizes a single radioactive ''source'' of high dose iridium with a 90-day life span. This single source is purchased and used multiple times in multiple patients over its life. One or more temporary catheters are inserted into the area requiring treatment, and the radioactive source is briefly inserted into each catheter and then removed. Because the source never comes in direct contact with the patient, it may be used for multiple patients. We note that the cost of the radioactive source, per procedure, is the same irrespective of how many catheters are inserted into the patient. We believe that the costs of this type of source should be amortized over the life of the source. Therefore, each hospital administering this type of therapy should include its own charge for the radiation source in the charge for the procedure. Therefore, we proposed to package the costs associated with high dose iridium into the HCPCS codes used to describe this procedure. Those codes are: 77781, 77782, 77783, and 77784.

Prostate Brachytherapy

The preponderance of brachytherapy claims under OPPS to date is for prostate brachytherapy. Brachytherapy is administered in several other organ systems, but the claims volume for non-prostate brachytherapy is very small, and hence our base of information on which to make payment decisions is slim. Furthermore, prostate brachytherapy uses only two isotopes, which are similar in cost, while brachytherapy on other organs involves a variety of isotopes with greater variation in cost. Consequently, we believe it would be prudent to wait for further experience to develop before proceeding to package non-prostate brachytherapy seeds.

A number of commenters at the April 5, 2002, Town Hall Meeting and elsewhere have stressed to us their views that brachytherapy seeds should remain unpackaged. The principle argument put forth in favor of this approach is that the number of seeds used is highly variable across patients. We do not find this argument compelling. Payments in the OPPS, as in other prospective payment systems, are based on averages. We believe the service volume at hospitals providing prostate brachytherapy is likely to be large enough for a payment reflecting average use of seeds to be appropriate.

Additionally, appropriate payment for prostate brachytherapy has been of concern to many commenters since implementation of the OPPS because facilities must use multiple HCPCS codes on a single claim to accurately describe the entire procedure. Because we determine APC relative weights using single procedure claims, commenters have argued that payments for prostate brachytherapy are, in part, based on error claims, resulting in underpayment for this important service. We agree that basing the relative weights for APCs reported for prostate brachytherapy services on only the small number of claims related to this service that are single procedure claims may be problematic. To increase the number of claims we could use to develop the proposed 2003 relative payment weights for prostate brachytherapy, we began by identifying all claims billed in 2001 for prostate brachytherapy. Unfortunately, closer analysis of these claims revealed that hospitals do not report prostate brachytherapy using a uniform combination of codes. Of the more than 12,000 claims for prostate brachytherapy that we identified in the 2001 claims data, no single combination of HCPCS codes occurred more than 25 times.

Therefore, in order to facilitate tracking of this service, we proposed to establish a G code for hospital use only that will specifically identify prostate brachytherapy. We proposed as the descriptor for this G code the following: ''Prostate brachytherapy, including transperineal placement of needles or catheters into the prostate, cystoscopy, and interstitial radiation source application.'' This G code would be used by hospitals instead of HCPCS codes 55859 and 77778 to bill for prostate brachytherapy. Hospitals would continue to use HCPCS codes 55859 and 77778 when reporting services other than prostate brachytherapy. We would also instruct hospitals to continue to report separately other services provided in conjunction with prostate brachytherapy, such as dosimetry and ultrasound guidance. These additional services would be paid according to the APC payment rate established by our usual methodology.

This G code will allow us to package brachytherapy seeds into the procedures for administering prostate brachytherapy while permitting us to pay separately for brachytherapy seeds which are administered for other procedures. Therefore, we proposed to package the costs of the brachytherapy seeds, catheters, and needles into the payment for the prostate brachytherapy G code. In order to develop a payment amount for this G code, we used all claims where both HCPCS codes 55859 and 77778 appeared. We packaged all revenue centers and appropriate HCPCS codes, that is, HCPCS with status indicator ''N.'' We then determined median costs of the line items for HCPCS codes 55859 and 77778 and added the two. Next, we packaged the costs of all C codes, whether an item-specific or a device category code, into the payment amount. We proposed to assign APC 0684 with status indicator ''T.'' We believe the payment rate proposed for this G code appropriately reflects the costs of the procedures, the brachytherapy seeds, and any other devices associated with these procedures. We solicited comments on this proposal.

Packaging of Other Device Costs Associated With Brachytherapy

We proposed to package the costs of brachytherapy needles and catheters with whichever procedures they are reported, similar to our proposal for packaging the costs of other devices that will no longer be eligible for a transitional pass-through payment in 2003. Because the HCPCS code descriptors for brachytherapy are based on the number of catheters or needles used, we believe the costs of these devices would be appropriately reflected within the costs of the associated procedure.

Brachytherapy

*Comment:* One commenter believed that assigning CPT Code 77799 to APC 313 was inappropriate because it was the highest paying brachytherapy APC and it violated the two times rule.

*Response:* We thank the commenter for bringing this to our attention. The CPT code 77799 should be assigned to APC 312, the lowest paying brachytherapy APC, which is consistent with our policy of assigning unspecified codes to the lowest paying similar APC because we do not know what procedures are being performed. However, we do not apply the two times rule to unspecified codes like 77799 for that same reason. We are assigning 77799 to APC 312.

*Comment:* Several commenters were concerned that the proposed payment rates for APCs 1718, for iodine seeds, and 1720, for palladium seeds were significantly lower than the 2002 payment rates for these brachytherapy sources. The commenters stated that the new rates do not reflect hospital acquisition costs and recommended that we continue pass-through status for these seeds in 2003 or refine the claims data used to set payment rates.

*Response:* Our payment rates for 1718 and 1720 are based on the median costs for these seeds in our 2001 claims data. We are confident that these data reflect actual hospital acquisition costs. By statutory mandate, the OPPS system, in aggregate, does not pay hospitals full costs for services. Therefore, it should not be expected that payment rates (which involve turning median costs into relative weights and applying scaling factors) will always reflect 100 percent of hospital acquisition cost.

*Comment:* Several commenters urged us to identify all sources currently used in brachytherapy and cover those sources on an interim basis. They suggested we retain a C code for ''unlisted'' brachytherapy sources to allow hospitals to bill for sources not on the current pass through list.

*Response:* We only create C codes for items based on formal applications for a specific device. We do not create C codes for unlisted devices. Interested parties may submit an application for a pass through device using the process described in the April 7, 2000 final rule (65 FR 18481–18482).

*Comment:* A commenter suggested continuing the pass-through categories for brachytherapy seeds, needles, and catheters for one year in order to collect more data.

*Response:* Statutory provisions preclude us from continuing these categories for an additional year.

*Comment:* One commenter asked us to refer to brachytherapy ''sources'' instead of brachytherapy ''seeds.''

*Response:* We agree and will do so.

*Comment:* One commenter responded to our solicitation of comments regarding the advisability of creating tumor specific brachytherapy HCPCS codes in the future. The commenter did not favor this idea because of the variability in number and type of brachytherapy devices used to treat a single disease. Additionally, it would create an overly complex coding system.

*Response:* We thank the commenter and are continuing to review this issue.

*Comment:* Several commenters were concerned about the proposed payment reduction for APC 313 (High Dose Afterloading Brachytherapy). The commenters stated that hospitals were coding incorrectly for these services because many claims did not use C codes for the sources or catheters. Therefore, our data did not reflect actual hospital costs. The commenters recommended that we increase the payment rate, use only claims that were correctly coded, or continue to pay separately for the sources.

*Response:* As described elsewhere in this rule, we have taken steps to mitigate the severe payment decreases that were proposed for several APCs including APC 313. Therefore the final payment rate for APC 313 will be higher than the proposed payment rate. We will continue to review the issues raised by the commenters. It is unclear how we should address the issue of coding for APC 313 because high dose brachytherapy sources are reusable whose costs must be amortized per use over a 90 day period. Furthermore, hospitals have been using these sources for many years; therefore, we would expect their charges would reflect this amortized cost even in the absence of using a C code. Additionally, it is likely we over estimated device costs for this APC because of the methodology we used for folding in device costs insetting 2002 payment rates. Lastly, we are unable to continue pass-through payments for devices used in APC 313 and do not think it is appropriate to pay separately for high dose brachytherapy sources for the reasons discussed.

*Comment:* Several commenters were concerned about the ''N'' status indicator assigned to Yttrium-90 brachytherapy sources. They stated that it is an implantable seed used in treating liver cancer. They also claimed that its median cost was much higher than the cost reflected in our claims data.

*Response:* We will place Yttrium-90 in an APC. Assigning status indicator ''N'' was an error. We will use our claims data to set the payment rate. We will continue to review our claims data and external data sources as we update the payment rate in 2004.

*Comment:* Several commenters suggested that we create HCPCS codes and APCs for high dose implantable brachytherapy sources. They explained that sources such as iodine-125 and palladium-103 may be ''high'' intensity or 'low'' intensity (that is, emit different amounts of radiation) and that our payment for these sources account for the cost variation associated with sources of different intensities. Another commenter requested that we create three levels of APCs for brachytherapy needles and catheters to account for cost variation of those devices. Lastly, another commenter suggested we create

three APCs to reflect levels of seed utilization (for example, simple for less than 85 seeds, intermediate for 85–99 seeds and complex for more than 100 seeds).

*Response:* We disagree. Our median cost data should reflect the cost variation among seeds of different intensity. For example if low intensity seeds cost $40 and are used 80 percent of the time, and high intensity seeds cost $50 and are used 20 percent of the time, then our cost data should reflect a cost of $42 per seed. Insofar as no hospital specializes in administering high intensity seeds, on average, hospitals should be paid appropriately for both types of seeds. Furthermore it would be administratively burdensome and make accurate coding very difficult, if we created APCs for every variation in seeds. We believe devices other than seeds should be packaged into procedure APCs, as we have done with all other devices. Because we pay for sources on a ''per seed'' basis there is no reason to create APCs for simple, intermediate, and complex seed utilization.

*Comment:* One commenter requested that we set up a system to account for the variability in use of brachytherapy devices. Another commenter said that brachytherapy codes were not well understood so all supplies and sources should be paid separately.

*Response:* We disagree and are finalizing our proposal to package all devices except for seeds in cases of non-prostate cancer brachytherapy. Doing what the commenters requested would create an extremely burdensome system with no discernable benefit.

*Comment:* Many commenters disagreed with our proposal to create a G code describing prostate brachytherapy with packaged implantable sources, needles, and catheters. They cited the following as reasons:

- The high variability in the number of sources used per treatment.
- The difference in cost between iodine and palladium seeds.
- Packaging of seeds violates the two times rule.
- Some hospitals specialize in complex cases requiring high numbers of seeds and would always be underpaid.
- A single payment rate would provide incentives to use cheaper (iodine) seeds when more expensive seeds (palladium) were clinically appropriate.
- A single payment rate would provide an incentive to use fewer, higher activity seeds even if use of more lower activity seeds was clinically appropriate.
- Underpayment for prostate brachytherapy will create an incentive to use more invasive, riskier, and costly treatments for prostate cancer.
- The proposed payment rate is too low as a result of using improperly coded claims.
- Creating a new G code is administratively burdensome.

Most commenters recommended that we continue to pay separately for brachytherapy sources used for prostate cancer, as we proposed to do for other forms of cancer. Some commenters requested that we withdraw our proposal for the G code describing brachytherapy and continue to recognize CPT codes 55859 and 77778 while other commenters agreed with our proposal to create the G code with packaged needles and catheters but asked that we not package brachytherapy sources into it. Some commenters requested that, if we finalize our G code, that it be paid as least as much as combined payment rate for the APCs containing CPT codes 55859 and 77778.

A few commenters agreed with our proposed G code approach but asked that we create 2 G codes, one for prostate brachytherapy using iodine seeds and another for prostate brachytherapy using palladium seeds. They also suggested that if CMS finalizes one or more G codes, coding edits should be developed to ensure proper coding of these procedures.

*Response:* We thank all the commenters. After review of all the comments we have decided to create 2 G codes describing prostate brachytherapy. G0256, Prostate brachytherapy using permanently implanted palladium seeds, including transperitoneal placement of needles or catheters into the prostate, cystoscopy and application of permanent interstitial radiation source, and G0261, Prostate brachytherapy using permanently implanted iodine seeds, including transperitoneal placement of needles or catheters into the prostate, cystoscopy and application of permanent interstitial radiation source. These codes package the costs of needles, catheters, and sources. In developing payment rates for these codes we used only correctly coded claims. For example, for G0256 we used only claims that included CPT codes 55859, 77778, and a C code for palladium sources. We did not use any claims where there was no C code for a brachytherapy source or a claim where there were C codes for more than one source (for example, palladium and iodine sources). Analysis of the claims we used in setting payment rates revealed that the median number of seeds packaged into both codes is 85. We believe that the median costs of these codes reflect the resources required to perform these procedures.

We believe that implementation of these G codes should address the clinical concerns of the commenters. We do not believe these codes will create an incentive to use one type of source rather than another. Additionally, because of the number of seeds packaged we do not believe there will be an incentive to use fewer seeds inappropriately. Furthermore, we believe the number of packaged seeds addresses the concerns about seed variability as we are not aware of facilities that specialize in using more palladium or iodine than are packaged in these codes. Finally, we do not have evidence that implementation of these G codes and their payment rates will create an incentive to treat prostate cancer with more invasive, more costly treatments.

For non-clinical concerns, we think that implementation of the G codes will actually decrease administrative burden as it will now be easier for hospitals to properly code for prostate brachytherapy procedures, and we believe that the methodology we used to develop median costs addresses the concerns about underpayment.

When performing prostate brachytherapy hospitals should use G0256 and G0261 and should not report CPT codes 55859 and 77778. Furthermore hospitals should not report the APCs for iodine and palladium brachytherapy sources. CMS will create edits to prevent billing of these items and services with prostate brachytherapy. However, other services provided during the provision of prostate brachytherapy such as intraoperative ultrasound, dosimetry, etc., are separately payable and should be reported on the claim if performed.

*F. Payment for Transitional Pass-Through Drugs and Biologicals for Calendar Year 2003*

As discussed in the November 13, 2000 interim final rule (65 FR 67809) and the November 30, 2001 final rule (66 FR 59895), we update the payment rates for pass-through drugs on an annual basis. Therefore, as we have done for prior updates, we proposed to update the APC rates for drugs that are eligible for pass-through payments in 2003 using the most recent version of the Red Book, the July 2002 version in this case. The updated rates effective January 1, 2003 would remain in effect until we implement the next annual

update in 2004, when we would again update the AWPs for any pass-through drugs based on the latest quarterly version of the Red Book. This retains the update of pass-through drug prices on the same calendar year schedule as the other annual OPPS updates.

As described in our final rule of November 30, 2001 (66 FR 59894), in order to establish the applicable beneficiary copayment amount and the pass-through payment amount, we must determine the cost of the pass-through eligible drug or biological that would have been included in the payment rate for its associated APC had the drug or biological been packaged. We used hospital acquisition costs as a proxy for the amount that would have been packaged, based on data from an external survey of hospital drug costs (see the April 7, 2000 final rule (65 FR 18481)). That survey concluded that—

- For drugs available through only one source drugs, the ratio of acquisition cost to AWP equals 0.68;
- For multisource drugs, the ratio of acquisition cost to AWP equals 0.61;
- For drugs with generic competitors, the ratio is 0.43.

As we stated in our final rule of November 30, 2001 (66 FR 59896), we considered the use of the study-derived ratios of drug costs to AWP to be an interim measure until we could obtain data on hospital costs from claims. We stated that we anticipated having this data to use in setting payment rates for 2003.

As described elsewhere in this preamble, we used 2001 claims data to calculate a median cost per unit of drug for each drug for which we are currently paying separately. We compared the median per unit cost of each drug to the AWP to determine a ratio of acquisition cost to AWP. Using the total units billed for each drug, we then calculated a weighted average for each of the above three categories of drugs. These calculations resulted in the following weighted average ratios:

- For sole-source drugs, the ratio of cost to AWP equals 71.0 percent.
- For multisource drugs, the ratio of cost to AWP equals 68.0 percent.
- For drugs with generic competitors, the ratio of cost to AWP equals 46.0 percent.

We proposed to use these percentages for determining the applicable beneficiary copayment amount and the pass-through payment amount for most drugs eligible for pass-through payment in 2003. However some drugs may fall into two other classes. The first class includes a drug that is new and for which no cost is yet included in an associated APC. For such a drug, because there is no cost for the drug yet included in an associated APC, the pass-through amount will be 95 percent of the AWP and there would be no copayment. The second class includes a drug that is new and is a substitute for only one drug that is recognized in the OPPS through an unpackaged APC. For drugs in this second class, the pass-through amount would be the difference between 95 percent of the AWP for the pass-through drug and the payment rate for the comparable dose of the associated drug's APC. The copayment would be based on the payment rate of its associated APC. We believe that using this methodology will yield a more accurate payment rate.

We have received questions for our definition of multisource drugs. In determining whether a drug is available from multiple sources, we consider repackagers to be among the sources. This is consistent with the findings of the survey cited above which indicated a lower ratio of acquisition cost to AWP from multiple sources including repackagers.

We note that determining that a drug is eligible for a pass-through payment or assigning a status indicator ''K'' to a drug or biological (indicating that the drugs or biologicals is paid based on a separate APC rate) indicates only the method by which the drug or biological is paid if it is covered by the Medicare program. It does not represent a determination that the drug is covered by the Medicare program. For example, Medicare contractors must determine whether the drug or biological is: (1) Reasonable and necessary to treat the beneficiary's conditions; and (2) excluded from payment because it is usually self-administered by the patient.

We received several comments on this proposal, which are summarized below.

*Comment:* A commenter stated that the payments for pass-through drugs were too generous compared to those for the devices.

*Response:* We calculated payments for pass-through drugs and devices in accordance with the statute in sections 1833(t)(6)(D)(i) and (ii) of the Act.

*Comment:* Numerous commenters were concerned with the time required to incorporate new drugs and biologicals into the APC system. Some commenters indicated that we frequently depart from our own timeframe of 4 to 7 months from the date of submission of an application to the potential effective data for pass-through status. Thus, they urged us to follow one of the following recommendations: Expedite the processing of pass-through applications and the creation of C codes; develop C codes for products pending FDA approval, or permit retroactive dates for new codes to allow for retroactive reimbursement for hospitals. Another commenter suggested that we create a centralized on-line listing of all current pass-through drugs, biologicals, and devices along with all of the new applications under review.

*Response:* We understand the commenters' concerns, and we would like to clarify the operation of our quarterly deadlines. We establish deadlines for submission of transitional pass-through applications that are 4 months in advance of the next quarterly update to the claims-payment system in order to accommodate time for review and decision and for revisions to the claims-payment systems. Thus an applicant submitting by the deadline can be assured we will consider the application for possible inclusion in the next quarterly update. However, we cannot guarantee that we will be able to make a decision regarding the application within that period of time. Incomplete applications or the need to answer technical questions that arise during review may extend the period of review.

We have instructed hospitals through our fiscal intermediaries that hospitals may bill for new drugs following FDA approval using an unspecified HCPCS code until a permanent HCPCS is established for the drug and/or we have approved pass-through payment for the drug. Payment for a new drug, if determined by the fiscal intermediary to be a covered drug, would be packaged. However inclusion of the drug charges for the procedure will be considered in determining outlier payments and will be used in future rate setting for the procedure and/or the drug once its pass-through status expires. Hospitals should note that we have lowered the threshold for outlier payments for 2003, and this new threshold requirement is described in section IX of the preamble.

We intend to minimize the delays in the review process as much as possible so that we can facilitate access to new products and services for our beneficiaries, which is why we review new pass-through applications on a quarterly basis. We disagree with the commenters who suggested that we allow retroactive reimbursement for hospitals to the date of FDA approval. Moving to such a policy would greatly increase the burden on our and hospitals' computer systems in programming, testing, and implementing updates to the payment system. We do not provide for retroactive changes in reimbursement because this is a prospectively

determined payment system and because retroactive payment rate changes are administratively burdensome and confusing for beneficiaries and providers.

We appreciate the suggestion to create an on-line listing of all transitional pass-through items and applications that are under review, and will consider it for the future.

*Comment:* Several national trade associations and drug companies were concerned with our proposal to consider drugs and biologicals that were subject to repackaging as multisource drugs. They indicated that repackagers do not manufacture the products; instead, they purchase the products from the manufacturers, package them differently, and then sell the products. The manufacturer of the product continues to be the sole source of the product; therefore, we should regard repackaged products as sole source drugs. Also, they recommended that we utilize the ''Orange Book'' to determine whether a drug should considered single source, multisource, or generic for OPPS purposes.

*Response:* We acknowledge that we treat certain drugs that have only one manufacturer as a multisource drug. Our rationale behind regarding a repackaged drug as a multisource product is that, even though there may be only one manufacturer of a repackaged drug, there is more than one party selling the repackaged drug in the market. Therefore, a repackager may charge a different price to hospitals for the same product sold by its manufacturer. Our intention in the payment system is to account for the economic relationship between market prices for repackagers, multisource drugs, and sole source drugs. From our analysis, we judged the drugs sold by repackagers to be similar to drugs available from more than one manufacturer in terms of price differentials and estimated hospital acquisition costs. We also note that if we were to recategorize these drugs as single source, we would have to recalculate the average values for acquisition costs for the three categories of drugs.

*Comment:* Several commenters suggested that we use the October 2002 Red Book information to set the final pass-through payment rates for 2003. Also, the commenters urged us to update the pass-through payment rates quarterly since there will be significantly fewer pass-through drugs in 2003.

*Response:* Upon considering the commenters' suggestions in using the October 2002 Red Book to set the pass-through payment rates for drugs and biologicals, we decided to continue using the July 2002 Red Book as we proposed since it is most consistent with our publication schedule. In the future, for all of our final rules that must be published by November, we will continue to use the July edition of the Red Book for that year.

We carefully considered the proposal to update the pass-through payments on a quarterly basis and decided to continue with only annual updates of the rates. From previous experience, we know that doing a quarterly update of the prices for all the pass-through drugs and biologicals would be burdensome on our contractors and disruptive to both our computer systems and pricing software. Although we make other updates on a quarterly basis, we do not include revision of rates in these updates unless an error was made in the calculation of the rate. We see no compelling reason to update the transitional pass-through drug prices under the OPPS more frequently than the other payment rates in the outpatient system.

*Comment:* Several commenters indicated that in the proposed rule we appeared intent on estimating pass-through expenditures that will exceed the statutory cap and trigger a pro-rata reduction of pass-through payments in 2003.

*Response:* Frankly, we find it puzzling that commenters would believe we would manipulate the estimates of pass-through spending with the intention of ensuring that a pro-rata reduction would be imposed. Our estimate of transitional pass-through spending indicates that no pro-rata reduction will be necessary in 2003.

*Comment:* A commenter urged us to develop a process for acknowledgement and payment adjustment when it is determined that the rates published in the Red Book are incorrect.

*Response:* As stated elsewhere in this final rule, we update payment rates for pass-through drugs and biologicals only on an annual basis using the information published in the July edition of the Red Book. We rely on information supplied by manufacturers to the Red Book to be accurate.

## V. Criteria for New Device Categories As Implemented in the November 2, 2001 Interim Final Rule With Comment

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), Public Law 106–113, amended section 1833(t) of the Act to make major changes that affected the new PPS for hospital outpatient services. Section 1833(t)(6) of the Act, which was added by section 201(b) of the BBRA, provided for temporary additional payments, referred to as ''transitional pass-through payments,'' for certain drugs, biologicals, and devices. Section 1833(t)(b) of the Act provided for payment of new medical devices, as well as new drugs and biologicals, in instances in which the item was not being paid as a hospital outpatient service as of December 31, 1996, and when the cost of the item is ''not insignificant'' in relation to the OPPS payment amount. Section 402 of BIPA, which amends section 1833(t)(6) of the Act, requires us to use categories in determining the eligibility of devices for transitional pass-through payments effective April 1, 2001. Section 1833(t)(6)(B)(ii)(IV) of the Act, as added by section 402(a) of BIPA, requires us to establish a new category for a medical device when—

- The cost of the device is not insignificant in relation to the OPPS payment amount;
- No existing or previously existing device category is appropriate for the device; and
- Payment was not being made for the device as an outpatient hospital service as of December 31, 1996. However, section 1833(t)(6)(B)(iv) of the Act, also added by section 402(a) of BIPA, provides that a medical device shall be treated as meeting the first and third requirements if either—
- The device is described by one of the initial categories established and in effect or
- The device is described by one of the additional categories we established and in effect, and—

—An application under section 515 of the Federal Food, Drug, and Cosmetic Act has been approved; or

—The device has been cleared for market under section 510(k) of the Federal Food, Drug, and Cosmetic Act; or

—The device is exempt from the requirements of section 510(k) of the Federal Food, Drug, and Cosmetic Act under section 510(l) or section 510(m) of that Act.

Thus, otherwise covered devices that are described by a currently existing category may be eligible for transitional pass-through payments even if they were paid as part of an outpatient service as of December 31, 1996. At the same time, no categories will be created on the basis of devices that were paid on or before December 31, 1996.

Section 1833(t)(6)(B)(i)(I) of the Act, as amended by BIPA, required us to establish, by April 1, 2001, an initial set of categories based on device by type in such a way that specific devices eligible

for transitional pass-through payments under sections 1833(t)(A)(ii) and (iv) of the Act as of January 1, 2001 would be included in a category. We developed this initial set of categories in consultation with groups representing hospitals, manufacturers of medical devices, and other affected parties, as required by section 1833(t)(6)(B)(i)(II) of the Act. We issued the list of initial categories on March 22, 2001, in Program Memorandum (PM) No. A–01–41. Subsequently, an additional two categories and clarifications of some of the categories' long descriptors were made. The latest PM that lists all the existing device categories (including three additional categories that became effective July 1, 2002) is Transmittal No. A–02–050, issued June 17, 2002, which can be accessed on our Web site, *http://cms.hhs.gov.*

Section 1833(t)(6)(B)(ii)(III) of the Act, as amended by BIPA, requires us to establish criteria by July 1, 2001 that will be used to create additional categories. Section 1833(t)(6)(B)(ii)(II) of the Act requires that no medical device is described by more than one category. In addition, the criteria must include a test of whether the average cost of devices that would be included in a category is ''not insignificant'' in relation to the APC payment amount for the associated service.

On November 2, 2001, we set forth in an interim final rule (66 FR 55850) the criteria for establishing new (that is, additional) categories of medical devices eligible for transitional pass-through payments under the OPPS as required by section 1833(t)(6)(B)(ii) of the Act. We received five comments regarding our criteria published in the November 2, 2001 interim final rule with comment period. We summarize and respond to these comments below.

*A. Criteria for Eligibility for Pass-Through Payment of a Medical Device*

As noted above, in our April 7, 2000 final rule with comment period (65 FR 18480), we defined new or innovative devices using eight criteria, three of which were revised in our August 3, 2000 interim final rule with comment period (65 FR 47673 through 47674). These criteria were set forth in regulations at § 419.43(e)(4). For the most part, these criteria remained applicable when defining a new category for devices. That is, devices to be included in a category must meet all previously established applicable criteria for a device eligible for transitional pass-through payments. The definition of an eligible device, however, needed to change to conform to the requirements of the amended section 1833(t)(6)(B)(ii) of the Act, that is, the requirement to establish additional categories, which we accomplished in our November 2, 2001 interim final rule.

In addition, we clarified our criterion that states that a device must be approved or cleared by the FDA. The approval or clearance criterion applies only if FDA approval or clearance is required for the device as specified at new § 419.66(b)(1). For example, a device that has received an FDA investigational device exemption (IDE) and has been classified as a Category B device by the FDA in accordance with § 405.203 through § 405.207 and § 405.211 through § 405.215 is exempt from this requirement. A device that has received an FDA IDE and is classified by the FDA as a Category B device is eligible for a transitional pass-through payment if all other requirements are met.

*B. Criteria for Establishing Additional Device Categories*

As described above, in determining the criteria for establishing additional categories, section 1833(t)(6)(B)(ii) of the Act mandates that new categories must be established for devices that were not being paid for as an outpatient hospital service as of December 31, 1996, and for which no category in effect (or previously in effect) is appropriate in such a way that no device is described by more than one category and the average cost of devices to be included in a category is not insignificant in relation to the APC payment amount for the associated service. Based on these requirements, we announced in the November 2, 2001 interim final rule that we will use the following criteria to establish a category of devices:

- *Substantial clinical improvement.* The category describes devices that demonstrate a substantial improvement in medical benefits for Medicare beneficiaries compared to the benefits obtained by devices in previously established (that is, existing or previously existing) categories or other available treatments, as described in regulations at new § 419.66(c)(1).

We stated our belief that this criterion ensures that no existing or previously existing category contains devices that are substantially similar to the devices to be included in the new category. This criterion is consistent with the statutory mandate that no device is described by more than one category.

In addition, we said that this criterion limits the number of new categories, and consequently transitional pass-through payments, to those categories containing devices that offer the prospect of substantial clinical improvement in the care of Medicare beneficiaries. Section 1833(t)(6)(E)(iii) of the Act, requires that, if the Secretary estimates before the beginning of the year that the total estimated amount of pass-through payments would exceed a specified percentage of total program payments (2.5 percent before 2004 and no more than 2 percent thereafter), we must uniformly reduce (prospectively) each pass-through payment in that year by an amount adequate to ensure that the limit is not exceeded.

We established this criterion because it is important for hospitals to receive pass-through payments for devices that offer substantial clinical improvement in the treatment of Medicare beneficiaries to facilitate access by beneficiaries to the advantages of the new technology. Conversely, the need for additional payments for devices that offer little or no clinical improvement over a previously existing device is less apparent. These devices can still be used by hospitals, and hospitals will be paid for them through the appropriate APC payment. To the extent these devices are used, the hospitals' charges for the associated procedures will reflect their use. We will use data on hospital charges to update the APC payment rates as part of the annual update cycle. Thus, the payment process will provide an avenue to reflect appropriate payments for devices that are not substantial improvements.

We are currently evaluating requests for a new category of devices against the following criteria in order to determine if it meets the substantial clinical improvement requirement:

- The device offers a treatment option for a patient population unresponsive to, or ineligible for, currently available treatments.
- The device offers the ability to diagnose a medical condition in a patient population where that medical condition is currently undetectable or offers the ability to diagnose a medical condition earlier in a patient population than allowed by currently available methods. There must also be evidence that use of the device to make a diagnosis affects the management of the patient.
- Use of the device significantly improves clinical outcomes for a patient population as compared to currently available treatments. Some examples of outcomes that are frequently evaluated in studies of medical devices are the following:

—Reduced mortality rate with use of the device.

—Reduced rate of device-related complications.

—Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process).
—Decreased number of future hospitalizations or physician visits.
—More rapid beneficial resolution of the disease process treated because of the use of the device.
—Decreased pain, bleeding, or other quantifiable symptom.
—Reduced recovery time.

As part of the application process (described in section V.B.1 of this final rule), we require the requesting party to submit evidence that the category of devices meets one or more of these criteria. We noted that the requirements set forth above will be used only for determining whether a device is eligible for a new category under section 1833(t)(6)(B) of the Act, which authorizes transitional pass-through payments for categories of devices. These criteria are not intended for use in making coverage decisions under section 1862(a)(1)(A) of the Act. We noted that adoption of these criteria is consistent with the recommendation of the Medicare Payment Advisory Commission, in its March 2001 Report to Congress, that pass-through payments for specific technologies be made only when a technology is new or substantially improved.

We stated that we determine which devices represent a substantial clinical improvement over existing devices by using a panel of Federal clinical and other experts, supplemented if appropriate by individual consultation with outside experts. These decisions are, in general, based on information submitted by the requester about the clinical benefit of the devices as described in the above criteria, including, where available, evidence from clinical trials or other clinical investigations. A panel of clinical experts from CMS has thus far made all of our decisions on eligibility for an additional device category.

As indicated in the November 2, 2001 interim final rule, we believe that almost all substantial clinical improvements in technology that are appropriately paid for under the transitional pass-through provisions result in measurable improvements in care from the perspective of the beneficiary. Nevertheless, there may be some improvements in the medical technology itself that are so significant that we may wish to recognize them for separate payment (as opposed to packaged payments) even though they do not directly result in substantial clinical improvements. For example, improvements in such factors as the strength of materials, increased battery life, miniaturization, might so improve convenience, durability, ease of operation, etc., that such an improvement in medical technology might be considered as a separate factor from ''substantial clinical improvement'' in beneficiary care.

We invited public comment on this issue and particularly asked for examples of medical technologies for which pass-through payments might be appropriate even though they would not also pass a test based on substantial improvement in beneficiary outcomes. Although we received a number of comments on this criterion, only one attempted to provide an example of new medical technology that might not also pass a test based on substantial improvement in beneficiary outcomes. This example is described in our summary of comments and responses below.

As we noted in the November 2, 2001 interim final rule, we will continue to evaluate these criteria as we gain experience in applying them, and we will consider revisions and refinements to them over time as appropriate.

*Comment:* Most commenters expressed concerns regarding our criterion that new device categories demonstrate substantial clinical improvement to be eligible for pass-through payment. Device manufacturers and representatives felt that evidence of clinical outcomes should not be part of the device category evaluation and eligibility process. Some maintained that we already have standards for determining clinical benefit as part of the Medicare coverage process and we should not have such requirements in payment determination. One commenter claimed that we would be unable to determine substantial clinical improvement for pass-through categories separately from national coverage decisions, since we will be reviewing the same types of evidence for both processes. This commenter held that a payment policy decision using clinical improvement criteria is a de facto coverage decision that our Coverage Analysis Group and carriers would feel compelled to go along with.

One device manufacturer was concerned that any employment of inappropriate evidentiary standards in evaluating improvement in diagnosis or treatment when applying this criterion could be a barrier to pass-through payment for some new technologies.

Yet, some manufacturers agree that pass-through payment should be limited to technologies that represent significant advancements in providing beneficial new therapy options. A number of commenters felt we should take into account improvements in devices' technology per se, for example, material, power source, size, etc., and not limit our criterion of improvement to clinical improvement. Some commenters held that only technological aspects of new medical devices should be analyzed to determine whether there are advancements over existing pass-through devices to determine whether a device should be considered for an additional category. A manufacturer stated that if we feel that a criterion based on clinical benefits is needed, we should employ a ''substantially different'' criterion to determine eligibility for a new category. Under this suggestion, any difference in therapeutic effect, indication, surgical approach, safety or side effects, mechanics or function that offers a ''new beneficial therapeutic alternative'' would be considered ''substantial.''

One manufacturer also stated that a ''substantial clinical improvement'' criterion may be unnecessary, because we already have a criterion that addresses costs that are ''not insignificant.''

*Response:* Although the information required for pass-through category applications is similar for coverage determinations, the information is used differently. The purpose of the ''reasonable and necessary'' condition in evaluating coverage is different than the OPPS purpose of determining appropriate pass-through payment for new technology items. We are not attempting to determine coverage under the OPPS, only whether a payment under the pass-through mechanism is warranted. We adopted the ''substantial clinical improvement'' criterion to help us identify those devices that are not adequately described by any previously established device categories.

Those who argue that we should employ a ''substantially different'' or a ''clinical benefit'' criterion rather than the ''substantial clinical improvement'' do not answer the question as to how different a new technology should be to be considered eligible for a new device category. It seems to us that many of the differences listed in the suggestion to base a criterion on ''substantial differences'' noted above may not reflect qualitatively meaningful differences and such devices could be adequately described by the existing or previously existing categories. If a new device technology were adequately described by a category of devices in terms of its clinical application and benefits, then an additional category would not seem

warranted. Still, as we have stated in the November 2, 2001 interim final rule and again above, there may be some improvements in the medical technology itself that are so significant that we may wish to recognize them for separate payment even though they do not directly result in substantial clinical improvements. We will continue to allow the flexibility in our evaluation process to consider such items for new categories.

We believe it is harder to make a determination of substantial difference than it is to make a determination as to substantial clinical benefit. Furthermore, we believe that, in general, transitional pass through payments should be made only for technologies that benefit beneficiaries beyond the technologies currently available.''

We believe it is harder to make a determination of substantial difference than it is to make a determination as to substantial clinical benefit. Furthermore, we believe that, in general, transitional pass-through payments should be made only for technologies that benefit beneficiaries beyond the technologies currently available.

The notion that a ''substantial clinical improvement'' criterion may be unnecessary, because we already have a criterion that addresses ''not insignificant cost,'' is misplaced. The cost of the new technology may or may not directly address a nominated device's clinical benefits. Payment for a costly device may be related to a number of factors, such as Medicare payment policy for a technology or the cost of raw materials or manufacturing process, irrespective of substantial clinical improvement. We established the clinical improvement criterion in addition to the cost significance criterion mandated under statute because one cannot accurately infer that a high relative cost is indicative that a device cannot be described by an existing or previous category of devices. Nor can we automatically infer that a substantially clinically improved device necessarily bears significantly higher cost than what we are currently paying for pass-through devices and procedural payments through the APC payment rates. Therefore, both criteria are needed.

*Comment:* In the November 2, 2001 interim final rule, we invited public comment on the issue of substantial improvement, saying we would be interested in examples of medical technologies for which pass-through payments might be appropriate even though they would not pass a test based on substantial improvement in clinical outcomes. Several commenters pointed to differences in brachytherapy devices as examples. These commenters said that differences in devices should be reflected by establishing separate device categories by: different chemical substances/radioisotope, therapeutic radiation activity levels, implantation arrays of brachytherapy devices, and mechanisms of injecting brachytherapy devices that improve safety and function.

*Response:* We have reviewed many applications for brachytherapy devices and believe that there is a congruence between new technologies that might be eligible for transitional pass-through payments in the absence of producing substantial clinical benefit and new technologies that do produce substantial clinical benefit.

*Comment:* Commenters requested that we clarify the process that is employed by Federal and external experts to evaluate substantial clinical improvement on the part of nominated devices. One commenter expressed concern that a Federal panel of experts may slow down decision-making and suggested a flexible process in reviewing category applications. The commenter suggested that we rely on our internal clinical staff to make decisions not requiring outside assistance. The commenter also suggested that our review process should be open and allow the manufacturer the opportunity to present information to the panel. The list of panelists, agendas, proceedings and decisions should be made public.

*Response:* Our panel consists of CMS clinical experts. We consult with outside experts as appropriate. We believe that this process results in making appropriate, timely decisions while allowing for maximum flexibility. Public meetings would inevitably slow the process. We give ample opportunity for manufacturers to provide information, and we frequently meet with manufacturers to discuss their applications.

*Comment:* One commenter felt that the language of the statute does not support our criterion that devices show evidence of substantial clinical improvement in order to be considered for an additional category. The commenter stated that the statutory standard that no medical device be described by more than one category does not support the substantial clinical improvement criterion.

*Response:* The statute explicitly requires us to establish criteria that will be used for creation of additional categories. (Section 1833(t)(6)(B)(ii)(I) of the Act) This statutory requirement permits the criteria that we have established, including demonstration of substantial clinical improvement.

We are continuing to review the issue of technological change that is not associated with substantial clinical benefit to beneficiaries. We will continue to review applications for such devices on a case by case basis and work with applicants to understand exactly what technological changes were made to a device that would make the device eligible for transitional pass through payments. We solicit further examples of such devices so that, in the future, we may establish a more definite criterion for when such changes make a device eligible for transitional pass through payments.

*Comment:* Associations representing manufacturers stated that our assertion in the preamble of the November 2, 2001 interim final rule that says MedPAC's recommendation that pass-through payments for specific technologies be made only when a technology is new or substantially improved is a misinterpretation. The commenters asserted that MedPAC considers the concepts of improvements in devices themselves and substantial improvement to be separate, and that either of the two should be required for a criterion related to device improvement for pass-through eligibility.

*Response:* While we continue to believe that, in general, new technologies without a demonstrated substantial clinical benefit to beneficiaries should not receive transitional pass-through payments, we do review nominated devices for technological changes that are not associated with substantial clinical benefit to beneficiaries.

*Comment:* An association representing device manufacturers stated that our substantial clinical improvement criterion would significantly increase the time between FDA approval to market the device and recognition of the device for pass-through payment. The commenter claimed that this is counter to an objective of the pass-through payment mechanism as a means to promote rapid payment in the OPPS for new technology. This commenter, therefore, recommended replacing the criterion to demonstrate substantial clinical improvement with a requirement to demonstrate ''potential improvement.''

Similarly, another manufacturers' association asserted that clinical outcomes information should not be required for eligibility for a new pass-through category. This commenter suggested that our rules should request information that is appropriate and

relevant for the product and related procedures, which should include information other than published clinical trials.

*Response:* We are making every effort to minimize the time lag between FDA approval and establishment of a device category. We believe that we have succeeded in making timely decisions in this regard.

We will consider other information in addition to clinical outcomes that is available when clinical trial data are not yet available.

We do not know how one can demonstrate ''potential'' clinical improvement. ''Potential'' refers to the anticipated or possible capability, belief, or expectation for clinical improvement, without the evidentiary demonstration yet.

We do not believe potential improvement is an appropriate criterion. First, it would be difficult to prove; second, we would be in the position of potentially making extra payments for technologies that actually harmed beneficiaries. Thus using ''potential'' clinical improvement would assure that all new devices would meet such a criteria if the manufacturer asserted that the device in question offers a ''potential'' clinical improvement.''

*Comment:* Some commenters expressed concern with our rule that devices that are described by an existing category are not eligible for new categories. Some call for flexibility in applying this criterion, claiming that some of our category descriptors are too broad and confusing. One manufacturer was particularly concerned that newer technology pacemakers, internal cardioverter-defibrillators (ICDs), and pacemaker and ICD leads would be precluded from achieving new categories because they could be described by widely defined existing categories. The commenter stated that we should revise definitions of existing categories whenever necessary in order to accommodate the creation of new categories. Revising category descriptions to make them less broadly worded was one such example provided, including categories related to pacemakers, ICDs, and pacemaker and ICD leads.

Some commenters felt that new categories would need to be created in order to track cost of newer devices, even if they are described by existing categories. These commenters asserted that device costs eventually must be placed into APCs that appropriately reflect costs for future payment. Some commenters claimed that investigational devices that attained pass-through status have low procedural volumes and therefore they are underrepresented in the cost data.

*Response:* We believe that broadly defined categories are appropriate. Such categories are easier for coders to understand and allow devices to immediately receive transitional pass-through payments upon being marketed (instead of going through an application process). We have applied this criterion appropriately. There are devices that have been deemed eligible for a new category because the clinical applications are substantially different than devices of existing categories.

Some category descriptions have been modified when it has been brought to our attention that the descriptor is unclear. We first revised the descriptors of device categories in Program Memorandum A–01–73, effective July 1, 2001, in order to clarify the devices covered by categories. However, we do not intend to revise descriptors solely to allow the creation of new categories. If a device or class of devices is described by the categories we initially created, we will apply the criteria we implemented to determine whether an additional category is warranted. If we determine that an additional category is needed to adequately describe and pay for new devices, we will create a category. If in the course of that determination, we find that clarification of an existing or previously existing category is needed so that only one category describes the device, as required by statute, then we will modify the description of the existing or previously existing category or categories, in order to achieve that clarification.

We are maintaining our criteria to establish a new category of devices for pass-through payment.

*Cost.* We determine that the estimated cost to hospitals of the devices in a new category (including any candidate devices and the other devices that we believe will be included in the category) is ''not insignificant'' relative to the payment rate for the applicable procedures. The estimated cost of devices in a category is considered ''not insignificant'' if it meets the following criteria found in regulations at new § 419.66(d):

- The estimated average reasonable cost of devices in the category exceeds 25 percent of the applicable APC payment amount for the service associated with the category of devices.
- The estimated average reasonable cost of devices in the category exceeds the cost of the device-related portion of the APC payment amount for the service associated with the category of devices by at least 25 percent.
- The difference between the estimated average reasonable cost of the devices in the category and the portion of the APC payment amount determined to be associated with the device in the associated APC exceeds 10 percent of the total APC payment.

Of these three cost criteria, the latter two remain unchanged from the existing thresholds for individual devices (however, as discussed below, their effective date was revised). The first criterion, however, represents a change in the percentage threshold.

In the April 7, 2000 final rule, we provided that a device's expected reasonable cost must exceed 25 percent of the applicable APC payment for the associated service as the criterion for determining when the cost of a specific device is ''not insignificant'' in relation to the APC payment (65 FR 18480). In the August 3, 2000 interim final rule, we lowered the threshold to 10 percent because we believed the 25 percent limit was too restrictive based on the brand specific approach at the time (65 FR 47673; § 419.43(e)(1)(iv)(C)). However, given our payment experience in 2001 using the 10 percent threshold, including our information on the estimated amount of pass-through payments in CY 2002, we determined a higher threshold was warranted. We believed that setting a higher cost threshold ensures that new categories are created only in those instances where they are most valuable to beneficiaries and hospitals, given the overall limits on pass-through payments. That is, pass-through payments will be targeted only to those devices where cost considerations might be most likely to interfere with patient access.

We found that once we lowered the threshold to 10 percent, a very small minority (less than 10 percent) of devices that met all other criteria for the pass-through payment was rejected on the basis of this criterion. Partly as a result, the list of devices qualified for pass-through payments increased to well over 1,000 devices by the end of 2000. Although the extensive number of qualified devices allowed hospitals to receive additional payment for many devices, we estimated that the overall pass-through payment amount for calendar year 2002 would exceed the 2.5 percent cap. Therefore, for that year, a substantial reduction in the amount of each pass-through payment, as required by section 1833(t)(6)(E)(iii) of the Act, was established. Thus, allowing a large number of marginally costly devices to qualify for the pass-through payment

would reduce the amount of additional payment a hospital would receive for any one device. We believe raising the threshold for this criterion benefits hospitals by focusing the pass-through payments on those devices that represent a substantial loss to the hospital. We believe this change also preserves beneficiary access to especially expensive devices.

In addition, once a category is established, devices included in the category are eligible for pass-through payments regardless of the cost of the devices. Therefore, we determined that it is reasonable to set a higher threshold than 10 percent to establish a new category. While the cost of most devices described by a category may equal or exceed the threshold we use in establishing a category, the cost of individual devices could easily fall below the threshold. Therefore, we believe that it is reasonable to use a higher threshold in establishing a category than in qualifying individual devices.

Concerning the latter two criteria for determining that the estimated cost of a category of devices is not insignificant, we intended to apply these criteria to devices for which a pass-through payment is first made on or after January 1, 2003, as we provided in the August 3, 2000 interim final rule (65 FR 47673). We stated that the delay would allow us sufficient time to gather and analyze data needed to determine the current portion of the APC payment associated with the devices.

Based on the outpatient claims data we have been using for analysis, we have been able, in many cases, to use these criteria as of the November 2, 2001 interim final rule. Although the 1996 data did not provide a level of information that allowed us to determine the portion of the APC payment that was related to the device (except in a very few cases such as pacemakers), the later data have generally provided this level of detail. Therefore we applied the second and third cost criteria for the purpose of determining eligibility of proposed new categories, as described in regulations at § 419.66(d)(2) and § 419.66(d)(3), as soon after the implementation of the November 2, 2001 interim final rule as we had data to do so rather than on January 1, 2003. Although in some instances the lack of specific data prevented the application of these criteria, we believed that should not delay our use of these criteria in those situations in which the data have been available.

In order to implement these second and third criteria for the purpose of creating new device categories, it is necessary to obtain the cost of the device-related portion of the APC payment amount. For evaluations of device category applications in 2002, we used the device-offset amounts published in our March 1, 2002 final rule (67 FR 9557 through 9558), which are used to calculate the subtractions to device pass-through payments. For 2003, we will use the device-offset amounts found in Table 11 in this rule as the device-related portion of the APC payment needed for cost criteria 2 and 3. The device-offset amounts represent the device costs that have been folded into the respective APC payment rates. In those cases where an application is received in which the service-related HCPCS codes for the device is mapped to no APC that has a device offset amount, we apply only the first cost criterion.

*Comment:* Some commenters wrote that while we need to limit pass-through payments for new categories to those devices that are clearly underpaid relative to the APC rates, our ''not insignificant'' cost tests set the bar too high. Some held that this is particularly the case for APCs with high relative weights and consequent payments, in which our 25 percent minimum percentage of the APC as well as the device offset represent a significant cost to the hospital in absolute terms. Commenters proposed alternate percentage thresholds with specific dollar caps (for example, 20 percent of the APC payment or $1,000, whichever is less).

*Response:* In the cases of APCs with high relative weights and payment rates, such payments already encompass much of the costs of devices. The thresholds in dollar terms in those cases should be set higher to test for cost significance. We have heard from many commenters to our August 9, 2002 proposed rule that many device costs consist of a large percentage of the APC cost. The ratio method (for example, 25 percent) therefore equitably accounts for APC payment differences for devices.

We do not see any compelling reason to adopt the proposed alternate percentages of the APC amount as the threshold of using as an alternative to our current cost significance threshold of 25 percent for device portions related to any respective APC. Moreover, the initial pass-through categories were based on devices that achieved pass-through status with a lower 10 percent threshold.

*Comment:* Another commenter claimed that the statutory language demonstrates the congressional intent that only the cost of the devices in a category be compared to the applicable APC payment. Therefore, only the first of our three prongs to test cost significance of a new device should be used. This commenter claimed that section 1833(t)(6) of the Act states that we shall provide pass-through payments only for categories of devices when ''the average cost of the category of devices is not insignificant in relation to the OPD fee schedule amount * * * .'' The commenter further advocated that our criteria be amended to reflect that a proposed category of devices be required to meet any one of the three prongs, to give some weight to the potential benefits of the second and third prongs.

*Response:* The statute requires that the average cost of a new device category is not insignificant in relation to the OPD fee schedule amount payable for the service or group of services involved. The statute further requires the Secretary to establish criteria for creating additional categories, including criteria for cost significance. Beyond those requirements, the statute allows the Secretary the discretion to determine how to apply the cost significant criterion.

In developing the specific criteria for meeting the statutory cost significance requirement, we established thresholds which we believe ensure that new categories are created where they are most valuable to beneficiaries and hospitals, given the overall limits on pass-through payments. Our goal is to target pass-through payments at those devices where cost considerations might be most likely to interfere with patient access.

To properly target the pass-through payments at devices that could represent a substantial loss to the hospital, it is important to both assess the incremental cost of performing the procedure using the new device as well as to compare the cost of the new device against the costs of existing devices already packaged into the APC payment for the procedure.

The first prong of our three prong criterion tests only the relationship of the new device to the cost of the entire procedure whereas the second and third prongs test for the relationship to device costs already incorporated into the payment rate for the procedure.

*Comment:* A hospital organization supported our two major criteria for establishing an additional device category for pass-through payment, that is, that a category of devices must demonstrate substantial clinical improvement and have costs that are ''not insignificant'' in relation to the APC payment. In particular, the

organization supported our decision to raise the threshold that device costs for a new category must exceed 25 percent of the related APC payment, as well as our re-institution of the two additional prongs of the not-insignificant cost test. However, the commenter noted that we had previously delayed the implementation of these latter two prongs of the ''not insignificant'' cost criterion until January 1, 2003, so that we could ensure reliable and accurate data to make the cost estimates. The organization would support the reinstitution of these cost prongs that establish that costs are not insignificant only when CMS has sufficiently accurate and reliable data to make such estimates. The commenter also believes that the data and methodology should be made available to the public for review.

This organization also felt that the (then) current number of initial categories is appropriate. It urged us to make application information regarding any proposed new categories public for comment before final creation of a new category.

*Response:* Based on the outpatient claims data we have been using for analysis, we have been able, in many cases, to use the second and third cost criteria since the November 2, 2001 interim final rule became effective. Although the 1996 data did not provide a level of information that allowed us to determine the portion of the APC payment that was related to the device (except in a very few cases such as pacemakers), the later data we have used has generally provided this level of detail. Therefore, we applied the second and third cost criteria. As noted earlier, for 2002, we have used the device offsets we calculated for subtracting the cost of existing devices in APCs as the portion of the APC payment related to the device. We feel the offsets have been appropriate as this portion of the APC payment, and we will use them for 2003 as well. We therefore feel this commenter's concerns have been addressed.

We will continue to use the three prongs of the not insignificant cost test as published in the November 2, 2001 interim final rule.

1. Application Process for Creation of a New Device Category

Device manufacturers, hospitals, or other interested parties may apply for a new device category for transitional pass-through payments. Details regarding the informational requirements, deadlines for quarterly review, and other aspects of the application process are available on our Web site, *http://cms.hhs.gov.*

We will accept applications at any time. However, we will establish new categories only at the beginning of a calendar quarter, in deference to our computer systems needs and those of our contractors and hospitals. We must receive applications in sufficient time before the beginning of the calendar quarter in which a category would be established to allow for decision-making and programming. For now, we will require that applications be received at least 4 months before the beginning of the quarter. Moreover, we have found, that, due to the complexity of the information and review process for additional categories, we cannot always complete our review within that time frame. Review of applications involving devices with new technologies often involves requesting additional information from the applicants, as well as consultation with experts in certain clinical specialties (usually here at CMS) or with other clinical personnel at CMS with expertise in Medicare coverage issues, as needed (for example, the hearing aid issue).

We may change the details of this application process in the future to reflect experience in evaluating applications and programmatic needs. If we revise these instructions, we will submit the revisions to the Office of Management and Budget under the Paperwork Reduction Act. We will also post the revisions on our Web site.

*Comment:* One commenter recommended that we post draft new categories and any draft changes to existing categories to our Web site for public review and comment before final publication, as a collaborative, informal process to be accomplished within the 4-month quarterly application evaluation and update time frame.

*Response:* Such process could not be accomplished within the 4-month time frame. We note that the greater part of the four month period is consumed in systems changes, not review of the application, so little time is available for further information. Thus, further consultation would result in longer timeframes for action. We have listened and met with many parties concerning recommendations for additional categories and heard their concerns related to our existing and new categories and will continue to do so. However, we believe that the review, evaluation, and decision process and publication process for new category applications to meet the closest feasible quarterly updates is already compact. However, we will continue to consider informal comments or feedback from hospitals, manufacturers, and other parties regarding our decisions.

*Comment:* An association of manufacturers of brachytherapy sources and other brachytherapy devices recommended that we establish several specific new categories.

*Response:* We have established a uniform method for evaluating applications for new categories, based on the application information published on our Web site. We evaluate the necessity of new categories based on the specific information we receive, such as clinical differences between items nominated for the new categories and the existing or previously existing categories. We therefore are not able to react to the specific categories recommended through public comments by this commenter without complete applications on the subject brachytherapy sources.

We are making no change to our application process at this time.

2. Announcing a New Device Category

When we determine a new category is warranted, we issue a Program Memorandum specifying a new Healthcare Common Procedure Coding System (HCPCS, formerly known as HCFA Common Procedure Coding System) code and short and long descriptors for the category. We may also include additional clarifying or definitional information to help distinguish the new category from other existing or previously existing categories. It may be necessary to redefine, or make other changes to, existing or previously existing categories to accommodate a new category and ensure that no medical device is described by more than one category, though we attempt to keep these changes to a minimum. We will post these Program Memoranda on our Web site on a quarterly basis. We may find it necessary occasionally to correct or amend the list of (and clarifying information associated with) pass-through device categories. We do not expect this step will be needed often, but if it is necessary, we will issue any changes in a Program Memorandum.

## VI. Wage-Index Changes for Calendar Year 2003

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, the 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) 2003 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 2003 hospital inpatient wage index to calculate the final CY 2003 payment rates and coinsurance amounts for OPPS. We used the final Federal FY 2003 hospital inpatient PPS wage index to make wage adjustments in determining the final payment rates set forth in this final rule with comment. The final FY 2003 hospital inpatient wage index published in the August 1, 2002 **Federal Register** (67 FR 39858) is reprinted in this final rule with comment 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 use the final FY 2003 hospital inpatient wage index to calculate the payment rates and coinsurance amounts published in this final rule with comment to implement the OPPS for CY 2003. 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 charges for OPPS in the same manner that they made mid-year changes for inpatient hospital prospective payment.

*Comment:* A commenter asked for an explanation of the rationale behind applying the area wage index to the device component of an APC. Also, another commenter urged us to clarify that APCs for drugs and biologicals would not be subject to geographic wage adjustment since the APC payment rates primarily reflect drug acquisition costs, not labor costs.

*Response:* Our rationale for applying the area wage index to the device component of an APC is that once a device cost is packaged into a procedure APC, we do not differentiate between which costs in the APC should or should not have the area wage index applied. We believe that it would be complicated and prone to error to segment out a device component of the APC and determine the appropriate portion of the APC payment amount that consists of device cost only. To address the second issue, we would like to clarify that we do not apply the area wage index to payment rates for drugs and biologicals that are assigned to the status indicator G or K.

## VII. Copayment for Calendar Year 2003

Section 1833(t)(8)(C)(ii) of the Act accelerates the reduction of beneficiary copayment amounts, providing that, for services furnished on or after April 1, 2001, and before January 1, 2002, the national unadjusted coinsurance for an APC cannot exceed 57 percent of the APC payment rate. The statute provides that the national unadjusted coinsurance for an APC cannot exceed 55 percent in 2002 and 2003. The statute provides for further reductions in future years so that the national unadjusted coinsurance for an APC cannot exceed 55 percent of the APC payment rate in 2002 and 2003, 50 percent in 2004, 45 percent in 2005, and 40 percent in 2006 and thereafter.

For 2003, we determined copayment amounts for new and revised APCs using the same methodology that we implemented for 2002 (see the November 30, 2001 final at 66 FR 59888). See Addendum B for national unadjusted copayments for 2003. Our regulations at § 419.41 conform to this provision of the Act.

## VIII. Conversion Factor Update for Calendar Year 2003

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 2003, 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 most recent forecast of the hospital market basket increase for FY 2003 is 3.5 percent. To set the proposed OPPS conversion factor for 2003, we increased the 2002 conversion factor of $50.904 (the figure from the March 1, 2002 final rule (67 FR 9556)) by 3.5 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the conversion factor for 2003 to ensure that the revisions we made to update the wage index are made on a budget-neutral basis. We calculated the proposed budget-neutrality factor of .98778 for wage-index changes by comparing total payments from our simulation model using the proposed FY 2003 hospital inpatient PPS wage-index values to those payments using the current (FY 2002) wage-index values.

The increase factor of 3.5 percent for 2003 and the required wage-index budget-neutrality adjustment of .98715 resulted in a proposed conversion factor for 2003 of 52.009.

In determining the proposed conversion factor of 52.009, we projected 2.5 percent pass-through payments based on our preliminary estimates of pass-through payments for CY 2003. As described in the section IV discussion of the pro-rata provisions, our final estimate of pass-through payments in CY 2003 is 2.3 percent of the total program payments for covered OPD services. Therefore, we have increased the final conversion factor to reflect the projected change in pass-through spending from 2.5 percent to 2.3 percent. After applying this adjustment, the 3.5 percent update factor and the final budget-neutrality adjustment of .98778 to account for changes due to the final FY 2003 hospital inpatient wage-index values, we establish the final conversion factor for 2003 at $52.151 (or 52.152).

We received several comments concerning the conversion factor update for 2003, which are summarized below along with our responses.

*Comment:* Several commenters contended that CMS imposed excessive pro-rata reductions in 2002, which exacerbated the inadequacy of Medicare payments and urged CMS to use its statutory authority under section 1833(t)(3)(C)(iii) to adjust the 2003 conversion factor for the unexpectedly low pass-through payments made in 2002.

*Response:* The commenters' estimates are based on 2001 claims. We do not know yet whether there will be excessive pro-rata reductions in 2002 because at the time of this rule, we do not have more than first-quarter 2002 claims data available. Therefore, it would not be appropriate to make such an adjustment. Furthermore, we do not believe that the statute permits us to make retroactive adjustments.

*Comment:* One commenter stated that the statute requires the conversion factor to be updated by the full increase in the hospital inpatient market basket of 3.5 percent, but the application of a budget-neutrality factor of .987156 results in an update factor of only 2.17 percent. Another commenter indicated the belief that the amount of reduction from the 3.5 percent market basket update is excessive and beyond what is required to achieve statutory goals. The commenter recommended that the 2003 conversion factor be increased.

*Response:* Statute requires us to ensure that a conversion factor for covered OPD services in subsequent years is an amount equal to the conversion factor applicable to the previous year before any increases due to the market-basket increase. In order to ensure that we maintain budget neutrality (except for the market-basket increase), we must make an adjustment to account for changes in the wage index. To do so, we calculate the total payments for 2002, using the 2002 wage index and weights, and compare that result to total payments calculated by applying the new 2003 wage index to

the 2002 APC weights. For 2003, that comparison resulted in the .969 adjustment.

**IX. Outlier Policy for Calendar Year 2003**

For OPPS services furnished between August 1, 2000, and April 1, 2002, we calculated outlier payments in the aggregate for all OPPS services that appear on a bill in accordance with section 1833(t)(5)(D) of the Act. In the November 30, 2001 final rule (66 FR 59856, 59888), we specified that beginning with 2002, we will calculate outlier payments based on each individual OPPS service. We revised the aggregate method that we had used to calculate outlier payments and began to determine outliers on a service-by-service basis.

As explained in the April 7, 2000 final rule (65 FR 18498), we set a target for outlier payments at 2.0 percent of total payments. For purposes of simulating payments to calculate outlier thresholds, we proposed to set the target for outlier payments at 2.0 percent. The target was 2.0 percent for CY 2001 and 1.5 percent for 2002. For 2002, the outlier threshold is met when costs of furnishing a service or procedure exceed 3.5 times the APC payment amount, and the current outlier payment percentage is 50 percent of the amount of costs in excess of the threshold. Based on our simulations for 2003, we proposed to set the threshold for 2003 at 2.75 times the APC payment amounts, and the proposed 2003 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 percent of total payments. Based on revised simulations performed for the final rule, in order to pay outlier payments at the target amount, we are adopting the proposed outlier threshold of 2.75 but decreasing the outlier payment percentage to 45 percent. Simulations using the final APC rates and projecting outlier payments for 2003 using a different set of claims than we used for the proposed rule (claims for the period April 1, 2001 through March 31, 2002 instead of claims for calendar year 2001) resulted in outlier payments that were in excess of the 2 percent outlier payment target. In order to meet, but not exceed, the target we found it necessary to either increase the proposed outlier threshold of 2.75 or reduce the proposed outlier payment percentage of 50 percent. Because we wanted to make it easier for more for high cost services to qualify for outlier payments, we chose to adopt the proposed outlier threshold but reduce the outlier payment percentage to 45 percent. For 2003, the outlier threshold will be met when costs of furnishing a service or procedure exceed 2.75 times the APC payment amount, and the outlier payment percent will be 45 percent of the amount of costs in excess of the threshold.

We received a number of comments concerning our proposed threshold and percentages for outlier payments, which are summarized below along with our responses. We also received comments concerning the changes that we proposed and finalized in 2002 with respect to the calculation of outliers on a service-by-service basis. Because we have not proposed any changes to the current policy, we do not summarize those comments in this preamble.

*Comment:* A number of commenters commended CMS on lowering the outlier threshold, but they urged CMS to reduce the threshold even further. The commenters also said that the outlier payment percentage of 50 percent of costs in excess of the outlier threshold was not sufficient to offset the losses hospitals incur in high-cost cases. Some of these commenters urged CMS to adopt the same marginal payment rate of 80 percent that is used for calculating outliers under the inpatient PPS.

*Response:* Under the OPPS, CMS must address two needs: the need to balance payment for high-cost cases with the need to ensure that appropriate payments are made for basic services for the average patient population. By setting our outlier target of 2 percent, we believe that we have struck the right balance to accomplish these goals.

*Comment:* According to one commenter, new technologies and drugs are expanding too rapidly for CMS to appropriately account for the costs in the APCs, which is a particular concern at larger hospitals that provide a wide scope of services and access to new technologies and drugs. The commenter said that outliers can help defray the costs of new technologies until adequately reflected in the APC payments and urged CMS to consider expanding the outlier target from 2 percent to 2.5 percent. Another commenter contended that the transition of expiring pass-through items into APCs will result in dramatic payment reductions and urged CMS to reduce the outlier threshold to 2.5 times the APC payment amount for 2003 and increase the outlier target as close as possible to the statutory maximum of 2.5 percent of total payments.

*Response:* As described elsewhere in this final rule, the recalibration of weights based on newer data and the additional steps that we have taken to limit the payment reductions should decrease the need for outliers. Also, the pass-through provisions for new drugs and devices and our payment mechanism for new technology procedures provide hospitals with an additional mechanism to defray costs for emerging technologies.

*Comment:* A number of commenters said that CMS does not provide sufficient data to support how outlier payments and thresholds are determined and to ensure that outlier payments are being made in the range of 2 percent to 2.5 percent. Additional outlier data that the commenters requested include information such as the actual outlays as compared to forecasted outlays 2001, estimated outlays for 2002, the historical outlier percentage of total OPPS payments, and information on the types of cases that are qualifying for outlier payments. The commenters wanted CMS to provide supporting information in the final rule, just as it does for the inpatient PPS.

*Response:* We agree with the commenters that we should provide this data. However, due to the time constraints in producing this final rule, we are unable to add this information to this preamble. Nonetheless, we will post this information to our Web site shortly after publication of the rule. We will notify the public through the CMS listserv when the information is available. To subscribe to this listserv, please go to the following Web site: *www.cms.hhs.gov/medlearn/listserv.* Follow the directions for subscribing to the OPPS listserv to get the most up-to-date information on OPPS directly from CMS.

*Comment:* One commenter expressed concern that CMS has made significant changes to the outlier target and eligibility thresholds in 2002 and 2003, in opposite directions, without sufficiently supporting the changes with experiential data. The commenter maintained that, in aggregate, outlier payments as a percentage of total payments should remain relatively predictable and, therefore, questions whether the experience in 2001 and 2002 would support the significant swings in funding and thresholds.

*Response:* It is too early for us to tell what the 2002 experience has been like in order to compare it to the 2001 experience. Nevertheless, as indicated in the previous response, we will also notify the public and share the 2001 data on our Web site.

*Comment:* One commenter urged CMS to provide clarification regarding the rationale to decrease the cost threshold that permits more items to qualify for outlier payments, rather than

to increase the payment percentage from its current level of 50 percent, which would provide more payments for high-cost cases.

*Response:* We apply an iterative process in which we try different combinations of thresholds and payment percentages until an appropriate combination results in outlier payments under our simulation that is equal to the target percentage of total OPPS payments. While some fluctuation is expected each year due to the use of newer and better data and policy changes, we attempt both to strike a balance and to prevent (to the extent possible) large changes in the outlier payments to hospitals. A significant increase in the threshold would limit the number of services and hospitals that qualify for outlier services.

*Comment:* One commenter expressed concern that without correcting for the significant reductions proposed for a number of high-cost APCs, those services may unnecessarily qualify for outlier payments because the costs that go into the outlier calculation are calculated using a hospital's overall cost-to-charge ratio (CCR), which may be higher than the departmental CCRs used to determine costs for payment-rate calculations. The commenter contends that, if this occurs, it will result in outlier payments that are higher than anticipated, which could unduly raise thresholds in the future and affect the integrity of the outlier policy.

*Response:* As described elsewhere in this rule, we believe that the adjustments we have made to many APC rates for this final rule will address the commenter's concerns about services unnecessarily qualifying for outlier payments.

## X. Other Policy Decisions and Changes

### *A. Hospital Coding for Evaluation and Management (E/M) Services*

Background

Currently, facilities code clinic and emergency department visits using the same current procedural terminology (CPT) codes as physicians. For both clinic and emergency department visits, there are five levels of care. While there is only one set of codes for emergency visits, clinic visits are differentiated by new patient, established patient, and consultation visits. CPT codes 99201 through 99205 are used for new patients, CPT codes 99211 through 99215 are used for established patients, and CPT codes 99281 through 99285 for emergency patients.

Physicians determine the proper code for reporting their services by referring to CPT descriptors and our documentation guidelines. The descriptors and guidelines are helpful to physicians because they reference taking a history, performing an examination, and making medical decisions. The lower levels of service (for example, CPT codes 99201, 99211, and 99281) are used for shorter visits and for patients with uncomplicated problems, and the higher levels of service (for example, CPT codes 99205, 99215, and 99285) are used for longer visits and patients with complex problems.

These codes were defined to reflect the activities of physicians. It is generally agreed, however, that they do not describe well the range and mix of services provided by facilities to clinic and emergency patients (for example, ongoing nursing care, preparation for diagnostic tests, and patient education).

Before the implementation of the OPPS, facilities were paid on the basis of charges reduced to costs. In that system, because use of a correct HCPCS code did not influence payment, there was little incentive to correctly report the level of service. In fact, many facilities reported all clinic and emergency visits with the lowest level of service (for example, CPT codes 99211, 99201, and 99281) simply to minimize administrative burden (for example, charge-masters might include only one level of service).

This situation changed with the implementation of the OPPS. The OPPS requires correct reporting of services using HCPCS codes as a prerequisite to payment. For emergency and clinic visits, the OPPS distinguishes three levels of service for payment purposes. These are referred to as ''low-level,'' ''mid-level,'' and ''high-level'' emergency or clinic visits. Payment rates for low-level visits are less than for mid-level visits, which are less than rates for high-level visits.

In the April 7, 2000 final rule (65 FR 18434), we stated that to pay hospitals properly, 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. We stated in the rule, that if hospitals set up these guidelines and follow them, they would be in compliance with OPPS coding requirements for the visits. Furthermore, we announced that we would be reviewing this issue and planned to set national guidelines for coding clinic and emergency visits in the future. 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. We also announced that we would compile these comments and present them to our APC Panel at the January 2002 meeting. We also announced that we planned to propose uniform national facility coding guidelines in the proposed rule for the 2003 OPPS.

During its January 2002 meeting, the APC Panel reviewed written comments, heard oral testimony, discussed the issue, and made recommendations concerning establishment of facility coding guidelines for emergency and clinic visits. Among those who submitted oral and written comments to us and to the Panel were national hospital organizations, national physician organizations, hospital systems, individual hospitals, coding organizations, and consultants.

APC Panel Recommendations

The APC Panel reviewed the comments that we received, reviewed background material we prepared, and heard oral testimony. Most commenters recommended that we adopt the ACEP guidelines. However, one organization representing cancer centers stated that the most appropriate proxy for facility resource consumption in cancer care is staff time and asked that we consider basing our guidelines on staff time. Commenters agreed that we needed to address this problem in the proposed rule for CY 2003. They also agreed that to address potential HIPAA compliance issues, we should develop new HCPCS codes for facility visits; and that we should maintain five levels of service for emergency and clinic visits until data are available to show that only three levels of service are required to ensure accurate payments. Commenters also agreed that, for the same level of service, clinic resource consumption should be similar for new, established, and consultation patients. Therefore, we need only create a single set of five codes for clinic visits.

After a thorough discussion, the APC technical panel made the following recommendations:

1. Propose and make final facility coding guidelines for E/M services for calendar year 2003.

2. Create a series of G codes with appropriate descriptors for facility E/M services.

3. Maintain a single set of codes, with five levels of service, for emergency department visits.

4. Develop a single set of codes, with five levels of service, for clinic visits.

The Panel specifically recommended that we not differentiate among visit types (for example, new, established, and consultation visits) for the purposes of facility coding of clinic visits.

5. Adopt the ACEP facility coding guidelines as the national guidelines for facility coding of emergency department visits.

6. Develop guidelines for clinic visits that are modeled on the ACEP guidelines but are appropriate for clinic visits.

7. Implement these guidelines as interim and continue to work with appropriate organizations and stakeholders to develop final guidelines.

Proposed Rule

We reviewed the written comments, the oral testimony before the APC Panel, and the Panel's recommendations; we agreed that facility-coding guidelines should be implemented as soon as possible. We were particularly concerned that facilities be able to comply with HIPAA requirements. We announced that we have worked, and will continue to work, on this issue with hospitals, organizations representing hospitals, physicians, and organizations representing physicians. We noted that the AMA CPT Editorial Panel is not currently considering the issue of facility coding guidelines for clinic visits and that the earliest any CPT guidelines could be implemented would be in January 2004. Additionally, consistent with the intent of the outpatient prospective payment system, we wanted to ensure that reporting of hospital emergency and clinic visits is resource based.

After careful review and consideration of written comments, oral testimony and the APC Panel's recommendations, we proposed the following (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 visits: 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.

With regard to the documentation guidelines, our primary concerns were to make appropriate payment for medically necessary care, to minimize the information collection and reporting burden on facilities, and to minimize any incentive to provide unnecessary or low quality care. We realized that many facilities use complaint or diagnosis driven care protocols and that current documentation standards do not include documentation of staff time or the complexity of diagnostic and therapeutic services provided. Therefore, in the interest of facilitating the delivery of medically necessary care in a clinically appropriate way, we believed that the potential drawbacks of each of the recommended sets of guidelines outweighed the potential benefits of creating uniformity and reproducibility. For example, any documentation system requiring counting or quantification of resource use has the potential to be burdensome, require clinically unnecessary documentation, and be susceptible to upcoding and gaming. Documentation systems using coding grids or a series of clinical examples for each level of service are subject to interpretation, may induce variability, may be overly complex and burdensome, and may result in disagreements with medical reviewers. We were also concerned that all the proposed guidelines allow counting of separately paid services (for example, intravenous infusion, x-ray, EKG, lab tests, and so forth) as ''interventions'' or ''staff time'' in determining a level of service. We believe that, within the constraints of clinical care and management protocols, the level of service for emergency and clinic visits should be determined by resource consumption that is not otherwise separately payable.

To address these concerns, in addition to reviewing written comments, oral comments, and the APC Panel recommendations, we also reviewed, for the proposed rule, the current distribution of paid emergency and clinic visit codes in the OPPS. With regard to emergency visits, we observed that well over 50 percent of the visits were considered ''multiple procedure claims'' because the claim includes services such as diagnostic tests (for example, EKGs and x-rays) or therapeutic interventions (for example, intravenous infusions). The distribution of all emergency services was in a bell-shaped curve with a slight left shift because there were more claims for CPT codes 99281 and 99282 than for CPT codes 99284 and 99285. This pattern of coding is significantly different from physician billing for emergency services, which is skewed and peaks at CPT code 99284. We also noted that the median costs for successive levels of emergency visits show an expected increase across APCs.

With regard to clinic visits, we observed that more than 50 percent of the services were considered ''single claims'' meaning that they were billed without any other significant procedures such as diagnostic tests or therapeutic interventions. We also noted that the distribution of clinic visits is skewed with the majority being low-level clinic visits. This distribution was consistent with pre-OPPS billing patterns where many facilities billed all clinic visits as low level visits. However, the median costs for different levels of clinic services, while similar within an APC, did not show the expected increase across the clinic visit APCs.

Based on our review, on the current distribution of coding for emergency and clinic visits, and on our understanding that hospitals set charges for services based on the resources used to provide those services, we believed that an incremental approach to developing and implementing documentation guidelines for emergency and clinic visits was appropriate. For example, as hospitals became more familiar with the OPPS and with the need to differentiate emergency and clinic visits based on resource consumption, we would continue to review the advantages and disadvantages of detailed, uniform documentation guidelines. We planned to begin the development of uniform guidelines over the next year. If we were ready, we would propose the guidelines for comments in our **Federal Register** document for the CY 2004 update. For CY 2003, we proposed the following new codes:

Emergency Visits

Because, our data indicated that, in general, hospitals under the OPPS were reporting emergency visits appropriately, we believed that insofar as hospitals have existing guidelines for determining the level of emergency service, those guidelines reflected facility resource consumption. Therefore, we proposed that GXXX1—Level 1 Facility Emergency Services be reported when facilities deliver, and document, basic emergency department services. These services included registration, triage, initial nursing assessment, minimal monitoring in the emergency department (for example,

one additional set of vital signs), minimal diagnostic and therapeutic services (for example, rapid strep test, urine dipstick), nursing discharge (including brief home instructions), and exam room set up/clean up. We expected that these services would be delivered to patients who present with minor problems of low acuity.

With regard to GXXX2 through GXXX5, we proposed to require that facilities develop internal documentation guidelines based on hospital resource consumption (for example, staff time). These guidelines would be appropriate for the type of services provided in the hospital and also clearly differentiate the relative resource consumption for each level of service so that a medical reviewer could easily infer the type, complexity, and medical necessity of the services provided and validate the level of service reported. Because of the great variability in available facility resources, staff, and clinical protocols among facilities, we did not believe that it is advisable to require a single set of guidelines for all facilities. Instead, we believed it is appropriate for each facility to develop its own documentation guidelines that took into account the facility's clinical protocols, available facility resources, and staff types. As stated above, we did not propose any specific requirements with regard to the basis of these guidelines. However, the guidelines were to be tied to actual resource consumption in the emergency department such as number and type of staff interventions, staff time, clinical examples, or patient acuity. We also proposed to require that facilities have documentation guidelines available for review upon request. The guidelines had to emphasize relative resource consumption and not, to the extent possible, set minimal requirements as a basis for determining the level of service (for example, require 30 minutes of staff time or five staff interventions to bill a level three emergency visit).

We proposed that these requirements, if made final, would be interim. We proposed to work with interested parties to revise these requirements and to propose any revision to these requirements in a future proposed rule.

**Clinic Visits**

We believed that the current distribution of codes for clinic visits were due to a facility's continued use of pre-OPPS coding policies for clinic visits. We believed that over time facilities would become as experienced differentiating levels of clinic visits as they were at differentiating levels of emergency visits. Therefore, we proposed a set of guidelines for clinic visits that paralleled the requirements for emergency visits. We proposed that GXXX6—Level 1 Facility Clinic Services, be reported when facilities deliver, and document, basic clinic services. These services included registration, triage, initial nursing assessment, minimal monitoring in the clinic (for example, one additional set of vital signs), minimal diagnostic and therapeutic services (for example, rapid strep test, urine dipstick), nursing discharge (including brief home instructions), and exam room set up/clean up. Our proposal for GXXX7 through GXXX10 was the same as for GXXX2 through GXXX5 except that the facility-specific guidelines were tied to actual resource consumption in the clinic such as number and type of staff intervention, staff time, clinical examples, or patient acuity. The guidelines had to differentiate the relative resource consumption in the clinic for each level of service sufficiently so that a medical reviewer could easily infer the type, complexity, and medical necessity of the services provided to validate the level of service provided.

We proposed that, if made final, these requirements would be interim. Any changes would be proposed in a future proposed rule.

We proposed to make final, in the 2003 OPPS final rule, changes in coding for clinic and emergency department visits and requirements related to the development of documentation guidelines for the new codes. However, we proposed to implement the new codes and documentation guidelines no earlier than January 1, 2004. This would have given hospitals time to develop documentation guidelines for the new codes and prepare their internal billing systems to accommodate the changes. We proposed to continue to work with hospitals throughout CY 2003 as they developed the documentation guidelines. In the proposed rule, we solicited comments on this proposal overall as well as the specific components of the proposal.

*Comment:* Many commenters recommended that CMS should keep the current E/M coding system until national coding guidelines with standard definitions can be established. Commenters also recommended that CMS convene a panel of experts to develop standard code definitions and guidelines that are simple to understand and implement and that allow for compliance with HIPAA requirements. Commenters generally recommended that code definitions and guidelines be established and implemented in 2003.

*Response:* We agree with many of the commenters concerns. While we agree that standard code definitions and guidelines should be implemented as soon as possible, we want to ensure that those definitions and guidelines are developed using an open process involving a variety of experts (for example, clinicians, coders, and compliance officers) in the field. Furthermore, the process should include adequate time 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 view of the comments received we believe that the most appropriate forum for development of code definitions and guidelines is an independent expert panel that makes recommendations to CMS in time for CMS to propose specific code definitions in the next year's proposed rule. Organizations such as the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA) have such expertise and are particularly well equipped to provide the ongoing education of providers. We believe it is critically important to the development, acceptance, and implementation of code definitions and guidelines for the organizations that develop the guidelines to also maintain them, update them, and provide ongoing education to providers concerning them. We would be happy to work with such an expert panel as code definitions and guidelines are developed.

We encourage any independent expert panel sending recommendations to CMS concerning guidelines to carefully review the principles and requirements for codes and guidelines that we announced in the proposed rule. We still believe that any set of national guidelines must adhere to those principles and requirements (for example, guidelines must be resource-based). Moreover, we encourage any such panel to address our concerns about existing guidelines (for example, potential for upcoding) in its recommendations to CMS. For example, our Advisory Panel on APC Groups recommended that CMS adopt the facility coding guidelines developed by the American College of Emergency Physicians (ACEP). While we understand that those guidelines have widespread support in the hospital community and that an independent panel may review them while developing guidelines, we would encourage such a panel to review the

ACEP guidelines in light of the principles, requirements, and concerns we enunciated in the proposed rule.

CMS hopes to receive recommendations on code definitions in time to include them in the notice of proposed rulemaking for 2004. We agree with the commenters who were concerned about implementing code definitions without national guidelines, and we will not propose or finalize code definitions until national guidelines for them have been developed.

*Comment:* Several commenters believed that use of G codes to describe facility visits would cause problems with payment by non-Medicare payers for these services. They believed this problem would worsen if the G codes were not accompanied by guidelines.

*Response:* G codes are national codes and must be recognized by other payers, though other payers do not need to use these codes for payment. We are unsure if the commenters' assertions are true. However, as stated in the previous response, we do not plan to finalize new codes for these services until guidelines for their use have been developed. Moreover, we will work with CPT, as appropriate, to develop CPT codes for these services once we have finalized and implemented them.

*Comment:* One commenter asked that CMS provide protection for hospitals against fraud and abuse allegations stemming from the current ambiguous guidelines.

*Response:* We are unsure if the commenter is referring to the CPT guidelines as being ambiguous for facilities or if the concern is over allowing facilities to develop and implement facility-specific guidelines until national codes and guidelines are implemented. In any case, we believe that written facility guidelines-developed in accordance with the principles (which we enunciated in the proposed rule and reaffirmed in this final rule) and which are widely disseminated in the facility, accompanied by appropriate education of clinicians and coders, and made available to reviewers-should address the concerns of the commenters.

*Comment:* Several commenters voiced concerns about what activities should be described in possible guidelines (*e.g.*, use of time as a criterion for selecting a level of service), the burden on facilities of having to adapt to a new set of codes for visits, and any requirements for facilities to develop their own guidelines. One commenter listed several principles for the development of facility codes and descriptors (that is, codes and guidelines should: focus on resource use, be supported by medical record documentation, support code assignment by the chargemaster, and provide a means for benchmarking medical-visit data across the industry).

*Response:* We believe that having an independent panel develop guidelines and make recommendations to CMS will address the concerns of these commenters. With regard to requiring facilities to develop internal guidelines for visit services, we believe that development of internal guidelines is critical for ensuring appropriate medical review and for enabling facilities to prove that billing for services were actually rendered.

*Comment:* One commenter asked CMS to clarify the terms ''nursing assessment'' and ''nursing discharge'' when assigning a level of service to a visit.

*Response:* Because we expect to receive recommendations from an independent panel regarding coding guidelines, we will not finalize the proposal describing what constitutes a level one emergency or clinic visit. Instead, we will continue to allow hospitals to develop their own internal guidelines for such visits until we finalize codes and guidelines.

*Comment:* One commenter asked that we create five payment rates for emergency and clinic visits, one for each level of service—instead of the three payment rates that we currently use.

*Response:* We review the relative weights of each APC on a yearly basis, and we would consider such a change if our claims data indicated such a change is appropriate.

*Comment:* One commenter asked that we craft a surgical global package for facilities to provide guidance for facility billing of surgical procedures and visits.

*Response:* The current APC structure and coding edits already do this. Payment for surgical procedures includes payment for all services related to the procedure (for example, postoperative care, preoperative valuation). Facilities may bill for visits in addition to surgical procedures when the visit is a separately identifiable service unrelated to the procedure. In such cases, the facilities attest to this by appending the –25 modifier to the line item for the visit.

*Comment:* One commenter said that CMS should provide guidance as to when it is appropriate to add together levels of service from two visits, and bill one visit at a higher level. Another commenter requested that CMS stop using the GO condition code in favor of the –27 modifier.

*Response:* We disagree. Each clinic visit should be coded separately. It is important to track utilization and for each clinic visit to be reported separately. This is critical for determining proper payment rates in the OPPS. Clinic visits should never be added together and billed as a single service with a higher level of service. We plan to continue using the GO modifier as it specifically addresses coding issues arising in the OPPS.

*Comment:* One commenter asked us to reconsider our G code descriptors for clinic and emergency visits.

*Response:* We will propose and finalize G code descriptors after we receive recommendations from an independent expert panel.

*Comment:* Several commenters asked us to develop guidelines based on a point or acuity system.

*Response:* The divergence of opinion in the hospital community makes it imperative that an independent expert panel be convened and that such a panel should make recommendations to CMS on these issues.

*Comment:* Several commenters were concerned about disparities between physician and facility coding for the same service. One commenter asked that hospitals be allowed to code a different level of service than the physicians.

*Response:* We do not believe that facilities and physicians would be expected to bill similar levels of service for the same encounter. The resources used by a facility for a visit may be quite different from the resources used by a physician for the same visit. Facilities should code a level of service based on facility resource consumption, not physician resource consumption. This includes situations where patients may see a physician only briefly, or not at all.

However, if a visit and another service is also billed (that is, chemotherapy, diagnostic test, surgical procedure) the visit must be separately identifiable from the other service because the resources used to provide non-visit services including staff time, equipment, supplies, and so forth, are captured in the line item for that service. Billing a visit in addition to another service merely because the patient interacted with hospital staff or spent time in a room for that service is inappropriate.

*Comment:* One commenter asked CMS to clarify proper billing for E/M services when a visit and another service, such as chemotherapy, have been provided.

*Response:* If a visit and another service is also billed (that is, chemotherapy, diagnostic test, or surgical procedure) the visit must be separately identifiable from the other

service. This is because the resources used to provide non-visit services (including staff time, equipment, supplies and so forth) are captured in the line item for that particular service. However, billing a visit in addition to another service—merely because the patient interacted with hospital staff or spent time in a room for that service—is inappropriate.

*B. Observation Services*

Coding and Billing Instructions

On November 30, 2001, we published a final rule updating changes to the OPPS for 2002. We implemented provisions that allow separate payment for observation services under certain conditions. That is, a hospital may bill for a separate APC payment (APC 0339) for observation services for patients with diagnoses of chest pain, asthma, or congestive heart failure when certain criteria are met. The criteria discussed in the November 30, 2001 final rule and as corrected in the March 1, 2002 final rule are also explained in detail in section XI of a Program Memorandum to intermediaries issued on March 28, 2002 (Transmittal A–02–026). Payment for HCPCS code G0244, observation care provided by a facility to a patient with congestive heart failure, chest pain or asthma, minimum eight hours, maximum 48 hours, was effective for services furnished on or after April 1, 2002.

Section XI of Transmittal A–02–026 that was issued on March 28, 2002, provides additional billing and coding instructions and requirements that flow from the basic criteria that we implemented in the November 30, 2001 and the March 1, 2002 final rules. Although we do not address them explicitly in the final rules, the additional instructions and requirements in Transmittal A–02–026 were developed to implement the basic observation criteria within the programming logic of the outpatient code editor (OCE), which is used to process claims submitted by hospitals for payment under the OPPS. For example, in the November 30, 2001 final rule, we state that an emergency department visit (APC 0610, 0611, or 0612) or a clinic visit (APC 0600, 0601, or 0602) must be billed in conjunction with each bill for observation services (66 FR 59879). In section XI of Transmittal A–02–026, we state that an E/M code (referred to, incorrectly, in Transmittal A–02–026 as an ''Emergency Management'' code), for the emergency room, clinic visit, or critical care is required to be billed on the day before or the day that the patient is admitted to observation. That is, unless one of the CPT codes assigned to APCs 0600, 0601, 0602, 0610, 0611, 0612, or 0620 is billed on the day before or the day that the patient is admitted to observation, separate payment for G0244 is not allowed. The codes assigned to these APCs are categorized by CPT as E/M codes. Although we did not include APC 0620, Critical Care, among the APCs that must be billed in order to receive separate payment for observation services, we added it in the program memorandum because critical care is an E/M service that can be furnished in a clinic or an emergency department. Critical care may appropriately precede admission to observation for chest pain, asthma, or congestive heart failure. We clarify in Transmittal A–02–026 that both the associated E/M code and G0244 are paid separately if the observation criteria are met. We also specify that the E/M code associated with observation must be billed on the same claim as the observation service.

Similarly, in the November 30, 2001 and the March 1, 2002 final rules, we require that certain diagnostic tests be performed in order to bill for separate payment for observation services. In Transmittal A–02–026, in section XI.B.2, we list the diagnostic tests that the OCE looks for on a bill for G0244. This list, which amplifies what we published in the November 30, 2001 and March 1, 2002 final rules, is incomplete and should read as follows to reflect the current OCE logic that is applied to claims for G0244:

- For chest pain, at least two sets of cardiac enzymes [either two CPK (82550, 82552, or 82553), or two troponin (84484 or 84512)], and two sequential electrocardiograms (93005);
- For asthma, a peak expiratory flow rate (94010) or pulse oximetry (94760, 94761, or 94762);
- For congestive heart failure, a chest x-ray (71010, 71020, or 71030) and an electrocardiogram (93005) and pulse oximetry (94760, 94761, or 94762).
- Note: Pulse oximetry codes 94760, 94761, and 94762 are treated as packaged services under the OPPS. Although no separate payment is made for packaged codes, hospitals must separately report the HCPCS code and a charge for pulse oximetry in order to establish that observation services for congestive heart failure and asthma diagnoses meet the criteria for separate payment.

Transmittal A–02–026 also provides specific coding instructions that hospitals must use when billing for observation services that do not meet the criteria for separate payment under APC 0339. In addition, Transmittal A–02–026 addresses the use of modifier –25 with the E/M code billed with G0244.

*Comment:* A few commenters requested clarification of the requirement that CPT 94010 (peak flow) be billed to establish a diagnosis of asthma. The commenter noted that CPT 94010 is the code for spirometry with recording and that it would be erroneous to bill peak flow, which is all that is relevant for asthma, as a spirometry, which requires a record and should include such elements as vital capacity and flow-volume loops. The commenter is concerned that we are instructing hospitals to bill incorrectly if our intention is solely to require peak flow.

*Response:* We are reviewing this comment and if we determine that a modification of the current requirement for peak flow is appropriate, we will revise the requirement in the program memorandum that implements the 2003 OPPS update effective January 1, 2003.

*Comment:* One commenter asked whether bedside services other than infusion, such as CVP placement, arterial punctures, and IV injections, can be billed when furnished to observation patients or whether these services are considered to be packaged into the observation payment.

*Response:* We would not expect that placement of a CVP line would be billed for a patient in observation. However, in general, any service that is separately payable under the OPPS, that is, procedures with status indicators S, X, K, G, V, or H, can be billed with G0244 and paid separately, although services with status indicator ''T'' (with the exception of Q0081), as we explain below, are *not* separately payable with G0244.

Direct Admissions to Observation

Since implementation of the provision for separate payment for observation services under APC 0339, a number of hospitals, hospital associations, and other interested parties have asked if separate payment for observation services would be allowed for a patient with chest pain, asthma, or congestive heart failure who is admitted directly into observation by order of the patient's physician but without having received critical care or E/M services in a hospital clinic or the emergency department on the day before or the day of admission to observation. We have responded during monthly CMS hospital open forum calls that, consistent with the criteria in the November 30, 2001 final rule, effective for services furnished on or after April

1, 2002, separate payment for observation services requires that an admission to observation be made by order of a physician in a hospital clinic or in a hospital emergency department. If a patient is directly admitted to observation but without an associated E/M service (including critical care) shown on the same bill, the hospital should bill observation services using revenue code 762 alone or revenue code 762 with one of the HCPCS codes for packaged observation services (CPT codes 99218, 99219, 99220, 99234, 99235, or 99236).

A related question has arisen in connection with a policy interpretation that was posted as a response to a ''Frequently Asked Question'' (FAQ) on our Web site on September 12, 2000. The FAQ follows:

''Q.97: If a patient is admitted from the physician's office to the observation room, will there be no reimbursement?

''A.97: Since observation is a packaged service, payment cannot be made if it is the only OPPS service on a claim. However, we believe that the ''admission'' of a patient to observation involves a low-level visit billed by the hospital, as well as whatever office visit the physician who arranged for the admission billed. Thus, when a patient arrives for observation arranged for by a physician in the community (that is, ''direct admit to observation''), and is not seen or assessed by a hospital-based physician, the hospital may bill a low-level visit code. This low-level visit code will capture the baseline nursing assessment, the creation of a medical record, the recording and initiation of telephone orders, and so forth. This visit may be coded only once during the period of observation. The observation charges should be shown in revenue code 762. The number of hours the patient was in observation status should be shown in the units field. Payment for those services is packaged into the APC for the visit. Other services performed in connection with observation, such as lab, radiology, and so forth, should be billed for as well. * * *''

We have been asked to clarify whether or not the low-level visit code suggested in the FAQ for patients directly admitted for observation services would satisfy the requirement that a line item for a hospital emergency visit, hospital clinic visit, or critical care appear on the same bill as HCPCS code G0244. Our response is that when we established the final criteria effective for services furnished on or after April 1, 2002, we did not contemplate that the low-level visit described in the FAQ would satisfy the requirement for the E/M code that a hospital must bill to show a hospital clinic visit or hospital emergency department visit was performed before observation services for asthma, congestive heart failure, or chest pain to bill and receive payment for G0244 under APC 0339.

In light of these questions, we have reviewed the criteria for separate payment for observation services under APC 0339, and we proposed to modify the criteria and coding for observation services furnished on or after January 1, 2003. Specifically, we proposed to create two new codes. These additional codes would allow us to collect data on the extent to which patients are directly admitted to hospital observation services without an associated hospital clinic visit or emergency department visit. The proposed codes were as follows:

G0LLL-Initial nursing assessment of patient directly admitted to observation with diagnosis of congestive heart failure, chest pain, or asthma.

G0MMM-Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma.

If a hospital directly admits to observation from a physician's office a patient with a diagnosis of congestive heart failure, asthma, or chest pain, we proposed to require that G0LLL be billed with G0244. The current requirement that the hospital bill an emergency department visit (APC 0600, 0601, or 0602) or a clinic visit (APC 0610, 0611, or 0612) or a critical care service (APC 0620) in order to receive separate payment for observation services for patients not admitted directly from a physician's office would remain in effect. However, because the initial nursing assessment is part of any observation service, we proposed not to make separate payment for G0LLL. Rather, we proposed to assign status indicator ''N'' to G0LLL, to designate that charges submitted with G0LLL would be packaged into the costs associated with APC 0339. If G0LLL is billed, we would require that the medical record show that the patient was admitted directly from a physician's office for purposes of evaluating and treating chest pain, asthma, or congestive heart failure.

G0MMM describes the initial nursing assessment of a patient directly admitted to observation with a diagnosis other than chest pain, asthma, or congestive heart failure. We proposed to assign G0MMM for payment under APC 0706, New Technology—Level I. We proposed to require hospitals to bill G0MMM instead of the low level clinic visit referred to in the FAQ above to describe the initial nursing assessment of a patient directly admitted to observation with a diagnosis other than chest pain, asthma, or congestive heart failure. Separate payment would not be made for observation services billed with G0MMM. Rather, when billing G0MMM, hospitals would be required to use revenue code 762 alone or revenue code 762 with one of the HCPCS codes for packaged observation services (99218, 99219, 99220, 99234, 992335, or 99236). We proposed to create G0MMM to establish a separately payable code into which costs for observation care for patients directly admitted for diagnoses other than asthma, chest pain, or congestive heart failure can be packaged and recognized.

We would use billing data for G0LLL and G0MMM in reviewing the provisions for payment of observation services in future updates of the OPPS. In the proposed rule, we invited comment on the extent to which these codes address the concerns that have been raised in connection with patients who are directly admitted to observation services.

*Comment:* Everyone who commented on our proposed refinements of the requirements to enable separate payment for observation services supported the proposal to allow separate payment for patients admitted to observation directly from physicians' offices. However, the majority of commenters opposed the coding and payment methodology that we proposed to implement this change.

Commenters stated that having to use G0LLL and G0MMM, combined with the other requirements that have to be met in order to receive separate payment for observation of patients with asthma, congestive heart failure, and chest pain, would be burdensome and confusing, and would create operational inconsistencies and problems for hospitals. Several commenters urged CMS to simplify, the observation rules in order to reduce their complexity and lessen the burden they currently impose on hospitals. Some commenters were concerned that other payors might not accept the proposed new codes and that the codes would not be HIPAA compliant.

A number of commenters recommended alternatives to the establishment of G0LLL and G0MMM that would utilize information already being reported by hospitals on the UB–92 within the existing coding system for revenue centers, diagnoses, and source and type of admission. One commenter suggested a single G code for ''Intake into observation after outside evaluation'' supported by appropriate diagnosis coding and claims edits. One

commenter recommended instituting a ''per visit'' payment logic in the OCE and PRICER similar to that used for mental health and PHP services. Several commenters suggested returning observation to a time-based charging and coding methodology based on hours. Several commenters supported using existing E/M codes instead of creating new codes.

*Response:* We agree with many of the commenters that our proposal for direct admissions to observation seems administratively burdensome. However, we believe that the importance of creating a payment mechanism for direct admissions to observation outweighs the administrative burden at this time. We also believe it is vital that we be able to track the utilization of these services so we will have data upon which to base policy decisions in the future.

A number of the alternatives suggested by commenters are promising and merit further analysis and review. However, our preliminary inquiries revealed that most of the suggested alternatives would require systems changes that could take six months or longer to develop and install, and that such changes could not be implemented effective January 1, 2003. Therefore, we have decided to implement the proposed G codes as follows:

G0263, Direct admission of patient with diagnosis of congestive heart failure, chest pain or asthma for observation.

G0264, Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma.

These codes would be HIPPA compliant. Other payers would make their own decisions about whether to use these codes for their own payment purposes.

*Comment:* One commenter asked that we instruct Fiscal Intermediaries to accept another revenue code in the 76X range for G0263 and G0264 because RC 762 may only be used to report observation charges.

*Response:* We are reviewing with our coding and claims processing experts to determine if there is a more appropriate revenue code to use when billing G0263 and G0264. We will provide specific instructions in the program memorandum issued to implement the January 2003 OPPS update.

*Comment:* Cancer centers urged CMS to expand the conditions for which we would make separate payment for observation to include febrile neutropenia, electrolyte disorders, chemotherapy hypersensitivity reaction, pulmonary embolisms, acute GI hemorrhage, and seizures presented by cancer patients under treatment at Cancer Centers. Other commenters suggested psychiatric conditions, acute abdominal pain, post-transplant threat of rejection, and pneumonia as appropriate for separate payment for observation.

*Response:* As we indicate in the November 30, 2001 final rule, we will review the indications for separately payable observation after we have acquired sufficient experience under the current system to make an informed decision as to whether an expansion is appropriate.

*Comment:* Most commenters asserted that our proposed payment for G0MMM for initial nursing assessment of a patient directly admitted to observation with a diagnosis other than chest pain, asthma, or congestive heart failure (APC 706) is too low and does not recognize the substantial type, level, and quality of the initial nursing services being provided. Commenters urged CMS either to set a higher payment rate for G0MMM or to allow an E/M code to be billed with G0MMM. Another commenter suggested assigning G0MMM to APC 0600 to be consistent with what CMS says in the FAQ 97. One commenter noted that it is inappropriate to assign G0MMM to a new technology APC because the code describes an E/M service, not a new technology service.

*Response:* We agree. We have therefore assigned G0264 for payment in APC 600, Low Level Clinic Visits.

*Comment:* One commenter wanted to know if G0LLL and G0MMM could be used for patients admitted from their homes, either (1) based solely upon a telephone call from the patient to the community physician and that physician's call to the hospital to order a direct admission for observation management, or (2) when directly admitted by the physician after going home following a visit to the physician's office, the patient's condition having deteriorated after seeing the physician.

*Response:* As long as the physician notifies the hospital that he/she is ordering the direct admission of the patient for observation and supports that order with the appropriate suspected diagnosis, we believe this would constitute a direct admission. Either G0263 or G0264 would be billed, depending on the final diagnosis supporting the direct admission observation services.

*C. Billing Intravenous Infusions With Observation*

Based on questions and concerns raised by hospitals since implementation of payment for APC 0339 effective April 1, 2002, we have also reviewed the current status of billing intravenous infusions with observation. Several hospitals have noted that claims for G0244 when billed with intravenous infusion services reported with HCPCS code Q0081 are denied because of the ''T'' status indicator assigned to HCPCS code Q0081. Our current payment rules for G0244 require that G0244 be denied if a service with status indicator ''T'' is performed the day before, the day of, or the day after observation care. Because patients in observation may require intravenous infusions of fluid, we proposed to create code G0EEE, Intravenous infusion during separately payable observation stay, per observation, payable under APC 0340 with status indicator ''X.'' When observation services that otherwise meet the billing requirements for separate payment under APC 0339 include an intravenous infusion administered as part of the observation care, G0EEE would be used to report the infusion service. We included instructions on the use of G0258 in the program memorandum issued to implement OPPS coding changes for the October 1, 2002 OCE. In the proposed rule, we solicited comment on the use of this code.

*Comment:* While appreciative of our recognizing the need for a mechanism that permits hospitals to bill for infusion therapy during observation, most commenters did not support our proposal to introduce a new code for the service. One commenter recommended terminating G0258 effective 12/31/02 because it creates operational burdens for the hospital and does not accurately reflect the resources used. Several commenters urged CMS to change the SI for APC 120 to which Q0081 is assigned to S. This would solve the problem and permit payment of Q0081 with G0244 and would also align the status indicators for the infusion of non-chemotherapy drugs with the infusion of chemotherapy drugs.

Commenters asked if CMS intends hospital to use G0258 instead of Q0081 when the infusion therapy is provided to the patient in the emergency department or clinic prior to patient's placement in observation when the observation stay ultimately qualifies for separate payment. The commenters pointed out that the hospital may not know when the patient is in the emergency department or clinic and the infusion therapy is initiated that the patient will subsequently be placed in an observation stay that qualifies for payment under G0244. Commenters

asked CMS to clarify how G0258 is to be used.

One commenter recommended, that we install an OCE edit to ignore Q0081 when checking for the presence of a procedure with SI=T.

Many commenters stated that the payment for G0248 should be the same as the payment for Q0081 because the resources expended for infusion therapy performed during a packaged observation stay are the same as those required for Q0081 furnished. These commenters disagreed with CMS's assertion that payment for G0258 should be discounted to equal 50 percent of the payment for Q0081 because Q0081 is invariably billed with a higher-paying procedure and is, therefore, discounted. Another commenter advocated adjusting the payment for G0244 to include the cost of infusion and eliminating a separate new code. The same commenter supported payment at 50 percent of the rate set for Q0081 because Q0081 would always be discounted because it is always billed with another procedure.

*Response:* Having reviewed the numerous concerns raised by commenters in connection with the use of HCPCS code G0258, Intravenous infusion during separately payable observation stay, per observation stay (must be reported with G0244), and our proposed payment for G0258, we agree with commenters that requiring the use of this code is problematic. We have determined that the OCE logic can be modified to allow payment for G0244, even though Q0081 is assigned to an APC with status indicator T. Therefore, effective for services furnished on or after January 1, 2003, we are withdrawing G0258. Instead hospitals may submit claims for G0244 with Q0081 when infusion therapy is provided, and the claim will be paid if all other requirements and conditions are met. The status indicator for G0081 will not change.

Annual Update of ICD–9 Diagnosis Codes

To receive payment for G0244, we require hospitals to bill specified ICD–9–CM diagnosis code(s). Because ICD–9–CM codes are updated effective October 1 of each year, we proposed to issue by Program Memorandum any changes in the diagnosis codes required for payment of G0244 resulting from the ICD–9–CM annual update.

In the March 1, 2002 final rule (67 FR 9559) and in Transmittal A–02–026 issued on March 28, 2002, we listed the diagnosis codes required in order for separate payment of observation services under APC 0339 to be made for patients with congestive heart failure. We added by program memorandum the following new ICD–9–CM codes to the list of allowed diagnosis codes for separate payment for observation of patients with congestive heart failure, effective for services furnished on or after October 1, 2002:

428.20 Unspecified systolic heart failure
428.21 Acute systolic heart failure
428.22 Chronic systolic heart failure
428.23 Acute on chronic systolic heart failure
428.30 Unspecified diastolic heart failure
428.31 Acute diastolic heart failure
428.32 Chronic diastolic heart failure
428.33 Acute on chronic diastolic heart failure
428.40 Unspecified combined systolic and diastolic heart failure
428.41 Acute combined systolic and diastolic heart failure
428.42 Chronic combined systolic and diastolic heart failure
428.43 Acute on chronic combined systolic and diastolic heart failure

In the August 9, 2002 proposed rule, we invited comment on the addition of these diagnosis codes to the criteria for separate payment for observation services under APC 0339.

*Comment:* One commenter recommended adding the following codes to the list of diagnoses for asthma: 493.00, 493.10, 493.20, and 493.90

*Response:* We are not including these diagnoses because they would not be appropriate for use with patients requiring observation services because they are experiencing acute exacerbations of asthma.

- Effective for services furnished on or after January 1, 2003, hospitals may bill for patients directly admitted for observation services using the following codes:

G0263, Direct admission of patient with diagnosis of congestive heart failure, chest pain or asthma for observation.

G0264, Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma.

- Payment for G0264 will be made under APC 600.
- Payment for G0263 will be packaged into the payment for APC 339
- Payment for G0244 will be allowed when billed with Q0081, Infusion therapy other than chemotherapy, when furnished to patients with asthma, congestive heart failure, or chest pain, subject to all other conditions for payment having been met.

*C. Payment Policy When a Surgical Procedure on the Inpatient List Is Performed on an Emergency Basis*

As we state in section II.B.5 of this preamble, the inpatient list specifies those services that are only paid when provided in an inpatient setting. The inpatient list proposed for 2003 is printed as Addendum E. In Addendum B, status indicator C designates a HCPCS code that is on the inpatient list.

Over the past year, some hospitals and hospital associations have asked how a hospital could receive Medicare payment for a procedure on the inpatient list that had to be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition who was transferred or died before being admitted as an inpatient. We reviewed within the context of our current policy the cases brought to our attention for which payment under the OPPS was denied because a procedure with status indicator C was on the bill. Based on that review, we proposed to clarify our policy regarding Medicare payment when a procedure with status indicator C is performed under certain life-threatening, emergent conditions. In the proposed rule, we solicited comments on the extent to which the payment policy described below addresses hospitals' concerns. We stated it would be most helpful if commenters provided specific examples of cases when hospitals have, in these instances, submitted bills for a procedure with OPPS status indicator C that were not paid.

1. Current Policy

In the April 7, 2000 final rule (65 FR 18451), in response to comments about the appropriate level of payment for patients who die in the emergency department, we set forth the following guidelines for fiscal intermediaries to use in determining how to make payment when a patient dies in the emergency department or is sent directly to surgery and dies there.

- If the patient dies in the emergency department, make payment under the outpatient PPS for services furnished.
- If the emergency department or other physician orders the patient to the operating room for a surgical procedure, and the patient dies in surgery, payment will be made based on the status of the patient. If the patient had been admitted as an inpatient, pay under the hospital inpatient PPS (a DRG-based payment).
- If the patient was not admitted as an inpatient, pay under the outpatient PPS (an APC-based payment).
- If the patient was not admitted as an inpatient and the procedure is

designated as an inpatient-only procedure (payment status indicator C), no Medicare payment will be made for the procedure, but payment will be made for emergency department services.

The OPPS outpatient code editor (OCE) currently has an edit in place that generates a ''line item denial'' for a line on a claim that has a status indicator C. A line item denial means that the claim can be processed for payment but with some line items denied for payment. A line item denial can be appealed under the provisions of section 1869 of the Act. The OCE includes another edit that denies all other line items furnished on the same day as a line item with a status indicator C. The rationale for this edit is that all line items for services furnished on the same date as the procedure with status indicator C would be considered inpatient services and paid under the appropriate DRG.

As part of the definition of line item denial in the program memorandum that we issue quarterly to update the OCE specifications (for example, see Program Memorandum/Intermediaries, Transmittal A–02–052, June 18, 2002, which is available on our Web site at *http://cms.hhs.gov/manuals/pm_trans/A02052.pdf*), we state that a line item denial cannot be resubmitted except for an emergency room visit in which a patient dies during a procedure that is categorized as an inpatient procedure: ''Under such circumstances, the claim can be resubmitted as an inpatient claim.''

In Addendum D of the March 1, 2002 final rule, we designate payment status indicator ''C'' as follows: ''Admit patient; bill as inpatient.''

2. Hospital Concerns

Hospitals have requested clarification regarding billing and payment in certain situations that our current policy does not seem to explicitly address. The following scenarios synthesize cases described by hospitals for which they have encountered problems when billing for a procedure with status indicator C.

*Scenario A:* A procedure assigned status indicator C under the OPPS is performed to resuscitate or stabilize a beneficiary who appears with or suddenly develops a life-threatening condition. The patient dies during surgery or postoperatively before being admitted.

*Scenario B:* An elective or emergent surgical procedure payable under the OPPS is being performed. Because of sudden, unexpected intra-operative complications, the physician must alter the surgical procedure and perform a procedure with OPPS status indicator C. The patient dies during the operation before he or she is admitted as an inpatient.

*Scenario C:* A procedure with status indicator C is performed to resuscitate or stabilize a beneficiary who appears with or suddenly develops a life-threatening condition. After the procedure, the patient is transferred to another facility for postoperative care.

3. Clarification of Payment Policy

We proposed the following policy for fiscal intermediaries and providers to use in determining the appropriate Medicare payment in cases such as those described in the section above.

A procedure assigned status indicator C under the OPPS is never payable under the OPPS. Therefore, for a hospital to receive payment when a procedure with OPPS status indicator C is performed and: (1) The patient dies during or after the procedure, before being admitted, or (2) the patient survives the procedure and is transferred following the procedure, the patient's medical record must contain all of the following information:

- Either orders to admit written by the physician responsible for the patient's care at the hospital to which the patient was to be admitted following the procedure for the purpose of receiving inpatient hospital services and occupying an inpatient bed, or written orders to admit and transfer the patient to another hospital following the procedure.
- Documentation that the reported HCPCS code for the surgical procedure with OPPS payment status indicator C (such as CPT code 61345) was actually performed.
- Documentation that the reported surgical procedure with status indicator C was medically necessary.
- If the patient is admitted and subsequently transferred to another facility, documentation that the transfer was medically necessary, such as the patient requiring postoperative treatment unavailable at the transferring facility.

In the case of a patient who dies during performance of a procedure with OPPS status indicator C before being admitted, the hospital would submit a claim for all services provided, including a line item for the status indicator C procedure. The claim would be rejected for payment under the OPPS and returned to the hospital. The hospital would resubmit the claim for payment as an inpatient stay under the appropriate DRG.

In the case of a patient who is admitted and transferred, the transferring hospital would be paid a per diem DRG rate if all the above conditions are met. (We proposed to revise § 3610.5 of the Medicare Intermediary Manual accordingly.) Because these services would be paid according to the appropriate DRG or per diem (see below), all services that were furnished before admission that would otherwise be payable under the OPPS would be paid in accordance with the provisions of § 3610.3 of the Medicare Intermediary Manual (''3-day rule'') and § 415.6 of the Medicare Hospital Manual.

Note that a physician's order to admit a patient to an observation bed following a procedure designated with OPPS status indicator C would not constitute an inpatient admission and, therefore, would not qualify the procedure with status indicator C for payment. In this instance, the only allowable Medicare payment would be for a code payable under APC 0610, 0611, or 0612 if those services were provided. Payment would not be allowed for either the procedure with status indicator C or for any ancillary services furnished on the same date.

*Comment:* Commenters agreed that the current policy on billing and payment when procedures on the inpatient list are performed on an outpatient basis requires clarification and modification. However, commenters stated that our proposals, if implemented, would be burdensome and create extra work for hospitals. Commenters opposed our proposal that an outpatient claim be submitted for rejection and then resubmitted as an inpatient claim. Commenters asserted that this would be unwieldy and create an unacceptable delay in payment. Many commenters were concerned that it would be difficult to expect a physician to write an order to admit a patient who expired during emergency surgery, and that asking physicians to do so to satisfy a billing requirement would not be appropriate. Some commenters were concerned that submitting an inpatient claim that is inconsistent with medical records documentation could create problems with medical review. However, commenters did not provide illustrations of actual cases when hospitals have submitted outpatient bills for a procedure with status indicator C that was performed in an emergency situation and not paid which would have added specificity to the general comments.

Commenters offered several alternatives to our proposal. Several commenters suggested that these cases be initially billed as inpatient stays,

supported by documentation that the procedure was performed and was medically necessary, and that a presumption of admission be made for payment purposes. Several commenters suggested that a reduced DRG-related amount be established as payment in these special cases. Several commenters suggested the use of a condition code that would allow submission of an outpatient claim when procedures on the inpatient list are performed in emergency situations.

*Response:* We appreciate commenters' reactions and suggestions of ways to make payment under the OPPS in emergency situations when procedures on the inpatient list are performed on a beneficiary who is not admitted as an inpatient. After careful review and consideration of the comments and recommendations, we have decided to modify certain aspects of our proposed policy, while retaining certain others. We are also taking steps to ensure that OCE edits are consistent with our policy.

The underlying principle is our policy that procedures on the inpatient list performed on patients whose status is that of outpatient are not payable as outpatient services.

However, we recognize that there are occasions when a procedure on the inpatient list must be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient. To receive payment in those cases, hospitals admit the patient and submit an inpatient claim.

In cases where a procedure on the inpatient list must be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient, the patient may be admitted and transferred to another hospital. In these cases, the transferring hospital is paid a per diem DRG rate. We shall revise section 3610.5 of the Medicare Intermediary Manual to reflect this policy.

On rare occasions, a procedure on the inpatient list must be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient and the patient dies before being admitted as an inpatient. For those rare and unusual cases, we are instructing hospitals to submit an outpatient claim for all services furnished, including the procedure code with status indicator C to which a new modifier is attached. The exact modifier that is to be used in these cases had not been issued by the HCPCS alpha-numeric workgroup in time for publication in this final rule. The modifier and instructions for its use will be included in the program memorandum for the January 2003 update. We believe that such patients would typically receive services such as those provided during a high-level emergency visit, appropriate diagnostic testing (X-ray, CT scan, EKG, and so forth), and administration of intravenous fluids and medication prior to the surgical procedure. Because these combined services constitute an episode of care, we will pay claims with a procedure code on the inpatient list that are billed with the new modifier under new technology APC 977. Separate payment will not be allowed for other services furnished on the same date. This approach allows hospitals to submit an outpatient claim and receive payment without additional paperwork, it results in consistency between the medical record and patient status, and it allows us to collect data on the costs associated with these very unusual and infrequent cases for future use in updating the OPPS.

Procedures with status indicator C but without the new modifier that are submitted on an outpatient bill will receive a line item denial, and no other services furnished on the same date are payable.

If an outpatient has a procedure that is on the inpatient list performed, and is subsequently admitted to an observation bed, the procedure with status indicator C submitted on an outpatient bill will receive a line item denial. Further, we have decided not to make final our proposal to make payment for APC 610, 611 or 612 under such circumstances. Rather, in such cases no other services furnished on the same date are payable.

We did not receive any comments on the documentation that we proposed to require in the patient's medical record when a procedure with status indicator C is performed and: (1) The patient dies before being admitted as an inpatient, or (2) the patient survives the procedure and is admitted and transferred. Therefore, we are making those requirements final.

4. Orders To Admit

Some hospitals have raised questions about the timing of a physician's order to admit a patient. The requirements for authenticating physician orders and the standards for medical record keeping fall outside the scope of this rule and OPPS payment policy. The payment provisions that we are making final in this rule are to assist hospitals and contractors in determining how to bill and pay for services appropriately under Medicare. The patient's admission status, as documented by the medical records, determines what Medicare payment is appropriate. Medical record keeping and documentation requirements are addressed in the Medicare hospital conditions of participation at § 482.24, and are governed by applicable State law and State licensing rules and hospital accreditation standards.

*Comment:* A few commenters requested clarification on what is meant by ''admit'' and the documentation that CMS would expect to see in order to substantiate that a patient was admitted as an inpatient. One commenter expressed concern about the variability in fiscal intermediaries' policies regarding the changing of an admission status after the service has been provided.

*Response:* As we have indicated, these issues are addressed in the Medicare hospital conditions of participation at § 482.24, and are governed by applicable State licensing rules and hospital accreditation standards. Questions and concerns related to these issues should be addressed to the parties who are responsible for these rules, regulations, and standards.

When a procedure on the inpatient list must be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient and the patient dies before being admitted as an inpatient, the hospital should submit an outpatient claim for all services furnished, including the procedure with status indicator C to which a new modifier, which will be announced by program memorandum is attached. Claims with a procedure code on the inpatient list that are billed with the new modifier will be paid under APC 977.

We are making final the requirement that information specified in the proposed rule be included in the medical record to support payment when a procedure with status indicator C is performed on an outpatient and the patient dies or is admitted and transferred.

*D. Status Indicators*

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 if a service represented by a HCPCS code is payable under the OPPS or another payment system and also if particular OPPS policies apply to the code. We are providing our status indicator assignments for APCs in Addendum A, HCPCS codes in

Addendum B, and definitions of the status indicators in Addendum D.

The OPPS is based on HCPCS codes for medical and other health services. These codes are used for a wide variety of payment systems under Medicare, including, but not limited to, the Medicare fee schedule for physician services, the Medicare fee schedule for durable medical equipment and prosthetic devices, and the Medicare clinical laboratory fee schedule. For purposes of making payment under the OPPS, we need a way to signal the claims processing system which HCPCS codes are paid under the OPPS and those codes to which particular OPPS payment policies apply. We accomplish this identification in the OPPS through the establishment of a system of status indicators with specific meanings. Addendum D defines the meaning of each status indicator for purposes of the OPPS.

We assign one and only one status indicator to each APC and to each HCPCS code. Each HCPCS code that is assigned to an APC has the same status indicator as the APC to which it is assigned.

Specifically, in 2003, we proposed to use the status indicators in the following manner:

- ''A'' to indicate services that are paid under some payment method other than OPPS, such as the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule or the physician fee schedule. Some but not all—of these other payment systems are identified in Addendum D.
- ''C'' to indicate inpatient services that are not payable under the OPPS.
- ''D'' to indicate a code that was deleted effective with the beginning of the calendar year.
- ''E'' to indicate services for which payment is not allowed under the OPPS or that are not covered by Medicare.
- ''F'' to indicate acquisition of corneal tissue, which is paid at reasonable cost.
- ''G'' to indicate drugs and biologicals that are paid under OPPS transitional pass-through rules.
- ''H'' to indicate devices that are paid under OPPS transitional pass-through rules.
- ''K'' to indicate drugs and biologicals (including blood and blood products) and certain brachytherapy seeds that are paid in separate APCs under the OPPS, but that are not paid under OPPS transitional pass-through rules.
- ''N'' to indicate services that are paid under the OPPS for which payment is packaged into another service or APC group.
- ''P'' to indicate services that are paid under the OPPS but only in partial hospitalization programs.
- ''S'' to indicate significant procedures that are paid under OPPS but to which the multiple procedure reduction does not apply.
- ''T'' to indicate significant services that are paid under the OPPS and to which the multiple procedure payment discount under OPPS applies.
- ''V'' to indicate medical visits (including clinic or emergency department visits) that are paid under the OPPS.
- ''X'' to indicate ancillary services that are paid under the OPPS.

The software that controls Medicare payment looks to the status indicators attached to the HCPCS codes and APCs for direction in the processing of the claim. Therefore, the assignment of the status indicators has significance for the payment of services. We sometimes change these indicators in the course of a year through program memoranda. Moreover, indicators are established for new codes that we establish in the middle of the year, either as a result of a national coverage decision or otherwise. A status indicator, as well as an APC, must be assigned so that payment can be made for the service identified by the new code.

Our proposed status indicators identified for each HCPCS code and each APC appear in Addenda A and B of the proposed rule. We requested comments on the appropriateness of the indicators we have assigned.

We received several comments on this proposal, which are summarized below:

*Comment:* Some commenters said that our proposed payment for influenza and pneumococceal pneumonia vaccines and orphan drugs were inadequate to ensure the provision of these drugs and biologicals.

*Response:* As discussed in section III.B, we will pay reasonable cost for these drugs and biologicals in 2003. Therefore, we have assigned orphan drugs a status indicator of F and have redefined the status indicator F to mean that the item or service is paid on a reasonable cost basis. Until now, only corneal tissue acquisition has been paid as reasonable cost under OPPS and, therefore, the status indicator was specific to corneal tissue. However, beginning January 1, 2003, the ''F'' status indicator will apply to any item or service paid at reasonable cost.

With regard to influenza and pneumococcal pneumonia vaccine, which we will also pay on a reasonable cost basis, effective January 1, 2003, we have created a new status indicator ''L'' ''Influenza vaccine; pneumococcal pneumonia vaccine'' to indicate that these vaccines are paid on a reasonable cost basis but deductible and coinsurance do not apply to the payment. We show the new status indicator in Addendum D and we show it for these services in Addendum B. We are doing the following:

- Redefining status F to indicate an item or service that is paid on a reasonable-cost basis.
- Changing the status indicator for influenza and pneumococceal pneumonia vaccines to status indicator L and change orphan drugs to status indicator F.
- Changing the status indicator for APC 225 to S.

*E. 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). Effective with implementation of the 2002 OPPS update on April 1, 2002, we deduct from the pass-through payments for those devices an amount that offsets the portion of the otherwise applicable APC payment amount that we determined is associated with the device, as required by section 1833(t)(6)(D)(ii) of the Act. In the March 1, 2002 final rule, we published the applicable offset amounts for 2002, which we had recalculated to reflect certain device cost assignments that were corrected in the same final rule (67 FR 9557).

For the 2003 OPPS update, we proposed to estimate 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 for services furnished between July 1, 2001, through December 31, 2001. We proposed to use only the last 6 months of 2001 claims data because bills for pass-through devices submitted during this time period would use only device category codes, allowing a more consistent analysis than would result were we to include pre-July 1 claims that might still show item-specific codes for pass-through devices. Using these claims, we would calculate a median cost for every APC without packaging the costs of associated C-codes for device categories that were billed with the APC. We would then calculate a median cost for every APC with the

costs of associated C-codes for device categories that were billed with the APC packaged into the median. Dividing the median APC cost minus device packaging by the median APC cost including device packaging would allow us to determine the percentage of the median APC cost that is attributable to associated pass-through devices. By applying these percentages to the APC payment amount, we would determine the applicable offset amount. Table 11 shows the offsets that we applied in 2003 to each APC that contains device costs. APCs were included for offsets if their device costs comprised at least 1 percent of the APC's costs. (However, if any APC's calculated offset had been less than 1 dollar, that APC and offset would not have been included.)

For this final rule, we used the device data for the 12 months ended March 31, 2002 to calculate the device and non-device portions of APCs median costs. We began with the same APCs that were listed on Table 9 of our proposed rule, with two additions. We added APCs 0648 and 0651, because they showed appreciable device percentages using our methodology. We again applied these percentages to the APC payment amounts and excluded any APC's percentage of device costs less than one percent and calculated offset amounts less than one dollar.

We received some comments on this proposal, which are summarized below:

*Comment.* A commenting party contended that our list of device offsets in our proposed rule is incorrect since it includes many computed offsets to APC payments for devices that will no longer receive pass-through payments. The commenter recommended that we exclude the offsets of all devices in categories that are bundled, since there is no separate pass-through payment to be offset.

*Response.* The offset list is a list of potential offsets. We, of course, do not know in advance which procedures and APCs will be mapped into new categories as the new categories are created and become effective. Yet, we are required to subtract the amount of similar devices in pass-through payment under section 1833(t)(6)(D)(ii) of the Act. Therefore, for the proposed rule, we calculate the device costs in each APC and include APCs on the offset list if their device costs were at least 1 percent of the APC's cost. We use a similar list for this final rule.

*Comment.* One commenter expressed concern about the difference in offset amounts proposed for APC 0107, Insertion of Cardioverter-Defibrilator, and APC 0108, Insertion/Replacement/Repair of Cardioverter-Defibrilator Leads. The commenter wondered why, when the cost of the cardioverter-defibrilator is 2 to 3 times the cost of the leads, the offset amount for APC 0107 is less than the offset amount for APC 0108.

*Response.* The commenter is incorrect that we proposed an offset amount for 0107 (83.18 percent) that is less than for 0108 (82.18 percent). Moreover, the commenter mistakenly believes that APC 0107 is for insertion/replacement/repair of cardioverter-defibrilator leads when, in fact, the definition of CPT code 33249 (the only CPT code in APC 0108) is ''Insertion or repositioning of electroleads for single or dual chamber pacing cardioverter-defibrilator and insertion of pulse generator.'' Hence, CPT code 33249 is for the insertion of a pulse generator and insertion or repositioning of leads. It is not, as the commenter indicates, for insertion or repositioning of leads alone. As shown in Table 11, the offset percent for APC 0107 is 93.29 and the offset percent for APC 0108 is 92.99.

*Comment.* A commenting party contended that the offsets appear to be computed using departmental cost-to-charge ratios (CCRs), yet pass-through payments for devices were computed using an overall hospital CCR. The party contended that in cases in which the hospital CCR is higher than the departmental CCR, there is effectively a zero pass-through payment for devices. Therefore, the party recommended that the offsets should be calculated using the same CCRs used to compute pass-through payments.

*Response:* Although the commenter states that calculating a device pass-through payment using a hospital CCR that is higher than the departmental CCR used to determine the applicable offset amount results in effectively no payment for a device, it appears to us that the opposite result would occur. That is, in the situation described, a lower offset amount would be applied to a higher calculated device cost, resulting in a higher net device payment. Offset amounts represent device costs that are included in the median costs of a procedure. The median cost of the procedure is determined, as we determine median costs for all services, by totaling all the procedure's component costs calculated using department-specific CCRs. We use department-specific CCRs to calculate the cost of the procedure, which includes devices, and because offsets are intended to represent the cost of devices that are included in the cost of the procedure, we believe the same departmental-CCR method must be applied in calculating offsets.

TABLE 11.—OFFSETS TO BE APPLIED FOR EACH APC THAT CONTAINS DEVICE COSTS

| APC | Description | APC percent attributed to devices | Device related costs to be subtracted from pass-through payment |
|---|---|---|---|
| 0032 | Insertion of Central Venous/Arterial Catheter | 31.96 | $191.22 |
| 0048 | Arthroplasty with Prosthesis | 29.92 | 633.96 |
| 0051 | Level III Musculoskeletal Procedures Except Hand and Foot | 1.31 | 22.48 |
| 0052 | Level IV Musculoskeletal Procedures Except Hand and Foot | 3.08 | 65.48 |
| 0080 | Diagnostic Cardiac Catheterization | 10.63 | 195.69 |
| 0081 | Non-Coronary Angioplasty or Atherectomy | 31.45 | 713.58 |
| 0082 | Coronary Atherectomy | 48.25 | 2,174.88 |
| 0083 | Coronary Angioplasty and Percutaneous Valvuloplasty | 29.59 | 802.06 |
| 0085 | Level II Electrophysiologic Evaluation | 37.00 | 805.10 |
| 0086 | Ablate Heart Dysrhythm Focus | 41.96 | 1,156.01 |
| 0087 | Cardiac Electrophysiologic Recording/Mapping | 51.40 | 1,056.10 |
| 0088 | Thrombectomy | 3.80 | 64.56 |
| 0089 | Insertion/Replacement of Permanent Pacemaker and Electrodes | 77.40 | 4,543.29 |
| 0655 | Insertion/Replacement/Conversion of a permanent dual chamber pacemaker | 77.14 | 4,942.78 |
| 0090 | Insertion/Replacement of Pacemaker Pulse Generator | 79.61 | 3,782.34 |
| 0654 | Insertion/Replacement of a permanent dual chamber pacemaker | 78.27 | 3,749.52 |

TABLE 11.—OFFSETS TO BE APPLIED FOR EACH APC THAT CONTAINS DEVICE COSTS—Continued

| APC | Description | APC percent attributed to devices | Device related costs to be subtracted from pass-through payment |
|---|---|---|---|
| 0091 | Level II Vascular Ligation | 1.08 | 15.04 |
| 0653 | Vascular Reconstruction/Fistula Repair with Device | 10.83 | 169.60 |
| 0104 | Transcatheter Placement of Intracoronary Stents | 46.65 | 1,862.31 |
| 0105 | Revision/Removal of Pacemakers, AICD, or Vascular | 4.60 | 44.61 |
| 0106 | Insertion/Replacement/Repair of Pacemaker and/or Electrodes | 50.46 | 1,442.72 |
| 0107 | Insertion of Cardioverter-Defibrillator | 93.29 | 15,871.30 |
| 0108 | Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads | 92.99 | 21,509.86 |
| 0109 | Removal of Implanted Devices | 1.61 | 6.27 |
| 0115 | Cannula/Access Device Procedures | 25.85 | 327.87 |
| 0119 | Implantation of Devices | 74.37 | 3,463.86 |
| 0122 | Level II Tube Changes and Repositioning | 40.26 | 225.62 |
| 0124 | Revision of Implanted Infusion Pump | 52.73 | 1,377.33 |
| 0151 | Endoscopic Retrograde Cholangio-Pancreatography (ERCP) | 2.87 | 26.21 |
| 0152 | Percutaneous Abdominal and Biliary Procedures | 31.57 | 165.11 |
| 0652 | Insertion of Intraperitoneal Catheters | 10.91 | 160.05 |
| 0154 | Hernia/Hydrocele Procedures | 2.73 | 36.63 |
| 0167 | Level III Urethral Procedures | 43.96 | 649.32 |
| 0168 | Level II Urethral Procedures | 1.15 | 14.67 |
| 0179 | Urinary Incontinence Procedures | 56.34 | 3,066.24 |
| 0182 | Insertion of Penile Prosthesis | 58.45 | 2,908.45 |
| 0202 | Level VIII Female Reproductive Proc | 38.35 | 911.22 |
| 0222 | Implantation of Neurological Device | 88.08 | 10,461.01 |
| 0223 | Implantation of Pain Management Device | 52.96 | 1,133.11 |
| 0225 | Implantation of Neurostimulator Electrodes | 81.03 | 5,888.13 |
| 0226 | Implantation of Drug Infusion Reservoir | 82.74 | 6,228.55 |
| 0227 | Implantation of Drug Infusion Device | 81.57 | 6,147.49 |
| 0229 | Transcatheter Placement of Intravascular Shunts | 63.65 | 1,907.33 |
| 0246 | Cataract Procedures with IOL Insert | 1.38 | 16.00 |
| 0259 | Level VI ENT Procedures | 84.07 | 16,118.86 |
| 0279 | Level II Angiography and Venography except Extremity | 2.18 | 9.83 |
| 0280 | Level III Angiography and Venography except Extremity | 4.89 | 38.80 |
| 0297 | Level II Therapeutic Radiologic Procedures | 1.35 | 5.41 |
| 0651 | Complex Interstitial Radiation Source Application | 85.13 | 2,429.25 |
| 0670 | Intravenous and Intracardiac Ultrasound | 53.75 | 847.71 |
| 0680 | Insertion of Patient Activated Event Recorders | 77.72 | 2,275.14 |
| 0681 | Knee Arthroplasty | 64.16 | 4,945.63 |
| 0686 | Level III Skin Repair | 37.79 | 280.72 |
| 0687 | Revision/Removal of Neurostimulator Electrodes | 35.06 | 472.51 |
| 0688 | Revision/Removal of Neurostimulator Pulse Generator Receiver | 69.42 | 2,699.74 |
| 0648 | Breast Reconstruction with Prosthesis | 31.69 | 740.32 |

2. Devices Paid With Multiple Procedures

As explained above, under section 1833(t)(6)(D)(ii) of the Act, the amount of additional payment for a device eligible for pass-through payment is the amount by which the hospital's cost exceeds the portion of the otherwise applicable APC payment amount that the Secretary determines is associated with the device. Thus, for devices eligible for pass-through payment, we reduce the pass-through payment amount by the cost attributable to the device that is already packaged into the APC payment for an associated procedure. For 2002, we developed offset amounts for 59 APCs (March 1, 2002 final rule, 67 FR 9556 through 9557, Table 1).

In our November 30, 2001 final rule (66 FR 59856), we articulated a policy regarding the calculation of the offsets for device costs already reflected in APCs in cases where the payment for the associated APC is reduced due to the multiple procedure discount. The policy was in response to several commenting parties that recommended that we apply the multiple procedure discount only to the non-device-related portion of the APC payment amount (66 FR 59906).

We agreed with the commenters that the full pass-through offset should not be applied when the APC payment is subject to the multiple procedure discount of 50 percent.

The purpose of the offset is to ensure that the OPPS is not making double payments for any portion of the cost associated with the use of the pass-through item. We stated in the November 30, 2001 rule that the offset should reflect that portion of the cost for the pass-through device actually reflected in the payment that is received for the associated APC. We consequently ruled that the most straightforward methodology for applying this principle is to reduce the amount of the offset amount by 50 percent whenever the multiple procedure discount applies to the associated APC. This discounting of the offset is applied in 2002 to bills subject to multiple procedure discounting that also include devices eligible for pass-through payment.

The significant number of device categories that are expiring in 2003 combined with our proposal to package 100 percent of device costs into their associated APCs has prompted us to revisit the current policy of reducing offsets for pass-through devices in instances when multiple procedure discounts are applied to procedures

associated with pass-through device categories. In order to determine the impact of multiple procedure discounting on APCs with full packaging of device costs, we reviewed the median costs of all APCs after incorporation of device costs and arrayed them in order of descending median cost. We also determined the contribution (in absolute dollars and as a percentage) of device costs to the median costs of each APC.

We then determined which APCs containing devices would be billed together. We next determined, based on median cost data, which device containing APCs would be subject to the 50 percent multiple procedure reduction. After identifying these APCs, we applied a 50 percent reduction to arrive at a discounted payment amount. We then reviewed the contribution of device costs to the discounted APC both as a percentage and in absolute dollars to determine if applying the 50 percent reduction would result in underpayment for the service. We determined that the reduced payment was adequate to pay both for the devices incorporated into the APC and for the procedure cost in the context of performing multiple procedures. We obtained the same results even when we overstated device costs in our model by 5 or 10 percent to offset concerns expressed by some manufacturers and physicians that hospital charges for transitional pass-through devices may be understated.

We noted that almost all APCs with high device costs (such as insertion of pacemakers, insertion of cardioverter-defibrillators, insertion of infusion pumps and neurostimulator electrodes) would never be subject to a multiple procedure discount. They have the highest relative weights in the OPPS, and we would not expect these procedures to be performed during the same operative session with a higher paying procedure with status indicator ''T.'' Therefore, we proposed to continue our current policy of multiple procedure discounting. That is, when two or more APCS with status indicator ''T'' are billed together we proposed to pay 100 percent for the highest cost APC and 50 percent for all other APCs with status indicator ''T.'' We proposed not to adjust these payments to account for device costs in the APCs.

We received a large number of comments on this proposal, which are summarized below:

*Comment:* Many commenters asked that the status indicator be changed from ''T'' to ''S'' for APCs for which a large amount of the cost of the APC is cost for a device that is packaged into the APC. They said that it is not appropriate to apply the multiple procedure discount that is applied to services with status indicator ''T'' to APCs for which the cost of a device is the majority of the cost of the APC because there is no efficiency in the provision of multiple devices. They said that the multiple procedure discount should only apply to the nondevice portion of the APC payment.

*Response:* We reviewed the data for combinations of APCs billed on the same claim and determined that it would not be typical for an APC, which is predominantly device cost, to be the second or subsequent APC on the same claim. Hence, it would not be typical that the predominantly device APC would be reduced (because a predominantly device APC would generally be the highest cost APC on the claim).

In the case of APC 225, however, we did change the status indicator to ''S'' because we were convinced that it must be performed when APC 222 also performed and that, therefore, a status indicator of ''T'' would not result in appropriate payment for 225.

*Comment:* A number of commenters took issue with our claim that almost all APCs with high device costs (such as insertion of pacemakers, insertion of cardioverter-defibrillators, insertion of infusion pumps, and neurostimulator electrodes) would never be subject to a multiple procedure discount. They asserted that some high cost APCs do incur multiple procedure discounting. The example most provided is the implantation of a neurostimulator (APC 0222) with neurostimulator electrodes or leads (APC 0225). They said that the multiple procedure discount along with proposed payment cuts to these APCs even more significantly impact the payment of these services and warrant extensive review, analysis, and consideration of outside data. They also recommended that we change the status indicators for these procedures to ''S'' (significant procedure), which are not reduced when performed as a multiple procedure in the same session. Other examples cited were: bilateral neurostimulator implants for patients with Parkinson's disease (APC 0222) and implantation of a spinal infusion pump, which involves implantation of a catheter (APC 0223) and infusion pump (APC 0227) and dual implantation of an artificial urinary sphincter and a penile prosthesis in prostate cancer survivors. One commenter recommended that all device-related APCs have a status indicator of ''S'' to reflect significant resources.

*Response:* We continue to believe that most procedures with significant device costs packaged in will, if provided on the same day and billed in conjunction with another procedure, be the most expensive procedure on the claim and thus not subject to discounting. We are concerned that, if we were to discontinue our policy of reducing payment for multiple procedures, we would overpay some lower valued procedures. We received many thoughtful comments on the multiple procedure discounting of certain APCs and we intend to take these comments under advisement and study this issue further.

*Comment:* One commenter objected to our proposal to stop applying the 50 percent discount to offsets to pass-through payments when there are multiple procedures involving a claim of a pass-through device also.

*Response:* As discussed above, the discount to offsets to pass-through payments will become a much less significant aspect beginning January 1, 2003, when we will retire 95 of 97 existing categories and add a limited number of new categories.

*F. Outpatient Billing for Dialysis*

Currently, Medicare does not pay for dialysis treatments furnished to End-Stage Renal Disease (ESRD) patients on an outpatient basis, unless the hospital also has a certified hospital-based ESRD facility. As a result of this policy, ESRD patients in need of emergency dialysis have been admitted to the hospital. These admissions have been found to be inappropriate by the Quality Improvement Organizations, and payment has been denied.

When ESRD patients come to the hospital for a medical emergency or for problems with their access sites, they typically miss their regularly scheduled dialysis appointments. If the ESRD patient's usual facility is unable to reschedule the dialysis treatment, the ESRD patient has to wait until the next scheduled dialysis appointment. We are concerned that by maintaining this policy, ESRD patients may be receiving interrupted care because there will be unnecessary lapses in treatment. The ESRD patient should not be prevented from receiving her or his normal dialysis because he or she experienced another unrelated medical situation. Therefore, we proposed to allow payment for dialysis treatments for ESRD patients in the outpatient department of a hospital in specific situations. Payment would be limited to unscheduled dialysis for ESRD patients in exceptional circumstances. Outpatient dialysis for acute patients

would not be included in this payment mechanism.

In certain instances, it is appropriate to dialyze ESRD patients on an outpatient basis. We proposed to allow payment for these nonroutine dialysis treatments in medical situations in which the ESRD patient cannot obtain her or his regularly scheduled dialysis treatment at a certified ESRD facility. The circumstances in which we proposed to allow payment are limited to:

- Dialysis performed following or in connection with a vascular access procedure;
- Dialysis performed following treatment for an unrelated medical emergency; for example, if a patient goes to the emergency room for chest pains and misses a regularly scheduled dialysis treatment that cannot be rescheduled, we would allow the hospital to provide and bill Medicare for the dialysis treatment; and
- Emergency dialysis—Currently, the only mechanism available for payment in this situation is through an inpatient admission. We will maintain our policy that routine treatments in non-ESRD certified hospitals would not be payable under OPPS.

We believe it is important to make this change in the policy for two reasons:

- To ensure that hospital outpatient departments are paid for providing this much needed service; and
- To prevent dialysis patients from receiving interrupted care. Non-ESRD certified hospital outpatient facilities would bill Medicare using a new G code, G0GGG, ''Unscheduled or emergency treatment for dialysis for ESRD patient in the outpatient department of a hospital that does not have a certified ESRD facility.'' We proposed that this new code will have status indicator ''S'' and be assigned to APC 0170. Payment would be roughly equivalent to the reimbursement rate for acute dialysis. We proposed to implement this change effective January 1, 2003. Effective January 1, 2003, this would be the only way for non-ESRD certified hospital outpatient facilities to bill Medicare and be paid for providing nonroutine outpatient dialysis to ESRD patients.

We will be monitoring the use of this new code to ensure the following:

- Certified dialysis facilities are not incorrectly using this code.
- The same dialysis patient is not repeatedly using this code, which would indicate routine dialysis treatment.

When ESRD patients receive outpatient dialysis in non-ESRD certified hospital outpatient facilities, the patient's home facility would be responsible for obtaining and reviewing the patient's medical records to ensure that appropriate care was provided in the hospital and that modifications are made, if necessary, to the patient's plan of care upon her or his return to the facility. This ensures continuity of care for the patient.

We received eight comments on our proposal to allow payment for dialysis treatments for ESRD patients in the outpatient department of a hospital. Although all of the comments support our proposed changes, some commenters asked for clarification on issues pertaining to this provision.

*Comment:* One commenter requested that we provide clarification on how the payment rate would be determined for this service.

*Response:* In the August 9, 2002 proposed rule, we provided the payment rate for providing dialysis treatments for ESRD patients in the outpatient department of a hospital. The proposed rule stated that this service would be assigned Ambulatory Payment Classification (APC) 0170, and Addendum A provides the payment rate for this APC. Effective January 1, 2003, the payment national unadjusted rate for this service will be $252.16.

*Comment:* One commenter wanted clarification on how services typically associated with outpatient dialysis such as covered pharmaceuticals and laboratory testing will be accounted for under the proposed policy.

*Response:* We would pay separately for laboratory tests based on the laboratory fee schedule. Drugs may or may not be paid separately from the payment for the dialysis treatment. The drugs that would be paid separately would have a separate APC. If there is not a separate APC, then the drugs would be packaged into the APC paid for the dialysis treatment.

*Comment:* One commenter expressed concern that the proposal to require the ESRD patient's home facility to obtain and review the patient's medical records from the hospital would create an additional information collection burden for dialysis facilities. The commenter requested that we include language in the final rule that specifically outlines the hospital's responsibilities in providing the patient's medical records to the home facility.

*Response:* There should be a regular exchange of information between a patient's home facility and any treating facilities to verify the care that has been provided and to ensure that patients are not receiving inappropriate or incorrect treatment. The dialysis facility is, however, ultimately responsible for effectively coordinating the care of its patients, including the inclusion of all information in the patient's medical record, and we believe obtaining and reviewing information from other treating facilities is part of this responsibility. The medical record indicates what care has actually been provided, and it also provides the data for evaluation and documentation of the quality and appropriateness of the care delivered. We believe subsequent dialysis treatment at the patient's home facility should not be provided without information from another treatment facility because the home facility may need to make adjustments to the plan of care when the patient returns to the facility, so the facility should obtain this information from the hospital to implement any new strategies, etc. Furthermore, since dialysis facilities should already be collecting medical records for home dialysis patients and for traveling patients, we do not view this as an additional information collection burden. We view this as a responsibility within the facilities scope of practice.

*Comment:* One commenter cautioned us about the potential for abuse with this proposal and recommended that we develop clear guidelines governing the use of this new code.

*Response:* We agree with the commenter, and we plan to issue instructions for the use of the code as well as develop code edits to monitor the use of this code to prevent potential fraud and abuse. The instructions will be issued at a later date.

*Comment:* Another commenter requested clarification of the word ''routine,'' and what criteria that we will apply to establish whether a patient is receiving ''routine'' dialysis treatment. The commenter also requested documentation requirements (for example, diagnoses, other procedures, etc.) for meeting these ''exceptional circumstances'' defined in the August 9, 2002 proposed rule.

*Response:* We define ''routine'' dialysis as the three times per week maintenance treatment the same patient would normally receive at his or her home facility. We would consider a patient to be receiving routine dialysis if the claims received from the outpatient department indicated that the same patient received dialysis treatment more than once a week in this setting.

The August 9, 2002 proposed rule states that we would allow payment for this unscheduled dialysis under exceptional circumstances, and these circumstances would be (1) dialysis

performed following or in connection with a vascular access procedure; (2) dialysis performed following treatment for an unrelated medical emergency; and (3) emergency dialysis. These are the only situations in which payment would be made for dialysis provided in the outpatient department of a hospital without a certified dialysis facility. As stated above, we plan on issuing instructions governing the specific use of this code at a later date.

*Comment:* The commenter requested clarification as to whether an emergency department that is part of a larger hospital that contains a certified dialysis unit is already considered an ESRD certified location. Specifically, is this proposed payment change only for those providers that do not have a certified dialysis unit on their premises, making them a non-ESRD certified outpatient facility? If the answer is yes, then would the emergency department that is part of the hospital that has an ESRD-certified location bill the new dialysis G code if dialysis is given on an emergency basis while the ESRD certified location is closed?

*Response:* The proposed G code is specifically designated for an outpatient department of a hospital that does not have a certified ESRD facility. Therefore, a hospital's emergency department cannot use the code just because the certified dialysis facility is closed. The basis for this decision is to prevent potential fraud and abuse. We do not want dialysis facilities to use this as a means of circumventing the current requirements to receive a higher reimbursement rate for providing dialysis treatment. As stated above, we plan on issuing instructions governing the specific use of this code at a later date.

**XI. Summary and Responses of Public Comments to CMS's Response to MedPAC Recommendations**

In the August 9, 2002 proposed rule, we responded to the Medicare Payment Advisory Commission (MedPAC) March 2002 Report to the Congress: ''Medicare Payment Policy,'' recommendations relating to the OPPS (67 FR 52141 through 52143). We received no comments on our responses to MedPAC's recommendations. Therefore, we will not discuss that response further here. We did receive comments from MedPAC on other issues in the proposed rule. For convenience we group those comments and our responses here:

*Comment:* MedPAC endorsed our proposal to create APCs for procedures involving drug-eluting stents and noted, ''This step illustrates that CMS can respond rapidly to ensure adequate payment for technologies that are thought to be of a breakthrough nature.'' The Commission noted that our reliance on data from other countries to set the payment rate for this new technology appeared adequate in this instance. However, it expressed some reservation about the long-term issues that might attend more general use of such data. MedPAC has begun to consider these issues in more depth and urges us to do so as well.

*Response:* We appreciate the Commission's views. We have adopted our proposal for drug-eluting stents, including our method of setting the payment rate. We will give further consideration to the issues involved in use of foreign data.

*Comment:* MedPAC discussed the possibility that a pro rata reduction to payments for transitional pass-through drugs and devices would be needed this year, though we had not reached a conclusion on this question in the August 9, 2002 proposed rule. The Commission commented that even if a modest pro rata reduction is needed, it does not anticipate serious consequences for access to new technology services for several reasons. First, the methods for calculating transitional pass-through payments may overcompensate for these services. Second, hospitals are still likely to use these items to improve care and maintain reputations for excellence. Third, little evidence is available that indicates access problems resulting from the large pro rata reduction in 2002. Fourth, asking hospitals to share in the costs of new technologies gives them incentives to assess their value before adopting them.

*Response:* We have concluded that no pro rata reduction will be necessary for 2003. We appreciate and agree with the Commission's analysis of the possible effects of a pro rata reduction.

*Comment:* Regarding payment for medical devices no longer eligible for transitional pass-through payments, MedPAC urged us to work with stakeholders in instances where creditable evidence is available that coding issues may have led to inaccurate payment rates. The Commission does not believe that an extension of transitional pass-through eligibility is warranted or that data other than hospital cost data should be used where reliable hospital cost data are available. It also urged us to monitor beneficiary access to procedures that include such devices if payments are cut significantly.

*Response:* We agree that extension of transitional pass-through eligibility is not warranted, and we do not believe that the statute contemplates that it could be continued. We also agree that stakeholders may have valuable input, and as we describe elsewhere in this final rule, we have received a great deal of helpful information that has informed the policies adopted in this rule designed to moderate payment reductions that may be associated with use of devices (and of drugs) previously in transitional pass-through status. We also agree that monitoring access by beneficiaries to these procedures is important, and we expect to do so to the extent feasible.

*Comment:* MedPAC expressed concern that our proposal to pay separately for high-cost drugs but not for other drugs has the potential to distort the payment system. Where drugs may substitute for one another, hospitals may face incentives to use those paid separately. The Commission urged us to limit the amount of time this policy is followed and to work to move more drugs into the procedure APCs.

*Response:* We agree that this policy may have distorting effects on incentives, and we do not intend to use it longer than necessary. In future years, we hope to propose additional changes to this policy, and in particular to package drugs into procedure APCs where this approach appears reasonable. We hope further improvements in our data and further attention to the structure of APCs involving the use of drugs, such as those for infusion and injection, will provide the foundation for future policy development in this area.

*Comment:* MedPAC commented that hospital cost data are preferable to AWPs set by manufacturers. The Commission indicated the need to give careful consideration to stakeholder comments on payment for drugs and the importance of monitoring beneficiary access.

*Response:* We agree.

*Comment:* MedPAC commented that the reductions in payments for drugs that may no longer be eligible for transitional pass-through payments based on 95 percent of average wholesale price (AWP) will result in lower payments for these drugs than in other settings, such as physicians' offices. These differences may lead to shifts in the site of care based on financial considerations. MedPAC commented that this effect is not sufficient reason to change payments for these drugs in the hospital outpatient setting, but that it indicates the need for a new approach to paying for Part B drugs.

*Response:* The possibility of inappropriate shifts in site of service is a source of concern. We note, however, that payment rates for these drugs only shifted to 95 percent of AWP at the inception of the OPPS; before that time, Medicare paid for drugs in outpatient departments at reasonable cost, subject to statutory reductions. Medicare payment for drugs in physicians' offices has been set at 95 percent of AWP throughout this period. It is not clear that the increase in drug payments in outpatient departments from August 2000 to the present has led to substantial shifts in site of service, and the response to the forthcoming reductions may be muted as well. Nonetheless, we believe that Medicare should attempt to align payments across settings to the greatest extent possible in order to avoid inappropriate incentives to shift the site of service. In particular, we agree that a new approach to paying for Part B drugs would be desirable.

*Comment:* MedPAC noted that we have the statutory authority to modify updates to correct for unnecessary increases in the volume of services or for ''upcoding'' by hospitals. The Commission urged us to carefully track the volume of services and increases in coding intensity.

*Response:* We have not proposed any adjustment to the update for either of these reasons, and we will not adopt any such adjustment for 2003. We continue to monitor the progress of the OPPS system to discern whether we should make any such adjustment in the future.

*Comment:* MedPAC noted that small rural hospitals will continue to be held harmless for losses under the OPPS in 2003. The Commission urged us to study the performance of small rural hospitals and evaluate the impact of the end of their hold-harmless status.

*Response:* We agree that small rural hospitals warrant special attention. We expect to study the effect of the transitional corridor provision, including the protection it affords these hospitals, in the period since the implementation of the OPPS so that we can help evaluate what provision would be appropriate for 2004 and beyond.

## XII. Provisions of the Final Rule With Comment for 2003

### *A. OPPS*

The provisions of this final rule with comment restate changes to the Medicare hospital OPPS and CY 2003 payment rates including changes used to determine these payment rates set forth in the August 9, 2002 proposed rule, except as noted elsewhere in the preamble. The following is a highlight of provisions implemented in this final rule, which are discussed in detail above.

1. Statutory and Discretionary Changes

- We revised the methodology for calculating relative weights to dampen the difference in the median costs for all APCs for which the median costs fell more than 15 percent from 2002 to 2003; used only claims on which devices were reported to set the median for APCs for which the device was either essential or frequently used in the procedures in the APC; split some APCs for which devices were an issue to achieve more accurate pricing; limited the reduction in median costs for blood and certain blood products to 11 percent, which limited the reduction in payment from 2002 to 2003 to about 15 percent; used acquisition costs from external sources as a factor together with claims data in setting adjusted medians for four APCs.
- We reviewed and revised the composition of APCs to comply with the limitation on variation in procedure medians and to achieve more accurate reflections of the costs.
- We removed from pass-through status those drugs and devices that will have been on pass-through status for at least 2 years on January 1, 2003. We packaged the costs of the expiring devices into the payments for the APCs with which the devices were billed. We packaged the costs of the expiring drugs into the APCs with which the drugs were billed if the per encounter drug cost was less than $150; we established APCs for those drugs for which the per encounter drug cost was more than $150 and for blood and certain blood products. We paid for influenza and pneumococcal pneumonia vaccines and orphan drugs on a reasonable cost basis.
- We estimated the amount of payment that would be made under the pass through provisions and compared it to 2.5 percent of the projected program expenditures; we determined that no pro rata reduction would be needed for 2003, and we adjusted the conversion factor accordingly.
- We established the percentages by which pass-through devices would be reduced to remove the part of the payment that is packaged into the APC when it is billed with the device.
- We finalized the regulations that describe the criteria that must be met for a device to get a pass-through code.
- We issued the 2003 wage index and conversion factor that would be applied to the relative weights to determine the amount of payment for a particular hospital.

2. Changes to the Regulations Text

- We amended § 419.21(d)(3) to delete influenza and pneumococcal pneumonia vaccines from the list of items that are paid to CORFs, HHAs, and hospices under OPPS.
- We amended § 419.66(c)(1) to specify that we must establish a new category for a medical device if it is not described by any category previously in effect as well as an existing category. We received no comments concerning this technical correction to our regulations text. We are making this proposal final in this final rule.

### *B. Payment Suspension for Unfiled Cost Reports*

We are adopting the provisions set forth in the proposed rule without change.

### *C. Partial Hospitalization Services*

In the August 9, 2002 proposed rule, we indicated we would be addressing comments received on our proposal to establish a new payment amount for partial hospitalization services and remove clinical social worker services from the partial hospitalization benefit. Upon further review we have determined that we will not include this issue in this final rule, but will address it in future rulemaking.

### *D. Pneumococcal and Influenza Vaccines*

Section 419.21(d)(3) states that ''Pneumococcal vaccine, influenza vaccine, and hepatitis B vaccine'' are paid under the OPPS for comprehensive outpatient rehabilitation facilities, home health agencies, and hospices. There is no specific inclusion of hospitals, but we have paid hospitals for them under the OPPS since the OPPS began. We are removing the pneumococcal vaccine and influenza vaccine from this paragraph and want to pay for it under reasonable cost. We are requesting public comment on this change.

## XIII. Response to Public Comments

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

**XIV. Collection of Information Requirements**

This rule does 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. Regulatory Impact Analysis**

The regulatory impact analysis for this final rule consists of an impact analysis for the OPPS provisions and a regulatory impact statement for the provision for payment suspension for unfiled cost reports.

*A. OPPS*

1. General

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We estimate the effects of the provisions that 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 2003 compared to CY 2002 to be approximately $1.372 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 would be considered to be small entities according to the SBA size standards. For the pharmaceutical preparation manufacturing industry (NAICS 325412), the size standard is 750 or fewer employees and $67.6 billion in annual sales (1997 business census). For biological products (except diagnostic) (NAICS 325414), with $5.7 billion in annual sales, and medical instruments (NAICS 339112), with $18.5 billion in annual sales, the standard is 50 or fewer employees (see the standards Web site at *http://www.sba.gov/regulations/siccodes/*). Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital 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 has a significant impact on a substantial number of small entities. However, the statute provides for small rural hospitals (of fewer than 100 beds) to be held harmless by the law and to continue to be paid at cost; therefore this final rule has no impact on them.

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 imposes no unfunded mandates on the private sector.

Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined this 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 10) shows that payments to governmental hospitals (including State, local, and tribal governmental hospitals) will increase by 5 percent under the final rule.

2. 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, 2003 as we discuss in sections VIII and VI, respectively, of this preamble. We are also revising the relative APC payment weights based on claims data from January 1, 2001 through December 31, 2001. Finally, we are removing 95 devices and more than 200 drugs and biologicals from pass-through payment status.

Under this final rule, the change to the conversion factor as provided by statute will increase total OPPS payments by 3.7 percent in 2003. The changes to the wage index and to the APC weights (which incorporate the cessation of pass-through payments for many drugs and devices) do not increase OPPS payments because the OPPS is budget neutral. However, the

wage index and APC weight changes do change the distribution of payments within the budget neutral system as shown in Table 10 and described in more detail in this section.

Alternatives Considered

Alternatives to the changes we are making and the reasons that we are choosing not to make them are discussed throughout this final rule. Below we discuss options we considered when analyzing methodologies to appropriately recognize the costs of former pass-through items. For a more detailed discussion, see section IV.C regarding the expiration of pass-through payment for devices and section IV.D regarding the expiration of pass-through payment for drugs and biologicals.

Payment for Categories of Devices

We considered establishing separate APCs for categories of devices and paying for them separately. We are not choosing this option because we believe that to the extent possible, hospital payment for procedures and visits should include all of the costs required to provide the procedures and visits.

A second option we considered involved (1) packaging some categories of devices into the procedures with which they were billed in 2001 and (2) paying the rest through separate APCs (as discussed in section IV of this final rule.). We are not choosing this option because we believe that devices are routinely used in the services for which they are needed and therefore are consistently paid at the cost of providing the service. Furthermore, criteria that will provide a basis for some devices to be packaged and for others to be paid separately must be developed and approved, thereby further complicating an already complex payment system.

Payment for Drugs and Biologicals

We considered continuing to make separate payment for all drugs and biologicals through separate APCs. We are not choosing to pay separately for all drugs through separate APCs because we believe that, to the extent possible, hospital payment for services should include all of the costs of the services. We believe that drugs should be packaged with the services in which they are furnished except when we determine that there is a valid reason to do otherwise. However, we recognize that (unlike the stability that exists with device usage with the applicable procedures) the use of drugs may vary widely depending upon patient and disease characteristics. Therefore, packaging payment for all drugs may, in some cases, provide inadequate payment for the services furnished. Where a hospital has a disproportionate share of patients who need greater amounts of expensive drugs, underpayment for the drugs needed by these patients could result in cessation of needed services. For the first year that we are ceasing transitional pass-through payment for drugs, we decided to proceed cautiously by paying separately for drugs when the cost per encounter was more than $150 or when special characteristics existed (for example, orphan drugs, blood products).

We also considered packaging the costs of all drugs into the cost of the associated procedures with which they were billed in 2001. We did not package all payment for drugs into the payment for the procedures because, while this packaging is ultimately our goal, we believe, for the reasons indicated above, that we need to proceed cautiously to ensure that we do not inadvertently threaten access to needed care.

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 2003 will have, overall, a positive effect for every category of hospital with the exception of children's hospitals, which are held harmless under the OPPS. These changes in the OPPS for 2003 will result in an overall 3.7 percent increase in Medicare payments to hospitals, exclusive of outlier and transitional pass-through payments and transitional corridor payments. As described in the preamble, budget neutrality adjustments are made to the conversion factor and the weights to ensure that the revisions in the wage index, APC groups, and relative weights do not affect aggregate payments. The impact of the wage and recalibration changes does vary somewhat by hospital group. Estimates of these impacts are displayed on Table 10.

The overall projected increase in payments for urban hospitals is slightly lower (3.1 percent) than the average increase for all hospitals (3.7 percent) while the increase for rural hospitals is significantly greater (6.2 percent) than the average increase. Rural hospitals gain 2.2 percent from the wage index change, and also gain 0.1 percent from APC changes. A discussion of the distribution of outlier payments that we project under this final rule can be found under section XV.A.4 below. Table 11 presents the outlier distribution that we expect to see under this final rule.

3. Limitations of Our Analysis

The distributional impacts represent the projected effects of the policy changes, as well as statutory changes effective for 2003, 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.

4. 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 redistributive effects of the wage index and APC changes. In some cases, under this final rule, hospitals will receive more total payment than in 2002 while in other cases they will receive less total payment than they received in 2002. 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 12 represents the full impact on each hospital group of all the changes for 2003. Columns 2 and 3 in the table reflect the independent effects of the 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 2003 OPPS rates that is summarized in Table 12. For that reason, the total number of hospitals included in Table 10 (4,551) is lower than in previous years. CAHs are excluded from the OPPS.

In general, the wage index changes favor rural hospitals, particularly the largest in bed size and volume. The only rural hospitals that will experience a negative impact due to wage index changes are those in Puerto Rico, a decrease of 3.2 percent. Conversely, the urban hospitals are generally negatively

affected by wage index changes, with the largest decreases occurring in those with 300 to 499 beds (−0.7 percent) and those in the Middle Atlantic (−1.0 percent), Pacific (−1.2 percent), and Puerto Rico Regions (−1.6 percent). 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 and have a negative effect on urban hospitals in excess of 200 beds. Specifically, urban hospitals with 300 to 499 beds (−0.6 percent decrease) and urban hospitals in excess of 500 beds (a −0.8 percent decrease) all show a decrease attributed to APC recalibration. However, this decrease is much less than what would have occurred under the proposed rule.

In urban 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 higher volumes are expected to receive higher increases in payments. In rural areas, hospitals with volumes greater than 42,999 services are projected to experience a significant increase in payments (7.7 percent). The less favorable impact for the high volume urban hospitals is attributable to both wage index and APC changes. For example, urban hospitals providing more than 42,999 services are projected to gain a combined 2.8 percent due to these changes.

Major teaching hospitals are projected to experience a smaller increase in payments (2.7 percent) than the aggregate for all hospitals (3.7 percent) due to negative impacts of the wage index (−0.3 percent) and recalibration (−0.8 percent). Hospitals with less intensive teaching programs are projected to experience an overall increase (3.2 percent) that is smaller than the average for all hospitals.

TABLE 12.—IMPACT OF CHANGES FOR CY 2003 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

[Percent change in total payments to hospitals (program and beneficiary); does not include hold harmless, corridor, outlier or transitional pass-through payments]

| | Number of Hospitals[1] (1) | New Wage Index[2] (2) | APC Changes[3] (3) | All CY 2003 Changes[4] (4) |
|---|---|---|---|---|
| ALL HOSPITALS | 4,519 | 0 | 0 | 3.7 |
| NON-TEFRA HOSPITALS | 3,989 | 0 | −0.1 | 3.6 |
| URBAN HOSPS | 2,420 | −0.5 | −0.1 | 3.1 |
| LARGE URBAN (GT 1 MILL.) | 1,397 | −0.6 | −0.1 | 3.1 |
| OTHER URBAN (LE 1 MILL.) | 1,023 | −0.5 | −0.1 | 3.1 |
| RURAL HOSPS | 1,569 | 2.2 | 0.1 | 6.2 |
| BEDS (URBAN): | | | | |
| 0–99 BEDS | 550 | −0.4 | 0.7 | 4.0 |
| 100–199 BEDS | 877 | −0.6 | 0.6 | 3.7 |
| 200–299 BEDS | 488 | −0.6 | 0.1 | 3.3 |
| 300–499 BEDS | 364 | −0.7 | −0.6 | 2.4 |
| 500+ BEDS | 141 | −0.1 | −0.8 | 2.8 |
| BEDS (RURAL): | | | | |
| 0–49 BEDS | 752 | 0.2 | 0 | 4.0 |
| 50–99 BEDS | 478 | 1.4 | −0.3 | 4.9 |
| 100–149 BEDS | 200 | 2.4 | 0.3 | 6.6 |
| 150–199 BEDS | 73 | 5.4 | −0.5 | 8.9 |
| 200+ BEDS | 66 | 3.1 | 0.8 | 8.0 |
| VOLUME (URBAN): | | | | |
| LT 5,000 | 182 | 0.9 | 3.4 | 8.0 |
| 5,000–10,999 | 293 | −0.8 | 2.2 | 5.2 |
| 11,000–20,999 | 476 | −0.7 | 1.1 | 4.2 |
| 21,000–42,999 | 667 | −0.7 | 0.2 | 3.2 |
| GT 42,999 | 802 | −0.5 | −0.4 | 2.8 |
| VOLUME (RURAL): | | | | |
| LT 5,000 | 334 | 0 | 1.1 | 4.9 |
| 5,000–10,999 | 419 | 0.3 | 1.2 | 5.4 |
| 11,000–20,999 | 387 | 1.2 | 0 | 5.0 |
| 21,000–42,999 | 295 | 1.9 | 0 | 5.8 |
| GT 42,999 | 134 | 4.1 | −0.3 | 7.7 |
| REGION (URBAN): | | | | |
| NEW ENGLAND | 127 | −0.6 | 0.4 | 3.4 |
| MIDDLE ATLANTIC | 372 | −1 | 0.1 | 2.7 |
| SOUTH ATLANTIC | 367 | −0.3 | 0.5 | 3.9 |
| EAST NORTH CENT. | 411 | −0.7 | −0.9 | 2.1 |
| EAST SOUTH CENT. | 153 | −0.8 | −0.1 | 2.8 |
| WEST NORTH CENT. | 170 | −0.6 | −1.1 | 2.0 |
| WEST SOUTH CENT. | 292 | 1 | 0 | 4.8 |
| MOUNTAIN | 122 | 0.2 | −0.8 | 3.0 |
| PACIFIC | 367 | −1.2 | 0.8 | 3.3 |
| PUERTO RICO | 39 | −1.6 | 2.1 | 4.1 |
| REGION (RURAL): | | | | |
| NEW ENGLAND | 40 | 1.7 | −0.2 | 5.3 |
| MIDDLE ATLANTIC | 63 | 1.9 | −0.5 | 5.3 |
| SOUTH ATLANTIC | 224 | 2.4 | 0.9 | 7.2 |
| EAST NORTH CENT. | 212 | 1.1 | −1.7 | 3.2 |
| EAST SOUTH CENT. | 232 | 2.2 | 1.2 | 7.3 |
| WEST NORTH CENT. | 271 | 1.8 | −0.6 | 5.0 |

TABLE 12.—IMPACT OF CHANGES FOR CY 2003 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent change in total payments to hospitals (program and beneficiary); does not include hold harmless, corridor, outlier or transitional pass-through payments]

| | Number of Hospitals[1] (1) | New Wage Index[2] (2) | APC Changes[3] (3) | All CY 2003 Changes[4] (4) |
|---|---|---|---|---|
| WEST SOUTH CENT. | 278 | 1.9 | 1.4 | 7.2 |
| MOUNTAIN | 141 | 4.6 | −0.6 | 7.9 |
| PACIFIC | 103 | 4.9 | 1 | 10.0 |
| PUERTO RICO | 5 | −3.2 | 7.2 | 7.6 |
| TEACHING STATUS: | | | | |
| NON-TEACHING | 2,922 | 0.3 | 0.3 | 4.4 |
| MINOR | 782 | −0.3 | −0.2 | 3.2 |
| MAJOR | 284 | −0.3 | −0.8 | 2.7 |
| DSH PATIENT PERCENT: | | | | |
| 0 | 11 | 5.3 | 5.5 | 15.3 |
| GT 0–0.10 | 975 | −0.2 | −0.6 | 2.9 |
| 0.10–0.16 | 872 | 0.6 | −0.6 | 3.7 |
| 0.16–0.23 | 766 | −0.6 | 0 | 3.1 |
| 0.23–0.35 | 755 | −0.1 | 0.4 | 4.1 |
| GE 0.35 | 610 | 0.1 | 1.6 | 5.5 |
| URBAN IME/DSH: | | | | |
| IME & DSH | 982 | −0.6 | −0.4 | 2.7 |
| IME/NO DSH | 0 | 0 | 0 | 0.0 |
| NO IME/DSH | 1,432 | −0.5 | 0.4 | 3.6 |
| NO IME/NO DSH | 6 | 6.1 | 5.1 | 15.7 |
| RURAL HOSP. TYPES: | | | | |
| NO SPECIAL STATUS | 607 | 0.5 | 0.3 | 4.6 |
| RRC | 167 | 4.2 | 0.2 | 8.4 |
| SCH/EACH | 507 | 1.4 | −0.1 | 5.1 |
| MDH | 199 | 0.5 | −0.7 | 3.6 |
| SCH AND RRC | 75 | 3.8 | 0.1 | 7.9 |
| TYPE OF OWNERSHIP: | | | | |
| VOLUNTARY | 2,434 | −0.1 | −0.2 | 3.5 |
| PROPRIETARY | 703 | −0.5 | 0.5 | 3.7 |
| GOVERNMENT | 852 | 0.6 | 0 | 4.4 |
| SPECIALTY HOSPITALS: | | | | |
| EYE AND EAR | 13 | −1.3 | 9.1 | 11.7 |
| TRAUMA | 153 | −0.3 | −0.6 | 2.9 |
| CANCER | 10 | 1 | −4.5 | 0.4 |
| TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES): | | | | |
| REHAB | 163 | 10.1 | 0.8 | 14.7 |
| PSYCH | 191 | 0 | 7.4 | 11.4 |
| LTC | 135 | 4.3 | 15.1 | 23.0 |
| CHILDREN | 41 | −1.4 | −1 | 1.3 |

[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 2003 hospital inpatient wage index after geographic reclassification by the Medicare Geographic Classification Review Board. The hospital inpatient final rule for FY 2003 was published in the **Federal Register** on May 9, 2002.

[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 2001 hospital claims data.

[4] This column shows changes in total payment from CY 2002 to CY 2003, 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 2003 payment update. The sum of the columns may be different from the percentage changes shown here due to rounding.

**Note:** For CY 2003, under the OPPS transitional corridor policy, the following categories of hospitals are held harmless compared to their 1996 payment margin for these services: cancer and children's hospitals and rural hospitals with 100 or fewer beds.

As stated elsewhere in this preamble, we have allocated 2 percent of the estimated 2003 expenditures to outlier payments. In Table 13 below, we provide a distribution by percentage of the total projected outlier payments for the categories of hospitals that we show in the impact table (Table 10).

We project, based on the mix of services for the hospitals that will be paid under the OPPS in 2003, that most hospitals will receive outlier payments.

The anticipated outlier payments for urban hospitals can be expected to ameliorate the impact of the wage index and APC changes on payments to urban hospitals.

TABLE 13.—DISTRIBUTION OF OUTLIER PAYMENTS FOR CY 2003 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

| | Number of Hospitals | Percent of Total Hospitals | Number of Hospitals with Outliers | Percent of Total Outlier Payments |
|---|---|---|---|---|
| ALL HOSPITALS | 4,519 | 100.00 | 4,298 | 100.00 |
| NON-TEFRA HOSPITALS | 3,989 | 88.20 | 3,977 | 99.40 |
| URBAN HOSPS | 2,420 | 53.60 | 2,413 | 83.20 |
| LARGE URBAN (GT 1 MILL.) | 1,397 | 31.00 | 1,394 | 56.00 |
| OTHER URBAN (LE 1 MILL.) | 1,023 | 22.60 | 1,019 | 27.20 |
| RURAL HOSPS | 1,569 | 34.80 | 1,564 | 16.20 |
| BEDS (URBAN): | | | | |
| 0–99 BEDS | 550 | 12.20 | 545 | 7.20 |
| 100–199 BEDS | 877 | 19.40 | 875 | 18.20 |
| 200–299 BEDS | 488 | 10.80 | 488 | 16.80 |
| 300–499 BEDS | 364 | 8.00 | 364 | 21.00 |
| 500 + BEDS | 141 | 3.20 | 141 | 19.80 |
| BEDS (RURAL): | | | | |
| 0–49 BEDS | 752 | 16.60 | 749 | 4.40 |
| 50–99 BEDS | 478 | 10.60 | 477 | 5.00 |
| 100–149 BEDS | 200 | 4.40 | 199 | 2.40 |
| 150–199 BEDS | 73 | 1.60 | 73 | 2.00 |
| 200 + BEDS | 66 | 1.40 | 66 | 2.20 |
| VOLUME (URBAN): | | | | |
| LT 5,000 | 182 | 4.00 | 176 | 1.00 |
| 5,000–10,999 | 293 | 6.40 | 292 | 2.80 |
| 11,000–20,999 | 476 | 10.60 | 476 | 6.80 |
| 21,000–42,999 | 667 | 14.80 | 667 | 17.60 |
| GT 42,999 | 802 | 17.80 | 802 | 55.00 |
| VOLUME (RURAL): | | | | |
| LT 5,000 | 334 | 7.40 | 330 | 1.00 |
| 5,000–10,999 | 419 | 9.20 | 418 | 2.40 |
| 11,000–20,999 | 387 | 8.60 | 387 | 4.00 |
| 21,000–42,999 | 295 | 6.60 | 295 | 4.20 |
| GT 42,999 | 134 | 3.00 | 134 | 4.40 |
| REGION (URBAN): | | | | |
| NEW ENGLAND | 127 | 2.80 | 126 | 5.60 |
| MIDDLE ATLANTIC | 372 | 8.20 | 371 | 24.20 |
| SOUTH ATLANTIC | 367 | 8.20 | 366 | 11.40 |
| EAST NORTH CENT | 411 | 9.00 | 408 | 14.80 |
| EAST SOUTH CENT | 153 | 3.40 | 153 | 3.20 |
| WEST NORTH CENT | 170 | 3.80 | 170 | 4.20 |
| WEST SOUTH CENT | 292 | 6.40 | 292 | 8.00 |
| MOUNTAIN | 122 | 2.60 | 122 | 3.00 |
| PACIFIC | 367 | 8.20 | 366 | 8.80 |
| PUERTO RICO | 39 | 0.80 | 39 | 0.00 |
| REGION (RURAL): | | | | |
| NEW ENGLAND | 40 | 0.80 | 40 | 1.00 |
| MIDDLE ATLANTIC | 63 | 1.40 | 63 | 1.00 |
| SOUTH ATLANTIC | 224 | 5.00 | 222 | 3.00 |
| EAST NORTH CENT | 212 | 4.60 | 211 | 3.00 |
| EAST SOUTH CENT | 232 | 5.20 | 232 | 1.60 |
| WEST NORTH CENT | 271 | 6.00 | 270 | 2.40 |
| WEST SOUTH CENT | 278 | 6.20 | 278 | 1.60 |
| MOUNTAIN | 141 | 3.20 | 141 | 1.40 |
| PACIFIC | 103 | 2.20 | 102 | 1.20 |
| PUERTO RICO | 5 | 0.20 | 5 | 0.00 |
| TEACHING STATUS: | | | | |
| NON-TEACHING | 2,922 | 64.60 | 2,910 | 40.40 |
| MINOR | 782 | 17.40 | 782 | 27.00 |
| MAJOR | 284 | 6.20 | 284 | 31.80 |
| DSH PATIENT PERCENT: | | | | |
| 0 | 11 | 0.20 | 11 | 0.00 |
| GT 0–0.10 | 975 | 21.60 | 973 | 24.60 |
| 0.10–0.16 | 872 | 19.20 | 872 | 19.20 |
| 0.16–0.23 | 766 | 17.00 | 764 | 17.60 |
| 0.23–0.35 | 755 | 16.80 | 752 | 19.40 |
| GE 0.35 | 610 | 13.40 | 605 | 18.40 |
| URBAN IME/DSH: | | | | |
| IME & DSH | 982 | 21.80 | 982 | 56.60 |
| IME/NO DSH | 0 | 0.00 | 0 | 0.00 |
| NO IME/DSH | 1,432 | 31.60 | 1,425 | 26.40 |
| NO IME/NO DSH | 6 | 0.20 | 6 | 0.00 |
| RURAL HOSP. TYPES: | | | | |
| NO SPECIAL STATUS | 607 | 13.40 | 605 | 5.00 |

TABLE 13.—DISTRIBUTION OF OUTLIER PAYMENTS FOR CY 2003 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

| | Number of Hospitals | Percent of Total Hospitals | Number of Hospitals with Outliers | Percent of Total Outlier Payments |
|---|---|---|---|---|
| RRC | 167 | 3.60 | 166 | 4.00 |
| SCH/EACH | 507 | 11.20 | 507 | 4.40 |
| MDH | 199 | 4.40 | 198 | 1.20 |
| SCH AND RRC | 75 | 1.60 | 75 | 1.60 |
| TYPE OF OWNERSHIP: | | | | |
| VOLUNTARY | 2,434 | 53.80 | 2,431 | 73.60 |
| PROPRIETARY | 703 | 15.60 | 699 | 10.60 |
| GOVERNMENT | 852 | 18.80 | 847 | 15.20 |
| SPECIALTY HOSPITALS: | | | | |
| EYE AND EAR | 13 | 0.20 | 13 | 0.20 |
| TRAUMA | 153 | 3.40 | 153 | 15.00 |
| CANCER | 10 | 0.20 | 10 | 3.60 |
| TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES): | | | | |
| REHAB | 163 | 3.60 | 115 | 0.20 |
| PSYCH | 191 | 4.20 | 67 | 0.00 |
| LTC | 135 | 3.00 | 99 | 0.20 |
| CHILDREN | 41 | 1.00 | 40 | 0.20 |

5. 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 copayment in 2002 was $9.67; under this final rule, the minimum unadjusted copayment for APC 601 is $10.11 because the OPPS payment for the service will increase under this final rule. For some services (those services for which a national unadjusted copayment amount is shown in Addendum B), however, the beneficiary copayment is frozen based on historic data and will not change, therefore not presenting any potential impact on beneficiaries.

However, in all cases, the statute limits beneficiary liability for copayment for a service to the inpatient hospital deductible for the applicable year. This amount was $812 for 2002, and is $840 for 2003. In general, the impact of this final rule on beneficiaries will vary based on the service the beneficiary receives and whether the copayment for the service is one that is frozen under the OPPS.

*B. Payment Suspension for Unfiled Cost Reports*

Overall Impact

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, Public Law 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. (A description of each of these requirements is stated above in section XV.A.1.)

We have determined that the payment suspension provision does not have an economic impact on Medicare payments or other payments to providers. We are allowing the Secretary flexibility in payment suspensions, but we are not altering the final payment determination in any way. With the implementation of the various prospective payment systems, the majority of the payment to providers is based on the PPS methodology and not on the cost report. Suspending all payments because the cost report is not timely filed negatively affects providers. Providing the Secretary with flexibility in payment suspension can lessen the financial impact on providers. For these reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals. Under the requirement for Unfunded Mandates, this final rule will not have an economic effect on State, local, or tribal governments, in the aggregate, or on the private sector.

*Anticipated Effects*

1. Effects on Providers That File Cost Reports

The majority of providers that file cost reports comply with the timeliness provisions and will be unaffected by this regulation. In FY 2000, collectively 16 percent of hospitals, skilled nursing facilities, and home health agencies filed late cost reports. Of this 16 percent, 65 percent of those were only 1 day late. Currently, when a provider fails to file an acceptable cost report, the provider is placed on a complete payment suspension. Under this provision, for those providers who do not file timely, an immediate payment suspension less than the total suspension currently required might be imposed if the Secretary deemed it appropriate, which will allow the provider to more easily continue operations while completing and submitting the acceptable cost report.

2. Effects on Other Providers

The payment suspension provision does not affect other providers.

3. Effects on the Medicare Program

The provision will allow the Secretary to more effectively manage the Medicare program by imposing other than complete payment suspension when it is appropriate to do so. The Medicare program benefits because immediate complete payment suspension can be disruptive to providers and may negatively affect the care of Medicare patients. There are no costs to the Medicare program to doing so, because when the cost report is submitted, the suspended payments are returned to the provider.

4. Effects on Beneficiaries

We have determined that this provision has a potentially positive impact on beneficiaries. Under this provision, the Secretary will have the

discretion to impose less than 100 percent payment suspension when a provider fails to timely file an acceptable cost report. Doing so will lessen the financial burden on the provider and thereby allow it to provide adequate services to its patient population as it works to complete and file an acceptable cost report.

Alternatives Considered

We considered not revising existing § 405.371(c) to provide that payment suspension could be ''in whole or in part.'' However, we did not choose this option because we believe the Secretary should have the discretion to impose partial payment suspensions when circumstances warrant in order to more effectively manage the Medicare program.

Conclusion

In conclusion, we have determined that the payment suspension provision does not have an economic impact on Medicare payments.

*C. Federalism*

Since this regulation does not impose any costs on State or local governments, it will not have an effect on State or local governments. State or local governments will have no roles or responsibilities associated with this provision.

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

**List of Subjects**

*42 CFR Part 405*

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

*42 CFR Part 419*

Hospitals, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

## PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

### Subpart C—Suspension of Payment, Recovery of Overpayments, and Repayment of Scholarships and Loans

1. The authority citation for subpart C of part 405 continues to read as follows:

**Authority:** Secs. 1102, 1815, 1833, 1842, 1866, 1870, 1871, 1879, and 1892 of the Social Security Act (42 U.S.C. 1302, 1395g, 1395l, 1395u, 1395cc, 1395gg, 1395hh, 1395pp, and 1395ccc) and 31 U.S.C. 3711.

2. Section 405.371(c) is revised to read as follows:

**§ 405.371 Suspension, offset and recoupment of Medicare payments to providers and suppliers of services.**

* * * * *

(c) Suspension of payment in the case of unfiled cost reports. If a provider has failed to timely file an acceptable cost report, payment to the provider is immediately suspended in whole or in part until a cost report is filed and determined by the intermediary to be acceptable. In the case of an unfiled cost report, the provisions of § 405.372 do not apply. (See § 405.372(a)(2) concerning failure to furnish other information.)

## PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

1. The authority citation for part 419 continues to read as follows:

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

2. In § 419.21, paragraph (d)(3) is revised to read as follows:

**§ 419.21 Hospital outpatient services subject to the outpatient prospective payment system.**

* * * * *

(d) * * *

(3) Hepatitis B vaccine.

**§ 419.66 [Amended]**

3. In § 419.66, paragraph (c)(1) is amended by adding the phrase ''or by any category previously in effect'' after ''categories'' and before ''and''.

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

Dated: October 23, 2002.

**Thomas A. Scully,**

*Administrator, Centers for Medicare and Medicaid Services.*

Approved: October 23, 2002.

**Tommy G. Thompson,**

*Secretary.*

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

[Calendar Year 2003]

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 0001 | Level I Photochemotherapy | S | 0.3779 | $19.71 | $7.09 | $3.94 |
| 0002 | Fine needle Biopsy/Aspiration | T | 0.5911 | $30.83 | ..... | $6.17 |
| 0003 | Bone Marrow Biopsy/Aspiration | T | 1.2306 | $64.18 | ..... | $12.84 |
| 0004 | Level I Needle Biopsy/ Aspiration Except Bone Marrow | T | 1.7441 | $90.96 | $23.47 | $18.19 |
| 0005 | Level II Needle Biopsy /Aspiration Except Bone Marrow | T | 3.1201 | $162.72 | $71.59 | $32.54 |
| 0006 | Level I Incision & Drainage | T | 1.7926 | $93.49 | $24.12 | $18.70 |
| 0007 | Level II Incision & Drainage | T | 10.0191 | $522.51 | $108.89 | $104.50 |
| 0008 | Level III Incision and Drainage | T | 16.1430 | $841.87 | ..... | $168.37 |
| 0009 | Nail Procedures | T | 0.6298 | $32.84 | $8.34 | $6.57 |
| 0010 | Level I Destruction of Lesion | T | 0.6589 | $34.36 | $10.08 | $6.87 |
| 0011 | Level II Destruction of Lesion | T | 1.8507 | $96.52 | $27.88 | $19.30 |
| 0012 | Level I Debridement & Destruction | T | 0.7849 | $40.93 | $11.18 | $8.19 |
| 0013 | Level II Debridement & Destruction | T | 1.0756 | $56.09 | $14.20 | $11.22 |
| 0015 | Level III Debridement & Destruction | T | 1.5407 | $80.35 | $20.35 | $16.07 |
| 0016 | Level IV Debridement & Destruction | T | 2.6162 | $136.44 | $57.31 | $27.29 |
| 0017 | Level VI Debridement & Destruction | T | 15.8233 | $825.20 | $227.84 | $165.04 |
| 0018 | Biopsy of Skin/Puncture of Lesion | T | 0.9399 | $49.02 | $16.04 | $9.80 |
| 0019 | Level I Excision/ Biopsy | T | 3.7693 | $196.57 | $71.87 | $39.31 |
| 0020 | Level II Excision/ Biopsy | T | 7.1898 | $374.96 | $113.25 | $74.99 |
| 0021 | Level III Excision/ Biopsy | T | 13.9338 | $726.66 | $219.48 | $145.33 |
| 0022 | Level IV Excision/ Biopsy | T | 17.3930 | $907.06 | $354.45 | $181.41 |
| 0023 | Exploration Penetrating Wound | T | 2.5193 | $131.38 | $40.37 | $26.28 |
| 0024 | Level I Skin Repair | T | 1.8507 | $96.52 | $34.75 | $19.30 |
| 0025 | Level II Skin Repair | T | 5.8623 | $305.72 | $115.49 | $61.14 |
| 0027 | Level IV Skin Repair | T | 15.2225 | $793.87 | $329.72 | $158.77 |
| 0028 | Level I Breast Surgery | T | 16.8698 | $879.78 | $303.74 | $175.96 |
| 0029 | Level II Breast Surgery | T | 28.7881 | $1,501.33 | $632.64 | $300.27 |
| 0030 | Level III Breast Surgery | T | 37.5185 | $1,956.63 | $763.55 | $391.33 |
| 0032 | Insertion of Central Venous/Arterial Catheter | T | 11.4726 | $598.31 | ..... | $119.66 |
| 0033 | Partial Hospitalization | P | 4.6026 | $240.03 | $48.17 | $48.01 |
| 0035 | Placement of Arterial or Central Venous Catheter | T | 0.2229 | $11.62 | $3.51 | $2.32 |
| 0041 | Level I Arthroscopy | T | 26.1234 | $1,362.36 | ..... | $272.47 |
| 0042 | Level II Arthroscopy | T | 40.9680 | $2,136.52 | $804.74 | $427.30 |
| 0043 | Closed Treatment Fracture Finger/Toe/Trunk | T | 2.4999 | $130.37 | ..... | $26.07 |
| 0045 | Bone/Joint Manipulation Under Anesthesia | T | 12.9357 | $674.61 | $268.47 | $134.92 |
| 0046 | Open/Percutaneous Treatment Fracture or Dislocation | T | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 0047 | Arthroplasty without Prosthesis | T | 28.2842 | $1,475.05 | $537.03 | $295.01 |
| 0048 | Arthroplasty with Prosthesis | T | 40.6289 | $2,118.84 | $695.60 | $423.77 |
| 0049 | Level I Musculoskeletal Procedures Except Hand and Foot | T | 18.6042 | $970.23 | $197.14 | $194.05 |
| 0050 | Level II Musculoskeletal Procedures Except Hand and Foot | T | 23.3037 | $1,215.31 | ..... | $243.06 |
| 0051 | Level III Musculoskeletal Procedures Except Hand and Foot | T | 32.9062 | $1,716.09 | ..... | $343.22 |
| 0052 | Level IV Musculoskeletal Procedures Except Hand and Foot | T | 40.7646 | $2,125.91 | ..... | $425.18 |
| 0053 | Level I Hand Musculoskeletal Procedures | T | 14.1760 | $739.29 | $253.49 | $147.86 |
| 0054 | Level II Hand Musculoskeletal Procedures | T | 22.7223 | $1,184.99 | ..... | $237.00 |
| 0055 | Level I Foot Musculoskeletal Procedures | T | 17.6740 | $921.72 | $355.34 | $184.34 |
| 0056 | Level II Foot Musculoskeletal Procedures | T | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 0057 | Bunion Procedures | T | 22.9064 | $1,194.59 | $475.91 | $238.92 |
| 0058 | Level I Strapping and Cast Application | S | 1.0368 | $54.07 | ..... | $10.81 |
| 0060 | Manipulation Therapy | S | 0.3294 | $17.18 | ..... | $3.44 |
| 0068 | CPAP Initiation | S | 2.0736 | $108.14 | $59.48 | $21.63 |
| 0069 | Thoracoscopy | T | 27.5575 | $1,437.15 | $591.64 | $287.43 |
| 0070 | Thoracentesis/Lavage Procedures | T | 3.3623 | $175.35 | ..... | $35.07 |
| 0071 | Level I Endoscopy Upper Airway | T | 0.9205 | $48.00 | $12.89 | $9.60 |
| 0072 | Level II Endoscopy Upper Airway | T | 1.1628 | $60.64 | $26.68 | $12.13 |
| 0073 | Level III Endoscopy Upper Airway | T | 3.1976 | $166.76 | $73.38 | $33.35 |
| 0074 | Level IV Endoscopy Upper Airway | T | 12.8582 | $670.57 | $295.70 | $134.11 |
| 0075 | Level V Endoscopy Upper Airway | T | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 0076 | Endoscopy Lower Airway | T | 8.9533 | $466.92 | $189.82 | $93.38 |
| 0077 | Level I Pulmonary Treatment | S | 0.2907 | $15.16 | $8.34 | $3.03 |
| 0078 | Level II Pulmonary Treatment | S | 0.6492 | $33.86 | $14.55 | $6.77 |
| 0079 | Ventilation Initiation and Management | S | 1.6376 | $85.40 | ..... | $17.08 |
| 0080 | Diagnostic Cardiac Catheterization | T | 35.2996 | $1,840.91 | $838.92 | $368.18 |
| 0081 | Non-Coronary Angioplasty or Atherectomy | T | 43.5067 | $2,268.92 | ..... | $453.78 |
| 0082 | Coronary Atherectomy | T | 86.4321 | $4,507.52 | $1,293.59 | $901.50 |
| 0083 | Coronary Angioplasty and Percutaneous Valvuloplasty | T | 51.9755 | $2,710.57 | ..... | $542.11 |
| 0084 | Level I Electrophysiologic Evaluation | S | 9.3312 | $486.63 | ..... | $97.33 |
| 0085 | Level II Electrophysiologic Evaluation | T | 41.7238 | $2,175.94 | $480.03 | $435.19 |
| 0086 | Ablate Heart Dysrhythm Focus | T | 52.8282 | $2,755.04 | $936.35 | $551.01 |

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

[Calendar Year 2003]

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 0087 | Cardiac Electrophysiologic Recording/Mapping | T | 39.3983 | $2,054.66 | ..... | $410.93 |
| 0088 | Thrombectomy | T | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 0089 | Insertion/Replacement of Permanent Pacemaker and Electrodes | T | 112.5555 | $5,869.88 | $1,722.59 | $1,173.98 |
| 0090 | Insertion/Replacement of Pacemaker Pulse Generator | T | 87.9631 | $4,587.36 | $1,651.45 | $917.47 |
| 0091 | Level II Vascular Ligation | T | 26.7048 | $1,392.68 | $348.23 | $278.54 |
| 0092 | Level I Vascular Ligation | T | 23.7882 | $1,240.58 | $505.37 | $248.12 |
| 0093 | Vascular Reconstruction/Fistula Repair without Device | T | 20.6294 | $1,075.84 | $277.34 | $215.17 |
| 0094 | Level I Resuscitation and Cardioversion | S | 3.8371 | $200.11 | $67.63 | $40.02 |
| 0095 | Cardiac Rehabilitation | S | 0.6105 | $31.84 | $16.73 | $6.37 |
| 0096 | Non-Invasive Vascular Studies | S | 1.7054 | $88.94 | $48.15 | $17.79 |
| 0097 | Cardiac and Ambulatory Blood Pressure Monitoring | X | 1.0077 | $52.55 | $23.80 | $10.51 |
| 0098 | Injection of Sclerosing Solution | T | 1.6666 | $86.91 | $20.88 | $17.38 |
| 0099 | Electrocardiograms | S | 0.3682 | $19.20 | ..... | $3.84 |
| 0100 | Cardiac Stress Tests | X | 1.6085 | $83.88 | $41.44 | $16.78 |
| 0101 | Tilt Table Evaluation | S | 4.2247 | $220.32 | $105.27 | $44.06 |
| 0103 | Miscellaneous Vascular Procedures | T | 11.8408 | $617.51 | $223.63 | $123.50 |
| 0104 | Transcatheter Placement of Intracoronary Stents | T | 76.5486 | $3,992.09 | ..... | $798.42 |
| 0105 | Revision/Removal of Pacemakers, AICD, or Vascular | T | 18.5945 | $969.72 | $370.40 | $193.94 |
| 0106 | Insertion/Replacement/Repair of Pacemaker and/or Electrodes | T | 54.8243 | $2,859.14 | ..... | $571.83 |
| 0107 | Insertion of Cardioverter-Defibrillator | T | 326.2231 | $17,012.86 | $3,699.14 | $3,402.57 |
| 0108 | Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads | T | 443.5460 | $23,131.37 | ..... | $4,626.27 |
| 0109 | Removal of Implanted Devices | T | 7.4708 | $389.61 | $131.49 | $77.92 |
| 0110 | Transfusion | S | 4.0309 | $210.22 | ..... | $42.04 |
| 0111 | Blood Product Exchange | S | 14.9803 | $781.24 | $217.61 | $156.25 |
| 0112 | Apheresis, Photopheresis, and Plasmapheresis | S | 36.4236 | $1,899.53 | $612.47 | $379.91 |
| 0113 | Excision Lymphatic System | T | 18.7496 | $977.81 | ..... | $195.56 |
| 0114 | Thyroid/Lymphadenectomy Procedures | T | 36.1135 | $1,883.36 | $485.91 | $376.67 |
| 0115 | Cannula/Access Device Procedures | T | 24.3211 | $1,268.37 | $459.35 | $253.67 |
| 0116 | Chemotherapy Administration by Other Technique Except Infusion | S | 0.7752 | $40.43 | ..... | $8.09 |
| 0117 | Chemotherapy Administration by Infusion Only | S | 3.6046 | $187.98 | $48.28 | $37.60 |
| 0118 | Chemotherapy Administration by Both Infusion and Other Technique. | S | 5.4844 | $286.02 | $72.03 | $57.20 |
| 0119 | Implantation of Devices | T | 89.3100 | $4,657.61 | ..... | $931.52 |
| 0120 | Infusion Therapy Except Chemotherapy | T | 2.1802 | $113.70 | $30.75 | $22.74 |
| 0121 | Level I Tube changes and Repositioning | T | 2.0833 | $108.65 | $43.80 | $21.73 |
| 0122 | Level II Tube changes and Repositioning | T | 10.7459 | $560.41 | $114.93 | $112.08 |
| 0123 | Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant | S | 6.4049 | $334.02 | ..... | $66.80 |
| 0124 | Revision of Implanted Infusion Pump | T | 50.0861 | $2,612.04 | ..... | $522.41 |
| 0125 | Refilling of Infusion Pump | T | 2.0639 | $107.63 | ..... | $21.53 |
| 0130 | Level I Laparoscopy | T | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 0131 | Level II Laparoscopy | T | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 0132 | Level III Laparoscopy | T | 56.9948 | $2,972.34 | $1,239.22 | $594.47 |
| 0140 | Esophageal Dilation without Endoscopy | T | 6.0948 | $317.85 | $107.24 | $63.57 |
| 0141 | Upper GI Procedures | T | 7.4126 | $386.57 | $143.38 | $77.31 |
| 0142 | Small Intestine Endoscopy | T | 8.1393 | $424.47 | $152.78 | $84.89 |
| 0143 | Lower GI Endoscopy | T | 7.9165 | $412.85 | $186.06 | $82.57 |
| 0146 | Level I Sigmoidoscopy | T | 3.4302 | $178.89 | $64.40 | $35.78 |
| 0147 | Level II Sigmoidoscopy | T | 7.0153 | $365.85 | $79.46 | $73.17 |
| 0148 | Level I Anal/Rectal Procedure | T | 3.4205 | $178.38 | $63.38 | $35.68 |
| 0149 | Level III Anal/Rectal Procedure | T | 16.3756 | $854.00 | $293.06 | $170.80 |
| 0150 | Level IV Anal/Rectal Procedure | T | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 0151 | Endoscopic Retrograde Cholangio-Pancreatography (ERCP) | T | 17.5093 | $913.13 | $245.46 | $182.63 |
| 0152 | Percutaneous Abdominal and Biliary Procedures | T | 10.0288 | $523.01 | $131.28 | $104.60 |
| 0153 | Peritoneal and Abdominal Procedures | T | 19.5441 | $1,019.24 | $410.87 | $203.85 |
| 0154 | Hernia/Hydrocele Procedures | T | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 0155 | Level II Anal/Rectal Procedure | T | 10.1936 | $531.61 | $188.89 | $106.32 |
| 0156 | Level II Urinary and Anal Procedures | T | 2.9747 | $155.13 | $46.55 | $31.03 |
| 0157 | Colorectal Cancer Screening: Barium Enema | S | 2.5387 | $132.40 | ..... | $26.48 |
| 0158 | Colorectal Cancer Screening: Colonoscopy | T | 7.0638 | $368.38 | ..... | $92.10 |
| 0159 | Colorectal Cancer Screening: Flexible Sigmoidoscopy | S | 2.3255 | $121.28 | ..... | $30.32 |
| 0160 | Level I Cystourethroscopy and other Genitourinary Procedures | T | 6.3080 | $328.97 | $105.06 | $65.79 |
| 0161 | Level II Cystourethroscopy and other Genitourinary Procedures | T | 15.7070 | $819.14 | $249.36 | $163.83 |
| 0162 | Level III Cystourethroscopy and other Genitourinary Procedures | T | 20.5906 | $1,073.82 | ..... | $214.76 |
| 0163 | Level IV Cystourethroscopy and other Genitourinary Procedures | T | 28.3714 | $1,479.60 | ..... | $295.92 |
| 0164 | Level I Urinary and Anal Procedures | T | 1.1240 | $58.62 | $17.59 | $11.72 |
| 0165 | Level III Urinary and Anal Procedures | T | 12.2672 | $639.75 | ..... | $127.95 |
| 0166 | Level I Urethral Procedures | T | 15.4163 | $803.98 | $218.73 | $160.80 |
| 0167 | Level III Urethral Procedures | T | 28.3230 | $1,477.07 | $555.84 | $295.41 |

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

[Calendar Year 2003]

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 0168 | Level II Urethral Procedures | T | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 0169 | Lithotripsy | T | 44.0978 | $2,299.74 | $1,115.69 | $459.95 |
| 0170 | Dialysis | S | 4.8352 | $252.16 | ..... | $50.43 |
| 0179 | Urinary Incontinence Procedures | T | 104.3581 | $5,442.38 | $2,340.22 | $1,088.48 |
| 0180 | Circumcision | T | 18.1004 | $943.95 | $304.87 | $188.79 |
| 0181 | Penile Procedures | T | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 0182 | Insertion of Penile Prosthesis | T | 95.4145 | $4,975.96 | ..... | $995.19 |
| 0183 | Testes/Epididymis Procedures | T | 21.2592 | $1,108.69 | ..... | $221.74 |
| 0184 | Prostate Biopsy | T | 3.6918 | $192.53 | $96.27 | $38.51 |
| 0187 | Miscellaneous Placement/Repositioning | X | 3.9534 | $206.17 | $90.71 | $41.23 |
| 0188 | Level II Female Reproductive Proc | T | 1.0465 | $54.58 | $11.95 | $10.92 |
| 0189 | Level III Female Reproductive Proc | T | 1.5310 | $79.84 | $18.60 | $15.97 |
| 0190 | Surgical Hysteroscopy | T | 19.0596 | $993.98 | $424.28 | $198.80 |
| 0191 | Level I Female Reproductive Proc | T | 0.2035 | $10.61 | $3.08 | $2.12 |
| 0192 | Level IV Female Reproductive Proc | T | 2.7228 | $142.00 | $39.11 | $28.40 |
| 0193 | Level V Female Reproductive Proc | T | 14.4764 | $754.96 | $171.13 | $150.99 |
| 0194 | Level VI Female Reproductive Proc | T | 18.0228 | $939.91 | $397.84 | $187.98 |
| 0195 | Level VII Female Reproductive Proc | T | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 0196 | Dilation and Curettage | T | 15.5035 | $808.52 | $338.23 | $161.70 |
| 0197 | Infertility Procedures | T | 1.5697 | $81.86 | $33.06 | $16.37 |
| 0198 | Pregnancy and Neonatal Care Procedures | T | 1.2597 | $65.69 | $32.19 | $13.14 |
| 0199 | Obstetrical Care Service | T | 3.9146 | $204.15 | $57.16 | $40.83 |
| 0200 | Therapeutic Abortion | T | 15.1838 | $791.85 | $307.83 | $158.37 |
| 0201 | Spontaneous Abortion | T | 15.3097 | $798.42 | $329.65 | $159.68 |
| 0202 | Level VIII Female Reproductive Proc | T | 45.5610 | $2,376.05 | $1,164.26 | $475.21 |
| 0203 | Level IV Nerve Injections | T | 11.7924 | $614.99 | $276.76 | $123.00 |
| 0204 | Level I Nerve Injections | T | 2.0251 | $105.61 | $40.13 | $21.12 |
| 0206 | Level II Nerve Injections | T | 4.7867 | $249.63 | $75.55 | $49.93 |
| 0207 | Level III Nerve Injections | T | 5.7654 | $300.67 | $123.69 | $60.13 |
| 0208 | Laminotomies and Laminectomies | T | 38.4487 | $2,005.14 | ..... | $401.03 |
| 0209 | Extended EEG Studies and Sleep Studies, Level II | S | 11.3369 | $591.23 | $280.58 | $118.25 |
| 0212 | Nervous System Injections | T | 3.3139 | $172.82 | $79.53 | $34.56 |
| 0213 | Extended EEG Studies and Sleep Studies, Level I | S | 3.2557 | $169.79 | $70.41 | $33.96 |
| 0214 | Electroencephalogram | S | 2.2286 | $116.22 | $58.12 | $23.24 |
| 0215 | Level I Nerve and Muscle Tests | S | 0.5814 | $30.32 | $15.76 | $6.06 |
| 0216 | Level III Nerve and Muscle Tests | S | 2.8972 | $151.09 | $67.98 | $30.22 |
| 0218 | Level II Nerve and Muscle Tests | S | 1.0077 | $52.55 | ..... | $10.51 |
| 0220 | Level I Nerve Procedures | T | 15.8136 | $824.70 | ..... | $164.94 |
| 0221 | Level II Nerve Procedures | T | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 0222 | Implantation of Neurological Device | T | 227.7370 | $11,876.71 | ..... | $2,375.34 |
| 0223 | Implantation of Pain Management Device | T | 41.0262 | $2,139.56 | ..... | $427.91 |
| 0224 | Implantation of Reservoir/Pump/Shunt | T | 34.0302 | $1,774.71 | $453.41 | $354.94 |
| 0225 | Implantation of Neurostimulator Electrodes | S | 139.3379 | $7,266.61 | ..... | $1,453.32 |
| 0226 | Implantation of Drug Infusion Reservoir | T | 144.3474 | $7,527.86 | ..... | $1,505.57 |
| 0227 | Implantation of Drug Infusion Device | T | 144.5122 | $7,536.46 | ..... | $1,507.29 |
| 0228 | Creation of Lumbar Subarachnoid Shunt | T | 59.6207 | $3,109.28 | $696.46 | $621.86 |
| 0229 | Transcatherter Placement of Intravascular Shunts | T | 57.4599 | $2,996.59 | $771.23 | $599.32 |
| 0230 | Level I Eye Tests & Treatments | S | 0.7364 | $38.40 | $14.97 | $7.68 |
| 0231 | Level III Eye Tests & Treatments | S | 2.1705 | $113.19 | $50.94 | $22.64 |
| 0232 | Level I Anterior Segment Eye Procedures | T | 4.4960 | $234.47 | $103.17 | $46.89 |
| 0233 | Level II Anterior Segment Eye Procedures | T | 13.4202 | $699.88 | $266.33 | $139.98 |
| 0234 | Level III Anterior Segment Eye Procedures | T | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 0235 | Level I Posterior Segment Eye Procedures | T | 5.0871 | $265.30 | $73.44 | $53.06 |
| 0236 | Level II Posterior Segment Eye Procedures | T | 19.4278 | $1,013.18 | ..... | $202.64 |
| 0237 | Level III Posterior Segment Eye Procedures | T | 33.2647 | $1,734.79 | $818.54 | $346.96 |
| 0238 | Level I Repair and Plastic Eye Procedures | T | 2.9747 | $155.13 | $58.96 | $31.03 |
| 0239 | Level II Repair and Plastic Eye Procedures | T | 6.8119 | $355.25 | $115.94 | $71.05 |
| 0240 | Level III Repair and Plastic Eye Procedures | T | 16.3078 | $850.47 | $315.31 | $170.09 |
| 0241 | Level IV Repair and Plastic Eye Procedures | T | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 0242 | Level V Repair and Plastic Eye Procedures | T | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 0243 | Strabismus/Muscle Procedures | T | 19.9705 | $1,041.48 | $431.39 | $208.30 |
| 0244 | Corneal Transplant | T | 35.6290 | $1,858.09 | $803.26 | $371.62 |
| 0245 | Level I Cataract Procedures without IOL Insert | T | 14.5442 | $758.49 | $251.21 | $151.70 |
| 0246 | Cataract Procedures with IOL Insert | T | 22.2379 | $1,159.73 | $495.96 | $231.95 |
| 0247 | Laser Eye Procedures Except Retinal | T | 4.7092 | $245.59 | $104.31 | $49.12 |
| 0248 | Laser Retinal Procedures | T | 4.2925 | $223.86 | $95.08 | $44.77 |
| 0249 | Level II Cataract Procedures without IOL Insert | T | 26.7242 | $1,393.69 | $524.67 | $278.74 |
| 0250 | Nasal Cauterization/Packing | T | 1.6376 | $85.40 | $29.89 | $17.08 |

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

[Calendar Year 2003]

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 0251 | Level I ENT Procedures | T | 1.9089 | $99.55 | ..... | $19.91 |
| 0252 | Level II ENT Procedures | T | 5.8041 | $302.69 | $113.41 | $60.54 |
| 0253 | Level III ENT Procedures | T | 14.4473 | $753.44 | $282.29 | $150.69 |
| 0254 | Level IV ENT Procedures | T | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 0256 | Level V ENT Procedures | T | 34.0302 | $1,774.71 | ..... | $354.94 |
| 0258 | Tonsil and Adenoid Procedures | T | 19.8736 | $1,036.43 | $437.25 | $207.29 |
| 0259 | Level VI ENT Procedures | T | 367.6466 | $19,173.14 | $9,394.83 | $3,834.63 |
| 0260 | Level I Plain Film Except Teeth | X | 0.7655 | $39.92 | $21.95 | $7.98 |
| 0261 | Level II Plain Film Except Teeth Including Bone Density Measurement. | X | 1.2887 | $67.21 | ..... | $13.44 |
| 0262 | Plain Film of Teeth | X | 0.5717 | $29.81 | $9.82 | $5.96 |
| 0263 | Level I Miscellaneous Radiology Procedures | X | 1.8992 | $99.05 | $43.58 | $19.81 |
| 0264 | Level II Miscellaneous Radiology Procedures | X | 2.8197 | $147.05 | $79.41 | $29.41 |
| 0265 | Level I Diagnostic Ultrasound Except Vascular | S | 0.9787 | $51.04 | $28.07 | $10.21 |
| 0266 | Level II Diagnostic Ultrasound Except Vascular | S | 1.5988 | $83.38 | $45.86 | $16.68 |
| 0267 | Level III Diagnostic Ultrasound Except Vascular | S | 2.4418 | $127.34 | $65.52 | $25.47 |
| 0268 | Ultrasound Guidance Procedures | S | 1.3856 | $72.26 | ..... | $14.45 |
| 0269 | Level III Echocardiogram Except Transesophageal | S | 3.2170 | $167.77 | $87.24 | $33.55 |
| 0270 | Transesophageal Echocardiogram | S | 5.3003 | $276.42 | $146.79 | $55.28 |
| 0271 | Mammography | S | 0.6492 | $33.86 | $16.80 | $6.77 |
| 0272 | Level I Fluoroscopy | X | 1.3372 | $69.74 | $38.36 | $13.95 |
| 0274 | Myelography | S | 3.8759 | $202.13 | $96.54 | $40.43 |
| 0275 | Arthrography | S | 2.9747 | $155.13 | $69.09 | $31.03 |
| 0276 | Level I Digestive Radiology | S | 1.5891 | $82.87 | $41.72 | $16.57 |
| 0277 | Level II Digestive Radiology | S | 2.3546 | $122.79 | $60.47 | $24.56 |
| 0278 | Diagnostic Urography | S | 2.5290 | $131.89 | $66.07 | $26.38 |
| 0279 | Level II Angiography and Venography except Extremity | S | 8.6432 | $450.75 | $174.57 | $90.15 |
| 0280 | Level III Angiography and Venography except Extremity | S | 15.2128 | $793.36 | $353.85 | $158.67 |
| 0281 | Venography of Extremity | S | 5.2227 | $272.37 | $115.16 | $54.47 |
| 0282 | Miscellaneous Computerized Axial Tomography | S | 1.6763 | $87.42 | $44.51 | $17.48 |
| 0283 | Computerized Axial Tomography with Contrast Material | S | 4.5057 | $234.98 | $126.27 | $47.00 |
| 0284 | Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast Material. | S | 7.2382 | $377.48 | $201.02 | $75.50 |
| 0285 | Myocardial Positron Emission Tomography (PET) | S | 18.1294 | $945.47 | $409.56 | $189.09 |
| 0286 | Myocardial Scans | S | 6.5309 | $340.59 | $187.32 | $68.12 |
| 0287 | Complex Venography | S | 6.9863 | $364.34 | $114.51 | $72.87 |
| 0288 | Bone Density:Axial Skeleton | S | 1.2984 | $67.71 | ..... | $13.54 |
| 0289 | Needle Localization for Breast Biopsy | X | 1.8992 | $99.05 | $44.80 | $19.81 |
| 0290 | Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans | S | 2.0251 | $105.61 | $53.17 | $21.12 |
| 0291 | Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans | S | 3.9825 | $207.69 | $104.55 | $41.54 |
| 0292 | Level III Diagnostic Nuclear Medicine Excluding Myocardial Scans | S | 4.2925 | $223.86 | $112.69 | $44.77 |
| 0294 | Level II Therapeutic Nuclear Medicine | S | 4.0794 | $212.74 | $117.01 | $42.55 |
| 0296 | Level I Therapeutic Radiologic Procedures | S | 2.4127 | $125.82 | $69.20 | $25.16 |
| 0297 | Level II Therapeutic Radiologic Procedures | S | 7.6839 | $400.72 | $172.51 | $80.14 |
| 0299 | Miscellaneous Radiation Treatment | S | 5.9785 | $311.78 | ..... | $62.36 |
| 0300 | Level I Radiation Therapy | S | 1.5794 | $82.37 | ..... | $16.47 |
| 0301 | Level II Radiation Therapy | S | 3.1588 | $164.73 | ..... | $32.95 |
| 0302 | Level III Radiation Therapy | S | 9.2343 | $481.58 | $182.43 | $96.32 |
| 0303 | Treatment Device Construction | X | 2.8391 | $148.06 | $66.95 | $29.61 |
| 0304 | Level I Therapeutic Radiation Treatment Preparation | X | 1.6182 | $84.39 | $41.52 | $16.88 |
| 0305 | Level II Therapeutic Radiation Treatment Preparation | X | 3.6530 | $190.51 | $91.38 | $38.10 |
| 0310 | Level III Therapeutic Radiation Treatment Preparation | X | 13.6625 | $712.51 | $325.27 | $142.50 |
| 0312 | Radioelement Applications | S | 52.8864 | $2,758.08 | ..... | $551.62 |
| 0313 | Brachytherapy | S | 21.0363 | $1,097.06 | ..... | $219.41 |
| 0314 | Hyperthermic Therapies | S | 4.1763 | $217.80 | $101.77 | $43.56 |
| 0320 | Electroconvulsive Therapy | S | 4.2635 | $222.35 | $80.06 | $44.47 |
| 0321 | Biofeedback and Other Training | S | 1.2112 | $63.17 | $21.78 | $12.63 |
| 0322 | Brief Individual Psychotherapy | S | 1.3275 | $69.23 | $12.40 | $13.85 |
| 0323 | Extended Individual Psychotherapy | S | 1.8410 | $96.01 | $21.26 | $19.20 |
| 0324 | Family Psychotherapy | S | 2.4612 | $128.35 | ..... | $25.67 |
| 0325 | Group Psychotherapy | S | 1.4244 | $74.28 | $18.27 | $14.86 |
| 0330 | Dental Procedures | S | 4.7770 | $249.13 | ..... | $49.83 |
| 0332 | Computerized Axial Tomography and Computerized Angiography without Contrast Material. | S | 3.4398 | $179.39 | $91.27 | $35.88 |
| 0333 | Computerized Axial Tomography and Computerized Angio w/o Contrast Material followed by Contrast. | S | 5.3681 | $279.95 | $146.98 | $55.99 |
| 0335 | Magnetic Resonance Imaging, Miscellaneous | S | 6.2983 | $328.46 | $151.46 | $65.69 |

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

[Calendar Year 2003]

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 0336 | Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast. | S | 6.5987 | $344.13 | $176.94 | $68.83 |
| 0337 | MRI and Magnetic Resonance Angiography without Contrast Material followed by Contrast Material. | S | 9.2440 | $482.08 | $240.77 | $96.42 |
| 0339 | Observation | S | 7.2188 | $376.47 | ..... | $75.29 |
| 0340 | Minor Ancillary Procedures | X | 0.6492 | $33.86 | ..... | $6.77 |
| 0341 | Skin Tests and Miscellaneous Red Blood Cell Tests | X | 0.1453 | $7.58 | $3.08 | $1.52 |
| 0342 | Level I Pathology | X | 0.2132 | $11.12 | $5.88 | $2.22 |
| 0343 | Level II Pathology | X | 0.4457 | $23.24 | $12.55 | $4.65 |
| 0344 | Level III Pathology | X | 0.6201 | $32.34 | $17.46 | $6.47 |
| 0345 | Level I Transfusion Laboratory Procedures | X | 0.1938 | $10.11 | $3.10 | $2.02 |
| 0346 | Level II Transfusion Laboratory Procedures | X | 0.5136 | $26.78 | $6.75 | $5.36 |
| 0347 | Level III Transfusion Laboratory Procedures | X | 1.1240 | $58.62 | $14.76 | $11.72 |
| 0348 | Fertility Laboratory Procedures | X | 0.5523 | $28.80 | ..... | $5.76 |
| 0352 | Level I Injections | X | 0.2229 | $11.62 | ..... | $2.32 |
| 0353 | Level II Allergy Injections | X | 0.3973 | $20.72 | ..... | $4.14 |
| 0355 | Level III Immunizations | K | 0.2132 | $11.12 | ..... | $2.22 |
| 0356 | Level IV Immunizations | K | 0.7655 | $39.92 | ..... | $7.98 |
| 0359 | Level II Injections | X | 1.1337 | $59.12 | ..... | $11.82 |
| 0360 | Level I Alimentary Tests | X | 1.6279 | $84.90 | $42.45 | $16.98 |
| 0361 | Level II Alimentary Tests | X | 3.3914 | $176.86 | $83.23 | $35.37 |
| 0362 | Level III Otorhinolaryngologic Function Tests | X | 2.8391 | $148.06 | ..... | $29.61 |
| 0363 | Level I Otorhinolaryngologic Function Tests | X | 1.0852 | $56.59 | $20.94 | $11.32 |
| 0364 | Level I Audiometry | X | 0.4457 | $23.24 | $9.06 | $4.65 |
| 0365 | Level II Audiometry | X | 1.2112 | $63.17 | $18.95 | $12.63 |
| 0367 | Level I Pulmonary Test | X | 0.5814 | $30.32 | $15.16 | $6.06 |
| 0368 | Level II Pulmonary Tests | X | 1.0562 | $55.08 | $27.55 | $11.02 |
| 0369 | Level III Pulmonary Tests | X | 2.5871 | $134.92 | $44.18 | $26.98 |
| 0370 | Allergy Tests | X | 0.7752 | $40.43 | $11.58 | $8.09 |
| 0371 | Level I Allergy Injections | X | 0.5039 | $26.28 | ..... | $5.26 |
| 0372 | Therapeutic Phlebotomy | X | 0.5329 | $27.79 | $10.09 | $5.56 |
| 0373 | Neuropsychological Testing | X | 2.2577 | $117.74 | ..... | $23.55 |
| 0374 | Monitoring Psychiatric Drugs | X | 1.1434 | $59.63 | $9.97 | $11.93 |
| 0600 | Low Level Clinic Visits | V | 0.8430 | $43.96 | ..... | $8.79 |
| 0601 | Mid Level Clinic Visits | V | 0.9690 | $50.53 | ..... | $10.11 |
| 0602 | High Level Clinic Visits | V | 1.4631 | $76.30 | ..... | $15.26 |
| 0610 | Low Level Emergency Visits | V | 1.4147 | $73.78 | $19.57 | $14.76 |
| 0611 | Mid Level Emergency Visits | V | 2.5290 | $131.89 | $36.47 | $26.38 |
| 0612 | High Level Emergency Visits | V | 4.3410 | $226.39 | $54.14 | $45.28 |
| 0620 | Critical Care | S | 9.9610 | $519.48 | $150.55 | $103.90 |
| 0648 | Breast Reconstruction with Prosthesis | T | 44.7955 | $2,336.13 | ..... | $467.23 |
| 0649 | Prostate Brachytherapy Palladium Seeds | T | 115.0167 | $5,998.24 | ..... | $1,199.65 |
| 0650 | Intermediate/Complex Proton Beam Radiation Therapy | S | 12.0152 | $626.60 | ..... | $125.32 |
| 0651 | Complex Interstitial Radiation Source Application | S | 54.7177 | $2,853.58 | ..... | $570.72 |
| 0652 | Insertion of Intraperitoneal Catheters | T | 28.1292 | $1,466.97 | ..... | $293.39 |
| 0653 | Vascular Reconstruction/Fistula Repair with Device | T | 30.0284 | $1,566.01 | ..... | $313.20 |
| 0654 | Insertion/Replacement of a permanent dual chamber pacemaker | T | 91.8583 | $4,790.50 | ..... | $958.10 |
| 0655 | Insertion/Replacement/Conversion of a permanent dual chamber pacemaker. | T | 122.8654 | $6,407.55 | ..... | $1,281.51 |
| 0656 | Transcatheter Placement of Intracoronary of Drug-Eluting Stents | T | 96.7516 | $5,045.69 | ..... | $1,009.14 |
| 0657 | Placement of Tissue Clips | S | 1.4438 | $75.30 | ..... | $15.06 |
| 0658 | Percutaneous Breast Biopsies | T | 5.2712 | $274.90 | ..... | $54.98 |
| 0659 | Hyperbaric Oxygen | S | 3.2364 | $168.78 | ..... | $33.76 |
| 0660 | Level II Otorhinolaryngologic Function Tests | X | 1.5891 | $82.87 | $30.66 | $16.57 |
| 0661 | Level IV Pathology | X | 3.5077 | $182.93 | $100.61 | $36.59 |
| 0662 | CT Angiography | S | 5.4553 | $284.50 | $156.47 | $56.90 |
| 0664 | Proton Beam Radiation Therapy | S | 10.0482 | $524.02 | ..... | $104.80 |
| 0665 | Bone Density:AppendicularSkeleton | S | 0.8236 | $42.95 | ..... | $8.59 |
| 0666 | Myocardial Add-on Scans | S | 2.9650 | $154.63 | $85.05 | $30.93 |
| 0668 | Level I Angiography and Venography except Extremity | S | 10.3292 | $538.68 | $237.76 | $107.74 |
| 0669 | Digital Mammography | S | 0.8915 | $46.49 | ..... | $9.30 |
| 0670 | Intravenous and Intracardiac Ultrasound | S | 30.2416 | $1,577.13 | $571.17 | $315.43 |
| 0671 | Level II Echocardiogram Except Transesophageal | S | 2.3643 | $123.30 | $64.12 | $24.66 |
| 0672 | Level IV Posterior Segment Procedures | T | 37.9061 | $1,976.84 | $988.43 | $395.37 |
| 0673 | Level IV Anterior Segment Eye Procedures | T | 25.9490 | $1,353.27 | $649.56 | $270.65 |
| 0674 | Prostate Cryoablation | T | 62.9152 | $3,281.09 | ..... | $656.22 |
| 0675 | Prostatic Thermotherapy | T | 48.5648 | $2,532.70 | ..... | $506.54 |
| 0676 | Level II Transcatheter Thrombolysis | T | 4.1278 | $215.27 | $58.21 | $43.05 |

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

[Calendar Year 2003]

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 0677 | Level I Transcatheter Thrombolysis | T | 2.6453 | $137.96 | | $27.59 |
| 0678 | External Counterpulsation | T | 2.2189 | $115.72 | | $23.14 |
| 0679 | Level II Resuscitation and Cardioversion | S | 5.4069 | $281.98 | $95.30 | $56.40 |
| 0680 | Insertion of Patient Activated Event Recorders | S | 56.1324 | $2,927.36 | | $585.47 |
| 0681 | Knee Arthroplasty | T | 147.8067 | $7,708.27 | $3,067.55 | $1,541.65 |
| 0682 | Level V Debridement & Destruction | T | 7.2770 | $379.50 | $174.57 | $75.90 |
| 0683 | Level II Photochemotherapy | S | 1.8992 | $99.05 | $35.65 | $19.81 |
| 0684 | Prostate Brachytherapy Iodine Seeds | T | 98.8349 | $5,154.34 | | $1,030.87 |
| 0685 | Level III Needle Biopsy/Aspiration Except Bone Marrow | T | 5.9882 | $312.29 | $137.40 | $62.46 |
| 0686 | Level III Skin Repair | T | 14.2439 | $742.83 | $341.70 | $148.57 |
| 0687 | Revision/Removal of Neurostimulator Electrodes | T | 25.8424 | $1,347.71 | $619.95 | $269.54 |
| 0688 | Revision/Removal of Neurostimulator Pulse Generator Receiver | T | 74.5719 | $3,889.00 | $1,905.61 | $777.80 |
| 0689 | Electronic Analysis of Cardioverter-defibrillators | S | 0.5814 | $30.32 | | $6.06 |
| 0690 | Electronic Analysis of Pacemakers and other Cardiac Devices | S | 0.4263 | $22.23 | $10.63 | $4.45 |
| 0691 | Electronic Analysis of Programmable Shunts/Pumps | S | 2.9166 | $152.10 | $83.65 | $30.42 |
| 0692 | Electronic Analysis of Neurostimulator Pulse Generators | S | 6.2595 | $326.44 | $179.54 | $65.29 |
| 0693 | Level II Breast Reconstruction | T | 37.5863 | $1,960.16 | $798.17 | $392.03 |
| 0694 | Mohs Surgery | T | 3.4689 | $180.91 | $72.36 | $36.18 |
| 0695 | Level VII Debridement & Destruction | T | 18.6817 | $974.27 | $266.59 | $194.85 |
| 0697 | Level I Echocardiogram Except Transesophageal | S | 1.5697 | $81.86 | $42.57 | $16.37 |
| 0698 | Level II Eye Tests & Treatments | S | 0.9205 | $48.00 | $18.72 | $9.60 |
| 0699 | Level IV Eye Tests & Treatments | T | 3.7596 | $196.07 | $88.23 | $39.21 |
| 0701 | SR 89 chloride, per mCi | K | 8.9920 | $468.94 | | $93.79 |
| 0702 | SM 153 lexidronam, 50 mCi | K | 14.6218 | $762.54 | | $152.51 |
| 0706 | New Technology - Level I ($0 - $50) | S | | $25.00 | | $5.00 |
| 0707 | New Technology - Level II ($50 - $100) | S | | $75.00 | | $15.00 |
| 0708 | New Technology - Level III ($100 - $200) | S | | $150.00 | | $30.00 |
| 0709 | New Technology - Level IV ($200 - $300) | S | | $250.00 | | $50.00 |
| 0710 | New Technology - Level V ($300 - $500) | S | | $400.00 | | $80.00 |
| 0711 | New Technology - Level VI ($500 - $750) | S | | $625.00 | | $125.00 |
| 0712 | New Technology - Level VII ($750 - $1000) | S | | $875.00 | | $175.00 |
| 0713 | New Technology - Level VIII ($1000 - $1250) | S | | $1,125.00 | | $225.00 |
| 0714 | New Technology - Level IX ($1250 - $1500) | S | | $1,375.00 | | $275.00 |
| 0715 | New Technology - Level X ($1500 - $1750) | S | | $1,625.00 | | $325.00 |
| 0716 | New Technology - Level XI ($1750 - $2000) | S | | $1,875.00 | | $375.00 |
| 0717 | New Technology - Level XII ($2000 - $2500) | S | | $2,250.00 | | $450.00 |
| 0718 | New Technology - Level XIII ($2500 - $3000) | S | | $2,750.00 | | $550.00 |
| 0719 | New Technology-Level XIV ($3000 - $3500) | S | | $3,250.00 | | $650.00 |
| 0720 | New Technology - Level XV ($3500 - $5000) | S | | $4,250.00 | | $850.00 |
| 0721 | New Technology - Level XVI ($5000 - $6000) | S | | $5,500.00 | | $1,100.00 |
| 0725 | New Technology - Level XX ($19500 - $20500) | S | | $20,000.00 | | $4,000.00 |
| 0726 | Dexrazoxane hcl injection, 250 mg | K | 2.2577 | $117.74 | | $23.55 |
| 0728 | Filgrastim 300 mcg injection | K | 2.1027 | $109.66 | | $21.93 |
| 0730 | Pamidronate disodium , 30 mg | K | 3.2654 | $170.29 | | $34.06 |
| 0732 | Mesna injection 200 mg | K | 0.5039 | $26.28 | | $5.26 |
| 0733 | Non esrd epoetin alpha inj, 1000 u | K | 0.1744 | $9.10 | | $1.82 |
| 0734 | Injection, darbepoetin alfa (for non-ESRD use), pre 1 mcg | K | 0.0454 | $2.37 | | $.47 |
| 0800 | Leuprolide acetate, 3.75 mg | K | 3.7984 | $198.09 | | $39.62 |
| 0802 | Etoposide oral 50 mg | K | 0.5523 | $28.80 | | $5.76 |
| 0807 | Aldesleukin/single use vial | K | 7.2867 | $380.01 | | $76.00 |
| 0810 | Goserelin acetate implant 3.6 mg | K | 5.5619 | $290.06 | | $58.01 |
| 0811 | Carboplatin injection 50 mg | K | 1.4922 | $77.82 | | $15.56 |
| 0812 | Carmustine, 100 mg | K | 1.5310 | $79.84 | | $15.97 |
| 0813 | Cisplatin 10 mg injection | K | 0.4263 | $22.23 | | $4.45 |
| 0820 | Daunorubicin 10 mg | K | 1.9379 | $101.06 | | $20.21 |
| 0821 | Daunorubicin citrate liposom 10 mg | K | 2.9069 | $151.60 | | $30.32 |
| 0822 | Diethylstilbestrol injection 250 mg | K | 2.0251 | $105.61 | | $21.12 |
| 0823 | Docetaxel, 20 mg | K | 3.8953 | $203.14 | | $40.63 |
| 0827 | Floxuridine injection 500 mg | K | 2.2189 | $115.72 | | $23.14 |
| 0828 | Gemcitabine HCL 200 mg | K | 1.2984 | $67.71 | | $13.54 |
| 0830 | Irinotecan injection 20 mg | K | 1.7538 | $91.46 | | $18.29 |
| 0831 | Ifosfomide injection 1 gm | K | 1.9186 | $100.06 | | $20.01 |
| 0832 | Idarubicin hcl injection 5 mg | K | 4.8642 | $253.67 | | $50.73 |
| 0838 | Interferon gamma 1-b inj, 3 million u | K | 3.0426 | $158.67 | | $31.73 |
| 0840 | Melphalan hydrochl 50 mg | K | 4.5348 | $236.49 | | $47.30 |
| 0842 | Fludarabine phosphate inj 50 mg | K | 3.2848 | $171.31 | | $34.26 |
| 0843 | Pegaspargase, singl dose vial | K | 8.8079 | $459.34 | | $91.87 |
| 0844 | Pentostatin injection, 10 mg | K | 19.8833 | $1,036.93 | | $207.39 |

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

[Calendar Year 2003]

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 0849 | Rituximab, 100 mg | K | 5.4941 | $286.52 | | $57.30 |
| 0852 | Topotecan, 4 mg | K | 7.7130 | $402.24 | | $80.45 |
| 0855 | Vinorelbine tartrate, 10 mg | K | 1.0756 | $56.09 | | $11.22 |
| 0856 | Porfimer sodium, 75 mg | K | 29.6117 | $1,544.28 | | $308.86 |
| 0857 | Bleomycin sulfate injection 15 u | K | 3.1879 | $166.25 | | $33.25 |
| 0858 | Cladribine, 1mg | K | 0.7946 | $41.44 | | $8.29 |
| 0861 | Leuprolide acetate injection 1 mg | K | 0.7752 | $40.43 | | $8.09 |
| 0862 | Mitomycin 5 mg inj | K | 1.1337 | $59.12 | | $11.82 |
| 0863 | Paclitaxel injection, 30 mg | K | 2.3158 | $120.77 | | $24.15 |
| 0864 | Mitoxantrone hcl, 5 mg | K | 2.9263 | $152.61 | | $30.52 |
| 0888 | Cyclosporine oral 100 mg | K | 0.0484 | $2.52 | | $.50 |
| 0890 | Lymphocyte immune globulin 250 mg | K | 3.3429 | $174.34 | | $34.87 |
| 0891 | Tacrolimus oral per 1 mg | K | 0.0291 | $1.52 | | $.30 |
| 0902 | Botulinum toxin a, per unit | K | 0.0484 | $2.52 | | $.50 |
| 0903 | Cytomegalovirus imm IV/vial | K | 4.7383 | $247.11 | | $49.42 |
| 0905 | Immune globulin 500 mg | K | 0.8333 | $43.46 | | $8.69 |
| 0906 | RSV-ivig, 50 mg | K | 0.5911 | $30.83 | | $6.17 |
| 0909 | Interferon beta-1a, 33 mcg | K | 2.7906 | $145.53 | | $29.11 |
| 0910 | Interferon beta-1b /0.25 mg | K | 1.9864 | $103.59 | | $20.72 |
| 0916 | Injection imiglucerase /unit | K | 0.0484 | $2.52 | | $.50 |
| 0917 | Inj, Adenosine, 90 mg | K | 3.1986 | $166.81 | | $33.36 |
| 0925 | Factor viii per iu | K | 0.0097 | $.51 | | $.10 |
| 0926 | Factor VIII (porcine) per iu | K | 0.0291 | $1.52 | | $.30 |
| 0927 | Factor viii recombinant per iu | K | 0.0194 | $1.01 | | $.20 |
| 0928 | Factor ix complex per iu | K | 0.0097 | $.51 | | $.10 |
| 0929 | Anti-inhibitor per iu | K | 0.0194 | $1.01 | | $.20 |
| 0930 | Antithrombin iii injection per iu | K | 0.0194 | $1.01 | | $.20 |
| 0931 | Factor IX non-recombinant, per iu | K | 0.0097 | $.51 | | $.10 |
| 0932 | Factor IX recombinant, per iu | K | 0.0194 | $1.01 | | $.20 |
| 0949 | Plasma, Pooled Multiple Donor, Solvent/Detergent T | K | 2.3837 | $124.31 | | $24.86 |
| 0950 | Blood (Whole) For Transfusion | K | 1.6860 | $87.93 | | $17.59 |
| 0952 | Cryoprecipitate | K | 0.5620 | $29.31 | | $5.86 |
| 0954 | RBC leukocytes reduced | K | 2.2868 | $119.26 | | $23.85 |
| 0955 | Plasma, Fresh Frozen | K | 1.8217 | $95.00 | | $19.00 |
| 0956 | Plasma Protein Fraction | K | 1.7829 | $92.98 | | $18.60 |
| 0957 | Platelet Concentrate | K | 0.7946 | $41.44 | | $8.29 |
| 0958 | Platelet Rich Plasma | K | 1.0271 | $53.56 | | $10.71 |
| 0959 | Red Blood Cells | K | 1.6569 | $86.41 | | $17.28 |
| 0960 | Washed Red Blood Cells | K | 3.0813 | $160.69 | | $32.14 |
| 0961 | Infusion, Albumin (Human) 5%, 50 ml | K | 0.9980 | $52.05 | | $10.41 |
| 0963 | Albumin (human), 5%, 250 ml | K | 4.9708 | $259.23 | | $51.85 |
| 0964 | Albumin (human), 25%, 20 ml | K | 1.0756 | $56.09 | | $11.22 |
| 0965 | Albumin (human), 25%, 50ml | K | 2.6840 | $139.97 | | $27.99 |
| 0966 | Plasmaprotein fract,5%,250ml | K | 8.9145 | $464.90 | | $92.98 |
| 0970 | New Technology - Level I ($0 - $50) | T | | $25.00 | | $5.00 |
| 0971 | New Technology - Level II ($50 - $100) | T | | $75.00 | | $15.00 |
| 0972 | New Technology - Level III ($100 - $200) | T | | $150.00 | | $30.00 |
| 0973 | New Technology - Level IV ($200 - $300) | T | | $250.00 | | $50.00 |
| 0974 | New Technology - Level V ($300 - $500) | T | | $400.00 | | $80.00 |
| 0975 | New Technology - Level VI ($500 - $750) | T | | $625.00 | | $125.00 |
| 0976 | New Technology - Level VII ($750 - $1000) | T | | $875.00 | | $175.00 |
| 0977 | New Technology - Level VIII ($1000 - $1250) | T | | $1,125.00 | | $225.00 |
| 0978 | New Technology - Level IX ($1250 - $1500) | T | | $1,375.00 | | $275.00 |
| 0979 | New Technology - Level X ($1500 - $1750) | T | | $1,625.00 | | $325.00 |
| 0980 | New Technology - Level XI ($1750 - $2000) | T | | $1,875.00 | | $375.00 |
| 0981 | New Technology - Level XII ($2000 - $2500) | T | | $2,250.00 | | $450.00 |
| 0982 | New Technology - Level XIII ($2500 - $3000) | T | | $2,750.00 | | $550.00 |
| 0983 | New Technology - Level XIV ($3000 - $3500) | T | | $3,250.00 | | $650.00 |
| 0984 | New Technology - Level XV ($3500 - $5000) | T | | $4,250.00 | | $850.00 |
| 0985 | New Technology - Level XVI ($5000 - $6000) | T | | $5,500.00 | | $1,100.00 |
| 0989 | New Technology - Level XX ($19500-$20500) | T | | $20,000.00 | | $4,000.00 |
| 1009 | Cryoprecip reduced plasma | K | 0.7170 | $37.39 | | $7.48 |
| 1010 | Blood, L/R, CMV-neg | K | 2.3352 | $121.78 | | $24.36 |
| 1011 | Platelets, HLA-m, L/R, unit | K | 9.5831 | $499.77 | | $99.95 |
| 1013 | Platelet concentrate, L/R, unit | K | 0.9496 | $49.52 | | $9.90 |
| 1016 | Blood, L/R, froz/deglycerol/washed | K | 5.7848 | $301.68 | | $60.34 |
| 1017 | Platelets, aph/pher, L/R, CMV-neg, unit | K | 7.5386 | $393.15 | | $78.63 |
| 1018 | Blood, L/R, irradiated | K | 2.5387 | $132.40 | | $26.48 |

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[Calendar Year 2003]

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 1019 | Platelets, aph/pher, L/R, irradiated, unit | K | 7.7905 | $406.28 | | $81.26 |
| 1020 | Pit, pher,L/R,CMV,irrad | K | 9.4959 | $495.22 | | $99.04 |
| 1021 | RBC, frz/deg/wsh, L/R, irrad | K | 6.4436 | $336.04 | | $67.21 |
| 1022 | RBC, L/R, CMV neg, irrad | K | 3.8565 | $201.12 | | $40.22 |
| 1045 | Iobenguane sulfate I-31per 0.5 mCi | K | 1.5697 | $81.86 | | $16.37 |
| 1059 | Cultured chondrocytes implnt | K | 114.2706 | $5,959.33 | | $1,191.87 |
| 1084 | Denileukin diftitox, 300 MCG | K | 12.1315 | $632.67 | | $126.53 |
| 1086 | Temozolomide,oral 5 mg | K | 0.0581 | $3.03 | | $.61 |
| 1091 | IN 111 Oxyquinoline, per .5 mCi | K | 4.7092 | $245.59 | | $49.12 |
| 1092 | IN 111 Pentetate, per 0.5 mCi | K | 4.4379 | $231.44 | | $46.29 |
| 1095 | Technetium TC 99M Depreotide | K | 5.6006 | $292.08 | | $58.42 |
| 1096 | TC 99M Exametazime, per dose | K | 4.4379 | $231.44 | | $46.29 |
| 1122 | TC 99M arcitumomab, per vial | K | 11.4726 | $598.31 | | $119.66 |
| 1167 | Epirubicin hcl, 2 mg | K | 0.3294 | $17.18 | | $3.44 |
| 1178 | Busulfan IV, 6 mg | K | 0.4845 | $25.27 | | $5.05 |
| 1203 | Verteporfin for injection | K | 16.5209 | $861.58 | | $172.32 |
| 1207 | Octreotide acetate depot 1mg | K | 1.4244 | $74.28 | | $14.86 |
| 1305 | Apligraf | K | 13.0520 | $680.67 | | $136.13 |
| 1348 | I-131 sol, per 1-6 mCi | K | 0.9399 | $49.02 | | $9.80 |
| 1409 | Factor viia recombinant, per 1.2 mg | K | 20.7844 | $1,083.93 | | $216.79 |
| 1604 | IN 111 capromab pendetide, per dose | K | 16.4434 | $857.54 | | $171.51 |
| 1605 | Abciximab injection, 10 mg | K | 5.8526 | $305.22 | | $61.04 |
| 1609 | Rho(D) immune globulin h, sd, 100 iu | K | 0.2229 | $11.62 | | $2.32 |
| 1611 | Hylan G-F 20 injection, 16 mg | K | 2.3643 | $123.30 | | $24.66 |
| 1612 | Daclizumab, parenteral, 25 mg | K | 4.3991 | $229.42 | | $45.88 |
| 1613 | Trastuzumab, 10 mg | K | 0.6298 | $32.84 | | $6.57 |
| 1614 | Valrubicin, 200 mg | K | 3.5658 | $185.96 | | $37.19 |
| 1615 | Basiliximab, 20 mg | K | 13.3621 | $696.85 | | $139.37 |
| 1618 | Vonwillebrandfactrcmplx, per iu | K | 0.0194 | $1.01 | | $.20 |
| 1620 | Technetium tc99m bicisate | K | 3.8759 | $202.13 | | $40.43 |
| 1625 | Indium 111-in pentetreotide | K | 8.2169 | $428.52 | | $85.70 |
| 1628 | Chromic phosphate p32 | K | 1.5891 | $82.87 | | $16.57 |
| 1716 | Brachytx seed, Gold 198 | K | 0.4360 | $22.74 | | $4.55 |
| 1718 | Brachytx seed, Iodine 125 | K | 0.6008 | $31.33 | | $6.27 |
| 1719 | Brachytxseed, Non-HDR Ir-192 | K | 0.5232 | $27.29 | | $5.46 |
| 1720 | Brachytx seed, Palladium 103 | K | 0.8430 | $43.96 | | $8.79 |
| 1765 | Adhesion barrier | H | | | | |
| 1775 | FDG, per dose (4-40 mCi/ml) | K | 7.5289 | $392.64 | | $78.53 |
| 1783 | Ocular implant, aqueous drain device | H | | | | |
| 1888 | Endovascular non-cardiac ablation catheter | H | | | | |
| 1900 | Lead coronary venous | H | | | | |
| 2614 | Probe, percutaneous lumbar disc | H | | | | |
| 2616 | Brachytx seed, Yttrium-90 | K | 8.8370 | $460.86 | | $92.17 |
| 2618 | Probe, cryoablation | H | | | | |
| 2632 | Brachytx sol, I-125, per mCi | H | | | | |
| 7000 | Amifostine, 500 mg | K | 4.5057 | $234.98 | | $47.00 |
| 7001 | Amphotericin B lipid complex, 50 mg | K | 2.3449 | $122.29 | | $24.46 |
| 7011 | Oprelvekin injection, 5 mg | K | 2.7325 | $142.50 | | $28.50 |
| 7024 | Corticorelin ovine triflutat | K | 2.2965 | $119.76 | | $23.95 |
| 7025 | Digoxin immune FAB (ovine) | K | 4.9805 | $259.74 | | $51.95 |
| 7030 | Hemin, per 1 mg | K | 0.0097 | $.51 | | $.10 |
| 7031 | Octreotide acetate injection | K | 1.2694 | $66.20 | | $13.24 |
| 7034 | Somatropin injection | K | 0.7170 | $37.39 | | $7.48 |
| 7035 | Teniposide, 50 mg | K | 1.9573 | $102.08 | | $20.42 |
| 7038 | Muromonab-CD3, 5 mg | K | 6.9572 | $362.82 | | $72.56 |
| 7041 | Tirofiban hydrochloride 12.5 mg | K | 4.9417 | $257.71 | | $51.54 |
| 7042 | Capecitabine, oral, 150 mg | K | 0.0291 | $1.52 | | $.30 |
| 7043 | Infliximab injection 10 mg | K | 0.7364 | $38.40 | | $7.68 |
| 7045 | Trimetrexate glucoronate | K | 1.3081 | $68.22 | | $13.64 |
| 7046 | Doxorubicin hcl liposome inj 10 mg | K | 4.3894 | $228.91 | | $45.78 |
| 7049 | Filgrastim 480 mcg injection | K | 3.2267 | $168.28 | | $33.66 |
| 7051 | Leuprolide acetate implant, 65 mg | G | | $5,399.80 | | $807.13 |
| 9000 | Na chromate Cr51, per 0.25mCi | K | 1.8798 | $98.03 | | $19.61 |
| 9002 | Tenecteplase, 50mg/vial | K | 27.5963 | $1,439.17 | | $287.83 |
| 9003 | Palivizumab, per 50mg | K | 8.5657 | $446.71 | | $89.34 |
| 9005 | Reteplase injection | K | 12.6547 | $659.96 | | $131.99 |
| 9009 | Baclofen refill kit - per 2000 mcg | K | 0.7267 | $37.90 | | $7.58 |
| 9010 | Baclofen refill kit - per 4000 mcg | K | 0.9205 | $48.00 | | $9.60 |

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

[Calendar Year 2003]

| APC | Group title | Status indicator | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|
| 9012 | Arsenic Trioxide | G | | $31.35 | | $4.69 |
| 9015 | Mycophenolate mofetil oral 250 mg | K | 0.0291 | $1.52 | | $.30 |
| 9016 | Echocardiography contrast | G | | $118.75 | | $17.75 |
| 9018 | Botulinum toxin B, per 100 u | G | | $8.79 | | $1.31 |
| 9019 | Caspofungin acetate, 5 mg | G | | $34.20 | | $5.11 |
| 9020 | Sirolimus tablet, 1 mg | K | 0.0581 | $3.03 | | $.61 |
| 9021 | Immune globulin 10 mg | K | 0.0097 | $.51 | | $.10 |
| 9022 | IM inj interferon beta 1-a | K | 0.9302 | $48.51 | | $9.70 |
| 9023 | Rho d immune globulin 50 mcg | K | 0.0484 | $2.52 | | $.50 |
| 9024 | Amphotericin b lipid complex | K | 0.4167 | $21.73 | | $4.35 |
| 9104 | Anti-thymocyte globulin rabbit | K | 2.6356 | $137.45 | | $27.49 |
| 9105 | Hep B imm glob, per 1 ml | K | 1.5116 | $78.83 | | $15.77 |
| 9108 | Thyrotropin alfa, per 1.1 mg | K | 7.5870 | $395.67 | | $79.13 |
| 9109 | Tirofliban hcl, per 6.25 mg | K | 2.1996 | $114.71 | | $22.94 |
| 9110 | Alemtuzumab, per ml | G | | $511.22 | | $76.41 |
| 9111 | Inj, bivalirudin, per 250 mg vial | G | | $397.81 | | $56.46 |
| 9112 | Perflutren lipid micro, per 2ml | G | | $4.94 | | $.74 |
| 9113 | Inj, pantoprazole sodium, vial | G | | $22.80 | | $3.41 |
| 9114 | Nesiritide, per 1.5 mg vial | G | | $433.20 | | $64.75 |
| 9115 | Inj, zoledronic acid, per 2 mg | G | | $406.78 | | $60.80 |
| 9116 | Inj, Ertapenem sodium, per 1 gm vial | G | | $45.31 | | $6.77 |
| 9119 | Inj, Pegfilgrastim, per 6 mg single dose vial | G | | $2,802.50 | | $418.90 |
| 9120 | Inj, Fulvestrant, per 50 mg | G | | $87.58 | | $13.09 |
| 9121 | Inj, Argatroban, per 5 mg | G | | $14.25 | | $2.13 |
| 9200 | Orcel, per 36 cm2 | G | | $1,135.25 | | $169.69 |
| 9201 | Dermagraft, per 37.5 sq cm | G | | $577.60 | | $86.34 |
| 9217 | Leuprolide acetate suspnsion, 7.5 mg | K | 6.5696 | $342.61 | | $68.52 |
| 9500 | Platelets, irradiated | K | 1.4341 | $74.79 | | $14.96 |
| 9501 | Platelets, pheresis | K | 7.8390 | $408.81 | | $81.76 |
| 9502 | Platelet pheresis irradiated | K | 8.5076 | $443.68 | | $88.74 |
| 9503 | Fresh frozen plasma, ea unit | K | 1.3372 | $69.74 | | $13.95 |
| 9504 | RBC deglycerolized | K | 3.5174 | $183.44 | | $36.69 |
| 9505 | RBC irradiated | K | 2.0833 | $108.65 | | $21.73 |
| 9506 | Granulocytes, pheresis | K | 23.9432 | $1,248.66 | | $249.73 |

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 0001T | C | | Endovas repr abdo ao aneurys | | | | | |
| 0002T | C | | Endovas repr abdo ao aneurys | | | | | |
| 0003T | S | | Cervicography | 0706 | | $25.00 | | $5.00 |
| 0005T | C | | Perc cath stent/brain cv art | | | | | |
| 0006T | C | | Perc cath stent/brain cv art | | | | | |
| 0007T | C | | Perc cath stent/brain cv art | | | | | |
| 0008T | E | | Upper gi endoscopy w/suture | | | | | |
| 0009T | T | | Endometrial cryoablation | 0980 | | $1,875.00 | | $375.00 |
| 00100 | N | | Anesth, salivary gland | | | | | |
| 00102 | N | | Anesth, repair of cleft lip | | | | | |
| 00103 | N | | Anesth, blepharoplasty | | | | | |
| 00104 | N | | Anesth, electroshock | | | | | |
| 0010T | A | | Tb test, gamma interferon | | | | | |
| 00120 | N | | Anesth, ear surgery | | | | | |
| 00124 | N | | Anesth, ear exam | | | | | |
| 00126 | N | | Anesth, tympanotomy | | | | | |
| 0012T | T | | Osteochondral knee autograft | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 0013T | T | | Osteochondral knee allograft | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 00140 | N | | Anesth, procedures on eye | | | | | |
| 00142 | N | | Anesth, lens surgery | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | 26.1234 | $1,362.36 | | $272.47 |
| 00160 | N | | Anesth, nose/sinus surgery | | | | | |
| 00162 | N | | Anesth, nose/sinus surgery | | | | | |
| 00164 | N | | Anesth, biopsy of nose | | | | | |
| 0016T | E | | Thermotx choroid vasc lesion | | | | | |
| 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 | 0.5814 | $30.32 | $15.76 | $6.06 |
| 00190 | N | | Anesth, face/skull bone surg | | | | | |
| 00192 | C | | Anesth, facial bone surgery | | | | | |
| 0019T | A | | 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 | | Ultrasonic pachymetry | 0230 | 0.7364 | $38.40 | $14.97 | $7.68 |
| 0026T | A | | Measure remnant lipoproteins | | | | | |
| 0027T | T | NI | Endoscopic epidural lysis | 0976 | | $875.00 | | $175.00 |
| 0028T | N | NI | Dexa body composition study | | | | | |
| 0029T | N | NI | Magnetic tx for incontinence | | | | | |
| 00300 | N | | Anesth, head/neck/ptrunk | | | | | |
| 0030T | A | NI | Antiprothrombin antibody | | | | | |
| 0031T | N | NI | Speculoscopy | | | | | |
| 00320 | N | | Anesth, neck organ surgery | | | | | |
| 00322 | N | | Anesth, biopsy of thyroid | | | | | |
| 00326 | N | NI | Anesth, larynx/trach, < 1 yr | | | | | |
| 0032T | N | NI | Speculoscopy w/direct sample | | | | | |
| 0033T | C | NI | Endovasc taa repr incl subcl | | | | | |
| 0034T | C | NI | Endovasc taa repr w/o subcl | | | | | |
| 00350 | N | | Anesth, neck vessel surgery | | | | | |
| 00352 | N | | Anesth, neck vessel surgery | | | | | |
| 0035T | C | NI | Insert endovasc prosth, taa | | | | | |
| 0036T | C | NI | Endovasc prosth, taa, add-on | | | | | |
| 0037T | C | NI | Artery transpose/endovas taa | | | | | |
| 0038T | C | NI | Rad endovasc taa rpr w/cover | | | | | |
| 0039T | C | NI | Rad s/i, endovasc taa repair | | | | | |
| 00400 | N | | Anesth, skin, ext/per/atrunk | | | | | |
| 00402 | N | | Anesth, surgery of breast | | | | | |
| 00404 | C | | Anesth, surgery of breast | | | | | |
| 00406 | C | | Anesth, surgery of breast | | | | | |
| 0040T | C | NI | Rad s/i, endovasc taa prosth | | | | | |
| 00410 | N | | Anesth, correct heart rhythm | | | | | |
| 0041T | A | NI | Detect ur infect agnt w/cpas | | | | | |
| 0042T | N | NI | Ct perfusion w/contrast, cbf | | | | | |
| 0043T | A | NI | Co expired gas analysis | | | | | |
| 0044T | N | NI | Whole body photography | | | | | |
| 00450 | N | | Anesth, surgery of shoulder | | | | | |
| 00452 | C | | Anesth, surgery of shoulder | | | | | |
| 00454 | N | | Anesth, collar bone biopsy | | | | | |
| 00470 | N | | Anesth, removal of rib | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 00472 | N | | Anesth, chest wall repair | | | | | |
| 00474 | C | | Anesth, surgery of rib(s) | | | | | |
| 00500 | N | | Anesth, esophageal surgery | | | | | |
| 00520 | N | | Anesth, chest procedure | | | | | |
| 00522 | N | | Anesth, chest lining biopsy | | | | | |
| 00524 | C | | Anesth, chest drainage | | | | | |
| 00528 | N | | Anesth, chest partition view | | | | | |
| 00530 | N | | Anesth, pacemaker insertion | | | | | |
| 00532 | N | | Anesth, vascular access | | | | | |
| 00534 | N | | Anesth, cardioverter/defib | | | | | |
| 00537 | N | | Anesth, cardiac electrophys | | | | | |
| 00539 | N | NI | Anesth, trach-bronch reconst | | | | | |
| 00540 | C | | Anesth, chest surgery | | | | | |
| 00541 | N | NI | Anesth, one lung ventilation | | | | | |
| 00542 | C | | Anesth, release of lung | | | | | |
| 00544 | C | | Anesth, chest lining removal | | | | | |
| 00546 | C | | Anesth, lung,chest wall surg | | | | | |
| 00548 | N | | Anesth, trachea,bronchi surg | | | | | |
| 00550 | N | | Anesth, sternal debridement | | | | | |
| 00560 | C | | Anesth, open heart surgery | | | | | |
| 00562 | C | | Anesth, open heart surgery | | | | | |
| 00563 | N | | Anesth, heart proc w/pump | | | | | |
| 00566 | N | | Anesth, cabg w/o pump | | | | | |
| 00580 | C | | Anesth, heart/lung transplnt | | | | | |
| 00600 | N | | Anesth, spine, cord surgery | | | | | |
| 00604 | C | | Anesth, sitting procedure | | | | | |
| 00620 | N | | Anesth, spine, cord surgery | | | | | |
| 00622 | C | | Anesth, removal of nerves | | | | | |
| 00630 | N | | Anesth, spine, cord surgery | | | | | |
| 00632 | C | | Anesth, removal of nerves | | | | | |
| 00634 | C | | Anesth for chemonucleolysis | | | | | |
| 00635 | N | | Anesth, lumbar puncture | | | | | |
| 00640 | N | NI | Anesth, spine manipulation | | | | | |
| 00670 | C | | Anesth, spine, cord surgery | | | | | |
| 00700 | N | | Anesth, abdominal wall surg | | | | | |
| 00702 | N | | Anesth, for liver biopsy | | | | | |
| 00730 | N | | Anesth, abdominal wall surg | | | | | |
| 00740 | N | | Anesth, upper gi visualize | | | | | |
| 00750 | N | | Anesth, repair of hernia | | | | | |
| 00752 | N | | Anesth, repair of hernia | | | | | |
| 00754 | N | | Anesth, repair of hernia | | | | | |
| 00756 | N | | Anesth, repair of hernia | | | | | |
| 00770 | N | | Anesth, blood vessel repair | | | | | |
| 00790 | N | | Anesth, surg upper abdomen | | | | | |
| 00792 | C | | Anesth, hemorr/excise liver | | | | | |
| 00794 | C | | Anesth, pancreas removal | | | | | |
| 00796 | C | | Anesth, for liver transplant | | | | | |
| 00797 | N | | Anesth, surgery for obesity | | | | | |
| 00800 | N | | Anesth, abdominal wall surg | | | | | |
| 00802 | C | | Anesth, fat layer removal | | | | | |
| 00810 | N | | Anesth, low intestine scope | | | | | |
| 00820 | N | | Anesth, abdominal wall surg | | | | | |
| 00830 | N | | Anesth, repair of hernia | | | | | |
| 00832 | N | | Anesth, repair of hernia | | | | | |
| 00834 | N | NI | Anesth, hernia repair< 1 yr | | | | | |
| 00836 | N | NI | 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 00865 | C | | Anesth, removal of prostate | | | | | |
| 00866 | C | | Anesth, removal of adrenal | | | | | |
| 00868 | C | | Anesth, kidney transplant | | | | | |
| 00869 | N | DG | Anesth, vasectomy | | | | | |
| 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 | NI | 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 | | | | | |
| 01180 | N | | Anesth, pelvis nerve removal | | | | | |
| 01190 | C | | Anesth, pelvis nerve removal | | | | | |
| 01200 | N | | Anesth, hip joint procedure | | | | | |
| 01202 | N | | Anesth, arthroscopy of hip | | | | | |
| 01210 | N | | Anesth, hip joint surgery | | | | | |
| 01212 | C | | Anesth, hip disarticulation | | | | | |
| 01214 | C | | Anesth, hip arthroplasty | | | | | |
| 01215 | N | | Anesth, revise hip repair | | | | | |
| 01220 | N | | Anesth, procedure on femur | | | | | |
| 01230 | N | | Anesth, surgery of femur | | | | | |
| 01232 | C | | Anesth, amputation of femur | | | | | |
| 01234 | C | | Anesth, radical femur surg | | | | | |
| 01250 | N | | Anesth, upper leg surgery | | | | | |
| 01260 | N | | Anesth, upper leg veins surg | | | | | |
| 01270 | N | | Anesth, thigh arteries surg | | | | | |
| 01272 | C | | Anesth, femoral artery surg | | | | | |
| 01274 | C | | Anesth, femoral embolectomy | | | | | |
| 01320 | N | | Anesth, knee area surgery | | | | | |
| 01340 | N | | Anesth, knee area procedure | | | | | |
| 01360 | N | | Anesth, knee area surgery | | | | | |
| 01380 | N | | Anesth, knee joint procedure | | | | | |
| 01382 | N | | Anesth, knee arthroscopy | | | | | |
| 01390 | N | | Anesth, knee area procedure | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 01392 | N | | Anesth, knee area surgery | | | | | |
| 01400 | N | | Anesth, knee joint surgery | | | | | |
| 01402 | C | | Anesth, knee arthroplasty | | | | | |
| 01404 | C | | Anesth, amputation at knee | | | | | |
| 01420 | N | | Anesth, knee joint casting | | | | | |
| 01430 | N | | Anesth, knee veins surgery | | | | | |
| 01432 | N | | Anesth, knee vessel surg | | | | | |
| 01440 | N | | Anesth, knee arteries surg | | | | | |
| 01442 | C | | Anesth, knee artery surg | | | | | |
| 01444 | C | | Anesth, knee artery repair | | | | | |
| 01462 | N | | Anesth, lower leg procedure | | | | | |
| 01464 | N | | Anesth, ankle arthroscopy | | | | | |
| 01470 | N | | Anesth, lower leg surgery | | | | | |
| 01472 | N | | Anesth, achilles tendon surg | | | | | |
| 01474 | N | | Anesth, lower leg surgery | | | | | |
| 01480 | N | | Anesth, lower leg bone surg | | | | | |
| 01482 | N | | Anesth, radical leg surgery | | | | | |
| 01484 | N | | Anesth, lower leg revision | | | | | |
| 01486 | C | | Anesth, ankle replacement | | | | | |
| 01490 | N | | Anesth, lower leg casting | | | | | |
| 01500 | N | | Anesth, leg arteries surg | | | | | |
| 01502 | C | | Anesth, lwr leg embolectomy | | | | | |
| 01520 | N | | Anesth, lower leg vein surg | | | | | |
| 01522 | N | | Anesth, lower leg vein surg | | | | | |
| 01610 | N | | Anesth, surgery of shoulder | | | | | |
| 01620 | N | | Anesth, shoulder procedure | | | | | |
| 01622 | N | | Anesth, shoulder arthroscopy | | | | | |
| 01630 | N | | Anesth, surgery of shoulder | | | | | |
| 01632 | C | | Anesth, surgery of shoulder | | | | | |
| 01634 | C | | Anesth, shoulder joint amput | | | | | |
| 01636 | C | | Anesth, forequarter amput | | | | | |
| 01638 | C | | Anesth, shoulder replacement | | | | | |
| 01650 | N | | Anesth, shoulder artery surg | | | | | |
| 01652 | C | | Anesth, shoulder vessel surg | | | | | |
| 01654 | C | | Anesth, shoulder vessel surg | | | | | |
| 01656 | C | | Anesth, arm-leg vessel surg | | | | | |
| 01670 | N | | Anesth, shoulder vein surg | | | | | |
| 01680 | N | | Anesth, shoulder casting | | | | | |
| 01682 | N | | Anesth, airplane cast | | | | | |
| 01710 | N | | Anesth, elbow area surgery | | | | | |
| 01712 | N | | Anesth, uppr arm tendon surg | | | | | |
| 01714 | N | | Anesth, uppr arm tendon surg | | | | | |
| 01716 | N | | Anesth, biceps tendon repair | | | | | |
| 01730 | N | | Anesth, uppr arm procedure | | | | | |
| 01732 | N | | Anesth, elbow arthroscopy | | | | | |
| 01740 | N | | Anesth, upper arm surgery | | | | | |
| 01742 | N | | Anesth, humerus surgery | | | | | |
| 01744 | N | | Anesth, humerus repair | | | | | |
| 01756 | C | | Anesth, radical humerus surg | | | | | |
| 01758 | N | | Anesth, humeral lesion surg | | | | | |
| 01760 | N | | Anesth, elbow replacement | | | | | |
| 01770 | N | | Anesth, uppr arm artery surg | | | | | |
| 01772 | N | | Anesth, uppr arm embolectomy | | | | | |
| 01780 | N | | Anesth, upper arm vein surg | | | | | |
| 01782 | N | | Anesth, uppr arm vein repair | | | | | |
| 01810 | N | | Anesth, lower arm surgery | | | | | |
| 01820 | N | | Anesth, lower arm procedure | | | | | |
| 01829 | N | NI | 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—Continued

[Calendar Year 2003]

| 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 | | | | | |
| 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 | NI | Anesth, nerve block/inj | | | | | |
| 01992 | N | NI | Anesth, n block/inj, prone | | | | | |
| 01995 | N | | Regional anesthesia limb | | | | | |
| 01996 | N | | Manage daily drug therapy | | | | | |
| 01999 | N | | Unlisted anesth procedure | | | | | |
| 10021 | T | | Fna w/o image | 0002 | 0.5911 | $30.83 | | $6.17 |
| 10022 | T | | Fna w/image | 0002 | 0.5911 | $30.83 | | $6.17 |
| 10040 | T | | Acne surgery | 0010 | 0.6589 | $34.36 | $10.08 | $6.87 |
| 10060 | T | | Drainage of skin abscess | 0006 | 1.7926 | $93.49 | $24.12 | $18.70 |
| 10061 | T | | Drainage of skin abscess | 0006 | 1.7926 | $93.49 | $24.12 | $18.70 |
| 10080 | T | | Drainage of pilonidal cyst | 0006 | 1.7926 | $93.49 | $24.12 | $18.70 |
| 10081 | T | | Drainage of pilonidal cyst | 0007 | 10.0191 | $522.51 | $108.89 | $104.50 |
| 10120 | T | | Remove foreign body | 0006 | 1.7926 | $93.49 | $24.12 | $18.70 |
| 10121 | T | | Remove foreign body | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 10140 | T | | Drainage of hematoma/fluid | 0007 | 10.0191 | $522.51 | $108.89 | $104.50 |
| 10160 | T | | Puncture drainage of lesion | 0018 | 0.9399 | $49.02 | $16.04 | $9.80 |
| 10180 | T | | Complex drainage, wound | 0007 | 10.0191 | $522.51 | $108.89 | $104.50 |
| 11000 | T | | Debride infected skin | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 11001 | T | | Debride infected skin add-on | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 11010 | T | | Debride skin, fx | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11011 | T | | Debride skin/muscle, fx | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11012 | T | | Debride skin/muscle/bone, fx | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11040 | T | | Debride skin, partial | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 11041 | T | | Debride skin, full | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 11042 | T | | Debride skin/tissue | 0016 | 2.6162 | $136.44 | $57.31 | $27.29 |
| 11043 | T | | Debride tissue/muscle | 0016 | 2.6162 | $136.44 | $57.31 | $27.29 |
| 11044 | T | | Debride tissue/muscle/bone | 0682 | 7.2770 | $379.50 | $174.57 | $75.90 |
| 11055 | T | | Trim skin lesion | 0012 | 0.7849 | $40.93 | $11.18 | $8.19 |
| 11056 | T | | Trim skin lesions, 2 to 4 | 0012 | 0.7849 | $40.93 | $11.18 | $8.19 |
| 11057 | T | | Trim skin lesions, over 4 | 0012 | 0.7849 | $40.93 | $11.18 | $8.19 |
| 11100 | T | | Biopsy of skin lesion | 0018 | 0.9399 | $49.02 | $16.04 | $9.80 |
| 11101 | T | | Biopsy, skin add-on | 0018 | 0.9399 | $49.02 | $16.04 | $9.80 |
| 11200 | T | | Removal of skin tags | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 11201 | T | | Remove skin tags add-on | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 11300 | T | | Shave skin lesion | 0012 | 0.7849 | $40.93 | $11.18 | $8.19 |
| 11301 | T | | Shave skin lesion | 0012 | 0.7849 | $40.93 | $11.18 | $8.19 |
| 11302 | T | | Shave skin lesion | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 11303 | T | | Shave skin lesion | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 11305 | T | | Shave skin lesion | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 11306 | T | | Shave skin lesion | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 11307 | T | | Shave skin lesion | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 11308 | T | | Shave skin lesion | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 11310 | T | | Shave skin lesion | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 11311 | T | | Shave skin lesion | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 11312 | T | | Shave skin lesion | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 11313 | T | | Shave skin lesion | 0016 | 2.6162 | $136.44 | $57.31 | $27.29 |
| 11400 | T | | Removal of skin lesion | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 11401 | T | | Removal of skin lesion | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 11402 | T | | Removal of skin lesion | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 11403 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11404 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11406 | T | | Removal of skin lesion | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 11420 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11421 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11422 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11423 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11424 | T | | Removal of skin lesion | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 11426 | T | | Removal of skin lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11440 | T | | Removal of skin lesion | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 11441 | T | | Removal of skin lesion | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 11442 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11443 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11444 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11446 | T | | Removal of skin lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11450 | T | | Removal, sweat gland lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11451 | T | | Removal, sweat gland lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11462 | T | | Removal, sweat gland lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11463 | T | | Removal, sweat gland lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11470 | T | | Removal, sweat gland lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11471 | T | | Removal, sweat gland lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11600 | T | | Removal of skin lesion | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 11601 | T | | Removal of skin lesion | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 11602 | T | | Removal of skin lesion | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 11603 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11604 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11606 | T | | Removal of skin lesion | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 11620 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11621 | T | | Removal of skin lesion | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 11622 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11623 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11624 | T | | Removal of skin lesion | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 11626 | T | | Removal of skin lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11640 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11641 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11642 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11643 | T | | Removal of skin lesion | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 11644 | T | | Removal of skin lesion | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 11646 | T | | Removal of skin lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11719 | T | | Trim nail(s) | 0009 | 0.6298 | $32.84 | $8.34 | $6.57 |
| 11720 | T | | Debride nail, 1-5 | 0009 | 0.6298 | $32.84 | $8.34 | $6.57 |
| 11721 | T | | Debride nail, 6 or more | 0009 | 0.6298 | $32.84 | $8.34 | $6.57 |
| 11730 | T | | Removal of nail plate | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 11732 | T | | Remove nail plate, add-on | 0012 | 0.7849 | $40.93 | $11.18 | $8.19 |
| 11740 | T | | Drain blood from under nail | 0009 | 0.6298 | $32.84 | $8.34 | $6.57 |
| 11750 | T | | Removal of nail bed | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 11752 | T | | Remove nail bed/finger tip | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11755 | T | | Biopsy, nail unit | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 11760 | T | | Repair of nail bed | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 11762 | T | | Reconstruction of nail bed | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 11765 | T | | Excision of nail fold, toe | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 11770 | T | | Removal of pilonidal lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11771 | T | | Removal of pilonidal lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11772 | T | | Removal of pilonidal lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11900 | T | | Injection into skin lesions | 0012 | 0.7849 | $40.93 | $11.18 | $8.19 |
| 11901 | T | | Added skin lesions injection | 0012 | 0.7849 | $40.93 | $11.18 | $8.19 |
| 11920 | T | | Correct skin color defects | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 11921 | T | | Correct skin color defects | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 11922 | T | | Correct skin color defects | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 11950 | T | | Therapy for contour defects | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 11951 | T | | Therapy for contour defects | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 11952 | T | | Therapy for contour defects | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 11954 | T | | Therapy for contour defects | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 11960 | T | | Insert tissue expander(s) | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 11970 | T | | Replace tissue expander | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 11971 | T | | Remove tissue expander(s) | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 11975 | E | | Insert contraceptive cap | | | | | |
| 11976 | T | | Removal of contraceptive cap | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 11977 | E | | Removal/reinsert contra cap | | | | | |
| 11980 | X | | Implant hormone pellet(s) | 0340 | 0.6492 | $33.86 | | $6.77 |
| 11981 | X | | Insert drug implant device | 0340 | 0.6492 | $33.86 | | $6.77 |
| 11982 | X | | Remove drug implant device | 0340 | 0.6492 | $33.86 | | $6.77 |
| 11983 | X | | Remove/insert drug implant | 0340 | 0.6492 | $33.86 | | $6.77 |
| 12001 | T | | Repair superficial wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12002 | T | | Repair superficial wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12004 | T | | Repair superficial wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12005 | T | | Repair superficial wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12006 | T | | Repair superficial wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12007 | T | | Repair superficial wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12011 | T | | Repair superficial wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12013 | T | | Repair superficial wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12014 | T | | Repair superficial wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12015 | T | | Repair superficial wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12016 | T | | Repair superficial wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12017 | T | | Repair superficial wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12018 | T | | Repair superficial wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12020 | T | | Closure of split wound | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12021 | T | | Closure of split wound | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12031 | T | | Layer closure of wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12032 | T | | Layer closure of wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12034 | T | | Layer closure of wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12035 | T | | Layer closure of wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12036 | T | | Layer closure of wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12037 | T | | Layer closure of wound(s) | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 12041 | T | | Layer closure of wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12042 | T | | Layer closure of wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12044 | T | | Layer closure of wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12045 | T | | Layer closure of wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12046 | T | | Layer closure of wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12047 | T | | Layer closure of wound(s) | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 12051 | T | | Layer closure of wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12052 | T | | Layer closure of wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12053 | T | | Layer closure of wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12054 | T | | Layer closure of wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12055 | T | | Layer closure of wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12056 | T | | Layer closure of wound(s) | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 12057 | T | | Layer closure of wound(s) | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 13100 | T | | Repair of wound or lesion | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 13101 | T | | Repair of wound or lesion | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 13102 | T | | Repair wound/lesion add-on | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 13120 | T | | Repair of wound or lesion | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 13121 | T | | Repair of wound or lesion | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 13122 | T | | Repair wound/lesion add-on | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 13131 | T | | Repair of wound or lesion | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 13132 | T | | Repair of wound or lesion | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 13133 | T | | Repair wound/lesion add-on | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 13150 | T | | Repair of wound or lesion | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 13151 | T | | Repair of wound or lesion | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 13152 | T | | Repair of wound or lesion | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 13153 | T | | Repair wound/lesion add-on | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 13160 | T | | Late closure of wound | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 14000 | T | | Skin tissue rearrangement | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 14001 | T | | Skin tissue rearrangement | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 14020 | T | | Skin tissue rearrangement | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 14021 | T | | Skin tissue rearrangement | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 14040 | T | | Skin tissue rearrangement | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 14041 | T | | Skin tissue rearrangement | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 14060 | T | | Skin tissue rearrangement | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 14061 | T | | Skin tissue rearrangement | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 14300 | T | | Skin tissue rearrangement | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 14350 | T | | Skin tissue rearrangement | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15000 | T | | Skin graft | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 15001 | T | | Skin graft add-on | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 15050 | T | | Skin pinch graft | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 15100 | T | | Skin split graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15101 | T | | Skin split graft add-on | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15120 | T | | Skin split graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15121 | T | | Skin split graft add-on | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15200 | T | | Skin full graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15201 | T | | Skin full graft add-on | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 15220 | T | | Skin full graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15221 | T | | Skin full graft add-on | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 15240 | T | | Skin full graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15241 | T | | Skin full graft add-on | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 15260 | T | | Skin full graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15261 | T | | Skin full graft add-on | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 15342 | T | | Cultured skin graft, 25 cm | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 15343 | T | | Culture skn graft addl 25 cm | 0024 | 1.8507 | $96.52 | $34.75 | $19.30 |
| 15350 | T | | Skin homograft | 0686 | 14.2439 | $742.83 | $341.70 | $148.57 |
| 15351 | T | | Skin homograft add-on | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15400 | T | | Skin heterograft | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 15401 | T | | Skin heterograft add-on | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 15570 | T | | Form skin pedicle flap | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15572 | T | | Form skin pedicle flap | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15574 | T | | Form skin pedicle flap | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15576 | T | | Form skin pedicle flap | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15600 | T | | Skin graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15610 | T | | Skin graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15620 | T | | Skin graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15630 | T | | Skin graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15650 | T | | Transfer skin pedicle flap | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15732 | T | | Muscle-skin graft, head/neck | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15734 | T | | Muscle-skin graft, trunk | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15736 | T | | Muscle-skin graft, arm | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15738 | T | | Muscle-skin graft, leg | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15740 | T | | Island pedicle flap graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15750 | T | | Neurovascular pedicle graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15756 | C | | Free muscle flap, microvasc | | | | | |
| 15757 | C | | Free skin flap, microvasc | | | | | |
| 15758 | C | | Free fascial flap, microvasc | | | | | |
| 15760 | T | | Composite skin graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15770 | T | | Derma-fat-fascia graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15775 | T | | Hair transplant punch grafts | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 15776 | T | | Hair transplant punch grafts | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 15780 | T | | Abrasion treatment of skin | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 15781 | T | | Abrasion treatment of skin | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 15782 | T | | Abrasion treatment of skin | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 15783 | T | | Abrasion treatment of skin | 0016 | 2.6162 | $136.44 | $57.31 | $27.29 |
| 15786 | T | | Abrasion, lesion, single | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 15787 | T | | Abrasion, lesions, add-on | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 15788 | T | | Chemical peel, face, epiderm | 0012 | 0.7849 | $40.93 | $11.18 | $8.19 |
| 15789 | T | | Chemical peel, face, dermal | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 15792 | T | | Chemical peel, nonfacial | 0012 | 0.7849 | $40.93 | $11.18 | $8.19 |
| 15793 | T | | Chemical peel, nonfacial | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 15810 | T | | Salabrasion | 0016 | 2.6162 | $136.44 | $57.31 | $27.29 |
| 15811 | T | | Salabrasion | 0016 | 2.6162 | $136.44 | $57.31 | $27.29 |
| 15819 | T | | Plastic surgery, neck | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 15820 | T | | Revision of lower eyelid | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15821 | T | | Revision of lower eyelid | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15822 | T | | Revision of upper eyelid | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15823 | T | | Revision of upper eyelid | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15824 | T | | Removal of forehead wrinkles | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15825 | T | | Removal of neck wrinkles | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15826 | T | | Removal of brow wrinkles | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15828 | T | | Removal of face wrinkles | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15829 | T | | Removal of skin wrinkles | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15831 | T | | Excise excessive skin tissue | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 15832 | T | | Excise excessive skin tissue | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 15833 | T | | Excise excessive skin tissue | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 15834 | T | | Excise excessive skin tissue | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 15835 | T | | Excise excessive skin tissue | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 15836 | T | | Excise excessive skin tissue | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 15837 | T | | Excise excessive skin tissue | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 15838 | T | | Excise excessive skin tissue | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 15839 | T | | Excise excessive skin tissue | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 15840 | T | | Graft for face nerve palsy | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15841 | T | | Graft for face nerve palsy | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15842 | T | | Flap for face nerve palsy | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15845 | T | | Skin and muscle repair, face | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15850 | T | | Removal of sutures | 0016 | 2.6162 | $136.44 | $57.31 | $27.29 |
| 15851 | T | | Removal of sutures | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 15852 | X | | Dressing change,not for burn | 0340 | 0.6492 | $33.86 | | $6.77 |
| 15860 | S | | Test for blood flow in graft | 0706 | | $25.00 | | $5.00 |
| 15876 | T | | Suction assisted lipectomy | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15877 | T | | Suction assisted lipectomy | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15878 | T | | Suction assisted lipectomy | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15879 | T | | Suction assisted lipectomy | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15920 | T | | Removal of tail bone ulcer | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 15922 | T | | Removal of tail bone ulcer | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15931 | T | | Remove sacrum pressure sore | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 15933 | T | | Remove sacrum pressure sore | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 15934 | T | | Remove sacrum pressure sore | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15935 | T | | Remove sacrum pressure sore | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15936 | T | | Remove sacrum pressure sore | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15937 | T | | Remove sacrum pressure sore | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15940 | T | | Remove hip pressure sore | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 15941 | T | | Remove hip pressure sore | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 15944 | T | | Remove hip pressure sore | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15945 | T | | Remove hip pressure sore | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15946 | T | | Remove hip pressure sore | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15950 | T | | Remove thigh pressure sore | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 15951 | T | | Remove thigh pressure sore | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 15952 | T | | Remove thigh pressure sore | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15953 | T | | Remove thigh pressure sore | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15956 | T | | Remove thigh pressure sore | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15958 | T | | Remove thigh pressure sore | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 15999 | T | | Removal of pressure sore | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 16000 | T | | Initial treatment of burn(s) | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 16010 | T | | Treatment of burn(s) | 0016 | 2.6162 | $136.44 | $57.31 | $27.29 |
| 16015 | T | | Treatment of burn(s) | 0017 | 15.8233 | $825.20 | $227.84 | $165.04 |
| 16020 | T | | Treatment of burn(s) | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 16025 | T | | Treatment of burn(s) | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 16030 | T | | Treatment of burn(s) | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 16035 | C | | Incision of burn scab, initi | | | | | |
| 16036 | C | | Incise burn scab, addl incis | | | | | |
| 17000 | T | | Destroy benign/premlg lesion | 0010 | 0.6589 | $34.36 | $10.08 | $6.87 |
| 17003 | T | | Destroy lesions, 2-14 | 0010 | 0.6589 | $34.36 | $10.08 | $6.87 |
| 17004 | T | | Destroy lesions, 15 or more | 0011 | 1.8507 | $96.52 | $27.88 | $19.30 |
| 17106 | T | | Destruction of skin lesions | 0011 | 1.8507 | $96.52 | $27.88 | $19.30 |
| 17107 | T | | Destruction of skin lesions | 0011 | 1.8507 | $96.52 | $27.88 | $19.30 |
| 17108 | T | | Destruction of skin lesions | 0011 | 1.8507 | $96.52 | $27.88 | $19.30 |
| 17110 | T | | Destruct lesion, 1-14 | 0010 | 0.6589 | $34.36 | $10.08 | $6.87 |

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*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 17111 | T | | Destruct lesion, 15 or more | 0011 | 1.8507 | $96.52 | $27.88 | $19.30 |
| 17250 | T | | Chemical cautery, tissue | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 17260 | T | | Destruction of skin lesions | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 17261 | T | | Destruction of skin lesions | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 17262 | T | | Destruction of skin lesions | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 17263 | T | | Destruction of skin lesions | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 17264 | T | | Destruction of skin lesions | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 17266 | T | | Destruction of skin lesions | 0016 | 2.6162 | $136.44 | $57.31 | $27.29 |
| 17270 | T | | Destruction of skin lesions | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 17271 | T | | Destruction of skin lesions | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 17272 | T | | Destruction of skin lesions | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 17273 | T | | Destruction of skin lesions | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 17274 | T | | Destruction of skin lesions | 0016 | 2.6162 | $136.44 | $57.31 | $27.29 |
| 17276 | T | | Destruction of skin lesions | 0016 | 2.6162 | $136.44 | $57.31 | $27.29 |
| 17280 | T | | Destruction of skin lesions | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 17281 | T | | Destruction of skin lesions | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 17282 | T | | Destruction of skin lesions | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 17283 | T | | Destruction of skin lesions | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 17284 | T | | Destruction of skin lesions | 0016 | 2.6162 | $136.44 | $57.31 | $27.29 |
| 17286 | T | | Destruction of skin lesions | 0015 | 1.5407 | $80.35 | $20.35 | $16.07 |
| 17304 | T | | Chemosurgery of skin lesion | 0694 | 3.4689 | $180.91 | $72.36 | $36.18 |
| 17305 | T | | 2 stage mohs, up to 5 spec | 0694 | 3.4689 | $180.91 | $72.36 | $36.18 |
| 17306 | T | | 3 stage mohs, up to 5 spec | 0694 | 3.4689 | $180.91 | $72.36 | $36.18 |
| 17307 | T | | Mohs addl stage up to 5 spec | 0694 | 3.4689 | $180.91 | $72.36 | $36.18 |
| 17310 | T | | Extensive skin chemosurgery | 0694 | 3.4689 | $180.91 | $72.36 | $36.18 |
| 17340 | T | | Cryotherapy of skin | 0012 | 0.7849 | $40.93 | $11.18 | $8.19 |
| 17360 | T | | Skin peel therapy | 0012 | 0.7849 | $40.93 | $11.18 | $8.19 |
| 17380 | T | | Hair removal by electrolysis | 0012 | 0.7849 | $40.93 | $11.18 | $8.19 |
| 17999 | T | | Skin tissue procedure | 0006 | 1.7926 | $93.49 | $24.12 | $18.70 |
| 19000 | T | | Drainage of breast lesion | 0004 | 1.7441 | $90.96 | $23.47 | $18.19 |
| 19001 | T | | Drain breast lesion add-on | 0004 | 1.7441 | $90.96 | $23.47 | $18.19 |
| 19020 | T | | Incision of breast lesion | 0008 | 16.1430 | $841.87 | | $168.37 |
| 19030 | N | | Injection for breast x-ray | | | | | |
| 19100 | T | | Bx breast percut w/o image | 0005 | 3.1201 | $162.72 | $71.59 | $32.54 |
| 19101 | T | | Biopsy of breast, open | 0028 | 16.8698 | $879.78 | $303.74 | $175.96 |
| 19102 | T | | Bx breast percut w/image | 0005 | 3.1201 | $162.72 | $71.59 | $32.54 |
| 19103 | T | | Bx breast percut w/device | 0658 | 5.2712 | $274.90 | | $54.98 |
| 19110 | T | | Nipple exploration | 0028 | 16.8698 | $879.78 | $303.74 | $175.96 |
| 19112 | T | | Excise breast duct fistula | 0028 | 16.8698 | $879.78 | $303.74 | $175.96 |
| 19120 | T | | Removal of breast lesion | 0028 | 16.8698 | $879.78 | $303.74 | $175.96 |
| 19125 | T | | Excision, breast lesion | 0028 | 16.8698 | $879.78 | $303.74 | $175.96 |
| 19126 | T | | Excision, addl breast lesion | 0028 | 16.8698 | $879.78 | $303.74 | $175.96 |
| 19140 | T | | Removal of breast tissue | 0028 | 16.8698 | $879.78 | $303.74 | $175.96 |
| 19160 | T | | Removal of breast tissue | 0028 | 16.8698 | $879.78 | $303.74 | $175.96 |
| 19162 | T | | Remove breast tissue, nodes | 0693 | 37.5863 | $1,960.16 | $798.17 | $392.03 |
| 19180 | T | | Removal of breast | 0029 | 28.7881 | $1,501.33 | $632.64 | $300.27 |
| 19182 | T | | Removal of breast | 0029 | 28.7881 | $1,501.33 | $632.64 | $300.27 |
| 19200 | C | | Removal of breast | | | | | |
| 19220 | C | | Removal of breast | | | | | |
| 19240 | T | | Removal of breast | 0030 | 37.5185 | $1,956.63 | $763.55 | $391.33 |
| 19260 | T | | Removal of chest wall lesion | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 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 | 1.4438 | $75.30 | | $15.06 |
| 19316 | T | | Suspension of breast | 0029 | 28.7881 | $1,501.33 | $632.64 | $300.27 |
| 19318 | T | | Reduction of large breast | 0693 | 37.5863 | $1,960.16 | $798.17 | $392.03 |
| 19324 | T | | Enlarge breast | 0693 | 37.5863 | $1,960.16 | $798.17 | $392.03 |
| 19325 | T | | Enlarge breast with implant | 0648 | 44.7955 | $2,336.13 | | $467.23 |
| 19328 | T | | Removal of breast implant | 0029 | 28.7881 | $1,501.33 | $632.64 | $300.27 |
| 19330 | T | | Removal of implant material | 0029 | 28.7881 | $1,501.33 | $632.64 | $300.27 |
| 19340 | T | | Immediate breast prosthesis | 0030 | 37.5185 | $1,956.63 | $763.55 | $391.33 |
| 19342 | T | | Delayed breast prosthesis | 0648 | 44.7955 | $2,336.13 | | $467.23 |
| 19350 | T | | Breast reconstruction | 0029 | 28.7881 | $1,501.33 | $632.64 | $300.27 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 19355 | T | | Correct inverted nipple(s) | 0029 | 28.7881 | $1,501.33 | $632.64 | $300.27 |
| 19357 | T | | Breast reconstruction | 0648 | 44.7955 | $2,336.13 | | $467.23 |
| 19361 | C | | Breast reconstruction | | | | | |
| 19364 | C | | Breast reconstruction | | | | | |
| 19366 | T | | Breast reconstruction | 0029 | 28.7881 | $1,501.33 | $632.64 | $300.27 |
| 19367 | C | | Breast reconstruction | | | | | |
| 19368 | C | | Breast reconstruction | | | | | |
| 19369 | C | | Breast reconstruction | | | | | |
| 19370 | T | | Surgery of breast capsule | 0029 | 28.7881 | $1,501.33 | $632.64 | $300.27 |
| 19371 | T | | Removal of breast capsule | 0029 | 28.7881 | $1,501.33 | $632.64 | $300.27 |
| 19380 | T | | Revise breast reconstruction | 0030 | 37.5185 | $1,956.63 | $763.55 | $391.33 |
| 19396 | T | | Design custom breast implant | 0029 | 28.7881 | $1,501.33 | $632.64 | $300.27 |
| 19499 | T | | Breast surgery procedure | 0028 | 16.8698 | $879.78 | $303.74 | $175.96 |
| 20000 | T | | Incision of abscess | 0006 | 1.7926 | $93.49 | $24.12 | $18.70 |
| 20005 | T | | Incision of deep abscess | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 20100 | T | | Explore wound, neck | 0023 | 2.5193 | $131.38 | $40.37 | $26.28 |
| 20101 | T | | Explore wound, chest | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 20102 | T | | Explore wound, abdomen | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 20103 | T | | Explore wound, extremity | 0023 | 2.5193 | $131.38 | $40.37 | $26.28 |
| 20150 | T | | Excise epiphyseal bar | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 20200 | T | | Muscle biopsy | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 20205 | T | | Deep muscle biopsy | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 20206 | T | | Needle biopsy, muscle | 0005 | 3.1201 | $162.72 | $71.59 | $32.54 |
| 20220 | T | | Bone biopsy, trocar/needle | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 20225 | T | | Bone biopsy, trocar/needle | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 20240 | T | | Bone biopsy, excisional | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 20245 | T | | Bone biopsy, excisional | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 20250 | T | | Open bone biopsy | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 20251 | T | | Open bone biopsy | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 20500 | T | | Injection of sinus tract | 0251 | 1.9089 | $99.55 | | $19.91 |
| 20501 | N | | Inject sinus tract for x-ray | | | | | |
| 20520 | T | | Removal of foreign body | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 20525 | T | | Removal of foreign body | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 20526 | T | | Ther injection, carp tunnel | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 20550 | T | | Inject tendon/ligament/cyst | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 20551 | T | | Inject tendon origin/insert | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 20552 | T | | Inject trigger point, 1 or 2 | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 20553 | T | | Inject trigger points, > 3 | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 20600 | T | | Drain/inject, joint/bursa | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 20605 | T | | Drain/inject, joint/bursa | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 20610 | T | | Drain/inject, joint/bursa | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 20612 | T | NI | Aspirate/inj ganglion cyst | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 20615 | T | | Treatment of bone cyst | 0004 | 1.7441 | $90.96 | $23.47 | $18.19 |
| 20650 | T | | Insert and remove bone pin | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 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 | 0.6492 | $33.86 | | $6.77 |
| 20670 | T | | Removal of support implant | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 20680 | T | | Removal of support implant | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 20690 | T | | Apply bone fixation device | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 20692 | T | | Apply bone fixation device | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 20693 | T | | Adjust bone fixation device | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 20694 | T | | Remove bone fixation device | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 20802 | C | | Replantation, arm, complete | | | | | |
| 20805 | C | | Replant forearm, complete | | | | | |
| 20808 | C | | Replantation hand, complete | | | | | |
| 20816 | C | | Replantation digit, complete | | | | | |
| 20822 | C | | Replantation digit, complete | | | | | |
| 20824 | C | | Replantation thumb, complete | | | | | |
| 20827 | C | | Replantation thumb, complete | | | | | |
| 20838 | C | | Replantation foot, complete | | | | | |
| 20900 | T | | Removal of bone for graft | 0050 | 23.3037 | $1,215.31 | | $243.06 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 20902 | T | | Removal of bone for graft | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 20910 | T | | Remove cartilage for graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 20912 | T | | Remove cartilage for graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 20920 | T | | Removal of fascia for graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 20922 | T | | Removal of fascia for graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 20924 | T | | Removal of tendon for graft | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 20926 | T | | Removal of tissue for graft | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 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 | 1.7926 | $93.49 | $24.12 | $18.70 |
| 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 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 20979 | A | | Us bone stimulation | | | | | |
| 20999 | T | | Musculoskeletal surgery | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 21010 | T | | Incision of jaw joint | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21015 | T | | Resection of facial tumor | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 21025 | T | | Excision of bone, lower jaw | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21026 | T | | Excision of facial bone(s) | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21029 | T | | Contour of face bone lesion | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21030 | T | | Removal of face bone lesion | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21031 | T | | Remove exostosis, mandible | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21032 | T | | Remove exostosis, maxilla | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21034 | T | | Removal of face bone lesion | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21040 | T | | Removal of jaw bone lesion | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21041 | T | DG | Removal of jaw bone lesion | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21044 | T | | Removal of jaw bone lesion | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21045 | C | | Extensive jaw surgery | | | | | |
| 21046 | T | NI | Remove mandible cyst complex | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21047 | T | NI | Excise lwr jaw cyst w/repair | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21048 | T | NI | Remove maxilla cyst complex | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21049 | T | NI | Excis uppr jaw cyst w/repair | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21050 | T | | Removal of jaw joint | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21060 | T | | Remove jaw joint cartilage | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21070 | T | | Remove coronoid process | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21076 | T | | Prepare face/oral prosthesis | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21077 | T | | Prepare face/oral prosthesis | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21079 | T | | Prepare face/oral prosthesis | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21080 | T | | Prepare face/oral prosthesis | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21081 | T | | Prepare face/oral prosthesis | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21082 | T | | Prepare face/oral prosthesis | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21083 | T | | Prepare face/oral prosthesis | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21084 | T | | Prepare face/oral prosthesis | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21085 | T | | Prepare face/oral prosthesis | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 21086 | T | | Prepare face/oral prosthesis | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21087 | T | | Prepare face/oral prosthesis | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21088 | T | | Prepare face/oral prosthesis | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21089 | T | | Prepare face/oral prosthesis | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 21100 | T | | Maxillofacial fixation | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21110 | T | | Interdental fixation | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 21116 | N | | Injection, jaw joint x-ray | | | | | |
| 21120 | T | | Reconstruction of chin | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21121 | T | | Reconstruction of chin | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21122 | T | | Reconstruction of chin | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21123 | T | | Reconstruction of chin | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 21125 | T | | Augmentation, lower jaw bone | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21127 | T | | Augmentation, lower jaw bone | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21137 | T | | Reduction of forehead | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21138 | T | | Reduction of forehead | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21139 | T | | Reduction of forehead | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 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 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 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 | 34.0302 | $1,774.71 | | $354.94 |
| 21199 | T | | Reconstr lwr jaw w/advance | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21206 | T | | Reconstruct upper jaw bone | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21208 | T | | Augmentation of facial bones | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21209 | T | | Reduction of facial bones | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21210 | T | | Face bone graft | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21215 | T | | Lower jaw bone graft | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21230 | T | | Rib cartilage graft | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21235 | T | | Ear cartilage graft | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21240 | T | | Reconstruction of jaw joint | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21242 | T | | Reconstruction of jaw joint | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21243 | T | | Reconstruction of jaw joint | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21244 | T | | Reconstruction of lower jaw | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21245 | T | | Reconstruction of jaw | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21246 | T | | Reconstruction of jaw | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21247 | C | | Reconstruct lower jaw bone | | | | | |
| 21248 | T | | Reconstruction of jaw | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21249 | T | | Reconstruction of jaw | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21255 | C | | Reconstruct lower jaw bone | | | | | |
| 21256 | C | | Reconstruction of orbit | | | | | |
| 21260 | T | | Revise eye sockets | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21261 | T | | Revise eye sockets | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21263 | T | | Revise eye sockets | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21267 | T | | Revise eye sockets | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21268 | C | | Revise eye sockets | | | | | |
| 21270 | T | | Augmentation, cheek bone | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21275 | T | | Revision, orbitofacial bones | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21280 | T | | Revision of eyelid | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 21282 | T | | Revision of eyelid | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 21295 | T | | Revision of jaw muscle/bone | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 21296 | T | | Revision of jaw muscle/bone | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21299 | T | | Cranio/maxillofacial surgery | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 21300 | T | | Treatment of skull fracture | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 21310 | X | | Treatment of nose fracture | 0340 | 0.6492 | $33.86 | | $6.77 |
| 21315 | X | | Treatment of nose fracture | 0340 | 0.6492 | $33.86 | | $6.77 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 21320 | X | ..... | Treatment of nose fracture | 0340 | 0.6492 | $33.86 | ..... | $6.77 |
| 21325 | T | ..... | Treatment of nose fracture | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21330 | T | ..... | Treatment of nose fracture | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21335 | T | ..... | Treatment of nose fracture | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21336 | T | ..... | Treat nasal septal fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 21337 | T | ..... | Treat nasal septal fracture | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 21338 | T | ..... | Treat nasoethmoid fracture | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21339 | T | ..... | Treat nasoethmoid fracture | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21340 | T | ..... | Treatment of nose fracture | 0256 | 34.0302 | $1,774.71 | ..... | $354.94 |
| 21343 | C | ..... | Treatment of sinus fracture | ..... | ..... | ..... | ..... | ..... |
| 21344 | C | ..... | Treatment of sinus fracture | ..... | ..... | ..... | ..... | ..... |
| 21345 | T | ..... | Treat nose/jaw fracture | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21346 | C | ..... | Treat nose/jaw fracture | ..... | ..... | ..... | ..... | ..... |
| 21347 | C | ..... | Treat nose/jaw fracture | ..... | ..... | ..... | ..... | ..... |
| 21348 | C | ..... | Treat nose/jaw fracture | ..... | ..... | ..... | ..... | ..... |
| 21355 | T | ..... | Treat cheek bone fracture | 0256 | 34.0302 | $1,774.71 | ..... | $354.94 |
| 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 | 34.0302 | $1,774.71 | ..... | $354.94 |
| 21395 | C | ..... | Treat eye socket fracture | ..... | ..... | ..... | ..... | ..... |
| 21400 | T | ..... | Treat eye socket fracture | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 21401 | T | ..... | Treat eye socket fracture | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 21406 | T | ..... | Treat eye socket fracture | 0256 | 34.0302 | $1,774.71 | ..... | $354.94 |
| 21407 | T | ..... | Treat eye socket fracture | 0256 | 34.0302 | $1,774.71 | ..... | $354.94 |
| 21408 | C | ..... | Treat eye socket fracture | ..... | ..... | ..... | ..... | ..... |
| 21421 | T | ..... | Treat mouth roof fracture | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 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 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21445 | T | ..... | Treat dental ridge fracture | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21450 | T | ..... | Treat lower jaw fracture | 0251 | 1.9089 | $99.55 | ..... | $19.91 |
| 21451 | T | ..... | Treat lower jaw fracture | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 21452 | T | ..... | Treat lower jaw fracture | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 21453 | T | ..... | Treat lower jaw fracture | 0256 | 34.0302 | $1,774.71 | ..... | $354.94 |
| 21454 | T | ..... | Treat lower jaw fracture | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 21461 | T | ..... | Treat lower jaw fracture | 0256 | 34.0302 | $1,774.71 | ..... | $354.94 |
| 21462 | T | ..... | Treat lower jaw fracture | 0256 | 34.0302 | $1,774.71 | ..... | $354.94 |
| 21465 | T | ..... | Treat lower jaw fracture | 0256 | 34.0302 | $1,774.71 | ..... | $354.94 |
| 21470 | T | ..... | Treat lower jaw fracture | 0256 | 34.0302 | $1,774.71 | ..... | $354.94 |
| 21480 | T | ..... | Reset dislocated jaw | 0251 | 1.9089 | $99.55 | ..... | $19.91 |
| 21485 | T | ..... | Reset dislocated jaw | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 21490 | T | ..... | Repair dislocated jaw | 0256 | 34.0302 | $1,774.71 | ..... | $354.94 |
| 21493 | T | ..... | Treat hyoid bone fracture | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 21494 | T | ..... | Treat hyoid bone fracture | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 21495 | C | ..... | Treat hyoid bone fracture | ..... | ..... | ..... | ..... | ..... |
| 21497 | T | ..... | Interdental wiring | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 21499 | T | ..... | Head surgery procedure | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 21501 | T | ..... | Drain neck/chest lesion | 0008 | 16.1430 | $841.87 | ..... | $168.37 |
| 21502 | T | ..... | Drain chest lesion | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 21510 | C | ..... | Drainage of bone lesion | ..... | ..... | ..... | ..... | ..... |
| 21550 | T | ..... | Biopsy of neck/chest | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 21555 | T | ..... | Remove lesion, neck/chest | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 21556 | T | ..... | Remove lesion, neck/chest | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 21557 | C | ..... | Remove tumor, neck/chest | ..... | ..... | ..... | ..... | ..... |
| 21600 | T | ..... | Partial removal of rib | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 21610 | T | | Partial removal of rib | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 21615 | C | | Removal of rib | | | | | |
| 21616 | C | | Removal of rib and nerves | | | | | |
| 21620 | C | | Partial removal of sternum | | | | | |
| 21627 | C | | Sternal debridement | | | | | |
| 21630 | C | | Extensive sternum surgery | | | | | |
| 21632 | C | | Extensive sternum surgery | | | | | |
| 21700 | T | | Revision of neck muscle | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 21705 | C | | Revision of neck muscle/rib | | | | | |
| 21720 | T | | Revision of neck muscle | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 21725 | T | | Revision of neck muscle | 0006 | 1.7926 | $93.49 | $24.12 | $18.70 |
| 21740 | C | | Reconstruction of sternum | | | | | |
| 21742 | T | NI | Repair stern/nuss w/o scope | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 21743 | T | NI | Repair sternum/nuss w/scope | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 21750 | C | | Repair of sternum separation | | | | | |
| 21800 | T | | Treatment of rib fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 21805 | T | | Treatment of rib fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 21810 | C | | Treatment of rib fracture(s) | | | | | |
| 21820 | T | | Treat sternum fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 21825 | C | | Treat sternum fracture | | | | | |
| 21899 | T | | Neck/chest surgery procedure | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 21920 | T | | Biopsy soft tissue of back | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 21925 | T | | Biopsy soft tissue of back | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 21930 | T | | Remove lesion, back or flank | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 21935 | T | | Remove tumor, back | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 22100 | T | | Remove part of neck vertebra | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 22101 | T | | Remove part, thorax vertebra | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 22102 | T | | Remove part, lumbar vertebra | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 22103 | T | | Remove extra spine segment | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 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 | 2.4999 | $130.37 | | $26.07 |
| 22310 | T | | Treat spine fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 22315 | T | | Treat spine fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 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 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 22520 | T | | Percut vertebroplasty thor | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 22521 | T | | Percut vertebroplasty lumb | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 22522 | T | | Percut vertebroplasty addl | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 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 | 38.4487 | $2,005.14 | | $401.03 |
| 22614 | T | | Spine fusion, extra segment | 0208 | 38.4487 | $2,005.14 | | $401.03 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | 2.4999 | $130.37 | ..... | $26.07 |
| 22900 | T | ..... | Remove abdominal wall lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 22999 | T | ..... | Abdomen surgery procedure | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 23000 | T | ..... | Removal of calcium deposits | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 23020 | T | ..... | Release shoulder joint | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 23030 | T | ..... | Drain shoulder lesion | 0008 | 16.1430 | $841.87 | ..... | $168.37 |
| 23031 | T | ..... | Drain shoulder bursa | 0008 | 16.1430 | $841.87 | ..... | $168.37 |
| 23035 | T | ..... | Drain shoulder bone lesion | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 23040 | T | ..... | Exploratory shoulder surgery | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23044 | T | ..... | Exploratory shoulder surgery | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23065 | T | ..... | Biopsy shoulder tissues | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 23066 | T | ..... | Biopsy shoulder tissues | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 23075 | T | ..... | Removal of shoulder lesion | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 23076 | T | ..... | Removal of shoulder lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 23077 | T | ..... | Remove tumor of shoulder | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 23100 | T | ..... | Biopsy of shoulder joint | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 23101 | T | ..... | Shoulder joint surgery | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23105 | T | ..... | Remove shoulder joint lining | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23106 | T | ..... | Incision of collarbone joint | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23107 | T | ..... | Explore treat shoulder joint | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23120 | T | ..... | Partial removal, collar bone | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 23125 | T | ..... | Removal of collar bone | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 23130 | T | ..... | Remove shoulder bone, part | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 23140 | T | ..... | Removal of bone lesion | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 23145 | T | ..... | Removal of bone lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23146 | T | ..... | Removal of bone lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23150 | T | ..... | Removal of humerus lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23155 | T | ..... | Removal of humerus lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23156 | T | ..... | Removal of humerus lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23170 | T | ..... | Remove collar bone lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23172 | T | ..... | Remove shoulder blade lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23174 | T | ..... | Remove humerus lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23180 | T | ..... | Remove collar bone lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23182 | T | ..... | Remove shoulder blade lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23184 | T | ..... | Remove humerus lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23190 | T | ..... | Partial removal of scapula | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23195 | T | ..... | Removal of head of humerus | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23200 | C | ..... | Removal of collar bone | ..... | ..... | ..... | ..... | ..... |
| 23210 | C | ..... | Removal of shoulder blade | ..... | ..... | ..... | ..... | ..... |
| 23220 | C | ..... | Partial removal of humerus | ..... | ..... | ..... | ..... | ..... |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 23221 | C | ..... | Partial removal of humerus | ..... | ..... | ..... | ..... | ..... |
| 23222 | C | ..... | Partial removal of humerus | ..... | ..... | ..... | ..... | ..... |
| 23330 | T | ..... | Remove shoulder foreign body | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 23331 | T | ..... | Remove shoulder foreign body | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 23332 | C | ..... | Remove shoulder foreign body | ..... | ..... | ..... | ..... | ..... |
| 23350 | N | ..... | Injection for shoulder x-ray | ..... | ..... | ..... | ..... | ..... |
| 23395 | T | ..... | Muscle transfer,shoulder/arm | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 23397 | T | ..... | Muscle transfers | 0052 | 40.7646 | $2,125.91 | ..... | $425.18 |
| 23400 | T | ..... | Fixation of shoulder blade | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23405 | T | ..... | Incision of tendon & muscle | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23406 | T | ..... | Incise tendon(s) & muscle(s) | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 23410 | T | ..... | Repair of tendon(s) | 0052 | 40.7646 | $2,125.91 | ..... | $425.18 |
| 23412 | T | ..... | Repair rotator cuff, chronic | 0052 | 40.7646 | $2,125.91 | ..... | $425.18 |
| 23415 | T | ..... | Release of shoulder ligament | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 23420 | T | ..... | Repair of shoulder | 0052 | 40.7646 | $2,125.91 | ..... | $425.18 |
| 23430 | T | ..... | Repair biceps tendon | 0052 | 40.7646 | $2,125.91 | ..... | $425.18 |
| 23440 | T | ..... | Remove/transplant tendon | 0052 | 40.7646 | $2,125.91 | ..... | $425.18 |
| 23450 | T | ..... | Repair shoulder capsule | 0052 | 40.7646 | $2,125.91 | ..... | $425.18 |
| 23455 | T | ..... | Repair shoulder capsule | 0052 | 40.7646 | $2,125.91 | ..... | $425.18 |
| 23460 | T | ..... | Repair shoulder capsule | 0052 | 40.7646 | $2,125.91 | ..... | $425.18 |
| 23462 | T | ..... | Repair shoulder capsule | 0052 | 40.7646 | $2,125.91 | ..... | $425.18 |
| 23465 | T | ..... | Repair shoulder capsule | 0052 | 40.7646 | $2,125.91 | ..... | $425.18 |
| 23466 | T | ..... | Repair shoulder capsule | 0052 | 40.7646 | $2,125.91 | ..... | $425.18 |
| 23470 | T | ..... | Reconstruct shoulder joint | 0048 | 40.6289 | $2,118.84 | $695.60 | $423.77 |
| 23472 | C | ..... | Reconstruct shoulder joint | ..... | ..... | ..... | ..... | ..... |
| 23480 | T | ..... | Revision of collar bone | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 23485 | T | ..... | Revision of collar bone | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 23490 | T | ..... | Reinforce clavicle | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 23491 | T | ..... | Reinforce shoulder bones | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 23500 | T | ..... | Treat clavicle fracture | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 23505 | T | ..... | Treat clavicle fracture | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 23515 | T | ..... | Treat clavicle fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 23520 | T | ..... | Treat clavicle dislocation | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 23525 | T | ..... | Treat clavicle dislocation | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 23530 | T | ..... | Treat clavicle dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 23532 | T | ..... | Treat clavicle dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 23540 | T | ..... | Treat clavicle dislocation | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 23545 | T | ..... | Treat clavicle dislocation | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 23550 | T | ..... | Treat clavicle dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 23552 | T | ..... | Treat clavicle dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 23570 | T | ..... | Treat shoulder blade fx | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 23575 | T | ..... | Treat shoulder blade fx | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 23585 | T | ..... | Treat scapula fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 23600 | T | ..... | Treat humerus fracture | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 23605 | T | ..... | Treat humerus fracture | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 23615 | T | ..... | Treat humerus fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 23616 | T | ..... | Treat humerus fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 23620 | T | ..... | Treat humerus fracture | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 23625 | T | ..... | Treat humerus fracture | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 23630 | T | ..... | Treat humerus fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 23650 | T | ..... | Treat shoulder dislocation | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 23655 | T | ..... | Treat shoulder dislocation | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 23660 | T | ..... | Treat shoulder dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 23665 | T | ..... | Treat dislocation/fracture | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 23670 | T | ..... | Treat dislocation/fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 23675 | T | ..... | Treat dislocation/fracture | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 23680 | T | ..... | Treat dislocation/fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 23700 | T | ..... | Fixation of shoulder | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 23800 | T | ..... | Fusion of shoulder joint | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 23802 | T | ..... | Fusion of shoulder joint | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 23900 | C | ..... | Amputation of arm & girdle | ..... | ..... | ..... | ..... | ..... |
| 23920 | C | ..... | Amputation at shoulder joint | ..... | ..... | ..... | ..... | ..... |
| 23921 | T | ..... | Amputation follow-up surgery | 0025 | 5.8623 | $305.72 | $115.49 | $61.14 |
| 23929 | T | ..... | Shoulder surgery procedure | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 23930 | T | ..... | Drainage of arm lesion | 0008 | 16.1430 | $841.87 | ..... | $168.37 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 23931 | T | ..... | Drainage of arm bursa | 0006 | 1.7926 | $93.49 | $24.12 | $18.70 |
| 23935 | T | ..... | Drain arm/elbow bone lesion | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 24000 | T | ..... | Exploratory elbow surgery | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24006 | T | ..... | Release elbow joint | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24065 | T | ..... | Biopsy arm/elbow soft tissue | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 24066 | T | ..... | Biopsy arm/elbow soft tissue | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 24075 | T | ..... | Remove arm/elbow lesion | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 24076 | T | ..... | Remove arm/elbow lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 24077 | T | ..... | Remove tumor of arm/elbow | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 24100 | T | ..... | Biopsy elbow joint lining | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 24101 | T | ..... | Explore/treat elbow joint | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24102 | T | ..... | Remove elbow joint lining | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24105 | T | ..... | Removal of elbow bursa | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 24110 | T | ..... | Remove humerus lesion | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 24115 | T | ..... | Remove/graft bone lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24116 | T | ..... | Remove/graft bone lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24120 | T | ..... | Remove elbow lesion | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 24125 | T | ..... | Remove/graft bone lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24126 | T | ..... | Remove/graft bone lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24130 | T | ..... | Removal of head of radius | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24134 | T | ..... | Removal of arm bone lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24136 | T | ..... | Remove radius bone lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24138 | T | ..... | Remove elbow bone lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24140 | T | ..... | Partial removal of arm bone | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24145 | T | ..... | Partial removal of radius | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24147 | T | ..... | Partial removal of elbow | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24149 | C | ..... | Radical resection of elbow | ..... | ..... | ..... | ..... | ..... |
| 24150 | T | ..... | Extensive humerus surgery | 0052 | 40.7646 | $2,125.91 | ..... | $425.18 |
| 24151 | T | ..... | Extensive humerus surgery | 0052 | 40.7646 | $2,125.91 | ..... | $425.18 |
| 24152 | T | ..... | Extensive radius surgery | 0052 | 40.7646 | $2,125.91 | ..... | $425.18 |
| 24153 | T | ..... | Extensive radius surgery | 0052 | 40.7646 | $2,125.91 | ..... | $425.18 |
| 24155 | T | ..... | Removal of elbow joint | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 24160 | T | ..... | Remove elbow joint implant | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24164 | T | ..... | Remove radius head implant | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24200 | T | ..... | Removal of arm foreign body | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 24201 | T | ..... | Removal of arm foreign body | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 24220 | N | ..... | Injection for elbow x-ray | ..... | ..... | ..... | ..... | ..... |
| 24300 | T | ..... | Manipulate elbow w/anesth | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 24301 | T | ..... | Muscle/tendon transfer | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24305 | T | ..... | Arm tendon lengthening | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24310 | T | ..... | Revision of arm tendon | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 24320 | T | ..... | Repair of arm tendon | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 24330 | T | ..... | Revision of arm muscles | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 24331 | T | ..... | Revision of arm muscles | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 24332 | T | ..... | Tenolysis, triceps | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 24340 | T | ..... | Repair of biceps tendon | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 24341 | T | ..... | Repair arm tendon/muscle | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 24342 | T | ..... | Repair of ruptured tendon | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 24343 | T | ..... | Repr elbow lat ligmnt w/tiss | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24344 | T | ..... | Reconstruct elbow lat ligmnt | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 24345 | T | ..... | Repr elbw med ligmnt w/tissu | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24346 | T | ..... | Reconstruct elbow med ligmnt | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 24350 | T | ..... | Repair of tennis elbow | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24351 | T | ..... | Repair of tennis elbow | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24352 | T | ..... | Repair of tennis elbow | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24354 | T | ..... | Repair of tennis elbow | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24356 | T | ..... | Revision of tennis elbow | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24360 | T | ..... | Reconstruct elbow joint | 0047 | 28.2842 | $1,475.05 | $537.03 | $295.01 |
| 24361 | T | ..... | Reconstruct elbow joint | 0048 | 40.6289 | $2,118.84 | $695.60 | $423.77 |
| 24362 | T | ..... | Reconstruct elbow joint | 0048 | 40.6289 | $2,118.84 | $695.60 | $423.77 |
| 24363 | T | ..... | Replace elbow joint | 0048 | 40.6289 | $2,118.84 | $695.60 | $423.77 |
| 24365 | T | ..... | Reconstruct head of radius | 0047 | 28.2842 | $1,475.05 | $537.03 | $295.01 |
| 24366 | T | ..... | Reconstruct head of radius | 0048 | 40.6289 | $2,118.84 | $695.60 | $423.77 |
| 24400 | T | ..... | Revision of humerus | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 24410 | T | ..... | Revision of humerus | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 24420 | T | | Revision of humerus | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 24430 | T | | Repair of humerus | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 24435 | T | | Repair humerus with graft | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 24470 | T | | Revision of elbow joint | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 24495 | T | | Decompression of forearm | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 24498 | T | | Reinforce humerus | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 24500 | T | | Treat humerus fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 24505 | T | | Treat humerus fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 24515 | T | | Treat humerus fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 24516 | T | | Treat humerus fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 24530 | T | | Treat humerus fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 24535 | T | | Treat humerus fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 24538 | T | | Treat humerus fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 24545 | T | | Treat humerus fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 24546 | T | | Treat humerus fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 24560 | T | | Treat humerus fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 24565 | T | | Treat humerus fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 24566 | T | | Treat humerus fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 24575 | T | | Treat humerus fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 24576 | T | | Treat humerus fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 24577 | T | | Treat humerus fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 24579 | T | | Treat humerus fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 24582 | T | | Treat humerus fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 24586 | T | | Treat elbow fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 24587 | T | | Treat elbow fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 24600 | T | | Treat elbow dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 24605 | T | | Treat elbow dislocation | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 24615 | T | | Treat elbow dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 24620 | T | | Treat elbow fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 24635 | T | | Treat elbow fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 24640 | T | | Treat elbow dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 24650 | T | | Treat radius fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 24655 | T | | Treat radius fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 24665 | T | | Treat radius fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 24666 | T | | Treat radius fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 24670 | T | | Treat ulnar fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 24675 | T | | Treat ulnar fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 24685 | T | | Treat ulnar fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 24800 | T | | Fusion of elbow joint | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 24802 | T | | Fusion/graft of elbow joint | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 24900 | C | | Amputation of upper arm | | | | | |
| 24920 | C | | Amputation of upper arm | | | | | |
| 24925 | T | | Amputation follow-up surgery | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 24930 | C | | Amputation follow-up surgery | | | | | |
| 24931 | C | | Amputate upper arm & implant | | | | | |
| 24935 | T | | Revision of amputation | 0052 | 40.7646 | $2,125.91 | | $425.18 |
| 24940 | C | | Revision of upper arm | | | | | |
| 24999 | T | | Upper arm/elbow surgery | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25000 | T | | Incision of tendon sheath | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 25001 | T | | Incise flexor carpi radialis | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 25020 | T | | Decompress forearm 1 space | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 25023 | T | | Decompress forearm 1 space | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25024 | T | | Decompress forearm 2 spaces | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25025 | T | | Decompress forarm 2 spaces | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25028 | T | | Drainage of forearm lesion | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 25031 | T | | Drainage of forearm bursa | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 25035 | T | | Treat forearm bone lesion | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 25040 | T | | Explore/treat wrist joint | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25065 | T | | Biopsy forearm soft tissues | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 25066 | T | | Biopsy forearm soft tissues | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 25075 | T | | Removel forearm lesion subcu | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 25076 | T | | Removel forearm lesion deep | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 25077 | T | | Remove tumor, forearm/wrist | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 25085 | T | | Incision of wrist capsule | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 25100 | T | | Biopsy of wrist joint | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 25101 | T | | Explore/treat wrist joint | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25105 | T | | Remove wrist joint lining | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25107 | T | | Remove wrist joint cartilage | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25110 | T | | Remove wrist tendon lesion | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 25111 | T | | Remove wrist tendon lesion | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 25112 | T | | Reremove wrist tendon lesion | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 25115 | T | | Remove wrist/forearm lesion | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 25116 | T | | Remove wrist/forearm lesion | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 25118 | T | | Excise wrist tendon sheath | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25119 | T | | Partial removal of ulna | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25120 | T | | Removal of forearm lesion | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25125 | T | | Remove/graft forearm lesion | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25126 | T | | Remove/graft forearm lesion | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25130 | T | | Removal of wrist lesion | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25135 | T | | Remove & graft wrist lesion | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25136 | T | | Remove & graft wrist lesion | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25145 | T | | Remove forearm bone lesion | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25150 | T | | Partial removal of ulna | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25151 | T | | Partial removal of radius | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25170 | T | | Extensive forearm surgery | 0052 | 40.7646 | $2,125.91 | | $425.18 |
| 25210 | T | | Removal of wrist bone | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 25215 | T | | Removal of wrist bones | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 25230 | T | | Partial removal of radius | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25240 | T | | Partial removal of ulna | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25246 | N | | Injection for wrist x-ray | | | | | |
| 25248 | T | | Remove forearm foreign body | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 25250 | T | | Removal of wrist prosthesis | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25251 | T | | Removal of wrist prosthesis | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25259 | T | | Manipulate wrist w/anesthes | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25260 | T | | Repair forearm tendon/muscle | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25263 | T | | Repair forearm tendon/muscle | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25265 | T | | Repair forearm tendon/muscle | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25270 | T | | Repair forearm tendon/muscle | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25272 | T | | Repair forearm tendon/muscle | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25274 | T | | Repair forearm tendon/muscle | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25275 | T | | Repair forearm tendon sheath | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25280 | T | | Revise wrist/forearm tendon | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25290 | T | | Incise wrist/forearm tendon | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25295 | T | | Release wrist/forearm tendon | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 25300 | T | | Fusion of tendons at wrist | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25301 | T | | Fusion of tendons at wrist | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25310 | T | | Transplant forearm tendon | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25312 | T | | Transplant forearm tendon | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25315 | T | | Revise palsy hand tendon(s) | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25316 | T | | Revise palsy hand tendon(s) | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25320 | T | | Repair/revise wrist joint | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25332 | T | | Revise wrist joint | 0047 | 28.2842 | $1,475.05 | $537.03 | $295.01 |
| 25335 | T | | Realignment of hand | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25337 | T | | Reconstruct ulna/radioulnar | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25350 | T | | Revision of radius | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25355 | T | | Revision of radius | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25360 | T | | Revision of ulna | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25365 | T | | Revise radius & ulna | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25370 | T | | Revise radius or ulna | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25375 | T | | Revise radius & ulna | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25390 | T | | Shorten radius or ulna | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25391 | T | | Lengthen radius or ulna | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25392 | T | | Shorten radius & ulna | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25393 | T | | Lengthen radius & ulna | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25394 | T | | Repair carpal bone, shorten | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 25400 | T | | Repair radius or ulna | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25405 | T | | Repair/graft radius or ulna | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25415 | T | | Repair radius & ulna | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 25420 | T | | Repair/graft radius & ulna | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25425 | T | | Repair/graft radius or ulna | 0051 | 32.9062 | $1,716.09 | | $343.22 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 25426 | T | | Repair/graft radius & ulna | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25430 | T | | Vasc graft into carpal bone | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 25431 | T | | Repair nonunion carpal bone | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 25440 | T | | Repair/graft wrist bone | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25441 | T | | Reconstruct wrist joint | 0048 | 40.6289 | $2,118.84 | $695.60 | $423.77 |
| 25442 | T | | Reconstruct wrist joint | 0048 | 40.6289 | $2,118.84 | $695.60 | $423.77 |
| 25443 | T | | Reconstruct wrist joint | 0048 | 40.6289 | $2,118.84 | $695.60 | $423.77 |
| 25444 | T | | Reconstruct wrist joint | 0048 | 40.6289 | $2,118.84 | $695.60 | $423.77 |
| 25445 | T | | Reconstruct wrist joint | 0048 | 40.6289 | $2,118.84 | $695.60 | $423.77 |
| 25446 | T | | Wrist replacement | 0048 | 40.6289 | $2,118.84 | $695.60 | $423.77 |
| 25447 | T | | Repair wrist joint(s) | 0047 | 28.2842 | $1,475.05 | $537.03 | $295.01 |
| 25449 | T | | Remove wrist joint implant | 0047 | 28.2842 | $1,475.05 | $537.03 | $295.01 |
| 25450 | T | | Revision of wrist joint | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25455 | T | | Revision of wrist joint | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25490 | T | | Reinforce radius | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25491 | T | | Reinforce ulna | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25492 | T | | Reinforce radius and ulna | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25500 | T | | Treat fracture of radius | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25505 | T | | Treat fracture of radius | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25515 | T | | Treat fracture of radius | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 25520 | T | | Treat fracture of radius | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25525 | T | | Treat fracture of radius | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 25526 | T | | Treat fracture of radius | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 25530 | T | | Treat fracture of ulna | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25535 | T | | Treat fracture of ulna | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25545 | T | | Treat fracture of ulna | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 25560 | T | | Treat fracture radius & ulna | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25565 | T | | Treat fracture radius & ulna | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25574 | T | | Treat fracture radius & ulna | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 25575 | T | | Treat fracture radius/ulna | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 25600 | T | | Treat fracture radius/ulna | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25605 | T | | Treat fracture radius/ulna | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25611 | T | | Treat fracture radius/ulna | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 25620 | T | | Treat fracture radius/ulna | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 25622 | T | | Treat wrist bone fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25624 | T | | Treat wrist bone fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25628 | T | | Treat wrist bone fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 25630 | T | | Treat wrist bone fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25635 | T | | Treat wrist bone fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25645 | T | | Treat wrist bone fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 25650 | T | | Treat wrist bone fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25651 | T | | Pin ulnar styloid fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 25652 | T | | Treat fracture ulnar styloid | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 25660 | T | | Treat wrist dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25670 | T | | Treat wrist dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 25671 | T | | Pin radioulnar dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 25675 | T | | Treat wrist dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25676 | T | | Treat wrist dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 25680 | T | | Treat wrist fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25685 | T | | Treat wrist fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 25690 | T | | Treat wrist dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 25695 | T | | Treat wrist dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 25800 | T | | Fusion of wrist joint | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25805 | T | | Fusion/graft of wrist joint | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25810 | T | | Fusion/graft of wrist joint | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25820 | T | | Fusion of hand bones | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 25825 | T | | Fuse hand bones with graft | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 25830 | T | | Fusion, radioulnar jnt/ulna | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 25900 | C | | Amputation of forearm | | | | | |
| 25905 | C | | Amputation of forearm | | | | | |
| 25907 | T | | Amputation follow-up surgery | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 25909 | C | | Amputation follow-up surgery | | | | | |
| 25915 | C | | Amputation of forearm | | | | | |
| 25920 | C | | Amputate hand at wrist | | | | | |
| 25922 | T | | Amputate hand at wrist | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 25924 | C | ..... | Amputation follow-up surgery | ..... | ..... | ..... | ..... | ..... |
| 25927 | C | ..... | Amputation of hand | ..... | ..... | ..... | ..... | ..... |
| 25929 | T | ..... | Amputation follow-up surgery | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 25931 | C | ..... | Amputation follow-up surgery | ..... | ..... | ..... | ..... | ..... |
| 25999 | T | ..... | Forearm or wrist surgery | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 26010 | T | ..... | Drainage of finger abscess | 0006 | 1.7926 | $93.49 | $24.12 | $18.70 |
| 26011 | T | ..... | Drainage of finger abscess | 0007 | 10.0191 | $522.51 | $108.89 | $104.50 |
| 26020 | T | ..... | Drain hand tendon sheath | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26025 | T | ..... | Drainage of palm bursa | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26030 | T | ..... | Drainage of palm bursa(s) | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26034 | T | ..... | Treat hand bone lesion | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26035 | T | ..... | Decompress fingers/hand | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26037 | T | ..... | Decompress fingers/hand | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26040 | T | ..... | Release palm contracture | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26045 | T | ..... | Release palm contracture | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26055 | T | ..... | Incise finger tendon sheath | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26060 | T | ..... | Incision of finger tendon | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26070 | T | ..... | Explore/treat hand joint | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26075 | T | ..... | Explore/treat finger joint | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26080 | T | ..... | Explore/treat finger joint | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26100 | T | ..... | Biopsy hand joint lining | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26105 | T | ..... | Biopsy finger joint lining | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26110 | T | ..... | Biopsy finger joint lining | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26115 | T | ..... | Removel hand lesion subcut | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 26116 | T | ..... | Removel hand lesion, deep | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 26117 | T | ..... | Remove tumor, hand/finger | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 26121 | T | ..... | Release palm contracture | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26123 | T | ..... | Release palm contracture | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26125 | T | ..... | Release palm contracture | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26130 | T | ..... | Remove wrist joint lining | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26135 | T | ..... | Revise finger joint, each | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26140 | T | ..... | Revise finger joint, each | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26145 | T | ..... | Tendon excision, palm/finger | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26160 | T | ..... | Remove tendon sheath lesion | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26170 | T | ..... | Removal of palm tendon, each | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26180 | T | ..... | Removal of finger tendon | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26185 | T | ..... | Remove finger bone | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26200 | T | ..... | Remove hand bone lesion | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26205 | T | ..... | Remove/graft bone lesion | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26210 | T | ..... | Removal of finger lesion | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26215 | T | ..... | Remove/graft finger lesion | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26230 | T | ..... | Partial removal of hand bone | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26235 | T | ..... | Partial removal, finger bone | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26236 | T | ..... | Partial removal, finger bone | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26250 | T | ..... | Extensive hand surgery | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26255 | T | ..... | Extensive hand surgery | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26260 | T | ..... | Extensive finger surgery | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26261 | T | ..... | Extensive finger surgery | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26262 | T | ..... | Partial removal of finger | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26320 | T | ..... | Removal of implant from hand | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 26340 | T | ..... | Manipulate finger w/anesth | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 26350 | T | ..... | Repair finger/hand tendon | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26352 | T | ..... | Repair/graft hand tendon | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26356 | T | ..... | Repair finger/hand tendon | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26357 | T | ..... | Repair finger/hand tendon | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26358 | T | ..... | Repair/graft hand tendon | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26370 | T | ..... | Repair finger/hand tendon | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26372 | T | ..... | Repair/graft hand tendon | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26373 | T | ..... | Repair finger/hand tendon | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26390 | T | ..... | Revise hand/finger tendon | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26392 | T | ..... | Repair/graft hand tendon | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26410 | T | ..... | Repair hand tendon | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26412 | T | ..... | Repair/graft hand tendon | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26415 | T | ..... | Excision, hand/finger tendon | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |
| 26416 | T | ..... | Graft hand or finger tendon | 0054 | 22.7223 | $1,184.99 | ..... | $237.00 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 26418 | T | | Repair finger tendon | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26420 | T | | Repair/graft finger tendon | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26426 | T | | Repair finger/hand tendon | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26428 | T | | Repair/graft finger tendon | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26432 | T | | Repair finger tendon | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26433 | T | | Repair finger tendon | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26434 | T | | Repair/graft finger tendon | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26437 | T | | Realignment of tendons | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26440 | T | | Release palm/finger tendon | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26442 | T | | Release palm & finger tendon | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26445 | T | | Release hand/finger tendon | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26449 | T | | Release forearm/hand tendon | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26450 | T | | Incision of palm tendon | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26455 | T | | Incision of finger tendon | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26460 | T | | Incise hand/finger tendon | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26471 | T | | Fusion of finger tendons | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26474 | T | | Fusion of finger tendons | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26476 | T | | Tendon lengthening | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26477 | T | | Tendon shortening | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26478 | T | | Lengthening of hand tendon | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26479 | T | | Shortening of hand tendon | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26480 | T | | Transplant hand tendon | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26483 | T | | Transplant/graft hand tendon | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26485 | T | | Transplant palm tendon | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26489 | T | | Transplant/graft palm tendon | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26490 | T | | Revise thumb tendon | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26492 | T | | Tendon transfer with graft | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26494 | T | | Hand tendon/muscle transfer | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26496 | T | | Revise thumb tendon | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26497 | T | | Finger tendon transfer | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26498 | T | | Finger tendon transfer | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26499 | T | | Revision of finger | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26500 | T | | Hand tendon reconstruction | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26502 | T | | Hand tendon reconstruction | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26504 | T | | Hand tendon reconstruction | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26508 | T | | Release thumb contracture | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26510 | T | | Thumb tendon transfer | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26516 | T | | Fusion of knuckle joint | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26517 | T | | Fusion of knuckle joints | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26518 | T | | Fusion of knuckle joints | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26520 | T | | Release knuckle contracture | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26525 | T | | Release finger contracture | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26530 | T | | Revise knuckle joint | 0047 | 28.2842 | $1,475.05 | $537.03 | $295.01 |
| 26531 | T | | Revise knuckle with implant | 0048 | 40.6289 | $2,118.84 | $695.60 | $423.77 |
| 26535 | T | | Revise finger joint | 0047 | 28.2842 | $1,475.05 | $537.03 | $295.01 |
| 26536 | T | | Revise/implant finger joint | 0048 | 40.6289 | $2,118.84 | $695.60 | $423.77 |
| 26540 | T | | Repair hand joint | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26541 | T | | Repair hand joint with graft | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26542 | T | | Repair hand joint with graft | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26545 | T | | Reconstruct finger joint | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26546 | T | | Repair nonunion hand | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26548 | T | | Reconstruct finger joint | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26550 | T | | Construct thumb replacement | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 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 | 22.7223 | $1,184.99 | | $237.00 |
| 26556 | C | | Toe joint transfer | | | | | |
| 26560 | T | | Repair of web finger | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26561 | T | | Repair of web finger | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26562 | T | | Repair of web finger | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26565 | T | | Correct metacarpal flaw | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26567 | T | | Correct finger deformity | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26568 | T | | Lengthen metacarpal/finger | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26580 | T | | Repair hand deformity | 0054 | 22.7223 | $1,184.99 | | $237.00 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 26587 | T | | Reconstruct extra finger | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26590 | T | | Repair finger deformity | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26591 | T | | Repair muscles of hand | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26593 | T | | Release muscles of hand | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26596 | T | | Excision constricting tissue | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26600 | T | | Treat metacarpal fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26605 | T | | Treat metacarpal fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26607 | T | | Treat metacarpal fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26608 | T | | Treat metacarpal fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 26615 | T | | Treat metacarpal fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 26641 | T | | Treat thumb dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26645 | T | | Treat thumb fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26650 | T | | Treat thumb fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 26665 | T | | Treat thumb fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 26670 | T | | Treat hand dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26675 | T | | Treat hand dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26676 | T | | Pin hand dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 26685 | T | | Treat hand dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 26686 | T | | Treat hand dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 26700 | T | | Treat knuckle dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26705 | T | | Treat knuckle dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26706 | T | | Pin knuckle dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26715 | T | | Treat knuckle dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 26720 | T | | Treat finger fracture, each | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26725 | T | | Treat finger fracture, each | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26727 | T | | Treat finger fracture, each | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 26735 | T | | Treat finger fracture, each | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 26740 | T | | Treat finger fracture, each | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26742 | T | | Treat finger fracture, each | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26746 | T | | Treat finger fracture, each | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 26750 | T | | Treat finger fracture, each | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26755 | T | | Treat finger fracture, each | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26756 | T | | Pin finger fracture, each | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 26765 | T | | Treat finger fracture, each | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 26770 | T | | Treat finger dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26775 | T | | Treat finger dislocation | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 26776 | T | | Pin finger dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 26785 | T | | Treat finger dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 26820 | T | | Thumb fusion with graft | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26841 | T | | Fusion of thumb | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26842 | T | | Thumb fusion with graft | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26843 | T | | Fusion of hand joint | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26844 | T | | Fusion/graft of hand joint | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26850 | T | | Fusion of knuckle | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26852 | T | | Fusion of knuckle with graft | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26860 | T | | Fusion of finger joint | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26861 | T | | Fusion of finger jnt, add-on | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26862 | T | | Fusion/graft of finger joint | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26863 | T | | Fuse/graft added joint | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26910 | T | | Amputate metacarpal bone | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 26951 | T | | Amputation of finger/thumb | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26952 | T | | Amputation of finger/thumb | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 26989 | T | | Hand/finger surgery | 0043 | 2.4999 | $130.37 | | $26.07 |
| 26990 | T | | Drainage of pelvis lesion | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 26991 | T | | Drainage of pelvis bursa | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 26992 | C | | Drainage of bone lesion | | | | | |
| 27000 | T | | Incision of hip tendon | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27001 | T | | Incision of hip tendon | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27003 | T | | Incision of hip tendon | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 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 | 32.9062 | $1,716.09 | | $343.22 |
| 27035 | T | | Denervation of hip joint | 0052 | 40.7646 | $2,125.91 | | $425.18 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 27036 | C | | Excision of hip joint/muscle | | | | | |
| 27040 | T | | Biopsy of soft tissues | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 27041 | T | | Biopsy of soft tissues | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 27047 | T | | Remove hip/pelvis lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 27048 | T | | Remove hip/pelvis lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 27049 | T | | Remove tumor, hip/pelvis | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 27050 | T | | Biopsy of sacroiliac joint | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27052 | T | | Biopsy of hip joint | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27054 | C | | Removal of hip joint lining | | | | | |
| 27060 | T | | Removal of ischial bursa | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27062 | T | | Remove femur lesion/bursa | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27065 | T | | Removal of hip bone lesion | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27066 | T | | Removal of hip bone lesion | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27067 | T | | Remove/graft hip bone lesion | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 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 | 23.3037 | $1,215.31 | | $243.06 |
| 27086 | T | | Remove hip foreign body | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 27087 | T | | Remove hip foreign body | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 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 | N | | Inject sacroiliac joint | | | | | |
| 27097 | T | | Revision of hip tendon | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27098 | T | | Transfer tendon to pelvis | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27100 | T | | Transfer of abdominal muscle | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27105 | T | | Transfer of spinal muscle | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27110 | T | | Transfer of iliopsoas muscle | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27111 | T | | Transfer of iliopsoas muscle | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 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 | | | | | |
| 27193 | T | | Treat pelvic ring fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27194 | T | | Treat pelvic ring fracture | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 27200 | T | | Treat tail bone fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27202 | T | | Treat tail bone fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27215 | C | | Treat pelvic fracture(s) | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 27216 | T | | Treat pelvic ring fracture | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27217 | C | | Treat pelvic ring fracture | | | | | |
| 27218 | C | | Treat pelvic ring fracture | | | | | |
| 27220 | T | | Treat hip socket fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 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 | 2.4999 | $130.37 | | $26.07 |
| 27232 | C | | Treat thigh fracture | | | | | |
| 27235 | T | | Treat thigh fracture | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27236 | C | | Treat thigh fracture | | | | | |
| 27238 | T | | Treat thigh fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27240 | C | | Treat thigh fracture | | | | | |
| 27244 | C | | Treat thigh fracture | | | | | |
| 27245 | C | | Treat thigh fracture | | | | | |
| 27246 | T | | Treat thigh fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27248 | C | | Treat thigh fracture | | | | | |
| 27250 | T | | Treat hip dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27252 | T | | Treat hip dislocation | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 27253 | C | | Treat hip dislocation | | | | | |
| 27254 | C | | Treat hip dislocation | | | | | |
| 27256 | T | | Treat hip dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27257 | T | | Treat hip dislocation | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 27258 | C | | Treat hip dislocation | | | | | |
| 27259 | C | | Treat hip dislocation | | | | | |
| 27265 | T | | Treat hip dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27266 | T | | Treat hip dislocation | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 27275 | T | | Manipulation of hip joint | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 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 | 2.4999 | $130.37 | | $26.07 |
| 27301 | T | | Drain thigh/knee lesion | 0008 | 16.1430 | $841.87 | | $168.37 |
| 27303 | C | | Drainage of bone lesion | | | | | |
| 27305 | T | | Incise thigh tendon & fascia | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27306 | T | | Incision of thigh tendon | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27307 | T | | Incision of thigh tendons | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27310 | T | | Exploration of knee joint | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27315 | T | | Partial removal, thigh nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 27320 | T | | Partial removal, thigh nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 27323 | T | | Biopsy, thigh soft tissues | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 27324 | T | | Biopsy, thigh soft tissues | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 27327 | T | | Removal of thigh lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 27328 | T | | Removal of thigh lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 27329 | T | | Remove tumor, thigh/knee | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 27330 | T | | Biopsy, knee joint lining | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27331 | T | | Explore/treat knee joint | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27332 | T | | Removal of knee cartilage | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27333 | T | | Removal of knee cartilage | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27334 | T | | Remove knee joint lining | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27335 | T | | Remove knee joint lining | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27340 | T | | Removal of kneecap bursa | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27345 | T | | Removal of knee cyst | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27347 | T | | Remove knee cyst | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27350 | T | | Removal of kneecap | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27355 | T | | Remove femur lesion | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27356 | T | | Remove femur lesion/graft | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27357 | T | | Remove femur lesion/graft | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27358 | T | | Remove femur lesion/fixation | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27360 | T | | Partial removal, leg bone(s) | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27365 | C | | Extensive leg surgery | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 27370 | N | | Injection for knee x-ray | | | | | |
| 27372 | T | | Removal of foreign body | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 27380 | T | | Repair of kneecap tendon | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27381 | T | | Repair/graft kneecap tendon | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27385 | T | | Repair of thigh muscle | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27386 | T | | Repair/graft of thigh muscle | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27390 | T | | Incision of thigh tendon | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27391 | T | | Incision of thigh tendons | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27392 | T | | Incision of thigh tendons | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27393 | T | | Lengthening of thigh tendon | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27394 | T | | Lengthening of thigh tendons | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27395 | T | | Lengthening of thigh tendons | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27396 | T | | Transplant of thigh tendon | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27397 | T | | Transplants of thigh tendons | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27400 | T | | Revise thigh muscles/tendons | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27403 | T | | Repair of knee cartilage | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27405 | T | | Repair of knee ligament | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27407 | T | | Repair of knee ligament | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27409 | T | | Repair of knee ligaments | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27418 | T | | Repair degenerated kneecap | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27420 | T | | Revision of unstable kneecap | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27422 | T | | Revision of unstable kneecap | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27424 | T | | Revision/removal of kneecap | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27425 | T | | Lateral retinacular release | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27427 | T | | Reconstruction, knee | 0052 | 40.7646 | $2,125.91 | | $425.18 |
| 27428 | T | | Reconstruction, knee | 0052 | 40.7646 | $2,125.91 | | $425.18 |
| 27429 | T | | Reconstruction, knee | 0052 | 40.7646 | $2,125.91 | | $425.18 |
| 27430 | T | | Revision of thigh muscles | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27435 | T | | Incision of knee joint | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27437 | T | | Revise kneecap | 0047 | 28.2842 | $1,475.05 | $537.03 | $295.01 |
| 27438 | T | | Revise kneecap with implant | 0048 | 40.6289 | $2,118.84 | $695.60 | $423.77 |
| 27440 | T | | Revision of knee joint | 0047 | 28.2842 | $1,475.05 | $537.03 | $295.01 |
| 27441 | T | | Revision of knee joint | 0047 | 28.2842 | $1,475.05 | $537.03 | $295.01 |
| 27442 | T | | Revision of knee joint | 0047 | 28.2842 | $1,475.05 | $537.03 | $295.01 |
| 27443 | T | | Revision of knee joint | 0047 | 28.2842 | $1,475.05 | $537.03 | $295.01 |
| 27445 | C | | Revision of knee joint | | | | | |
| 27446 | T | | Revision of knee joint | 0681 | 147.8067 | $7,708.27 | $3,067.55 | $1,541.65 |
| 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 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27497 | T | | Decompression of thigh/knee | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27498 | T | | Decompression of thigh/knee | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27499 | T | | Decompression of thigh/knee | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27500 | T | | Treatment of thigh fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27501 | T | | Treatment of thigh fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27502 | T | | Treatment of thigh fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27503 | T | | Treatment of thigh fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27506 | C | | Treatment of thigh fracture | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| 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 | 2.4999 | $130.37 | ..... | $26.07 |
| 27509 | T | ..... | Treatment of thigh fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27510 | T | ..... | Treatment of thigh fracture | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 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 | 2.4999 | $130.37 | ..... | $26.07 |
| 27517 | T | ..... | Treat thigh fx growth plate | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 27519 | C | ..... | Treat thigh fx growth plate | ..... | ..... | ..... | ..... | ..... |
| 27520 | T | ..... | Treat kneecap fracture | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 27524 | T | ..... | Treat kneecap fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27530 | T | ..... | Treat knee fracture | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 27532 | T | ..... | Treat knee fracture | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 27535 | C | ..... | Treat knee fracture | ..... | ..... | ..... | ..... | ..... |
| 27536 | C | ..... | Treat knee fracture | ..... | ..... | ..... | ..... | ..... |
| 27538 | T | ..... | Treat knee fracture(s) | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 27540 | C | ..... | Treat knee fracture | ..... | ..... | ..... | ..... | ..... |
| 27550 | T | ..... | Treat knee dislocation | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 27552 | T | ..... | Treat knee dislocation | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 27556 | C | ..... | Treat knee dislocation | ..... | ..... | ..... | ..... | ..... |
| 27557 | C | ..... | Treat knee dislocation | ..... | ..... | ..... | ..... | ..... |
| 27558 | C | ..... | Treat knee dislocation | ..... | ..... | ..... | ..... | ..... |
| 27560 | T | ..... | Treat kneecap dislocation | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 27562 | T | ..... | Treat kneecap dislocation | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 27566 | T | ..... | Treat kneecap dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27570 | T | ..... | Fixation of knee joint | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 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 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27596 | C | ..... | Amputation follow-up surgery | ..... | ..... | ..... | ..... | ..... |
| 27598 | C | ..... | Amputate lower leg at knee | ..... | ..... | ..... | ..... | ..... |
| 27599 | T | ..... | Leg surgery procedure | 0043 | 2.4999 | $130.37 | ..... | $26.07 |
| 27600 | T | ..... | Decompression of lower leg | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27601 | T | ..... | Decompression of lower leg | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27602 | T | ..... | Decompression of lower leg | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27603 | T | ..... | Drain lower leg lesion | 0008 | 16.1430 | $841.87 | ..... | $168.37 |
| 27604 | T | ..... | Drain lower leg bursa | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27605 | T | ..... | Incision of achilles tendon | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 27606 | T | ..... | Incision of achilles tendon | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27607 | T | ..... | Treat lower leg bone lesion | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27610 | T | ..... | Explore/treat ankle joint | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 27612 | T | ..... | Exploration of ankle joint | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 27613 | T | ..... | Biopsy lower leg soft tissue | 0020 | 7.1898 | $374.96 | $113.25 | $74.99 |
| 27614 | T | ..... | Biopsy lower leg soft tissue | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 27615 | T | ..... | Remove tumor, lower leg | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27618 | T | ..... | Remove lower leg lesion | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 27619 | T | ..... | Remove lower leg lesion | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 27620 | T | ..... | Explore/treat ankle joint | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 27625 | T | ..... | Remove ankle joint lining | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 27626 | T | ..... | Remove ankle joint lining | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 27630 | T | ..... | Removal of tendon lesion | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27635 | T | ..... | Remove lower leg bone lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 27637 | T | ..... | Remove/graft leg bone lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 27638 | T | ..... | Remove/graft leg bone lesion | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 27640 | T | ..... | Partial removal of tibia | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 27641 | T | ..... | Partial removal of fibula | 0050 | 23.3037 | $1,215.31 | ..... | $243.06 |
| 27645 | C | ..... | Extensive lower leg surgery | ..... | ..... | ..... | ..... | ..... |
| 27646 | C | ..... | Extensive lower leg surgery | ..... | ..... | ..... | ..... | ..... |
| 27647 | T | ..... | Extensive ankle/heel surgery | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 27648 | N | ..... | Injection for ankle x-ray | ..... | ..... | ..... | ..... | ..... |
| 27650 | T | ..... | Repair achilles tendon | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |
| 27652 | T | ..... | Repair/graft achilles tendon | 0051 | 32.9062 | $1,716.09 | ..... | $343.22 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 27654 | T | | Repair of achilles tendon | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27656 | T | | Repair leg fascia defect | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27658 | T | | Repair of leg tendon, each | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27659 | T | | Repair of leg tendon, each | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27664 | T | | Repair of leg tendon, each | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27665 | T | | Repair of leg tendon, each | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27675 | T | | Repair lower leg tendons | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27676 | T | | Repair lower leg tendons | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27680 | T | | Release of lower leg tendon | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27681 | T | | Release of lower leg tendons | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27685 | T | | Revision of lower leg tendon | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27686 | T | | Revise lower leg tendons | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27687 | T | | Revision of calf tendon | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27690 | T | | Revise lower leg tendon | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27691 | T | | Revise lower leg tendon | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27692 | T | | Revise additional leg tendon | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27695 | T | | Repair of ankle ligament | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27696 | T | | Repair of ankle ligaments | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27698 | T | | Repair of ankle ligament | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27700 | T | | Revision of ankle joint | 0047 | 28.2842 | $1,475.05 | $537.03 | $295.01 |
| 27702 | C | | Reconstruct ankle joint | | | | | |
| 27703 | C | | Reconstruction, ankle joint | | | | | |
| 27704 | T | | Removal of ankle implant | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27705 | T | | Incision of tibia | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27707 | T | | Incision of fibula | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27709 | T | | Incision of tibia & fibula | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 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 | 23.3037 | $1,215.31 | | $243.06 |
| 27732 | T | | Repair of fibula epiphysis | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27734 | T | | Repair lower leg epiphyses | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27740 | T | | Repair of leg epiphyses | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27742 | T | | Repair of leg epiphyses | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27745 | T | | Reinforce tibia | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27750 | T | | Treatment of tibia fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27752 | T | | Treatment of tibia fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27756 | T | | Treatment of tibia fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27758 | T | | Treatment of tibia fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27759 | T | | Treatment of tibia fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27760 | T | | Treatment of ankle fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27762 | T | | Treatment of ankle fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27766 | T | | Treatment of ankle fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27780 | T | | Treatment of fibula fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27781 | T | | Treatment of fibula fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27784 | T | | Treatment of fibula fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27786 | T | | Treatment of ankle fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27788 | T | | Treatment of ankle fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27792 | T | | Treatment of ankle fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27808 | T | | Treatment of ankle fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27810 | T | | Treatment of ankle fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27814 | T | | Treatment of ankle fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27816 | T | | Treatment of ankle fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27818 | T | | Treatment of ankle fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27822 | T | | Treatment of ankle fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27823 | T | | Treatment of ankle fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27824 | T | | Treat lower leg fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27825 | T | | Treat lower leg fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27826 | T | | Treat lower leg fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27827 | T | | Treat lower leg fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27828 | T | | Treat lower leg fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 27829 | T | | Treat lower leg joint | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27830 | T | | Treat lower leg dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27831 | T | | Treat lower leg dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27832 | T | | Treat lower leg dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27840 | T | | Treat ankle dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 27842 | T | | Treat ankle dislocation | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 27846 | T | | Treat ankle dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27848 | T | | Treat ankle dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 27860 | T | | Fixation of ankle joint | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 27870 | T | | Fusion of ankle joint | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 27871 | T | | Fusion of tibiofibular joint | 0051 | 32.9062 | $1,716.09 | | $343.22 |
| 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 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27886 | C | | Amputation follow-up surgery | | | | | |
| 27888 | C | | Amputation of foot at ankle | | | | | |
| 27889 | T | | Amputation of foot at ankle | 0050 | 23.3037 | $1,215.31 | | $243.06 |
| 27892 | T | | Decompression of leg | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27893 | T | | Decompression of leg | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27894 | T | | Decompression of leg | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 27899 | T | | Leg/ankle surgery procedure | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28001 | T | | Drainage of bursa of foot | 0008 | 16.1430 | $841.87 | | $168.37 |
| 28002 | T | | Treatment of foot infection | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 28003 | T | | Treatment of foot infection | 0049 | 18.6042 | $970.23 | $197.14 | $194.05 |
| 28005 | T | | Treat foot bone lesion | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28008 | T | | Incision of foot fascia | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28010 | T | | Incision of toe tendon | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28011 | T | | Incision of toe tendons | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28020 | T | | Exploration of foot joint | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28022 | T | | Exploration of foot joint | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28024 | T | | Exploration of toe joint | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28030 | T | | Removal of foot nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 28035 | T | | Decompression of tibia nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 28043 | T | | Excision of foot lesion | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 28045 | T | | Excision of foot lesion | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28046 | T | | Resection of tumor, foot | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28050 | T | | Biopsy of foot joint lining | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28052 | T | | Biopsy of foot joint lining | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28054 | T | | Biopsy of toe joint lining | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28060 | T | | Partial removal, foot fascia | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28062 | T | | Removal of foot fascia | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28070 | T | | Removal of foot joint lining | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28072 | T | | Removal of foot joint lining | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28080 | T | | Removal of foot lesion | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28086 | T | | Excise foot tendon sheath | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28088 | T | | Excise foot tendon sheath | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28090 | T | | Removal of foot lesion | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28092 | T | | Removal of toe lesions | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28100 | T | | Removal of ankle/heel lesion | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28102 | T | | Remove/graft foot lesion | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28103 | T | | Remove/graft foot lesion | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28104 | T | | Removal of foot lesion | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28106 | T | | Remove/graft foot lesion | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28107 | T | | Remove/graft foot lesion | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28108 | T | | Removal of toe lesions | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28110 | T | | Part removal of metatarsal | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28111 | T | | Part removal of metatarsal | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28112 | T | | Part removal of metatarsal | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28113 | T | | Part removal of metatarsal | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28114 | T | | Removal of metatarsal heads | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28116 | T | | Revision of foot | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28118 | T | | Removal of heel bone | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28119 | T | | Removal of heel spur | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28120 | T | | Part removal of ankle/heel | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 28122 | T | | Partial removal of foot bone | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28124 | T | | Partial removal of toe | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28126 | T | | Partial removal of toe | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28130 | T | | Removal of ankle bone | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28140 | T | | Removal of metatarsal | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28150 | T | | Removal of toe | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28153 | T | | Partial removal of toe | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28160 | T | | Partial removal of toe | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28171 | T | | Extensive foot surgery | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28173 | T | | Extensive foot surgery | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28175 | T | | Extensive foot surgery | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28190 | T | | Removal of foot foreign body | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 28192 | T | | Removal of foot foreign body | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 28193 | T | | Removal of foot foreign body | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 28200 | T | | Repair of foot tendon | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28202 | T | | Repair/graft of foot tendon | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28208 | T | | Repair of foot tendon | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28210 | T | | Repair/graft of foot tendon | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28220 | T | | Release of foot tendon | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28222 | T | | Release of foot tendons | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28225 | T | | Release of foot tendon | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28226 | T | | Release of foot tendons | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28230 | T | | Incision of foot tendon(s) | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28232 | T | | Incision of toe tendon | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28234 | T | | Incision of foot tendon | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28238 | T | | Revision of foot tendon | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28240 | T | | Release of big toe | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28250 | T | | Revision of foot fascia | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28260 | T | | Release of midfoot joint | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28261 | T | | Revision of foot tendon | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28262 | T | | Revision of foot and ankle | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28264 | T | | Release of midfoot joint | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28270 | T | | Release of foot contracture | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28272 | T | | Release of toe joint, each | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28280 | T | | Fusion of toes | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28285 | T | | Repair of hammertoe | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28286 | T | | Repair of hammertoe | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28288 | T | | Partial removal of foot bone | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28289 | T | | Repair hallux rigidus | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28290 | T | | Correction of bunion | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28292 | T | | Correction of bunion | 0057 | 22.9064 | $1,194.59 | $475.91 | $238.92 |
| 28293 | T | | Correction of bunion | 0057 | 22.9064 | $1,194.59 | $475.91 | $238.92 |
| 28294 | T | | Correction of bunion | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28296 | T | | Correction of bunion | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28297 | T | | Correction of bunion | 0057 | 22.9064 | $1,194.59 | $475.91 | $238.92 |
| 28298 | T | | Correction of bunion | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28299 | T | | Correction of bunion | 0057 | 22.9064 | $1,194.59 | $475.91 | $238.92 |
| 28300 | T | | Incision of heel bone | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28302 | T | | Incision of ankle bone | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28304 | T | | Incision of midfoot bones | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28305 | T | | Incise/graft midfoot bones | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28306 | T | | Incision of metatarsal | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28307 | T | | Incision of metatarsal | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28308 | T | | Incision of metatarsal | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28309 | T | | Incision of metatarsals | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28310 | T | | Revision of big toe | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28312 | T | | Revision of toe | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28313 | T | | Repair deformity of toe | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28315 | T | | Removal of sesamoid bone | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28320 | T | | Repair of foot bones | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28322 | T | | Repair of metatarsals | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28340 | T | | Resect enlarged toe tissue | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28341 | T | | Resect enlarged toe | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28344 | T | | Repair extra toe(s) | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28345 | T | | Repair webbed toe(s) | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 28360 | T | | Reconstruct cleft foot | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28400 | T | | Treatment of heel fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28405 | T | | Treatment of heel fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28406 | T | | Treatment of heel fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28415 | T | | Treat heel fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28420 | T | | Treat/graft heel fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28430 | T | | Treatment of ankle fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28435 | T | | Treatment of ankle fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28436 | T | | Treatment of ankle fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28445 | T | | Treat ankle fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28450 | T | | Treat midfoot fracture, each | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28455 | T | | Treat midfoot fracture, each | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28456 | T | | Treat midfoot fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28465 | T | | Treat midfoot fracture, each | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28470 | T | | Treat metatarsal fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28475 | T | | Treat metatarsal fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28476 | T | | Treat metatarsal fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28485 | T | | Treat metatarsal fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28490 | T | | Treat big toe fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28495 | T | | Treat big toe fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28496 | T | | Treat big toe fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28505 | T | | Treat big toe fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28510 | T | | Treatment of toe fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28515 | T | | Treatment of toe fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28525 | T | | Treat toe fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28530 | T | | Treat sesamoid bone fracture | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28531 | T | | Treat sesamoid bone fracture | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28540 | T | | Treat foot dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28545 | T | | Treat foot dislocation | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 28546 | T | | Treat foot dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28555 | T | | Repair foot dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28570 | T | | Treat foot dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28575 | T | | Treat foot dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28576 | T | | Treat foot dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28585 | T | | Repair foot dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28600 | T | | Treat foot dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28605 | T | | Treat foot dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28606 | T | | Treat foot dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28615 | T | | Repair foot dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28630 | T | | Treat toe dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28635 | T | | Treat toe dislocation | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 28636 | T | | Treat toe dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28645 | T | | Repair toe dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28660 | T | | Treat toe dislocation | 0043 | 2.4999 | $130.37 | | $26.07 |
| 28665 | T | | Treat toe dislocation | 0045 | 12.9357 | $674.61 | $268.47 | $134.92 |
| 28666 | T | | Treat toe dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28675 | T | | Repair of toe dislocation | 0046 | 29.2920 | $1,527.61 | $535.76 | $305.52 |
| 28705 | T | | Fusion of foot bones | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28715 | T | | Fusion of foot bones | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28725 | T | | Fusion of foot bones | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28730 | T | | Fusion of foot bones | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28735 | T | | Fusion of foot bones | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28737 | T | | Revision of foot bones | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28740 | T | | Fusion of foot bones | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28750 | T | | Fusion of big toe joint | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28755 | T | | Fusion of big toe joint | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28760 | T | | Fusion of big toe joint | 0056 | 22.1700 | $1,156.19 | $405.81 | $231.24 |
| 28800 | C | | Amputation of midfoot | | | | | |
| 28805 | C | | Amputation thru metatarsal | | | | | |
| 28810 | T | | Amputation toe & metatarsal | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28820 | T | | Amputation of toe | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28825 | T | | Partial amputation of toe | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 28899 | T | | Foot/toes surgery procedure | 0043 | 2.4999 | $130.37 | | $26.07 |
| 29000 | S | | Application of body cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29010 | S | | Application of body cast | 0058 | 1.0368 | $54.07 | | $10.81 |

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*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 29015 | S | | Application of body cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29020 | S | | Application of body cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29025 | S | | Application of body cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29035 | S | | Application of body cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29040 | S | | Application of body cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29044 | S | | Application of body cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29046 | S | | Application of body cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29049 | S | | Application of figure eight | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29055 | S | | Application of shoulder cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29058 | S | | Application of shoulder cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29065 | S | | Application of long arm cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29075 | S | | Application of forearm cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29085 | S | | Apply hand/wrist cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29086 | S | | Apply finger cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29105 | S | | Apply long arm splint | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29125 | S | | Apply forearm splint | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29126 | S | | Apply forearm splint | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29130 | S | | Application of finger splint | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29131 | S | | Application of finger splint | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29200 | S | | Strapping of chest | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29220 | S | | Strapping of low back | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29240 | S | | Strapping of shoulder | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29260 | S | | Strapping of elbow or wrist | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29280 | S | | Strapping of hand or finger | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29305 | S | | Application of hip cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29325 | S | | Application of hip casts | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29345 | S | | Application of long leg cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29355 | S | | Application of long leg cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29358 | S | | Apply long leg cast brace | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29365 | S | | Application of long leg cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29405 | S | | Apply short leg cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29425 | S | | Apply short leg cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29435 | S | | Apply short leg cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29440 | S | | Addition of walker to cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29445 | S | | Apply rigid leg cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29450 | S | | Application of leg cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29505 | S | | Application, long leg splint | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29515 | S | | Application lower leg splint | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29520 | S | | Strapping of hip | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29530 | S | | Strapping of knee | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29540 | S | | Strapping of ankle | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29550 | S | | Strapping of toes | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29580 | S | | Application of paste boot | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29590 | S | | Application of foot splint | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29700 | S | | Removal/revision of cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29705 | S | | Removal/revision of cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29710 | S | | Removal/revision of cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29715 | S | | Removal/revision of cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29720 | S | | Repair of body cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29730 | S | | Windowing of cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29740 | S | | Wedging of cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29750 | S | | Wedging of clubfoot cast | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29799 | S | | Casting/strapping procedure | 0058 | 1.0368 | $54.07 | | $10.81 |
| 29800 | T | | Jaw arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29804 | T | | Jaw arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29805 | T | | Shoulder arthroscopy, dx | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29806 | T | | Shoulder arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29807 | T | | Shoulder arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29819 | T | | Shoulder arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29820 | T | | Shoulder arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29821 | T | | Shoulder arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29822 | T | | Shoulder arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29823 | T | | Shoulder arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29824 | T | | Shoulder arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29825 | T | | Shoulder arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 29826 | T | | Shoulder arthroscopy/surgery | 0042 | 40.9680 | $2,136.52 | $804.74 | $427.30 |
| 29827 | T | NI | Arthroscop rotator cuff repr | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29830 | T | | Elbow arthroscopy | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29834 | T | | Elbow arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29835 | T | | Elbow arthroscopy/surgery | 0042 | 40.9680 | $2,136.52 | $804.74 | $427.30 |
| 29836 | T | | Elbow arthroscopy/surgery | 0042 | 40.9680 | $2,136.52 | $804.74 | $427.30 |
| 29837 | T | | Elbow arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29838 | T | | Elbow arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29840 | T | | Wrist arthroscopy | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29843 | T | | Wrist arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29844 | T | | Wrist arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29845 | T | | Wrist arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29846 | T | | Wrist arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29847 | T | | Wrist arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29848 | T | | Wrist endoscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29850 | T | | Knee arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29851 | T | | Knee arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29855 | T | | Tibial arthroscopy/surgery | 0042 | 40.9680 | $2,136.52 | $804.74 | $427.30 |
| 29856 | T | | Tibial arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29860 | T | | Hip arthroscopy, dx | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29861 | T | | Hip arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29862 | T | | Hip arthroscopy/surgery | 0042 | 40.9680 | $2,136.52 | $804.74 | $427.30 |
| 29863 | T | | Hip arthroscopy/surgery | 0042 | 40.9680 | $2,136.52 | $804.74 | $427.30 |
| 29870 | T | | Knee arthroscopy, dx | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29871 | T | | Knee arthroscopy/drainage | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29873 | T | NI | Knee arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29874 | T | | Knee arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29875 | T | | Knee arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29876 | T | | Knee arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29877 | T | | Knee arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29879 | T | | Knee arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29880 | T | | Knee arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29881 | T | | Knee arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29882 | T | | Knee arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29883 | T | | Knee arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29884 | T | | Knee arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29885 | T | | Knee arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29886 | T | | Knee arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29887 | T | | Knee arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29888 | T | | Knee arthroscopy/surgery | 0042 | 40.9680 | $2,136.52 | $804.74 | $427.30 |
| 29889 | T | | Knee arthroscopy/surgery | 0042 | 40.9680 | $2,136.52 | $804.74 | $427.30 |
| 29891 | T | | Ankle arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29892 | T | | Ankle arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29893 | T | | Scope, plantar fasciotomy | 0055 | 17.6740 | $921.72 | $355.34 | $184.34 |
| 29894 | T | | Ankle arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29895 | T | | Ankle arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29897 | T | | Ankle arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29898 | T | | Ankle arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29899 | T | NI | Ankle arthroscopy/surgery | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 29900 | T | | Mcp joint arthroscopy, dx | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 29901 | T | | Mcp joint arthroscopy, surg | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 29902 | T | | Mcp joint arthroscopy, surg | 0053 | 14.1760 | $739.29 | $253.49 | $147.86 |
| 29999 | T | | Arthroscopy of joint | 0041 | 26.1234 | $1,362.36 | | $272.47 |
| 30000 | T | | Drainage of nose lesion | 0251 | 1.9089 | $99.55 | | $19.91 |
| 30020 | T | | Drainage of nose lesion | 0251 | 1.9089 | $99.55 | | $19.91 |
| 30100 | T | | Intranasal biopsy | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 30110 | T | | Removal of nose polyp(s) | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 30115 | T | | Removal of nose polyp(s) | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 30117 | T | | Removal of intranasal lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 30118 | T | | Removal of intranasal lesion | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 30120 | T | | Revision of nose | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 30124 | T | | Removal of nose lesion | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 30125 | T | | Removal of nose lesion | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 30130 | T | | Removal of turbinate bones | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 30140 | T | | Removal of turbinate bones | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 30150 | T | | Partial removal of nose | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 30160 | T | | Removal of nose | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 30200 | T | | Injection treatment of nose | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 30210 | T | | Nasal sinus therapy | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 30220 | T | | Insert nasal septal button | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 30300 | X | | Remove nasal foreign body | 0340 | 0.6492 | $33.86 | | $6.77 |
| 30310 | T | | Remove nasal foreign body | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 30320 | T | | Remove nasal foreign body | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 30400 | T | | Reconstruction of nose | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 30410 | T | | Reconstruction of nose | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 30420 | T | | Reconstruction of nose | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 30430 | T | | Revision of nose | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 30435 | T | | Revision of nose | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 30450 | T | | Revision of nose | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 30460 | T | | Revision of nose | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 30462 | T | | Revision of nose | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 30465 | T | | Repair nasal stenosis | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 30520 | T | | Repair of nasal septum | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 30540 | T | | Repair nasal defect | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 30545 | T | | Repair nasal defect | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 30560 | T | | Release of nasal adhesions | 0251 | 1.9089 | $99.55 | | $19.91 |
| 30580 | T | | Repair upper jaw fistula | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 30600 | T | | Repair mouth/nose fistula | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 30620 | T | | Intranasal reconstruction | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 30630 | T | | Repair nasal septum defect | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 30801 | T | | Cauterization, inner nose | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 30802 | T | | Cauterization, inner nose | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 30901 | T | | Control of nosebleed | 0250 | 1.6376 | $85.40 | $29.89 | $17.08 |
| 30903 | T | | Control of nosebleed | 0250 | 1.6376 | $85.40 | $29.89 | $17.08 |
| 30905 | T | | Control of nosebleed | 0250 | 1.6376 | $85.40 | $29.89 | $17.08 |
| 30906 | T | | Repeat control of nosebleed | 0250 | 1.6376 | $85.40 | $29.89 | $17.08 |
| 30915 | T | | Ligation, nasal sinus artery | 0091 | 26.7048 | $1,392.68 | $348.23 | $278.54 |
| 30920 | T | | Ligation, upper jaw artery | 0092 | 23.7882 | $1,240.58 | $505.37 | $248.12 |
| 30930 | T | | Therapy, fracture of nose | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 30999 | T | | Nasal surgery procedure | 0251 | 1.9089 | $99.55 | | $19.91 |
| 31000 | T | | Irrigation, maxillary sinus | 0251 | 1.9089 | $99.55 | | $19.91 |
| 31002 | T | | Irrigation, sphenoid sinus | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 31020 | T | | Exploration, maxillary sinus | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 31030 | T | | Exploration, maxillary sinus | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31032 | T | | Explore sinus, remove polyps | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31040 | T | | Exploration behind upper jaw | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 31050 | T | | Exploration, sphenoid sinus | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31051 | T | | Sphenoid sinus surgery | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31070 | T | | Exploration of frontal sinus | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 31075 | T | | Exploration of frontal sinus | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31080 | T | | Removal of frontal sinus | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31081 | T | | Removal of frontal sinus | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31084 | T | | Removal of frontal sinus | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31085 | T | | Removal of frontal sinus | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31086 | T | | Removal of frontal sinus | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31087 | T | | Removal of frontal sinus | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31090 | T | | Exploration of sinuses | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31200 | T | | Removal of ethmoid sinus | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31201 | T | | Removal of ethmoid sinus | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31205 | T | | Removal of ethmoid sinus | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31225 | C | | Removal of upper jaw | | | | | |
| 31230 | C | | Removal of upper jaw | | | | | |
| 31231 | T | | Nasal endoscopy, dx | 0071 | 0.9205 | $48.00 | $12.89 | $9.60 |
| 31233 | T | | Nasal/sinus endoscopy, dx | 0073 | 3.1976 | $166.76 | $73.38 | $33.35 |
| 31235 | T | | Nasal/sinus endoscopy, dx | 0074 | 12.8582 | $670.57 | $295.70 | $134.11 |
| 31237 | T | | Nasal/sinus endoscopy, surg | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31238 | T | | Nasal/sinus endoscopy, surg | 0074 | 12.8582 | $670.57 | $295.70 | $134.11 |
| 31239 | T | | Nasal/sinus endoscopy, surg | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31240 | T | | Nasal/sinus endoscopy, surg | 0074 | 12.8582 | $670.57 | $295.70 | $134.11 |
| 31254 | T | | Revision of ethmoid sinus | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 31255 | T | | Removal of ethmoid sinus | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31256 | T | | Exploration maxillary sinus | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31267 | T | | Endoscopy, maxillary sinus | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31276 | T | | Sinus endoscopy, surgical | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31287 | T | | Nasal/sinus endoscopy, surg | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31288 | T | | Nasal/sinus endoscopy, surg | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 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 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 31300 | T | | Removal of larynx lesion | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31320 | T | | Diagnostic incision, larynx | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 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 | 34.0302 | $1,774.71 | | $354.94 |
| 31420 | T | | Removal of epiglottis | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31500 | S | | Insert emergency airway | 0094 | 3.8371 | $200.11 | $67.63 | $40.02 |
| 31502 | T | | Change of windpipe airway | 0121 | 2.0833 | $108.65 | $43.80 | $21.73 |
| 31505 | T | | Diagnostic laryngoscopy | 0072 | 1.1628 | $60.64 | $26.68 | $12.13 |
| 31510 | T | | Laryngoscopy with biopsy | 0074 | 12.8582 | $670.57 | $295.70 | $134.11 |
| 31511 | T | | Remove foreign body, larynx | 0072 | 1.1628 | $60.64 | $26.68 | $12.13 |
| 31512 | T | | Removal of larynx lesion | 0074 | 12.8582 | $670.57 | $295.70 | $134.11 |
| 31513 | T | | Injection into vocal cord | 0072 | 1.1628 | $60.64 | $26.68 | $12.13 |
| 31515 | T | | Laryngoscopy for aspiration | 0074 | 12.8582 | $670.57 | $295.70 | $134.11 |
| 31520 | T | | Diagnostic laryngoscopy | 0072 | 1.1628 | $60.64 | $26.68 | $12.13 |
| 31525 | T | | Diagnostic laryngoscopy | 0074 | 12.8582 | $670.57 | $295.70 | $134.11 |
| 31526 | T | | Diagnostic laryngoscopy | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31527 | T | | Laryngoscopy for treatment | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31528 | T | | Laryngoscopy and dilation | 0074 | 12.8582 | $670.57 | $295.70 | $134.11 |
| 31529 | T | | Laryngoscopy and dilation | 0074 | 12.8582 | $670.57 | $295.70 | $134.11 |
| 31530 | T | | Operative laryngoscopy | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31531 | T | | Operative laryngoscopy | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31535 | T | | Operative laryngoscopy | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31536 | T | | Operative laryngoscopy | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31540 | T | | Operative laryngoscopy | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31541 | T | | Operative laryngoscopy | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31560 | T | | Operative laryngoscopy | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31561 | T | | Operative laryngoscopy | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31570 | T | | Laryngoscopy with injection | 0074 | 12.8582 | $670.57 | $295.70 | $134.11 |
| 31571 | T | | Laryngoscopy with injection | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31575 | T | | Diagnostic laryngoscopy | 0071 | 0.9205 | $48.00 | $12.89 | $9.60 |
| 31576 | T | | Laryngoscopy with biopsy | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31577 | T | | Remove foreign body, larynx | 0073 | 3.1976 | $166.76 | $73.38 | $33.35 |
| 31578 | T | | Removal of larynx lesion | 0075 | 19.6604 | $1,025.31 | $445.92 | $205.06 |
| 31579 | T | | Diagnostic laryngoscopy | 0073 | 3.1976 | $166.76 | $73.38 | $33.35 |
| 31580 | T | | Revision of larynx | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31582 | T | | Revision of larynx | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31584 | C | | Treat larynx fracture | | | | | |
| 31585 | T | | Treat larynx fracture | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 31586 | T | | Treat larynx fracture | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31587 | C | | Revision of larynx | | | | | |
| 31588 | T | | Revision of larynx | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31590 | T | | Reinnervate larynx | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31595 | T | | Larynx nerve surgery | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31599 | T | | Larynx surgery procedure | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 31600 | T | | Incision of windpipe | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 31601 | T | | Incision of windpipe | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 31603 | T | | Incision of windpipe | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 31605 | T | | Incision of windpipe | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 31610 | T | | Incision of windpipe | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 31611 | T | | Surgery/speech prosthesis | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 31612 | T | | Puncture/clear windpipe | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 31613 | T | | Repair windpipe opening | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 31614 | T | | Repair windpipe opening | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31615 | T | | Visualization of windpipe | 0076 | 8.9533 | $466.92 | $189.82 | $93.38 |
| 31622 | T | | Dx bronchoscope/wash | 0076 | 8.9533 | $466.92 | $189.82 | $93.38 |
| 31623 | T | | Dx bronchoscope/brush | 0076 | 8.9533 | $466.92 | $189.82 | $93.38 |
| 31624 | T | | Dx bronchoscope/lavage | 0076 | 8.9533 | $466.92 | $189.82 | $93.38 |
| 31625 | T | | Bronchoscopy w/biopsy(s) | 0076 | 8.9533 | $466.92 | $189.82 | $93.38 |
| 31628 | T | | Bronchoscopy/lung bx, each | 0076 | 8.9533 | $466.92 | $189.82 | $93.38 |
| 31629 | T | | Bronchoscopy/needle bx, each | 0076 | 8.9533 | $466.92 | $189.82 | $93.38 |
| 31630 | T | | Bronchoscopy dilate/fx repr | 0076 | 8.9533 | $466.92 | $189.82 | $93.38 |
| 31631 | T | | Bronchoscopy, dilate w/stent | 0076 | 8.9533 | $466.92 | $189.82 | $93.38 |
| 31635 | T | | Bronchoscopy w/fb removal | 0076 | 8.9533 | $466.92 | $189.82 | $93.38 |
| 31640 | T | | Bronchoscopy w/tumor excise | 0076 | 8.9533 | $466.92 | $189.82 | $93.38 |
| 31641 | T | | Bronchoscopy, treat blockage | 0076 | 8.9533 | $466.92 | $189.82 | $93.38 |
| 31643 | T | | Diag bronchoscope/catheter | 0076 | 8.9533 | $466.92 | $189.82 | $93.38 |
| 31645 | T | | Bronchoscopy, clear airways | 0076 | 8.9533 | $466.92 | $189.82 | $93.38 |
| 31646 | T | | Bronchoscopy, reclear airway | 0076 | 8.9533 | $466.92 | $189.82 | $93.38 |
| 31656 | T | | Bronchoscopy, inj for x-ray | 0076 | 8.9533 | $466.92 | $189.82 | $93.38 |
| 31700 | T | | Insertion of airway catheter | 0072 | 1.1628 | $60.64 | $26.68 | $12.13 |
| 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 | 3.1976 | $166.76 | $73.38 | $33.35 |
| 31720 | T | | Clearance of airways | 0072 | 1.1628 | $60.64 | $26.68 | $12.13 |
| 31725 | C | | Clearance of airways | | | | | |
| 31730 | T | | Intro, windpipe wire/tube | 0073 | 3.1976 | $166.76 | $73.38 | $33.35 |
| 31750 | T | | Repair of windpipe | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 31755 | T | | Repair of windpipe | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 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 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 31786 | C | | Remove windpipe lesion | | | | | |
| 31800 | C | | Repair of windpipe injury | | | | | |
| 31805 | C | | Repair of windpipe injury | | | | | |
| 31820 | T | | Closure of windpipe lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 31825 | T | | Repair of windpipe defect | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 31830 | T | | Revise windpipe scar | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 31899 | T | | Airways surgical procedure | 0076 | 8.9533 | $466.92 | $189.82 | $93.38 |
| 32000 | T | | Drainage of chest | 0070 | 3.3623 | $175.35 | | $35.07 |
| 32002 | T | | Treatment of collapsed lung | 0070 | 3.3623 | $175.35 | | $35.07 |
| 32005 | T | | Treat lung lining chemically | 0070 | 3.3623 | $175.35 | | $35.07 |
| 32020 | T | | Insertion of chest tube | 0070 | 3.3623 | $175.35 | | $35.07 |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 32200 | C | ..... | Drain, open, lung lesion | ..... | ..... | ..... | ..... | ..... |
| 32201 | T | ..... | Drain, percut, lung lesion | 0070 | 3.3623 | $175.35 | ..... | $35.07 |
| 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 | 3.1201 | $162.72 | $71.59 | $32.54 |
| 32402 | C | ..... | Open biopsy chest lining | ..... | ..... | ..... | ..... | ..... |
| 32405 | T | ..... | Biopsy, lung or mediastinum | 0685 | 5.9882 | $312.29 | $137.40 | $62.46 |
| 32420 | T | ..... | Puncture/clear lung | 0070 | 3.3623 | $175.35 | ..... | $35.07 |
| 32440 | C | ..... | Removal of lung | ..... | ..... | ..... | ..... | ..... |
| 32442 | C | ..... | Sleeve pneumonectomy | ..... | ..... | ..... | ..... | ..... |
| 32445 | C | ..... | Removal of lung | ..... | ..... | ..... | ..... | ..... |
| 32480 | C | ..... | Partial removal of lung | ..... | ..... | ..... | ..... | ..... |
| 32482 | C | ..... | Bilobectomy | ..... | ..... | ..... | ..... | ..... |
| 32484 | C | ..... | Segmentectomy | ..... | ..... | ..... | ..... | ..... |
| 32486 | C | ..... | Sleeve lobectomy | ..... | ..... | ..... | ..... | ..... |
| 32488 | C | ..... | Completion pneumonectomy | ..... | ..... | ..... | ..... | ..... |
| 32491 | C | ..... | Lung volume reduction | ..... | ..... | ..... | ..... | ..... |
| 32500 | C | ..... | Partial removal of lung | ..... | ..... | ..... | ..... | ..... |
| 32501 | C | ..... | Repair bronchus add-on | ..... | ..... | ..... | ..... | ..... |
| 32520 | C | ..... | Remove lung & revise chest | ..... | ..... | ..... | ..... | ..... |
| 32522 | C | ..... | Remove lung & revise chest | ..... | ..... | ..... | ..... | ..... |
| 32525 | C | ..... | Remove lung & revise chest | ..... | ..... | ..... | ..... | ..... |
| 32540 | C | ..... | Removal of lung lesion | ..... | ..... | ..... | ..... | ..... |
| 32601 | T | ..... | Thoracoscopy, diagnostic | 0069 | 27.5575 | $1,437.15 | $591.64 | $287.43 |
| 32602 | T | ..... | Thoracoscopy, diagnostic | 0069 | 27.5575 | $1,437.15 | $591.64 | $287.43 |
| 32603 | T | ..... | Thoracoscopy, diagnostic | 0069 | 27.5575 | $1,437.15 | $591.64 | $287.43 |
| 32604 | T | ..... | Thoracoscopy, diagnostic | 0069 | 27.5575 | $1,437.15 | $591.64 | $287.43 |
| 32605 | T | ..... | Thoracoscopy, diagnostic | 0069 | 27.5575 | $1,437.15 | $591.64 | $287.43 |
| 32606 | T | ..... | Thoracoscopy, diagnostic | 0069 | 27.5575 | $1,437.15 | $591.64 | $287.43 |
| 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 | 3.3623 | $175.35 | ..... | $35.07 |
| 32997 | C | ..... | Total lung lavage | ..... | ..... | ..... | ..... | ..... |
| 32999 | T | ..... | Chest surgery procedure | 0070 | 3.3623 | $175.35 | ..... | $35.07 |
| 33010 | T | ..... | Drainage of heart sac | 0070 | 3.3623 | $175.35 | ..... | $35.07 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 33011 | T | | Repeat drainage of heart sac | 0070 | 3.3623 | $175.35 | | $35.07 |
| 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 | 112.5555 | $5,869.88 | $1,722.59 | $1,173.98 |
| 33207 | T | | Insertion of heart pacemaker | 0089 | 112.5555 | $5,869.88 | $1,722.59 | $1,173.98 |
| 33208 | T | | Insertion of heart pacemaker | 0655 | 122.8654 | $6,407.55 | | $1,281.51 |
| 33210 | T | | Insertion of heart electrode | 0106 | 54.8243 | $2,859.14 | | $571.83 |
| 33211 | T | | Insertion of heart electrode | 0106 | 54.8243 | $2,859.14 | | $571.83 |
| 33212 | T | | Insertion of pulse generator | 0090 | 87.9631 | $4,587.36 | $1,651.45 | $917.47 |
| 33213 | T | | Insertion of pulse generator | 0654 | 91.8583 | $4,790.50 | | $958.10 |
| 33214 | T | | Upgrade of pacemaker system | 0655 | 122.8654 | $6,407.55 | | $1,281.51 |
| 33215 | T | NI | Reposition pacing-defib lead | 0105 | 18.5945 | $969.72 | $370.40 | $193.94 |
| 33216 | T | | Revise eltrd pacing-defib | 0106 | 54.8243 | $2,859.14 | | $571.83 |
| 33217 | T | | Insert lead pace-defib, dual | 0106 | 54.8243 | $2,859.14 | | $571.83 |
| 33218 | T | | Repair lead pace-defib, one | 0106 | 54.8243 | $2,859.14 | | $571.83 |
| 33220 | T | | Repair lead pace-defib, dual | 0106 | 54.8243 | $2,859.14 | | $571.83 |
| 33222 | T | | Revise pocket, pacemaker | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 33223 | T | | Revise pocket, pacing-defib | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 33224 | T | NI | Insert pacing lead & connect | 0976 | | $875.00 | | $175.00 |
| 33225 | T | NI | L ventric pacing lead add-on | 0977 | | $1,125.00 | | $225.00 |
| 33226 | T | NI | Reposition l ventric lead | 0105 | 18.5945 | $969.72 | $370.40 | $193.94 |
| 33233 | T | | Removal of pacemaker system | 0105 | 18.5945 | $969.72 | $370.40 | $193.94 |
| 33234 | T | | Removal of pacemaker system | 0105 | 18.5945 | $969.72 | $370.40 | $193.94 |
| 33235 | T | | Removal pacemaker electrode | 0105 | 18.5945 | $969.72 | $370.40 | $193.94 |
| 33236 | C | | Remove electrode/thoracotomy | | | | | |
| 33237 | C | | Remove electrode/thoracotomy | | | | | |
| 33238 | C | | Remove electrode/thoracotomy | | | | | |
| 33240 | T | | Insert pulse generator | 0107 | 326.2231 | $17,012.86 | $3,699.14 | $3,402.57 |
| 33241 | T | | Remove pulse generator | 0105 | 18.5945 | $969.72 | $370.40 | $193.94 |
| 33243 | C | | Remove eltrd/thoracotomy | | | | | |
| 33244 | T | | Remove eltrd, transven | 0105 | 18.5945 | $969.72 | $370.40 | $193.94 |
| 33245 | C | | Insert epic eltrd pace-defib | | | | | |
| 33246 | C | | Insert epic eltrd/generator | | | | | |
| 33249 | T | | Eltrd/insert pace-defib | 0108 | 443.5460 | $23,131.37 | | $4,626.27 |
| 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 | 56.1324 | $2,927.36 | | $585.47 |
| 33284 | T | | Remove pat-active ht record | 0109 | 7.4708 | $389.61 | $131.49 | $77.92 |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | NI | Endoscopic vein harvest | | | | | |
| 33510 | C | | CABG, vein, single | | | | | |
| 33511 | C | | CABG, vein, two | | | | | |
| 33512 | C | | CABG, vein, three | | | | | |
| 33513 | C | | CABG, vein, four | | | | | |
| 33514 | C | | CABG, vein, five | | | | | |
| 33516 | C | | Cabg, vein, six or more | | | | | |
| 33517 | C | | CABG, artery-vein, single | | | | | |
| 33518 | C | | CABG, artery-vein, two | | | | | |
| 33519 | C | | CABG, artery-vein, three | | | | | |
| 33521 | C | | CABG, artery-vein, four | | | | | |
| 33522 | C | | CABG, artery-vein, five | | | | | |
| 33523 | C | | Cabg, art-vein, six or more | | | | | |
| 33530 | C | | Coronary artery, bypass/reop | | | | | |
| 33533 | C | | CABG, arterial, single | | | | | |
| 33534 | C | | CABG, arterial, two | | | | | |
| 33535 | C | | CABG, arterial, three | | | | | |
| 33536 | C | | Cabg, arterial, four or more | | | | | |
| 33542 | C | | Removal of heart lesion | | | | | |
| 33545 | C | | Repair of heart damage | | | | | |
| 33572 | C | | Open coronary endarterectomy | | | | | |
| 33600 | C | | Closure of valve | | | | | |
| 33602 | C | | Closure of valve | | | | | |
| 33606 | C | | Anastomosis/artery-aorta | | | | | |
| 33608 | C | | Repair anomaly w/conduit | | | | | |
| 33610 | C | | Repair by enlargement | | | | | |
| 33611 | C | | Repair double ventricle | | | | | |
| 33612 | C | | Repair double ventricle | | | | | |
| 33615 | C | | Repair, modified fontan | | | | | |
| 33617 | C | | Repair single ventricle | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | | | | | |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | 3.3623 | $175.35 | | $35.07 |
| 34001 | C | | Removal of artery clot | | | | | |
| 34051 | C | | Removal of artery clot | | | | | |
| 34101 | T | | Removal of artery clot | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 34111 | T | | Removal of arm artery clot | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 34151 | C | | Removal of artery clot | | | | | |
| 34201 | T | | Removal of artery clot | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 34203 | T | | Removal of leg artery clot | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 34401 | C | | Removal of vein clot | | | | | |
| 34421 | T | | Removal of vein clot | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 34451 | C | | Removal of vein clot | | | | | |
| 34471 | T | | Removal of vein clot | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 34490 | T | | Removal of vein clot | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 34501 | T | | Repair valve, femoral vein | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 34502 | C | | Reconstruct vena cava | | | | | |
| 34510 | T | | Transposition of vein valve | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 34520 | T | | Cross-over vein graft | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 34530 | T | | Leg vein fusion | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 34800 | C | | Endovasc abdo repair w/tube | | | | | |
| 34802 | C | | Endovasc abdo repr w/device | | | | | |
| 34804 | C | | Endovasc abdo repr w/device | | | | | |
| 34808 | C | | Endovasc abdo occlud device | | | | | |
| 34812 | C | | Xpose for endoprosth, aortic | | | | | |
| 34813 | C | | Femoral endovas graft add-on | | | | | |
| 34820 | C | | Xpose for endoprosth, iliac | | | | | |
| 34825 | C | | Endovasc extend prosth, init | | | | | |
| 34826 | C | | Endovasc exten prosth, addl | | | | | |
| 34830 | C | | Open aortic tube prosth repr | | | | | |
| 34831 | C | | Open aortoiliac prosth repr | | | | | |
| 34832 | C | | Open aortofemor prosth repr | | | | | |
| 34833 | C | NI | Xpose for endoprosth, iliac | | | | | |
| 34834 | C | NI | Xpose, endoprosth, brachial | | | | | |
| 34900 | C | NI | 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 | 30.0284 | $1,566.01 | | $313.20 |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | 20.6294 | $1,075.84 | $277.34 | $215.17 |
| 35182 | C | ..... | Repair blood vessel lesion | ..... | ..... | ..... | ..... | ..... |
| 35184 | T | ..... | Repair blood vessel lesion | 0093 | 20.6294 | $1,075.84 | $277.34 | $215.17 |
| 35188 | T | ..... | Repair blood vessel lesion | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 35189 | C | ..... | Repair blood vessel lesion | ..... | ..... | ..... | ..... | ..... |
| 35190 | T | ..... | Repair blood vessel lesion | 0093 | 20.6294 | $1,075.84 | $277.34 | $215.17 |
| 35201 | T | ..... | Repair blood vessel lesion | 0093 | 20.6294 | $1,075.84 | $277.34 | $215.17 |
| 35206 | T | ..... | Repair blood vessel lesion | 0093 | 20.6294 | $1,075.84 | $277.34 | $215.17 |
| 35207 | T | ..... | Repair blood vessel lesion | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 35211 | C | ..... | Repair blood vessel lesion | ..... | ..... | ..... | ..... | ..... |
| 35216 | C | ..... | Repair blood vessel lesion | ..... | ..... | ..... | ..... | ..... |
| 35221 | C | ..... | Repair blood vessel lesion | ..... | ..... | ..... | ..... | ..... |
| 35226 | T | ..... | Repair blood vessel lesion | 0093 | 20.6294 | $1,075.84 | $277.34 | $215.17 |
| 35231 | T | ..... | Repair blood vessel lesion | 0093 | 20.6294 | $1,075.84 | $277.34 | $215.17 |
| 35236 | T | ..... | Repair blood vessel lesion | 0093 | 20.6294 | $1,075.84 | $277.34 | $215.17 |
| 35241 | C | ..... | Repair blood vessel lesion | ..... | ..... | ..... | ..... | ..... |
| 35246 | C | ..... | Repair blood vessel lesion | ..... | ..... | ..... | ..... | ..... |
| 35251 | C | ..... | Repair blood vessel lesion | ..... | ..... | ..... | ..... | ..... |
| 35256 | T | ..... | Repair blood vessel lesion | 0093 | 20.6294 | $1,075.84 | $277.34 | $215.17 |
| 35261 | T | ..... | Repair blood vessel lesion | 0653 | 30.0284 | $1,566.01 | ..... | $313.20 |
| 35266 | T | ..... | Repair blood vessel lesion | 0653 | 30.0284 | $1,566.01 | ..... | $313.20 |
| 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 | 30.0284 | $1,566.01 | ..... | $313.20 |
| 35301 | C | ..... | Rechanneling of artery | ..... | ..... | ..... | ..... | ..... |
| 35311 | C | ..... | Rechanneling of artery | ..... | ..... | ..... | ..... | ..... |
| 35321 | T | ..... | Rechanneling of artery | 0093 | 20.6294 | $1,075.84 | $277.34 | $215.17 |
| 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 | 43.5067 | $2,268.92 | ..... | $453.78 |
| 35459 | T | ..... | Repair arterial blockage | 0081 | 43.5067 | $2,268.92 | ..... | $453.78 |
| 35460 | T | ..... | Repair venous blockage | 0081 | 43.5067 | $2,268.92 | ..... | $453.78 |
| 35470 | T | ..... | Repair arterial blockage | 0081 | 43.5067 | $2,268.92 | ..... | $453.78 |
| 35471 | T | ..... | Repair arterial blockage | 0081 | 43.5067 | $2,268.92 | ..... | $453.78 |
| 35472 | T | ..... | Repair arterial blockage | 0081 | 43.5067 | $2,268.92 | ..... | $453.78 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 35473 | T | | Repair arterial blockage | 0081 | 43.5067 | $2,268.92 | | $453.78 |
| 35474 | T | | Repair arterial blockage | 0081 | 43.5067 | $2,268.92 | | $453.78 |
| 35475 | T | | Repair arterial blockage | 0081 | 43.5067 | $2,268.92 | | $453.78 |
| 35476 | T | | Repair venous blockage | 0081 | 43.5067 | $2,268.92 | | $453.78 |
| 35480 | C | | Atherectomy, open | | | | | |
| 35481 | C | | Atherectomy, open | | | | | |
| 35482 | C | | Atherectomy, open | | | | | |
| 35483 | C | | Atherectomy, open | | | | | |
| 35484 | T | | Atherectomy, open | 0081 | 43.5067 | $2,268.92 | | $453.78 |
| 35485 | T | | Atherectomy, open | 0081 | 43.5067 | $2,268.92 | | $453.78 |
| 35490 | T | | Atherectomy, percutaneous | 0081 | 43.5067 | $2,268.92 | | $453.78 |
| 35491 | T | | Atherectomy, percutaneous | 0081 | 43.5067 | $2,268.92 | | $453.78 |
| 35492 | T | | Atherectomy, percutaneous | 0081 | 43.5067 | $2,268.92 | | $453.78 |
| 35493 | T | | Atherectomy, percutaneous | 0081 | 43.5067 | $2,268.92 | | $453.78 |
| 35494 | T | | Atherectomy, percutaneous | 0081 | 43.5067 | $2,268.92 | | $453.78 |
| 35495 | T | | Atherectomy, percutaneous | 0081 | 43.5067 | $2,268.92 | | $453.78 |
| 35500 | T | | Harvest vein for bypass | 0081 | 43.5067 | $2,268.92 | | $453.78 |
| 35501 | C | | Artery bypass graft | | | | | |
| 35506 | C | | Artery bypass graft | | | | | |
| 35507 | C | | Artery bypass graft | | | | | |
| 35508 | C | | Artery bypass graft | | | | | |
| 35509 | C | | Artery bypass graft | | | | | |
| 35511 | C | | Artery bypass graft | | | | | |
| 35515 | C | | Artery bypass graft | | | | | |
| 35516 | C | | Artery bypass graft | | | | | |
| 35518 | C | | Artery bypass graft | | | | | |
| 35521 | C | | Artery bypass graft | | | | | |
| 35526 | C | | Artery bypass graft | | | | | |
| 35531 | C | | Artery bypass graft | | | | | |
| 35533 | C | | Artery bypass graft | | | | | |
| 35536 | C | | Artery bypass graft | | | | | |
| 35541 | C | | Artery bypass graft | | | | | |
| 35546 | C | | Artery bypass graft | | | | | |
| 35548 | C | | Artery bypass graft | | | | | |
| 35549 | C | | Artery bypass graft | | | | | |
| 35551 | C | | Artery bypass graft | | | | | |
| 35556 | C | | Artery bypass graft | | | | | |
| 35558 | C | | Artery bypass graft | | | | | |
| 35560 | C | | Artery bypass graft | | | | | |
| 35563 | C | | Artery bypass graft | | | | | |
| 35565 | C | | Artery bypass graft | | | | | |
| 35566 | C | | Artery bypass graft | | | | | |
| 35571 | C | | Artery bypass graft | | | | | |
| 35572 | N | NI | 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | 20.6294 | $1,075.84 | $277.34 | $215.17 |
| 35686 | T | ..... | Bypass graft/av fist patency | 0093 | 20.6294 | $1,075.84 | $277.34 | $215.17 |
| 35691 | C | ..... | Arterial transposition | ..... | ..... | ..... | ..... | ..... |
| 35693 | C | ..... | Arterial transposition | ..... | ..... | ..... | ..... | ..... |
| 35694 | C | ..... | Arterial transposition | ..... | ..... | ..... | ..... | ..... |
| 35695 | C | ..... | Arterial transposition | ..... | ..... | ..... | ..... | ..... |
| 35700 | C | ..... | Reoperation, bypass graft | ..... | ..... | ..... | ..... | ..... |
| 35701 | C | ..... | Exploration, carotid artery | ..... | ..... | ..... | ..... | ..... |
| 35721 | C | ..... | Exploration, femoral artery | ..... | ..... | ..... | ..... | ..... |
| 35741 | C | ..... | Exploration popliteal artery | ..... | ..... | ..... | ..... | ..... |
| 35761 | T | ..... | Exploration of artery/vein | 0115 | 24.3211 | $1,268.37 | $459.35 | $253.67 |
| 35800 | C | ..... | Explore neck vessels | ..... | ..... | ..... | ..... | ..... |
| 35820 | C | ..... | Explore chest vessels | ..... | ..... | ..... | ..... | ..... |
| 35840 | C | ..... | Explore abdominal vessels | ..... | ..... | ..... | ..... | ..... |
| 35860 | T | ..... | Explore limb vessels | 0093 | 20.6294 | $1,075.84 | $277.34 | $215.17 |
| 35870 | C | ..... | Repair vessel graft defect | ..... | ..... | ..... | ..... | ..... |
| 35875 | T | ..... | Removal of clot in graft | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 35876 | T | ..... | Removal of clot in graft | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 35879 | T | ..... | Revise graft w/vein | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 35881 | T | ..... | Revise graft w/vein | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 35901 | C | ..... | Excision, graft, neck | ..... | ..... | ..... | ..... | ..... |
| 35903 | T | ..... | Excision, graft, extremity | 0115 | 24.3211 | $1,268.37 | $459.35 | $253.67 |
| 35905 | C | ..... | Excision, graft, thorax | ..... | ..... | ..... | ..... | ..... |
| 35907 | C | ..... | Excision, graft, abdomen | ..... | ..... | ..... | ..... | ..... |
| 36000 | N | ..... | Place needle in vein | ..... | ..... | ..... | ..... | ..... |
| 36002 | S | ..... | Pseudoaneurysm injection trt | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 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 | 89.3100 | $4,657.61 | ..... | $931.52 |
| 36261 | T | ..... | Revision of infusion pump | 0124 | 50.0861 | $2,612.04 | ..... | $522.41 |
| 36262 | T | ..... | Removal of infusion pump | 0109 | 7.4708 | $389.61 | $131.49 | $77.92 |
| 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 | ..... | ..... | ..... | ..... | ..... |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 36415 | E | | Drawing blood | | | | | |
| 36416 | E | NI | Capillary blood draw | | | | | |
| 36420 | T | | Vein access cutdown < 1 yr | 0035 | 0.2229 | $11.62 | $3.51 | $2.32 |
| 36425 | T | | Vein access cutdown > 1 yr | 0035 | 0.2229 | $11.62 | $3.51 | $2.32 |
| 36430 | S | | Blood transfusion service | 0110 | 4.0309 | $210.22 | | $42.04 |
| 36440 | S | | Bl push transfuse, 2 yr or < | 0110 | 4.0309 | $210.22 | | $42.04 |
| 36450 | S | | Bl exchange/transfuse, nb | 0110 | 4.0309 | $210.22 | | $42.04 |
| 36455 | S | | Bl exchange/transfuse non-nb | 0110 | 4.0309 | $210.22 | | $42.04 |
| 36460 | S | | Transfusion service, fetal | 0110 | 4.0309 | $210.22 | | $42.04 |
| 36468 | T | | Injection(s), spider veins | 0098 | 1.6666 | $86.91 | $20.88 | $17.38 |
| 36469 | T | | Injection(s), spider veins | 0098 | 1.6666 | $86.91 | $20.88 | $17.38 |
| 36470 | T | | Injection therapy of vein | 0098 | 1.6666 | $86.91 | $20.88 | $17.38 |
| 36471 | T | | Injection therapy of veins | 0098 | 1.6666 | $86.91 | $20.88 | $17.38 |
| 36481 | N | | Insertion of catheter, vein | | | | | |
| 36488 | T | | Insertion of catheter, vein | 0032 | 11.4726 | $598.31 | | $119.66 |
| 36489 | T | | Insertion of catheter, vein | 0032 | 11.4726 | $598.31 | | $119.66 |
| 36490 | T | | Insertion of catheter, vein | 0032 | 11.4726 | $598.31 | | $119.66 |
| 36491 | T | | Insertion of catheter, vein | 0032 | 11.4726 | $598.31 | | $119.66 |
| 36493 | X | | Repositioning of cvc | 0187 | 3.9534 | $206.17 | $90.71 | $41.23 |
| 36500 | N | | Insertion of catheter, vein | | | | | |
| 36510 | C | | Insertion of catheter, vein | | | | | |
| 36511 | S | NI | Apheresis wbc | 0111 | 14.9803 | $781.24 | $217.61 | $156.25 |
| 36512 | S | NI | Apheresis rbc | 0111 | 14.9803 | $781.24 | $217.61 | $156.25 |
| 36513 | S | NI | Apheresis platelets | 0111 | 14.9803 | $781.24 | $217.61 | $156.25 |
| 36514 | S | NI | Apheresis plasma | 0111 | 14.9803 | $781.24 | $217.61 | $156.25 |
| 36515 | S | NI | Apheresis, adsorp/reinfuse | 0112 | 36.4236 | $1,899.53 | $612.47 | $379.91 |
| 36516 | S | NI | Apheresis, selective | 0112 | 36.4236 | $1,899.53 | $612.47 | $379.91 |
| 36520 | S | DG | Plasma and/or cell exchange | 0111 | 14.9803 | $781.24 | $217.61 | $156.25 |
| 36521 | S | DG | Apheresis w/ adsorp/reinfuse | 0112 | 36.4236 | $1,899.53 | $612.47 | $379.91 |
| 36522 | S | | Photopheresis | 0112 | 36.4236 | $1,899.53 | $612.47 | $379.91 |
| 36530 | T | | Insertion of infusion pump | 0119 | 89.3100 | $4,657.61 | | $931.52 |
| 36531 | T | | Revision of infusion pump | 0124 | 50.0861 | $2,612.04 | | $522.41 |
| 36532 | T | | Removal of infusion pump | 0109 | 7.4708 | $389.61 | $131.49 | $77.92 |
| 36533 | T | | Insertion of access device | 0115 | 24.3211 | $1,268.37 | $459.35 | $253.67 |
| 36534 | T | | Revision of access device | 0109 | 7.4708 | $389.61 | $131.49 | $77.92 |
| 36535 | T | | Removal of access device | 0109 | 7.4708 | $389.61 | $131.49 | $77.92 |
| 36536 | T | NI | Remove cva device obstruct | 0973 | | $250.00 | | $50.00 |
| 36537 | T | NI | Remove cva lumen obstruct | 0973 | | $250.00 | | $50.00 |
| 36540 | N | | Collect blood venous device | | | | | |
| 36550 | T | | Declot vascular device | 0677 | 2.6453 | $137.96 | | $27.59 |
| 36600 | N | | Withdrawal of arterial blood | | | | | |
| 36620 | N | | Insertion catheter, artery | | | | | |
| 36625 | N | | Insertion catheter, artery | | | | | |
| 36640 | T | | Insertion catheter, artery | 0032 | 11.4726 | $598.31 | | $119.66 |
| 36660 | C | | Insertion catheter, artery | | | | | |
| 36680 | T | | Insert needle, bone cavity | 0120 | 2.1802 | $113.70 | $30.75 | $22.74 |
| 36800 | T | | Insertion of cannula | 0115 | 24.3211 | $1,268.37 | $459.35 | $253.67 |
| 36810 | T | | Insertion of cannula | 0115 | 24.3211 | $1,268.37 | $459.35 | $253.67 |
| 36815 | T | | Insertion of cannula | 0115 | 24.3211 | $1,268.37 | $459.35 | $253.67 |
| 36819 | T | | Av fusion/uppr arm vein | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 36820 | T | | Av fusion/forearm vein | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 36821 | T | | Av fusion direct any site | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 36822 | C | | Insertion of cannula(s) | | | | | |
| 36823 | C | | Insertion of cannula(s) | | | | | |
| 36825 | T | | Artery-vein autograft | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 36830 | T | | Artery-vein graft | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 36831 | T | | Open thrombect av fistula | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 36832 | T | | Av fistula revision, open | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 36833 | T | | Av fistula revision | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 36834 | T | | Repair A-V aneurysm | 0088 | 32.5768 | $1,698.91 | $655.22 | $339.78 |
| 36835 | T | | Artery to vein shunt | 0115 | 24.3211 | $1,268.37 | $459.35 | $253.67 |
| 36860 | T | | External cannula declotting | 0103 | 11.8408 | $617.51 | $223.63 | $123.50 |
| 36861 | T | | Cannula declotting | 0115 | 24.3211 | $1,268.37 | $459.35 | $253.67 |
| 36870 | T | | Percut thrombect av fistula | 0653 | 30.0284 | $1,566.01 | | $313.20 |
| 37140 | C | | Revision of circulation | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 37145 | C | | Revision of circulation | | | | | |
| 37160 | C | | Revision of circulation | | | | | |
| 37180 | C | | Revision of circulation | | | | | |
| 37181 | C | | Splice spleen/kidney veins | | | | | |
| 37182 | C | NI | Insert hepatic shunt (tips) | | | | | |
| 37183 | C | NI | Remove hepatic shunt (tips) | | | | | |
| 37195 | C | | Thrombolytic therapy, stroke | | | | | |
| 37200 | T | | Transcatheter biopsy | 0685 | 5.9882 | $312.29 | $137.40 | $62.46 |
| 37201 | T | | Transcatheter therapy infuse | 0676 | 4.1278 | $215.27 | $58.21 | $43.05 |
| 37202 | T | | Transcatheter therapy infuse | 0677 | 2.6453 | $137.96 | | $27.59 |
| 37203 | T | | Transcatheter retrieval | 0103 | 11.8408 | $617.51 | $223.63 | $123.50 |
| 37204 | T | | Transcatheter occlusion | 0115 | 24.3211 | $1,268.37 | $459.35 | $253.67 |
| 37205 | T | | Transcatheter stent | 0229 | 57.4599 | $2,996.59 | $771.23 | $599.32 |
| 37206 | T | | Transcatheter stent add-on | 0229 | 57.4599 | $2,996.59 | $771.23 | $599.32 |
| 37207 | T | | Transcatheter stent | 0229 | 57.4599 | $2,996.59 | $771.23 | $599.32 |
| 37208 | T | | Transcatheter stent add-on | 0229 | 57.4599 | $2,996.59 | $771.23 | $599.32 |
| 37209 | T | | Exchange arterial catheter | 0103 | 11.8408 | $617.51 | $223.63 | $123.50 |
| 37250 | S | | Iv us first vessel add-on | 0670 | 30.2416 | $1,577.13 | $571.17 | $315.43 |
| 37251 | S | | Iv us each add vessel add-on | 0670 | 30.2416 | $1,577.13 | $571.17 | $315.43 |
| 37500 | T | NI | Endoscopy ligate perf veins | 0092 | 23.7882 | $1,240.58 | $505.37 | $248.12 |
| 37501 | T | NI | Vascular endoscopy procedure | 0092 | 23.7882 | $1,240.58 | $505.37 | $248.12 |
| 37565 | T | | Ligation of neck vein | 0093 | 20.6294 | $1,075.84 | $277.34 | $215.17 |
| 37600 | T | | Ligation of neck artery | 0093 | 20.6294 | $1,075.84 | $277.34 | $215.17 |
| 37605 | T | | Ligation of neck artery | 0091 | 26.7048 | $1,392.68 | $348.23 | $278.54 |
| 37606 | T | | Ligation of neck artery | 0091 | 26.7048 | $1,392.68 | $348.23 | $278.54 |
| 37607 | T | | Ligation of a-v fistula | 0092 | 23.7882 | $1,240.58 | $505.37 | $248.12 |
| 37609 | T | | Temporal artery procedure | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 37615 | T | | Ligation of neck artery | 0091 | 26.7048 | $1,392.68 | $348.23 | $278.54 |
| 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 | 26.7048 | $1,392.68 | $348.23 | $278.54 |
| 37650 | T | | Revision of major vein | 0091 | 26.7048 | $1,392.68 | $348.23 | $278.54 |
| 37660 | C | | Revision of major vein | | | | | |
| 37700 | T | | Revise leg vein | 0091 | 26.7048 | $1,392.68 | $348.23 | $278.54 |
| 37720 | T | | Removal of leg vein | 0092 | 23.7882 | $1,240.58 | $505.37 | $248.12 |
| 37730 | T | | Removal of leg veins | 0092 | 23.7882 | $1,240.58 | $505.37 | $248.12 |
| 37735 | T | | Removal of leg veins/lesion | 0092 | 23.7882 | $1,240.58 | $505.37 | $248.12 |
| 37760 | T | | Revision of leg veins | 0091 | 26.7048 | $1,392.68 | $348.23 | $278.54 |
| 37780 | T | | Revision of leg vein | 0091 | 26.7048 | $1,392.68 | $348.23 | $278.54 |
| 37785 | T | | Revise secondary varicosity | 0091 | 26.7048 | $1,392.68 | $348.23 | $278.54 |
| 37788 | C | | Revascularization, penis | | | | | |
| 37790 | T | | Penile venous occlusion | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 37799 | T | | Vascular surgery procedure | 0035 | 0.2229 | $11.62 | $3.51 | $2.32 |
| 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 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 38129 | T | | Laparoscope proc, spleen | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 38200 | N | | Injection for spleen x-ray | | | | | |
| 38204 | E | NI | Bl donor search management | | | | | |
| 38205 | S | NI | Harvest allogenic stem cells | 0111 | 14.9803 | $781.24 | $217.61 | $156.25 |
| 38206 | S | NI | Harvest auto stem cells | 0111 | 14.9803 | $781.24 | $217.61 | $156.25 |
| 38207 | E | NI | Cryopreserve stem cells | | | | | |
| 38208 | E | NI | Thaw preserved stem cells | | | | | |
| 38209 | E | NI | Wash harvest stem cells | | | | | |
| 38210 | E | NI | T-cell depletion of harvest | | | | | |
| 38211 | E | NI | Tumor cell deplete of harvst | | | | | |
| 38212 | E | NI | Rbc depletion of harvest | | | | | |
| 38213 | E | NI | Platelet deplete of harvest | | | | | |
| 38214 | E | NI | Volume deplete of harvest | | | | | |
| 38215 | E | NI | Harvest stem cell concentrte | | | | | |
| 38220 | T | | Bone marrow aspiration | 0003 | 1.2306 | $64.18 | | $12.84 |
| 38221 | T | | Bone marrow biopsy | 0003 | 1.2306 | $64.18 | | $12.84 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 38230 | S | | Bone marrow collection | 0123 | 6.4049 | $334.02 | | $66.80 |
| 38231 | S | DG | Stem cell collection | 0111 | 14.9803 | $781.24 | $217.61 | $156.25 |
| 38240 | S | | Bone marrow/stem transplant | 0123 | 6.4049 | $334.02 | | $66.80 |
| 38241 | S | | Bone marrow/stem transplant | 0123 | 6.4049 | $334.02 | | $66.80 |
| 38242 | S | NI | Lymphocyte infuse transplant | 0111 | 14.9803 | $781.24 | $217.61 | $156.25 |
| 38300 | T | | Drainage, lymph node lesion | 0008 | 16.1430 | $841.87 | | $168.37 |
| 38305 | T | | Drainage, lymph node lesion | 0008 | 16.1430 | $841.87 | | $168.37 |
| 38308 | T | | Incision of lymph channels | 0113 | 18.7496 | $977.81 | | $195.56 |
| 38380 | C | | Thoracic duct procedure | | | | | |
| 38381 | C | | Thoracic duct procedure | | | | | |
| 38382 | C | | Thoracic duct procedure | | | | | |
| 38500 | T | | Biopsy/removal, lymph nodes | 0113 | 18.7496 | $977.81 | | $195.56 |
| 38505 | T | | Needle biopsy, lymph nodes | 0005 | 3.1201 | $162.72 | $71.59 | $32.54 |
| 38510 | T | | Biopsy/removal, lymph nodes | 0113 | 18.7496 | $977.81 | | $195.56 |
| 38520 | T | | Biopsy/removal, lymph nodes | 0113 | 18.7496 | $977.81 | | $195.56 |
| 38525 | T | | Biopsy/removal, lymph nodes | 0113 | 18.7496 | $977.81 | | $195.56 |
| 38530 | T | | Biopsy/removal, lymph nodes | 0113 | 18.7496 | $977.81 | | $195.56 |
| 38542 | T | | Explore deep node(s), neck | 0114 | 36.1135 | $1,883.36 | $485.91 | $376.67 |
| 38550 | T | | Removal, neck/armpit lesion | 0113 | 18.7496 | $977.81 | | $195.56 |
| 38555 | T | | Removal, neck/armpit lesion | 0113 | 18.7496 | $977.81 | | $195.56 |
| 38562 | C | | Removal, pelvic lymph nodes | | | | | |
| 38564 | C | | Removal, abdomen lymph nodes | | | | | |
| 38570 | T | | Laparoscopy, lymph node biop | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 38571 | T | | Laparoscopy, lymphadenectomy | 0132 | 56.9948 | $2,972.34 | $1,239.22 | $594.47 |
| 38572 | T | | Laparoscopy, lymphadenectomy | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 38589 | T | | Laparoscope proc, lymphatic | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 38700 | T | | Removal of lymph nodes, neck | 0113 | 18.7496 | $977.81 | | $195.56 |
| 38720 | T | | Removal of lymph nodes, neck | 0113 | 18.7496 | $977.81 | | $195.56 |
| 38724 | C | | Removal of lymph nodes, neck | | | | | |
| 38740 | T | | Remove armpit lymph nodes | 0114 | 36.1135 | $1,883.36 | $485.91 | $376.67 |
| 38745 | T | | Remove armpit lymph nodes | 0114 | 36.1135 | $1,883.36 | $485.91 | $376.67 |
| 38746 | C | | Remove thoracic lymph nodes | | | | | |
| 38747 | C | | Remove abdominal lymph nodes | | | | | |
| 38760 | T | | Remove groin lymph nodes | 0113 | 18.7496 | $977.81 | | $195.56 |
| 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 | 4.0309 | $210.22 | | $42.04 |
| 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 | 27.5575 | $1,437.15 | $591.64 | $287.43 |
| 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 | 1.9089 | $99.55 | | $19.91 |
| 40500 | T | | Partial excision of lip | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 40510 | T | | Partial excision of lip | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 40520 | T | | Partial excision of lip | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 40525 | T | | Reconstruct lip with flap | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 40527 | T | | Reconstruct lip with flap | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 40530 | T | | Partial removal of lip | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 40650 | T | | Repair lip | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 40652 | T | | Repair lip | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 40654 | T | | Repair lip | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 40700 | T | | Repair cleft lip/nasal | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 40701 | T | | Repair cleft lip/nasal | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 40702 | T | | Repair cleft lip/nasal | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 40720 | T | | Repair cleft lip/nasal | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 40761 | T | | Repair cleft lip/nasal | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 40799 | T | | Lip surgery procedure | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 40800 | T | | Drainage of mouth lesion | 0251 | 1.9089 | $99.55 | | $19.91 |
| 40801 | T | | Drainage of mouth lesion | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 40804 | X | | Removal, foreign body, mouth | 0340 | 0.6492 | $33.86 | | $6.77 |
| 40805 | T | | Removal, foreign body, mouth | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 40806 | T | | Incision of lip fold | 0251 | 1.9089 | $99.55 | | $19.91 |
| 40808 | T | | Biopsy of mouth lesion | 0251 | 1.9089 | $99.55 | | $19.91 |
| 40810 | T | | Excision of mouth lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 40812 | T | | Excise/repair mouth lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 40814 | T | | Excise/repair mouth lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 40816 | T | | Excision of mouth lesion | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 40818 | T | | Excise oral mucosa for graft | 0251 | 1.9089 | $99.55 | | $19.91 |
| 40819 | T | | Excise lip or cheek fold | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 40820 | T | | Treatment of mouth lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 40830 | T | | Repair mouth laceration | 0251 | 1.9089 | $99.55 | | $19.91 |
| 40831 | T | | Repair mouth laceration | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 40840 | T | | Reconstruction of mouth | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 40842 | T | | Reconstruction of mouth | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 40843 | T | | Reconstruction of mouth | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 40844 | T | | Reconstruction of mouth | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 40845 | T | | Reconstruction of mouth | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 40899 | T | | Mouth surgery procedure | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 41000 | T | | Drainage of mouth lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41005 | T | | Drainage of mouth lesion | 0251 | 1.9089 | $99.55 | | $19.91 |
| 41006 | T | | Drainage of mouth lesion | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 41007 | T | | Drainage of mouth lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41008 | T | | Drainage of mouth lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41009 | T | | Drainage of mouth lesion | 0251 | 1.9089 | $99.55 | | $19.91 |
| 41010 | T | | Incision of tongue fold | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41015 | T | | Drainage of mouth lesion | 0251 | 1.9089 | $99.55 | | $19.91 |
| 41016 | T | | Drainage of mouth lesion | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 41017 | T | | Drainage of mouth lesion | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 41018 | T | | Drainage of mouth lesion | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 41100 | T | | Biopsy of tongue | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 41105 | T | | Biopsy of tongue | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41108 | T | | Biopsy of floor of mouth | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 41110 | T | | Excision of tongue lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41112 | T | | Excision of tongue lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41113 | T | | Excision of tongue lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41114 | T | | Excision of tongue lesion | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 41115 | T | | Excision of tongue fold | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 41116 | T | | Excision of mouth lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41120 | T | | Partial removal of tongue | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 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 | 1.9089 | $99.55 | | $19.91 |
| 41251 | T | | Repair tongue laceration | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 41252 | T | | Repair tongue laceration | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 41500 | T | | Fixation of tongue | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 41510 | T | | Tongue to lip surgery | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41520 | T | | Reconstruction, tongue fold | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 41599 | T | | Tongue and mouth surgery | 0251 | 1.9089 | $99.55 | | $19.91 |
| 41800 | T | | Drainage of gum lesion | 0251 | 1.9089 | $99.55 | | $19.91 |
| 41805 | T | | Removal foreign body, gum | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 41806 | T | | Removal foreign body,jawbone | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41820 | T | | Excision, gum, each quadrant | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 41821 | T | | Excision of gum flap | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 41822 | T | | Excision of gum lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41823 | T | | Excision of gum lesion | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 41825 | T | | Excision of gum lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41826 | T | | Excision of gum lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41827 | T | | Excision of gum lesion | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 41828 | T | | Excision of gum lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41830 | T | | Removal of gum tissue | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41850 | T | | Treatment of gum lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41870 | T | | Gum graft | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 41872 | T | | Repair gum | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 41874 | T | | Repair tooth socket | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 41899 | T | | Dental surgery procedure | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42000 | T | | Drainage mouth roof lesion | 0251 | 1.9089 | $99.55 | | $19.91 |
| 42100 | T | | Biopsy roof of mouth | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 42104 | T | | Excision lesion, mouth roof | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42106 | T | | Excision lesion, mouth roof | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42107 | T | | Excision lesion, mouth roof | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 42120 | T | | Remove palate/lesion | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42140 | T | | Excision of uvula | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 42145 | T | | Repair palate, pharynx/uvula | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 42160 | T | | Treatment mouth roof lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42180 | T | | Repair palate | 0251 | 1.9089 | $99.55 | | $19.91 |
| 42182 | T | | Repair palate | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42200 | T | | Reconstruct cleft palate | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42205 | T | | Reconstruct cleft palate | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42210 | T | | Reconstruct cleft palate | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42215 | T | | Reconstruct cleft palate | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42220 | T | | Reconstruct cleft palate | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42225 | T | | Reconstruct cleft palate | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42226 | T | | Lengthening of palate | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42227 | T | | Lengthening of palate | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42235 | T | | Repair palate | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42260 | T | | Repair nose to lip fistula | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 42280 | T | | Preparation, palate mold | 0251 | 1.9089 | $99.55 | | $19.91 |
| 42281 | T | | Insertion, palate prosthesis | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42299 | T | | Palate/uvula surgery | 0251 | 1.9089 | $99.55 | | $19.91 |
| 42300 | T | | Drainage of salivary gland | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42305 | T | | Drainage of salivary gland | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42310 | T | | Drainage of salivary gland | 0251 | 1.9089 | $99.55 | | $19.91 |
| 42320 | T | | Drainage of salivary gland | 0251 | 1.9089 | $99.55 | | $19.91 |
| 42325 | T | | Create salivary cyst drain | 0251 | 1.9089 | $99.55 | | $19.91 |
| 42326 | T | | Create salivary cyst drain | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 42330 | T | | Removal of salivary stone | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42335 | T | | Removal of salivary stone | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42340 | T | | Removal of salivary stone | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42400 | T | | Biopsy of salivary gland | 0005 | 3.1201 | $162.72 | $71.59 | $32.54 |
| 42405 | T | | Biopsy of salivary gland | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42408 | T | | Excision of salivary cyst | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42409 | T | | Drainage of salivary cyst | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42410 | T | | Excise parotid gland/lesion | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42415 | T | | Excise parotid gland/lesion | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42420 | T | | Excise parotid gland/lesion | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42425 | T | | Excise parotid gland/lesion | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42426 | C | | Excise parotid gland/lesion | | | | | |
| 42440 | T | | Excise submaxillary gland | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42450 | T | | Excise sublingual gland | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 42500 | T | | Repair salivary duct | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 42505 | T | | Repair salivary duct | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42507 | T | | Parotid duct diversion | 0256 | 34.0302 | $1,774.71 | | $354.94 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 42508 | T | | Parotid duct diversion | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42509 | T | | Parotid duct diversion | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42510 | T | | Parotid duct diversion | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42550 | N | | Injection for salivary x-ray | | | | | |
| 42600 | T | | Closure of salivary fistula | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42650 | T | | Dilation of salivary duct | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 42660 | T | | Dilation of salivary duct | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 42665 | T | | Ligation of salivary duct | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 42699 | T | | Salivary surgery procedure | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42700 | T | | Drainage of tonsil abscess | 0251 | 1.9089 | $99.55 | | $19.91 |
| 42720 | T | | Drainage of throat abscess | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42725 | T | | Drainage of throat abscess | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42800 | T | | Biopsy of throat | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 42802 | T | | Biopsy of throat | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42804 | T | | Biopsy of upper nose/throat | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42806 | T | | Biopsy of upper nose/throat | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 42808 | T | | Excise pharynx lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42809 | X | | Remove pharynx foreign body | 0340 | 0.6492 | $33.86 | | $6.77 |
| 42810 | T | | Excision of neck cyst | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 42815 | T | | Excision of neck cyst | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42820 | T | | Remove tonsils and adenoids | 0258 | 19.8736 | $1,036.43 | $437.25 | $207.29 |
| 42821 | T | | Remove tonsils and adenoids | 0258 | 19.8736 | $1,036.43 | $437.25 | $207.29 |
| 42825 | T | | Removal of tonsils | 0258 | 19.8736 | $1,036.43 | $437.25 | $207.29 |
| 42826 | T | | Removal of tonsils | 0258 | 19.8736 | $1,036.43 | $437.25 | $207.29 |
| 42830 | T | | Removal of adenoids | 0258 | 19.8736 | $1,036.43 | $437.25 | $207.29 |
| 42831 | T | | Removal of adenoids | 0258 | 19.8736 | $1,036.43 | $437.25 | $207.29 |
| 42835 | T | | Removal of adenoids | 0258 | 19.8736 | $1,036.43 | $437.25 | $207.29 |
| 42836 | T | | Removal of adenoids | 0258 | 19.8736 | $1,036.43 | $437.25 | $207.29 |
| 42842 | T | | Extensive surgery of throat | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 42844 | T | | Extensive surgery of throat | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42845 | C | | Extensive surgery of throat | | | | | |
| 42860 | T | | Excision of tonsil tags | 0258 | 19.8736 | $1,036.43 | $437.25 | $207.29 |
| 42870 | T | | Excision of lingual tonsil | 0258 | 19.8736 | $1,036.43 | $437.25 | $207.29 |
| 42890 | T | | Partial removal of pharynx | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42892 | T | | Revision of pharyngeal walls | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42894 | C | | Revision of pharyngeal walls | | | | | |
| 42900 | T | | Repair throat wound | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 42950 | T | | Reconstruction of throat | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 42953 | C | | Repair throat, esophagus | | | | | |
| 42955 | T | | Surgical opening of throat | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 42960 | T | | Control throat bleeding | 0250 | 1.6376 | $85.40 | $29.89 | $17.08 |
| 42961 | C | | Control throat bleeding | | | | | |
| 42962 | T | | Control throat bleeding | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 42970 | T | | Control nose/throat bleeding | 0250 | 1.6376 | $85.40 | $29.89 | $17.08 |
| 42971 | C | | Control nose/throat bleeding | | | | | |
| 42972 | T | | Control nose/throat bleeding | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 42999 | T | | Throat surgery procedure | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 43020 | T | | Incision of esophagus | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 43030 | T | | Throat muscle surgery | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 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 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 43135 | C | | Removal of esophagus pouch | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 43200 | T | | Esophagus endoscopy | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43201 | T | NI | Esoph scope w/submucous inj | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43202 | T | | Esophagus endoscopy, biopsy | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43204 | T | | Esoph scope w/sclerosis inj | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43205 | T | | Esophagus endoscopy/ligation | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43215 | T | | Esophagus endoscopy | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43216 | T | | Esophagus endoscopy/lesion | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43217 | T | | Esophagus endoscopy | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43219 | T | | Esophagus endoscopy | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43220 | T | | Esoph endoscopy, dilation | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43226 | T | | Esoph endoscopy, dilation | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43227 | T | | Esoph endoscopy, repair | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43228 | T | | Esoph endoscopy, ablation | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43231 | T | | Esoph endoscopy w/us exam | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43232 | T | | Esoph endoscopy w/us fn bx | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43234 | T | | Upper GI endoscopy, exam | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43235 | T | | Uppr gi endoscopy, diagnosis | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43236 | T | NI | Uppr gi scope w/submuc inj | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43239 | T | | Upper GI endoscopy, biopsy | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43240 | T | | Esoph endoscope w/drain cyst | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43241 | T | | Upper GI endoscopy with tube | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43242 | T | | Uppr gi endoscopy w/us fn bx | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43243 | T | | Upper gi endoscopy & inject | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43244 | T | | Upper GI endoscopy/ligation | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43245 | T | | Uppr gi scope dilate strictr | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43246 | T | | Place gastrostomy tube | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43247 | T | | Operative upper GI endoscopy | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43248 | T | | Uppr gi endoscopy/guide wire | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43249 | T | | Esoph endoscopy, dilation | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43250 | T | | Upper GI endoscopy/tumor | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43251 | T | | Operative upper GI endoscopy | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43255 | T | | Operative upper GI endoscopy | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43256 | T | | Uppr gi endoscopy w stent | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43258 | T | | Operative upper GI endoscopy | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43259 | T | | Endoscopic ultrasound exam | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43260 | T | | Endo cholangiopancreatograph | 0151 | 17.5093 | $913.13 | $245.46 | $182.63 |
| 43261 | T | | Endo cholangiopancreatograph | 0151 | 17.5093 | $913.13 | $245.46 | $182.63 |
| 43262 | T | | Endo cholangiopancreatograph | 0151 | 17.5093 | $913.13 | $245.46 | $182.63 |
| 43263 | T | | Endo cholangiopancreatograph | 0151 | 17.5093 | $913.13 | $245.46 | $182.63 |
| 43264 | T | | Endo cholangiopancreatograph | 0151 | 17.5093 | $913.13 | $245.46 | $182.63 |
| 43265 | T | | Endo cholangiopancreatograph | 0151 | 17.5093 | $913.13 | $245.46 | $182.63 |
| 43267 | T | | Endo cholangiopancreatograph | 0151 | 17.5093 | $913.13 | $245.46 | $182.63 |
| 43268 | T | | Endo cholangiopancreatograph | 0151 | 17.5093 | $913.13 | $245.46 | $182.63 |
| 43269 | T | | Endo cholangiopancreatograph | 0151 | 17.5093 | $913.13 | $245.46 | $182.63 |
| 43271 | T | | Endo cholangiopancreatograph | 0151 | 17.5093 | $913.13 | $245.46 | $182.63 |
| 43272 | T | | Endo cholangiopancreatograph | 0151 | 17.5093 | $913.13 | $245.46 | $182.63 |
| 43280 | T | | Laparoscopy, fundoplasty | 0132 | 56.9948 | $2,972.34 | $1,239.22 | $594.47 |
| 43289 | T | | Laparoscope proc, esoph | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | 6.0948 | $317.85 | $107.24 | $63.57 |
| 43453 | T | ..... | Dilate esophagus | 0140 | 6.0948 | $317.85 | $107.24 | $63.57 |
| 43456 | T | ..... | Dilate esophagus | 0140 | 6.0948 | $317.85 | $107.24 | $63.57 |
| 43458 | T | ..... | Dilate esophagus | 0140 | 6.0948 | $317.85 | $107.24 | $63.57 |
| 43460 | C | ..... | Pressure treatment esophagus | ..... | ..... | ..... | ..... | ..... |
| 43496 | C | ..... | Free jejunum flap, microvasc | ..... | ..... | ..... | ..... | ..... |
| 43499 | T | ..... | Esophagus surgery procedure | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 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 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43605 | C | ..... | Biopsy of stomach | ..... | ..... | ..... | ..... | ..... |
| 43610 | C | ..... | Excision of stomach lesion | ..... | ..... | ..... | ..... | ..... |
| 43611 | C | ..... | Excision of stomach lesion | ..... | ..... | ..... | ..... | ..... |
| 43620 | C | ..... | Removal of stomach | ..... | ..... | ..... | ..... | ..... |
| 43621 | C | ..... | Removal of stomach | ..... | ..... | ..... | ..... | ..... |
| 43622 | C | ..... | Removal of stomach | ..... | ..... | ..... | ..... | ..... |
| 43631 | C | ..... | Removal of stomach, partial | ..... | ..... | ..... | ..... | ..... |
| 43632 | C | ..... | Removal of stomach, partial | ..... | ..... | ..... | ..... | ..... |
| 43633 | C | ..... | Removal of stomach, partial | ..... | ..... | ..... | ..... | ..... |
| 43634 | C | ..... | Removal of stomach, partial | ..... | ..... | ..... | ..... | ..... |
| 43635 | C | ..... | Removal of stomach, partial | ..... | ..... | ..... | ..... | ..... |
| 43638 | C | ..... | Removal of stomach, partial | ..... | ..... | ..... | ..... | ..... |
| 43639 | C | ..... | Removal of stomach, partial | ..... | ..... | ..... | ..... | ..... |
| 43640 | C | ..... | Vagotomy & pylorus repair | ..... | ..... | ..... | ..... | ..... |
| 43641 | C | ..... | Vagotomy & pylorus repair | ..... | ..... | ..... | ..... | ..... |
| 43651 | T | ..... | Laparoscopy, vagus nerve | 0132 | 56.9948 | $2,972.34 | $1,239.22 | $594.47 |
| 43652 | T | ..... | Laparoscopy, vagus nerve | 0132 | 56.9948 | $2,972.34 | $1,239.22 | $594.47 |
| 43653 | T | ..... | Laparoscopy, gastrostomy | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 43659 | T | ..... | Laparoscope proc, stom | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 43750 | T | ..... | Place gastrostomy tube | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43752 | E | ..... | Nasal/orogastric w/stent | ..... | ..... | ..... | ..... | ..... |
| 43760 | T | ..... | Change gastrostomy tube | 0121 | 2.0833 | $108.65 | $43.80 | $21.73 |
| 43761 | T | ..... | Reposition gastrostomy tube | 0121 | 2.0833 | $108.65 | $43.80 | $21.73 |
| 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 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43831 | T | ..... | Place gastrostomy tube | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 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 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 43880 | C | ..... | Repair stomach-bowel fistula | ..... | ..... | ..... | ..... | ..... |
| 43999 | T | ..... | Stomach surgery procedure | 0141 | 7.4126 | $386.57 | $143.38 | $77.31 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | 7.4126 | $386.57 | $143.38 | $77.31 |
| 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 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 44201 | T | | Laparoscopy, jejunostomy | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 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 | NI | Lap part colectomy w/stoma | 0132 | 56.9948 | $2,972.34 | $1,239.22 | $594.47 |
| 44207 | T | NI | L colectomy/coloproctostomy | 0132 | 56.9948 | $2,972.34 | $1,239.22 | $594.47 |
| 44208 | T | NI | L colectomy/coloproctostomy | 0132 | 56.9948 | $2,972.34 | $1,239.22 | $594.47 |
| 44209 | T | DG | Laparoscope proc, intestine | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 44210 | C | NI | Laparo total proctocolectomy | | | | | |
| 44211 | C | NI | Laparo total proctocolectomy | | | | | |
| 44212 | C | NI | Laparo total proctocolectomy | | | | | |
| 44238 | T | NI | Laparoscope proc, intestine | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 44239 | T | NI | Laparoscope proc, rectum | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 44300 | C | | Open bowel to skin | | | | | |
| 44310 | C | | Ileostomy/jejunostomy | | | | | |
| 44312 | T | | Revision of ileostomy | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 44314 | C | | Revision of ileostomy | | | | | |
| 44316 | C | | Devise bowel pouch | | | | | |
| 44320 | C | | Colostomy | | | | | |
| 44322 | C | | Colostomy with biopsies | | | | | |
| 44340 | T | | Revision of colostomy | 0027 | 15.2225 | $793.87 | $329.72 | $158.77 |
| 44345 | C | | Revision of colostomy | | | | | |
| 44346 | C | | Revision of colostomy | | | | | |
| 44360 | T | | Small bowel endoscopy | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |
| 44361 | T | | Small bowel endoscopy/biopsy | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |
| 44363 | T | | Small bowel endoscopy | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 44364 | T | | Small bowel endoscopy | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |
| 44365 | T | | Small bowel endoscopy | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |
| 44366 | T | | Small bowel endoscopy | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |
| 44369 | T | | Small bowel endoscopy | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |
| 44370 | T | | Small bowel endoscopy/stent | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |
| 44372 | T | | Small bowel endoscopy | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |
| 44373 | T | | Small bowel endoscopy | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |
| 44376 | T | | Small bowel endoscopy | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |
| 44377 | T | | Small bowel endoscopy/biopsy | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |
| 44378 | T | | Small bowel endoscopy | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |
| 44379 | T | | S bowel endoscope w/stent | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |
| 44380 | T | | Small bowel endoscopy | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |
| 44382 | T | | Small bowel endoscopy | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |
| 44383 | T | | Ileoscopy w/stent | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |
| 44385 | T | | Endoscopy of bowel pouch | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 44386 | T | | Endoscopy, bowel pouch/biop | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 44388 | T | | Colon endoscopy | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 44389 | T | | Colonoscopy with biopsy | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 44390 | T | | Colonoscopy for foreign body | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 44391 | T | | Colonoscopy for bleeding | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 44392 | T | | Colonoscopy & polypectomy | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 44393 | T | | Colonoscopy, lesion removal | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 44394 | T | | Colonoscopy w/snare | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 44397 | T | | Colonoscopy w/stent | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 44500 | T | | Intro, gastrointestinal tube | 0121 | 2.0833 | $108.65 | $43.80 | $21.73 |
| 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 | NI | Intraop colon lavage add-on | | | | | |
| 44799 | T | | Intestine surgery procedure | 0142 | 8.1393 | $424.47 | $152.78 | $84.89 |
| 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 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 44979 | T | | Laparoscope proc, app | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 45000 | T | | Drainage of pelvic abscess | 0149 | 16.3756 | $854.00 | $293.06 | $170.80 |
| 45005 | T | | Drainage of rectal abscess | 0148 | 3.4205 | $178.38 | $63.38 | $35.68 |
| 45020 | T | | Drainage of rectal abscess | 0149 | 16.3756 | $854.00 | $293.06 | $170.80 |
| 45100 | T | | Biopsy of rectum | 0149 | 16.3756 | $854.00 | $293.06 | $170.80 |
| 45108 | T | | Removal of anorectal lesion | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 45121 | C | ..... | Removal of rectum and colon | ..... | ..... | ..... | ..... | ..... |
| 45123 | C | ..... | Partial proctectomy | ..... | ..... | ..... | ..... | ..... |
| 45126 | C | ..... | Pelvic exenteration | ..... | ..... | ..... | ..... | ..... |
| 45130 | C | ..... | Excision of rectal prolapse | ..... | ..... | ..... | ..... | ..... |
| 45135 | C | ..... | Excision of rectal prolapse | ..... | ..... | ..... | ..... | ..... |
| 45136 | C | ..... | Excise ileoanal reservior | ..... | ..... | ..... | ..... | ..... |
| 45150 | T | ..... | Excision of rectal stricture | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 45160 | T | ..... | Excision of rectal lesion | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 45170 | T | ..... | Excision of rectal lesion | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 45190 | T | ..... | Destruction, rectal tumor | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 45300 | T | ..... | Proctosigmoidoscopy dx | 0146 | 3.4302 | $178.89 | $64.40 | $35.78 |
| 45303 | T | ..... | Proctosigmoidoscopy dilate | 0146 | 3.4302 | $178.89 | $64.40 | $35.78 |
| 45305 | T | ..... | Proctosigmoidoscopy w/bx | 0146 | 3.4302 | $178.89 | $64.40 | $35.78 |
| 45307 | T | ..... | Proctosigmoidoscopy fb | 0146 | 3.4302 | $178.89 | $64.40 | $35.78 |
| 45308 | T | ..... | Proctosigmoidoscopy removal | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 45309 | T | ..... | Proctosigmoidoscopy removal | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 45315 | T | ..... | Proctosigmoidoscopy removal | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 45317 | T | ..... | Proctosigmoidoscopy bleed | 0146 | 3.4302 | $178.89 | $64.40 | $35.78 |
| 45320 | T | ..... | Proctosigmoidoscopy ablate | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 45321 | T | ..... | Proctosigmoidoscopy volvul | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 45327 | T | ..... | Proctosigmoidoscopy w/stent | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 45330 | T | ..... | Diagnostic sigmoidoscopy | 0146 | 3.4302 | $178.89 | $64.40 | $35.78 |
| 45331 | T | ..... | Sigmoidoscopy and biopsy | 0146 | 3.4302 | $178.89 | $64.40 | $35.78 |
| 45332 | T | ..... | Sigmoidoscopy w/fb removal | 0146 | 3.4302 | $178.89 | $64.40 | $35.78 |
| 45333 | T | ..... | Sigmoidoscopy & polypectomy | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 45334 | T | ..... | Sigmoidoscopy for bleeding | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 45335 | T | NI | Sigmoidoscope w/submuc inj | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 45337 | T | ..... | Sigmoidoscopy & decompress | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 45338 | T | ..... | Sigmoidoscpy w/tumr remove | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 45339 | T | ..... | Sigmoidoscopy w/ablate tumr | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 45340 | T | NI | Sig w/balloon dilation | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 45341 | T | ..... | Sigmoidoscopy w/ultrasound | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 45342 | T | ..... | Sigmoidoscopy w/us guide bx | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 45345 | T | ..... | Sigmoidoscopy w/stent | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 45355 | T | ..... | Surgical colonoscopy | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 45378 | T | ..... | Diagnostic colonoscopy | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 45379 | T | ..... | Colonoscopy w/fb removal | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 45380 | T | ..... | Colonoscopy and biopsy | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 45381 | T | NI | Colonoscope, submucous inj | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 45382 | T | ..... | Colonoscopy/control bleeding | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 45383 | T | ..... | Lesion removal colonoscopy | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 45384 | T | ..... | Lesion remove colonoscopy | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 45385 | T | ..... | Lesion removal colonoscopy | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 45386 | T | NI | Colonoscope dilate stricture | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 45387 | T | ..... | Colonoscopy w/stent | 0143 | 7.9165 | $412.85 | $186.06 | $82.57 |
| 45500 | T | ..... | Repair of rectum | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 45505 | T | ..... | Repair of rectum | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 45520 | T | ..... | Treatment of rectal prolapse | 0098 | 1.6666 | $86.91 | $20.88 | $17.38 |
| 45540 | C | ..... | Correct rectal prolapse | ..... | ..... | ..... | ..... | ..... |
| 45541 | C | ..... | Correct rectal prolapse | ..... | ..... | ..... | ..... | ..... |
| 45550 | C | ..... | Repair rectum/remove sigmoid | ..... | ..... | ..... | ..... | ..... |
| 45560 | T | ..... | Repair of rectocele | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 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 | 3.4205 | $178.38 | $63.38 | $35.68 |
| 45905 | T | ..... | Dilation of anal sphincter | 0149 | 16.3756 | $854.00 | $293.06 | $170.80 |
| 45910 | T | ..... | Dilation of rectal narrowing | 0149 | 16.3756 | $854.00 | $293.06 | $170.80 |
| 45915 | T | ..... | Remove rectal obstruction | 0148 | 3.4205 | $178.38 | $63.38 | $35.68 |
| 45999 | T | ..... | Rectum surgery procedure | 0148 | 3.4205 | $178.38 | $63.38 | $35.68 |
| 46020 | T | ..... | Placement of seton | 0148 | 3.4205 | $178.38 | $63.38 | $35.68 |
| 46030 | T | ..... | Removal of rectal marker | 0148 | 3.4205 | $178.38 | $63.38 | $35.68 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 46040 | T | | Incision of rectal abscess | 0155 | 10.1936 | $531.61 | $188.89 | $106.32 |
| 46045 | T | | Incision of rectal abscess | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46050 | T | | Incision of anal abscess | 0148 | 3.4205 | $178.38 | $63.38 | $35.68 |
| 46060 | T | | Incision of rectal abscess | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46070 | T | | Incision of anal septum | 0155 | 10.1936 | $531.61 | $188.89 | $106.32 |
| 46080 | T | | Incision of anal sphincter | 0149 | 16.3756 | $854.00 | $293.06 | $170.80 |
| 46083 | T | | Incise external hemorrhoid | 0148 | 3.4205 | $178.38 | $63.38 | $35.68 |
| 46200 | T | | Removal of anal fissure | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46210 | T | | Removal of anal crypt | 0149 | 16.3756 | $854.00 | $293.06 | $170.80 |
| 46211 | T | | Removal of anal crypts | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46220 | T | | Removal of anal tag | 0149 | 16.3756 | $854.00 | $293.06 | $170.80 |
| 46221 | T | | Ligation of hemorrhoid(s) | 0148 | 3.4205 | $178.38 | $63.38 | $35.68 |
| 46230 | T | | Removal of anal tags | 0149 | 16.3756 | $854.00 | $293.06 | $170.80 |
| 46250 | T | | Hemorrhoidectomy | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46255 | T | | Hemorrhoidectomy | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46257 | T | | Remove hemorrhoids & fissure | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46258 | T | | Remove hemorrhoids & fistula | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46260 | T | | Hemorrhoidectomy | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46261 | T | | Remove hemorrhoids & fissure | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46262 | T | | Remove hemorrhoids & fistula | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46270 | T | | Removal of anal fistula | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46275 | T | | Removal of anal fistula | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46280 | T | | Removal of anal fistula | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46285 | T | | Removal of anal fistula | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46288 | T | | Repair anal fistula | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46320 | T | | Removal of hemorrhoid clot | 0148 | 3.4205 | $178.38 | $63.38 | $35.68 |
| 46500 | T | | Injection into hemorrhoid(s) | 0155 | 10.1936 | $531.61 | $188.89 | $106.32 |
| 46600 | X | | Diagnostic anoscopy | 0340 | 0.6492 | $33.86 | | $6.77 |
| 46604 | T | | Anoscopy and dilation | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 46606 | T | | Anoscopy and biopsy | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 46608 | T | | Anoscopy, remove for body | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 46610 | T | | Anoscopy, remove lesion | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 46611 | T | | Anoscopy | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 46612 | T | | Anoscopy, remove lesions | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 46614 | T | | Anoscopy, control bleeding | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 46615 | T | | Anoscopy | 0147 | 7.0153 | $365.85 | $79.46 | $73.17 |
| 46700 | T | | Repair of anal stricture | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46705 | C | | Repair of anal stricture | | | | | |
| 46706 | T | NI | Repr of anal fistula w/glue | 0148 | 3.4205 | $178.38 | $63.38 | $35.68 |
| 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 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46751 | C | | Repair of anal sphincter | | | | | |
| 46753 | T | | Reconstruction of anus | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46754 | T | | Removal of suture from anus | 0149 | 16.3756 | $854.00 | $293.06 | $170.80 |
| 46760 | T | | Repair of anal sphincter | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46761 | T | | Repair of anal sphincter | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46762 | T | | Implant artificial sphincter | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46900 | T | | Destruction, anal lesion(s) | 0016 | 2.6162 | $136.44 | $57.31 | $27.29 |
| 46910 | T | | Destruction, anal lesion(s) | 0017 | 15.8233 | $825.20 | $227.84 | $165.04 |
| 46916 | T | | Cryosurgery, anal lesion(s) | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 46917 | T | | Laser surgery, anal lesions | 0695 | 18.6817 | $974.27 | $266.59 | $194.85 |
| 46922 | T | | Excision of anal lesion(s) | 0695 | 18.6817 | $974.27 | $266.59 | $194.85 |
| 46924 | T | | Destruction, anal lesion(s) | 0695 | 18.6817 | $974.27 | $266.59 | $194.85 |
| 46934 | T | | Destruction of hemorrhoids | 0155 | 10.1936 | $531.61 | $188.89 | $106.32 |
| 46935 | T | | Destruction of hemorrhoids | 0155 | 10.1936 | $531.61 | $188.89 | $106.32 |
| 46936 | T | | Destruction of hemorrhoids | 0149 | 16.3756 | $854.00 | $293.06 | $170.80 |
| 46937 | T | | Cryotherapy of rectal lesion | 0149 | 16.3756 | $854.00 | $293.06 | $170.80 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 46938 | T | | Cryotherapy of rectal lesion | 0150 | 21.2398 | $1,107.68 | $437.12 | $221.54 |
| 46940 | T | | Treatment of anal fissure | 0149 | 16.3756 | $854.00 | $293.06 | $170.80 |
| 46942 | T | | Treatment of anal fissure | 0148 | 3.4205 | $178.38 | $63.38 | $35.68 |
| 46945 | T | | Ligation of hemorrhoids | 0155 | 10.1936 | $531.61 | $188.89 | $106.32 |
| 46946 | T | | Ligation of hemorrhoids | 0155 | 10.1936 | $531.61 | $188.89 | $106.32 |
| 46999 | T | | Anus surgery procedure | 0148 | 3.4205 | $178.38 | $63.38 | $35.68 |
| 47000 | T | | Needle biopsy of liver | 0685 | 5.9882 | $312.29 | $137.40 | $62.46 |
| 47001 | N | | Needle biopsy, liver add-on | | | | | |
| 47010 | C | | Open drainage, liver lesion | | | | | |
| 47011 | T | | Percut drain, liver lesion | 0005 | 3.1201 | $162.72 | $71.59 | $32.54 |
| 47015 | C | | Inject/aspirate liver cyst | | | | | |
| 47100 | C | | Wedge biopsy of liver | | | | | |
| 47120 | C | | Partial removal of liver | | | | | |
| 47122 | C | | Extensive removal of liver | | | | | |
| 47125 | C | | Partial removal of liver | | | | | |
| 47130 | C | | Partial removal of liver | | | | | |
| 47133 | C | | Removal of donor liver | | | | | |
| 47134 | C | | Partial removal, donor liver | | | | | |
| 47135 | C | | Transplantation of liver | | | | | |
| 47136 | C | | Transplantation of liver | | | | | |
| 47300 | C | | Surgery for liver lesion | | | | | |
| 47350 | C | | Repair liver wound | | | | | |
| 47360 | C | | Repair liver wound | | | | | |
| 47361 | C | | Repair liver wound | | | | | |
| 47362 | C | | Repair liver wound | | | | | |
| 47370 | T | | Laparo ablate liver tumor rf | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 47371 | T | | Laparo ablate liver cryosurg | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 47379 | T | | Laparoscope procedure, liver | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 47380 | C | | Open ablate liver tumor rf | | | | | |
| 47381 | C | | Open ablate liver tumor cryo | | | | | |
| 47382 | T | | Percut ablate liver rf | 0980 | | $1,875.00 | | $375.00 |
| 47399 | T | | Liver surgery procedure | 0005 | 3.1201 | $162.72 | $71.59 | $32.54 |
| 47400 | C | | Incision of liver duct | | | | | |
| 47420 | C | | Incision of bile duct | | | | | |
| 47425 | C | | Incision of bile duct | | | | | |
| 47460 | C | | Incise bile duct sphincter | | | | | |
| 47480 | C | | Incision of gallbladder | | | | | |
| 47490 | T | | Incision of gallbladder | 0152 | 10.0288 | $523.01 | $131.28 | $104.60 |
| 47500 | N | | Injection for liver x-rays | | | | | |
| 47505 | N | | Injection for liver x-rays | | | | | |
| 47510 | T | | Insert catheter, bile duct | 0152 | 10.0288 | $523.01 | $131.28 | $104.60 |
| 47511 | T | | Insert bile duct drain | 0152 | 10.0288 | $523.01 | $131.28 | $104.60 |
| 47525 | T | | Change bile duct catheter | 0122 | 10.7459 | $560.41 | $114.93 | $112.08 |
| 47530 | T | | Revise/reinsert bile tube | 0121 | 2.0833 | $108.65 | $43.80 | $21.73 |
| 47550 | C | | Bile duct endoscopy add-on | | | | | |
| 47552 | T | | Biliary endoscopy thru skin | 0152 | 10.0288 | $523.01 | $131.28 | $104.60 |
| 47553 | T | | Biliary endoscopy thru skin | 0152 | 10.0288 | $523.01 | $131.28 | $104.60 |
| 47554 | T | | Biliary endoscopy thru skin | 0152 | 10.0288 | $523.01 | $131.28 | $104.60 |
| 47555 | T | | Biliary endoscopy thru skin | 0152 | 10.0288 | $523.01 | $131.28 | $104.60 |
| 47556 | T | | Biliary endoscopy thru skin | 0152 | 10.0288 | $523.01 | $131.28 | $104.60 |
| 47560 | T | | Laparoscopy w/cholangio | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 47561 | T | | Laparo w/cholangio/biopsy | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 47562 | T | | Laparoscopic cholecystectomy | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 47563 | T | | Laparo cholecystectomy/graph | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 47564 | T | | Laparo cholecystectomy/explr | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 47570 | C | | Laparo cholecystoenterostomy | | | | | |
| 47579 | T | | Laparoscope proc, biliary | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 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 | 10.0288 | $523.01 | $131.28 | $104.60 |
| 47700 | C | | Exploration of bile ducts | | | | | |
| 47701 | C | | Bile duct revision | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | 10.0288 | $523.01 | $131.28 | $104.60 |
| 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 | 5.9882 | $312.29 | $137.40 | $62.46 |
| 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 | 0005 | 3.1201 | $162.72 | $71.59 | $32.54 |
| 48520 | C | ..... | Fuse pancreas cyst and bowel | ..... | ..... | ..... | ..... | ..... |
| 48540 | C | ..... | Fuse pancreas cyst and bowel | ..... | ..... | ..... | ..... | ..... |
| 48545 | C | ..... | Pancreatorrhaphy | ..... | ..... | ..... | ..... | ..... |
| 48547 | C | ..... | Duodenal exclusion | ..... | ..... | ..... | ..... | ..... |
| 48550 | E | ..... | Donor pancreatectomy | ..... | ..... | ..... | ..... | ..... |
| 48554 | E | ..... | Transpl allograft pancreas | ..... | ..... | ..... | ..... | ..... |
| 48556 | C | ..... | Removal, allograft pancreas | ..... | ..... | ..... | ..... | ..... |
| 48999 | T | ..... | Pancreas surgery procedure | 0005 | 3.1201 | $162.72 | $71.59 | $32.54 |
| 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 | 3.3623 | $175.35 | ..... | $35.07 |
| 49081 | T | ..... | Removal of abdominal fluid | 0070 | 3.3623 | $175.35 | ..... | $35.07 |
| 49085 | T | ..... | Remove abdomen foreign body | 0153 | 19.5441 | $1,019.24 | $410.87 | $203.85 |
| 49180 | T | ..... | Biopsy, abdominal mass | 0685 | 5.9882 | $312.29 | $137.40 | $62.46 |
| 49200 | T | ..... | Removal of abdominal lesion | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 49201 | C | ..... | Remove abdom lesion, complex | ..... | ..... | ..... | ..... | ..... |
| 49215 | C | ..... | Excise sacral spine tumor | ..... | ..... | ..... | ..... | ..... |
| 49220 | C | ..... | Multiple surgery, abdomen | ..... | ..... | ..... | ..... | ..... |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 49250 | T | | Excision of umbilicus | 0153 | 19.5441 | $1,019.24 | $410.87 | $203.85 |
| 49255 | C | | Removal of omentum | | | | | |
| 49320 | T | | Diag laparo separate proc | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 49321 | T | | Laparoscopy, biopsy | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 49322 | T | | Laparoscopy, aspiration | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 49323 | T | | Laparo drain lymphocele | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 49329 | T | | Laparo proc, abdm/per/oment | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 49400 | N | | Air injection into abdomen | | | | | |
| 49419 | T | NI | Insrt abdom cath for chemotx | 0119 | 89.3100 | $4,657.61 | | $931.52 |
| 49420 | T | | Insert abdom drain, temp | 0652 | 28.1292 | $1,466.97 | | $293.39 |
| 49421 | T | | Insert abdom drain, perm | 0652 | 28.1292 | $1,466.97 | | $293.39 |
| 49422 | T | | Remove perm cannula/catheter | 0105 | 18.5945 | $969.72 | $370.40 | $193.94 |
| 49423 | T | | Exchange drainage catheter | 0152 | 10.0288 | $523.01 | $131.28 | $104.60 |
| 49424 | N | | Assess cyst, contrast inject | | | | | |
| 49425 | C | | Insert abdomen-venous drain | | | | | |
| 49426 | T | | Revise abdomen-venous shunt | 0153 | 19.5441 | $1,019.24 | $410.87 | $203.85 |
| 49427 | N | | Injection, abdominal shunt | | | | | |
| 49428 | C | | Ligation of shunt | | | | | |
| 49429 | T | | Removal of shunt | 0105 | 18.5945 | $969.72 | $370.40 | $193.94 |
| 49491 | T | | Rpr hern preemie reduc | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49492 | T | | Rpr ing hern premie, blocked | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49495 | T | | Rpr ing hernia baby, reduc | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49496 | T | | Rpr ing hernia baby, blocked | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49500 | T | | Rpr ing hernia, init, reduce | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49501 | T | | Rpr ing hernia, init blocked | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49505 | T | | Prp i/hern init reduc>5 yr | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49507 | T | | Prp i/hern init block>5 yr | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49520 | T | | Rerepair ing hernia, reduce | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49521 | T | | Rerepair ing hernia, blocked | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49525 | T | | Repair ing hernia, sliding | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49540 | T | | Repair lumbar hernia | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49550 | T | | Rpr rem hernia, init, reduce | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49553 | T | | Rpr fem hernia, init blocked | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49555 | T | | Rerepair fem hernia, reduce | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49557 | T | | Rerepair fem hernia, blocked | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49560 | T | | Rpr ventral hern init, reduc | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49561 | T | | Rpr ventral hern init, block | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49565 | T | | Rerepair ventrl hern, reduce | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49566 | T | | Rerepair ventrl hern, block | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49568 | T | | Hernia repair w/mesh | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49570 | T | | Rpr epigastric hern, reduce | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49572 | T | | Rpr epigastric hern, blocked | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49580 | T | | Rpr umbil hern, reduc < 5 yr | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49582 | T | | Rpr umbil hern, block < 5 yr | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49585 | T | | Rpr umbil hern, reduc > 5 yr | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49587 | T | | Rpr umbil hern, block > 5 yr | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49590 | T | | Repair spigilian hernia | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 49600 | T | | Repair umbilical lesion | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 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 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 49651 | T | | Laparo hernia repair recur | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 49659 | T | | Laparo proc, hernia repair | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 49900 | C | | Repair of abdominal wall | | | | | |
| 49904 | C | NI | Omental flap, extra-abdom | | | | | |
| 49905 | C | | Omental flap | | | | | |
| 49906 | C | | Free omental flap, microvasc | | | | | |
| 49999 | T | | Abdomen surgery procedure | 0153 | 19.5441 | $1,019.24 | $410.87 | $203.85 |
| 50010 | C | | Exploration of kidney | | | | | |
| 50020 | C | | Renal abscess, open drain | | | | | |
| 50021 | T | | Renal abscess, percut drain | 0005 | 3.1201 | $162.72 | $71.59 | $32.54 |
| 50040 | C | | Drainage of kidney | | | | | |
| 50045 | C | | Exploration of kidney | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | 28.3714 | $1,479.60 | | $295.92 |
| 50081 | T | | Removal of kidney stone | 0163 | 28.3714 | $1,479.60 | | $295.92 |
| 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 | 5.9882 | $312.29 | $137.40 | $62.46 |
| 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 | 5.9882 | $312.29 | $137.40 | $62.46 |
| 50392 | T | | Insert kidney drain | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 50393 | T | | Insert ureteral tube | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 50394 | N | | Injection for kidney x-ray | | | | | |
| 50395 | T | | Create passage to kidney | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 50396 | T | | Measure kidney pressure | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 50398 | T | | Change kidney tube | 0122 | 10.7459 | $560.41 | $114.93 | $112.08 |
| 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 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 50542 | T | NI | Laparo ablate renal mass | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 50543 | T | NI | Laparo partial nephrectomy | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 50544 | T | | Laparoscopy, pyeloplasty | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 50545 | C | | Laparo radical nephrectomy | | | | | |
| 50546 | C | | Laparoscopic nephrectomy | | | | | |
| 50547 | C | | Laparo removal donor kidney | | | | | |
| 50548 | C | | Laparo remove k/ureter | | | | | |
| 50549 | T | | Laparoscope proc, renal | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 50551 | T | | Kidney endoscopy | 0160 | 6.3080 | $328.97 | $105.06 | $65.79 |
| 50553 | T | | Kidney endoscopy | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 50555 | T | | Kidney endoscopy & biopsy | 0160 | 6.3080 | $328.97 | $105.06 | $65.79 |
| 50557 | T | | Kidney endoscopy & treatment | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 50559 | T | | Renal endoscopy/radiotracer | 0160 | 6.3080 | $328.97 | $105.06 | $65.79 |
| 50561 | T | | Kidney endoscopy & treatment | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 50562 | T | NI | Renal scope w/tumor resect | 0160 | 6.3080 | $328.97 | $105.06 | $65.79 |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 50590 | T | | Fragmenting of kidney stone | 0169 | 44.0978 | $2,299.74 | $1,115.69 | $459.95 |
| 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 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 50688 | T | | Change of ureter tube | 0121 | 2.0833 | $108.65 | $43.80 | $21.73 |
| 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 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 50947 | T | | Laparo new ureter/bladder | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 50948 | T | | Laparo new ureter/bladder | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 50949 | T | | Laparoscope proc, ureter | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 50951 | T | | Endoscopy of ureter | 0160 | 6.3080 | $328.97 | $105.06 | $65.79 |
| 50953 | T | | Endoscopy of ureter | 0160 | 6.3080 | $328.97 | $105.06 | $65.79 |
| 50955 | T | | Ureter endoscopy & biopsy | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 50957 | T | | Ureter endoscopy & treatment | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 50959 | T | | Ureter endoscopy & tracer | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 50961 | T | | Ureter endoscopy & treatment | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 50970 | T | | Ureter endoscopy | 0160 | 6.3080 | $328.97 | $105.06 | $65.79 |
| 50972 | T | | Ureter endoscopy & catheter | 0160 | 6.3080 | $328.97 | $105.06 | $65.79 |
| 50974 | T | | Ureter endoscopy & biopsy | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 50976 | T | | Ureter endoscopy & treatment | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 50978 | T | | Ureter endoscopy & tracer | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 50980 | T | | Ureter endoscopy & treatment | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 51000 | T | | Drainage of bladder | 0165 | 12.2672 | $639.75 | | $127.95 |
| 51005 | T | | Drainage of bladder | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 51010 | T | | Drainage of bladder | 0165 | 12.2672 | $639.75 | | $127.95 |
| 51020 | T | | Incise & treat bladder | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 51030 | T | | Incise & treat bladder | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 51040 | T | | Incise & drain bladder | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 51045 | T | | Incise bladder/drain ureter | 0160 | 6.3080 | $328.97 | $105.06 | $65.79 |
| 51050 | T | | Removal of bladder stone | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 51060 | C | | Removal of ureter stone | | | | | |
| 51065 | T | | Remove ureter calculus | 0162 | 20.5906 | $1,073.82 | | $214.76 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 51080 | T | | Drainage of bladder abscess | 0007 | 10.0191 | $522.51 | $108.89 | $104.50 |
| 51500 | T | | Removal of bladder cyst | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 51520 | T | | Removal of bladder lesion | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 51525 | C | | Removal of bladder lesion | | | | | |
| 51530 | C | | Removal of bladder lesion | | | | | |
| 51535 | C | | Repair of ureter lesion | | | | | |
| 51550 | C | | Partial removal of bladder | | | | | |
| 51555 | C | | Partial removal of bladder | | | | | |
| 51565 | C | | Revise bladder & ureter(s) | | | | | |
| 51570 | C | | Removal of bladder | | | | | |
| 51575 | C | | Removal of bladder & nodes | | | | | |
| 51580 | C | | Remove bladder/revise tract | | | | | |
| 51585 | C | | Removal of bladder & nodes | | | | | |
| 51590 | C | | Remove bladder/revise tract | | | | | |
| 51595 | C | | Remove bladder/revise tract | | | | | |
| 51596 | C | | Remove bladder/create pouch | | | | | |
| 51597 | C | | Removal of pelvic structures | | | | | |
| 51600 | N | | Injection for bladder x-ray | | | | | |
| 51605 | N | | Preparation for bladder xray | | | | | |
| 51610 | N | | Injection for bladder x-ray | | | | | |
| 51700 | T | | Irrigation of bladder | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 51701 | N | NI | Insert bladder catheter | | | | | |
| 51702 | N | NI | Insert temp bladder cath | | | | | |
| 51703 | N | NI | Insert bladder cath, complex | | | | | |
| 51705 | T | | Change of bladder tube | 0121 | 2.0833 | $108.65 | $43.80 | $21.73 |
| 51710 | T | | Change of bladder tube | 0121 | 2.0833 | $108.65 | $43.80 | $21.73 |
| 51715 | T | | Endoscopic injection/implant | 0167 | 28.3230 | $1,477.07 | $555.84 | $295.41 |
| 51720 | T | | Treatment of bladder lesion | 0156 | 2.9747 | $155.13 | $46.55 | $31.03 |
| 51725 | T | | Simple cystometrogram | 0156 | 2.9747 | $155.13 | $46.55 | $31.03 |
| 51726 | T | | Complex cystometrogram | 0156 | 2.9747 | $155.13 | $46.55 | $31.03 |
| 51736 | T | | Urine flow measurement | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 51741 | T | | Electro-uroflowmetry, first | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 51772 | T | | Urethra pressure profile | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 51784 | T | | Anal/urinary muscle study | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 51785 | T | | Anal/urinary muscle study | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 51792 | T | | Urinary reflex study | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 51795 | T | | Urine voiding pressure study | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 51797 | T | | Intraabdominal pressure test | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 51798 | X | NI | Us urine capacity measure | 0340 | 0.6492 | $33.86 | | $6.77 |
| 51800 | C | | Revision of bladder/urethra | | | | | |
| 51820 | C | | Revision of urinary tract | | | | | |
| 51840 | C | | Attach bladder/urethra | | | | | |
| 51841 | C | | Attach bladder/urethra | | | | | |
| 51845 | C | | Repair bladder neck | | | | | |
| 51860 | C | | Repair of bladder wound | | | | | |
| 51865 | C | | Repair of bladder wound | | | | | |
| 51880 | T | | Repair of bladder opening | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 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 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 51992 | T | | Laparo sling operation | 0132 | 56.9948 | $2,972.34 | $1,239.22 | $594.47 |
| 52000 | T | | Cystoscopy | 0160 | 6.3080 | $328.97 | $105.06 | $65.79 |
| 52001 | T | | Cystoscopy, removal of clots | 0160 | 6.3080 | $328.97 | $105.06 | $65.79 |
| 52005 | T | | Cystoscopy & ureter catheter | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 52007 | T | | Cystoscopy and biopsy | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 52010 | T | | Cystoscopy & duct catheter | 0160 | 6.3080 | $328.97 | $105.06 | $65.79 |
| 52204 | T | | Cystoscopy | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 52214 | T | | Cystoscopy and treatment | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52224 | T | | Cystoscopy and treatment | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52234 | T | | Cystoscopy and treatment | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52235 | T | | Cystoscopy and treatment | 0162 | 20.5906 | $1,073.82 | | $214.76 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 52240 | T | | Cystoscopy and treatment | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52250 | T | | Cystoscopy and radiotracer | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52260 | T | | Cystoscopy and treatment | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 52265 | T | | Cystoscopy and treatment | 0160 | 6.3080 | $328.97 | $105.06 | $65.79 |
| 52270 | T | | Cystoscopy & revise urethra | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 52275 | T | | Cystoscopy & revise urethra | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 52276 | T | | Cystoscopy and treatment | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 52277 | T | | Cystoscopy and treatment | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52281 | T | | Cystoscopy and treatment | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 52282 | T | | Cystoscopy, implant stent | 0163 | 28.3714 | $1,479.60 | | $295.92 |
| 52283 | T | | Cystoscopy and treatment | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 52285 | T | | Cystoscopy and treatment | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 52290 | T | | Cystoscopy and treatment | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 52300 | T | | Cystoscopy and treatment | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 52301 | T | | Cystoscopy and treatment | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 52305 | T | | Cystoscopy and treatment | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 52310 | T | | Cystoscopy and treatment | 0160 | 6.3080 | $328.97 | $105.06 | $65.79 |
| 52315 | T | | Cystoscopy and treatment | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 52317 | T | | Remove bladder stone | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52318 | T | | Remove bladder stone | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52320 | T | | Cystoscopy and treatment | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52325 | T | | Cystoscopy, stone removal | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52327 | T | | Cystoscopy, inject material | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52330 | T | | Cystoscopy and treatment | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52332 | T | | Cystoscopy and treatment | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52334 | T | | Create passage to kidney | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52341 | T | | Cysto w/ureter stricture tx | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52342 | T | | Cysto w/up stricture tx | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52343 | T | | Cysto w/renal stricture tx | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52344 | T | | Cysto/uretero, stone remove | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52345 | T | | Cysto/uretero w/up stricture | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52346 | T | | Cystouretero w/renal strict | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52347 | T | | Cystoscopy, resect ducts | 0160 | 6.3080 | $328.97 | $105.06 | $65.79 |
| 52351 | T | | Cystouretero & or pyeloscope | 0160 | 6.3080 | $328.97 | $105.06 | $65.79 |
| 52352 | T | | Cystouretero w/stone remove | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52353 | T | | Cystouretero w/lithotripsy | 0163 | 28.3714 | $1,479.60 | | $295.92 |
| 52354 | T | | Cystouretero w/biopsy | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52355 | T | | Cystouretero w/excise tumor | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52400 | T | | Cystouretero w/congen repr | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52450 | T | | Incision of prostate | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52500 | T | | Revision of bladder neck | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52510 | T | | Dilation prostatic urethra | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 52601 | T | | Prostatectomy (TURP) | 0163 | 28.3714 | $1,479.60 | | $295.92 |
| 52606 | T | | Control postop bleeding | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52612 | T | | Prostatectomy, first stage | 0163 | 28.3714 | $1,479.60 | | $295.92 |
| 52614 | T | | Prostatectomy, second stage | 0163 | 28.3714 | $1,479.60 | | $295.92 |
| 52620 | T | | Remove residual prostate | 0163 | 28.3714 | $1,479.60 | | $295.92 |
| 52630 | T | | Remove prostate regrowth | 0163 | 28.3714 | $1,479.60 | | $295.92 |
| 52640 | T | | Relieve bladder contracture | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 52647 | T | | Laser surgery of prostate | 0163 | 28.3714 | $1,479.60 | | $295.92 |
| 52648 | T | | Laser surgery of prostate | 0163 | 28.3714 | $1,479.60 | | $295.92 |
| 52700 | T | | Drainage of prostate abscess | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 53000 | T | | Incision of urethra | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 53010 | T | | Incision of urethra | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 53020 | T | | Incision of urethra | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 53025 | T | | Incision of urethra | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 53040 | T | | Drainage of urethra abscess | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 53060 | T | | Drainage of urethra abscess | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 53080 | T | | Drainage of urinary leakage | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 53085 | C | | Drainage of urinary leakage | | | | | |
| 53200 | T | | Biopsy of urethra | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 53210 | T | | Removal of urethra | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53215 | T | | Removal of urethra | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53220 | T | | Treatment of urethra lesion | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53230 | T | | Removal of urethra lesion | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 53235 | T | | Removal of urethra lesion | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53240 | T | | Surgery for urethra pouch | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53250 | T | | Removal of urethra gland | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 53260 | T | | Treatment of urethra lesion | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 53265 | T | | Treatment of urethra lesion | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 53270 | T | | Removal of urethra gland | 0167 | 28.3230 | $1,477.07 | $555.84 | $295.41 |
| 53275 | T | | Repair of urethra defect | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 53400 | T | | Revise urethra, stage 1 | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53405 | T | | Revise urethra, stage 2 | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53410 | T | | Reconstruction of urethra | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53415 | C | | Reconstruction of urethra | | | | | |
| 53420 | T | | Reconstruct urethra, stage 1 | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53425 | T | | Reconstruct urethra, stage 2 | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53430 | T | | Reconstruction of urethra | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53431 | T | | Reconstruct urethra/bladder | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53440 | T | | Correct bladder function | 0179 | 104.3581 | $5,442.38 | $2,340.22 | $1,088.48 |
| 53442 | T | | Remove perineal prosthesis | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 53444 | T | | Insert tandem cuff | 0179 | 104.3581 | $5,442.38 | $2,340.22 | $1,088.48 |
| 53445 | T | | Insert uro/ves nck sphincter | 0179 | 104.3581 | $5,442.38 | $2,340.22 | $1,088.48 |
| 53446 | T | | Remove uro sphincter | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53447 | T | | Remove/replace ur sphincter | 0179 | 104.3581 | $5,442.38 | $2,340.22 | $1,088.48 |
| 53448 | C | | Remov/replc ur sphinctr comp | | | | | |
| 53449 | T | | Repair uro sphincter | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53450 | T | | Revision of urethra | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53460 | T | | Revision of urethra | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53502 | T | | Repair of urethra injury | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 53505 | T | | Repair of urethra injury | 0167 | 28.3230 | $1,477.07 | $555.84 | $295.41 |
| 53510 | T | | Repair of urethra injury | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 53515 | T | | Repair of urethra injury | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53520 | T | | Repair of urethra defect | 0168 | 24.4665 | $1,275.95 | $405.60 | $255.19 |
| 53600 | T | | Dilate urethra stricture | 0156 | 2.9747 | $155.13 | $46.55 | $31.03 |
| 53601 | T | | Dilate urethra stricture | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 53605 | T | | Dilate urethra stricture | 0161 | 15.7070 | $819.14 | $249.36 | $163.83 |
| 53620 | T | | Dilate urethra stricture | 0165 | 12.2672 | $639.75 | | $127.95 |
| 53621 | T | | Dilate urethra stricture | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 53660 | T | | Dilation of urethra | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 53661 | T | | Dilation of urethra | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 53665 | T | | Dilation of urethra | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 53670 | N | DG | Insert urinary catheter | | | | | |
| 53675 | T | DG | Insert urinary catheter | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 53850 | T | | Prostatic microwave thermotx | 0675 | 48.5648 | $2,532.70 | | $506.54 |
| 53852 | T | | Prostatic rf thermotx | 0675 | 48.5648 | $2,532.70 | | $506.54 |
| 53853 | T | | Prostatic water thermother | 0977 | | $1,125.00 | | $225.00 |
| 53899 | T | | Urology surgery procedure | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 54000 | T | | Slitting of prepuce | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 54001 | T | | Slitting of prepuce | 0166 | 15.4163 | $803.98 | $218.73 | $160.80 |
| 54015 | T | | Drain penis lesion | 0007 | 10.0191 | $522.51 | $108.89 | $104.50 |
| 54050 | T | | Destruction, penis lesion(s) | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 54055 | T | | Destruction, penis lesion(s) | 0017 | 15.8233 | $825.20 | $227.84 | $165.04 |
| 54056 | T | | Cryosurgery, penis lesion(s) | 0012 | 0.7849 | $40.93 | $11.18 | $8.19 |
| 54057 | T | | Laser surg, penis lesion(s) | 0017 | 15.8233 | $825.20 | $227.84 | $165.04 |
| 54060 | T | | Excision of penis lesion(s) | 0017 | 15.8233 | $825.20 | $227.84 | $165.04 |
| 54065 | T | | Destruction, penis lesion(s) | 0695 | 18.6817 | $974.27 | $266.59 | $194.85 |
| 54100 | T | | Biopsy of penis | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 54105 | T | | Biopsy of penis | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 54110 | T | | Treatment of penis lesion | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54111 | T | | Treat penis lesion, graft | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54112 | T | | Treat penis lesion, graft | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54115 | T | | Treatment of penis lesion | 0008 | 16.1430 | $841.87 | | $168.37 |
| 54120 | T | | Partial removal of penis | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54125 | C | | Removal of penis | | | | | |
| 54130 | C | | Remove penis & nodes | | | | | |
| 54135 | C | | Remove penis & nodes | | | | | |
| 54150 | T | | Circumcision | 0180 | 18.1004 | $943.95 | $304.87 | $188.79 |
| 54152 | T | | Circumcision | 0180 | 18.1004 | $943.95 | $304.87 | $188.79 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 54160 | T | | Circumcision | 0180 | 18.1004 | $943.95 | $304.87 | $188.79 |
| 54161 | T | | Circumcision | 0180 | 18.1004 | $943.95 | $304.87 | $188.79 |
| 54162 | T | | Lysis penil circumic lesion | 0180 | 18.1004 | $943.95 | $304.87 | $188.79 |
| 54163 | T | | Repair of circumcision | 0180 | 18.1004 | $943.95 | $304.87 | $188.79 |
| 54164 | T | | Frenulotomy of penis | 0180 | 18.1004 | $943.95 | $304.87 | $188.79 |
| 54200 | T | | Treatment of penis lesion | 0156 | 2.9747 | $155.13 | $46.55 | $31.03 |
| 54205 | T | | Treatment of penis lesion | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54220 | T | | Treatment of penis lesion | 0156 | 2.9747 | $155.13 | $46.55 | $31.03 |
| 54230 | N | | Prepare penis study | | | | | |
| 54231 | T | | Dynamic cavernosometry | 0165 | 12.2672 | $639.75 | | $127.95 |
| 54235 | T | | Penile injection | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 54240 | T | | Penis study | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 54250 | T | | Penis study | 0165 | 12.2672 | $639.75 | | $127.95 |
| 54300 | T | | Revision of penis | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54304 | T | | Revision of penis | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54308 | T | | Reconstruction of urethra | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54312 | T | | Reconstruction of urethra | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54316 | T | | Reconstruction of urethra | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54318 | T | | Reconstruction of urethra | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54322 | T | | Reconstruction of urethra | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54324 | T | | Reconstruction of urethra | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54326 | T | | Reconstruction of urethra | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54328 | T | | Revise penis/urethra | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54332 | C | | Revise penis/urethra | | | | | |
| 54336 | C | | Revise penis/urethra | | | | | |
| 54340 | T | | Secondary urethral surgery | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54344 | T | | Secondary urethral surgery | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54348 | T | | Secondary urethral surgery | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54352 | T | | Reconstruct urethra/penis | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54360 | T | | Penis plastic surgery | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54380 | T | | Repair penis | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54385 | T | | Repair penis | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54390 | C | | Repair penis and bladder | | | | | |
| 54400 | T | | Insert semi-rigid prosthesis | 0182 | 95.4145 | $4,975.96 | | $995.19 |
| 54401 | T | | Insert self-contd prosthesis | 0182 | 95.4145 | $4,975.96 | | $995.19 |
| 54405 | T | | Insert multi-comp penis pros | 0182 | 95.4145 | $4,975.96 | | $995.19 |
| 54406 | T | | Remove muti-comp penis pros | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54408 | T | | Repair multi-comp penis pros | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54410 | T | | Remove/replace penis prosth | 0182 | 95.4145 | $4,975.96 | | $995.19 |
| 54411 | C | | Remov/replc penis pros, comp | | | | | |
| 54415 | T | | Remove self-contd penis pros | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54416 | T | | Remv/repl penis contain pros | 0182 | 95.4145 | $4,975.96 | | $995.19 |
| 54417 | C | | Remv/replc penis pros, compl | | | | | |
| 54420 | T | | Revision of penis | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54430 | C | | Revision of penis | | | | | |
| 54435 | T | | Revision of penis | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54440 | T | | Repair of penis | 0181 | 29.2435 | $1,525.08 | $621.82 | $305.02 |
| 54450 | T | | Preputial stretching | 0156 | 2.9747 | $155.13 | $46.55 | $31.03 |
| 54500 | T | | Biopsy of testis | 0005 | 3.1201 | $162.72 | $71.59 | $32.54 |
| 54505 | T | | Biopsy of testis | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 54512 | T | | Excise lesion testis | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 54520 | T | | Removal of testis | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 54522 | T | | Orchiectomy, partial | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 54530 | T | | Removal of testis | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 54535 | C | | Extensive testis surgery | | | | | |
| 54550 | T | | Exploration for testis | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 54560 | C | | Exploration for testis | | | | | |
| 54600 | T | | Reduce testis torsion | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 54620 | T | | Suspension of testis | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 54640 | T | | Suspension of testis | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 54650 | C | | Orchiopexy (Fowler-Stephens) | | | | | |
| 54660 | T | | Revision of testis | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 54670 | T | | Repair testis injury | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 54680 | T | | Relocation of testis(es) | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 54690 | T | | Laparoscopy, orchiectomy | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 54692 | T | | Laparoscopy, orchiopexy | 0132 | 56.9948 | $2,972.34 | $1,239.22 | $594.47 |
| 54699 | T | | Laparoscope proc, testis | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 54700 | T | | Drainage of scrotum | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 54800 | T | | Biopsy of epididymis | 0004 | 1.7441 | $90.96 | $23.47 | $18.19 |
| 54820 | T | | Exploration of epididymis | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 54830 | T | | Remove epididymis lesion | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 54840 | T | | Remove epididymis lesion | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 54860 | T | | Removal of epididymis | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 54861 | T | | Removal of epididymis | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 54900 | T | | Fusion of spermatic ducts | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 54901 | T | | Fusion of spermatic ducts | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 55000 | T | | Drainage of hydrocele | 0004 | 1.7441 | $90.96 | $23.47 | $18.19 |
| 55040 | T | | Removal of hydrocele | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 55041 | T | | Removal of hydroceles | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 55060 | T | | Repair of hydrocele | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 55100 | T | | Drainage of scrotum abscess | 0007 | 10.0191 | $522.51 | $108.89 | $104.50 |
| 55110 | T | | Explore scrotum | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 55120 | T | | Removal of scrotum lesion | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 55150 | T | | Removal of scrotum | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 55175 | T | | Revision of scrotum | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 55180 | T | | Revision of scrotum | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 55200 | T | | Incision of sperm duct | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 55250 | T | | Removal of sperm duct(s) | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 55300 | N | | Prepare, sperm duct x-ray | | | | | |
| 55400 | T | | Repair of sperm duct | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 55450 | T | | Ligation of sperm duct | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 55500 | T | | Removal of hydrocele | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 55520 | T | | Removal of sperm cord lesion | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 55530 | T | | Revise spermatic cord veins | 0183 | 21.2592 | $1,108.69 | | $221.74 |
| 55535 | T | | Revise spermatic cord veins | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 55540 | T | | Revise hernia & sperm veins | 0154 | 25.7262 | $1,341.65 | $464.85 | $268.33 |
| 55550 | T | | Laparo ligate spermatic vein | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 55559 | T | | Laparo proc, spermatic cord | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 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 | 21.2592 | $1,108.69 | | $221.74 |
| 55700 | T | | Biopsy of prostate | 0184 | 3.6918 | $192.53 | $96.27 | $38.51 |
| 55705 | T | | Biopsy of prostate | 0184 | 3.6918 | $192.53 | $96.27 | $38.51 |
| 55720 | T | | Drainage of prostate abscess | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 55725 | T | | Drainage of prostate abscess | 0162 | 20.5906 | $1,073.82 | | $214.76 |
| 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 | 28.3714 | $1,479.60 | | $295.92 |
| 55860 | T | | Surgical exposure, prostate | 0165 | 12.2672 | $639.75 | | $127.95 |
| 55862 | C | | Extensive prostate surgery | | | | | |
| 55865 | C | | Extensive prostate surgery | | | | | |
| 55866 | C | NI | Laparo radical prostatectomy | | | | | |
| 55870 | T | | Vag hyst w/enterocele repair | 0197 | 1.5697 | $81.86 | $33.06 | $16.37 |
| 55873 | T | | Cryoablate prostate | 0674 | 62.9152 | $3,281.09 | | $656.22 |
| 55899 | T | | Genital surgery procedure | 0164 | 1.1240 | $58.62 | $17.59 | $11.72 |
| 55970 | E | | Sex transformation, M to F | | | | | |
| 55980 | E | | Sex transformation, F to M | | | | | |
| 56405 | T | | I & D of vulva/perineum | 0192 | 2.7228 | $142.00 | $39.11 | $28.40 |
| 56420 | T | | Drainage of gland abscess | 0192 | 2.7228 | $142.00 | $39.11 | $28.40 |
| 56440 | T | | Surgery for vulva lesion | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 56441 | T | | Lysis of labial lesion(s) | 0193 | 14.4764 | $754.96 | $171.13 | $150.99 |
| 56501 | T | | Destroy, vulva lesions, sim | 0017 | 15.8233 | $825.20 | $227.84 | $165.04 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 56515 | T | | Destroy vulva lesion/s compl | 0695 | 18.6817 | $974.27 | $266.59 | $194.85 |
| 56605 | T | | Biopsy of vulva/perineum | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 56606 | T | | Biopsy of vulva/perineum | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 56620 | T | | Partial removal of vulva | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 56625 | T | | Complete removal of vulva | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 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 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 56720 | T | | Incision of hymen | 0193 | 14.4764 | $754.96 | $171.13 | $150.99 |
| 56740 | T | | Remove vagina gland lesion | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 56800 | T | | Repair of vagina | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 56805 | T | | Repair clitoris | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 56810 | T | | Repair of perineum | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 56820 | T | NI | Exam of vulva w/scope | 0188 | 1.0465 | $54.58 | $11.95 | $10.92 |
| 56821 | T | NI | Exam/biopsy of vulva w/scope | 0189 | 1.5310 | $79.84 | $18.60 | $15.97 |
| 57000 | T | | Exploration of vagina | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57010 | T | | Drainage of pelvic abscess | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57020 | T | | Drainage of pelvic fluid | 0192 | 2.7228 | $142.00 | $39.11 | $28.40 |
| 57022 | T | | I & d vaginal hematoma, pp | 0007 | 10.0191 | $522.51 | $108.89 | $104.50 |
| 57023 | T | | I & d vag hematoma, non-ob | 0007 | 10.0191 | $522.51 | $108.89 | $104.50 |
| 57061 | T | | Destroy vag lesions, simple | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57065 | T | | Destroy vag lesions, complex | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57100 | T | | Biopsy of vagina | 0192 | 2.7228 | $142.00 | $39.11 | $28.40 |
| 57105 | T | | Biopsy of vagina | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57106 | T | | Remove vagina wall, partial | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57107 | T | | Remove vagina tissue, part | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57109 | T | | Vaginectomy partial w/nodes | 0202 | 45.5610 | $2,376.05 | $1,164.26 | $475.21 |
| 57110 | C | | Remove vagina wall, complete | | | | | |
| 57111 | C | | Remove vagina tissue, compl | | | | | |
| 57112 | C | | Vaginectomy w/nodes, compl | | | | | |
| 57120 | T | | Closure of vagina | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57130 | T | | Remove vagina lesion | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57135 | T | | Remove vagina lesion | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57150 | T | | Treat vagina infection | 0191 | 0.2035 | $10.61 | $3.08 | $2.12 |
| 57155 | T | | Insert uteri tandems/ovoids | 0192 | 2.7228 | $142.00 | $39.11 | $28.40 |
| 57160 | T | | Insert pessary/other device | 0188 | 1.0465 | $54.58 | $11.95 | $10.92 |
| 57170 | T | | Fitting of diaphragm/cap | 0191 | 0.2035 | $10.61 | $3.08 | $2.12 |
| 57180 | T | | Treat vaginal bleeding | 0192 | 2.7228 | $142.00 | $39.11 | $28.40 |
| 57200 | T | | Repair of vagina | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57210 | T | | Repair vagina/perineum | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57220 | T | | Revision of urethra | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57230 | T | | Repair of urethral lesion | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57240 | T | | Repair bladder & vagina | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57250 | T | | Repair rectum & vagina | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57260 | T | | Repair of vagina | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57265 | T | | Extensive repair of vagina | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57268 | T | | Repair of bowel bulge | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57270 | C | | Repair of bowel pouch | | | | | |
| 57280 | C | | Suspension of vagina | | | | | |
| 57282 | C | | Repair of vaginal prolapse | | | | | |
| 57284 | T | | Repair paravaginal defect | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57287 | T | | Revise/remove sling repair | 0202 | 45.5610 | $2,376.05 | $1,164.26 | $475.21 |
| 57288 | T | | Repair bladder defect | 0202 | 45.5610 | $2,376.05 | $1,164.26 | $475.21 |
| 57289 | T | | Repair bladder & vagina | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57291 | T | | Construction of vagina | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57292 | C | | Construct vagina with graft | | | | | |
| 57300 | T | | Repair rectum-vagina fistula | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57305 | C | | Repair rectum-vagina fistula | | | | | |
| 57307 | C | | Fistula repair & colostomy | | | | | |
| 57308 | C | | Fistula repair, transperine | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 57310 | T | | Repair urethrovaginal lesion | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57311 | C | | Repair urethrovaginal lesion | | | | | |
| 57320 | T | | Repair bladder-vagina lesion | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57330 | T | | Repair bladder-vagina lesion | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57335 | C | | Repair vagina | | | | | |
| 57400 | T | | Dilation of vagina | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57410 | T | | Pelvic examination | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57415 | T | | Remove vaginal foreign body | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57420 | T | NI | Exam of vagina w/scope | 0192 | 2.7228 | $142.00 | $39.11 | $28.40 |
| 57421 | T | NI | Exam/biopsy of vag w/scope | 0192 | 2.7228 | $142.00 | $39.11 | $28.40 |
| 57452 | T | | Examination of vagina | 0189 | 1.5310 | $79.84 | $18.60 | $15.97 |
| 57454 | T | | Vagina examination & biopsy | 0192 | 2.7228 | $142.00 | $39.11 | $28.40 |
| 57455 | T | NI | Biopsy of cervix w/scope | 0192 | 2.7228 | $142.00 | $39.11 | $28.40 |
| 57456 | T | NI | Endocerv curettage w/scope | 0192 | 2.7228 | $142.00 | $39.11 | $28.40 |
| 57460 | T | | Cervix excision | 0193 | 14.4764 | $754.96 | $171.13 | $150.99 |
| 57461 | T | NI | Conz of cervix w/scope, leep | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57500 | T | | Biopsy of cervix | 0192 | 2.7228 | $142.00 | $39.11 | $28.40 |
| 57505 | T | | Endocervical curettage | 0192 | 2.7228 | $142.00 | $39.11 | $28.40 |
| 57510 | T | | Cauterization of cervix | 0193 | 14.4764 | $754.96 | $171.13 | $150.99 |
| 57511 | T | | Cryocautery of cervix | 0189 | 1.5310 | $79.84 | $18.60 | $15.97 |
| 57513 | T | | Laser surgery of cervix | 0193 | 14.4764 | $754.96 | $171.13 | $150.99 |
| 57520 | T | | Conization of cervix | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57522 | T | | Conization of cervix | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57530 | T | | Removal of cervix | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 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 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57555 | T | | Remove cervix/repair vagina | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57556 | T | | Remove cervix, repair bowel | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 57700 | T | | Revision of cervix | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57720 | T | | Revision of cervix | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 57800 | T | | Dilation of cervical canal | 0193 | 14.4764 | $754.96 | $171.13 | $150.99 |
| 57820 | T | | D & c of residual cervix | 0196 | 15.5035 | $808.52 | $338.23 | $161.70 |
| 58100 | T | | Biopsy of uterus lining | 0188 | 1.0465 | $54.58 | $11.95 | $10.92 |
| 58120 | T | | Dilation and curettage | 0196 | 15.5035 | $808.52 | $338.23 | $161.70 |
| 58140 | C | | Removal of uterus lesion | | | | | |
| 58145 | T | | Myomectomy vag method | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 58146 | C | NI | 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 | NI | Vag hyst complex | | | | | |
| 58291 | C | NI | Vag hyst incl t/o, complex | | | | | |
| 58292 | C | NI | Vag hyst t/o & repair, compl | | | | | |
| 58293 | C | NI | Vag hyst w/uro repair, compl | | | | | |
| 58294 | C | NI | Vag hyst w/enterocele, compl | | | | | |
| 58300 | E | | Insert intrauterine device | | | | | |
| 58301 | T | | Remove intrauterine device | 0189 | 1.5310 | $79.84 | $18.60 | $15.97 |
| 58321 | T | | Artificial insemination | 0197 | 1.5697 | $81.86 | $33.06 | $16.37 |
| 58322 | T | | Artificial insemination | 0197 | 1.5697 | $81.86 | $33.06 | $16.37 |
| 58323 | T | | Sperm washing | 0197 | 1.5697 | $81.86 | $33.06 | $16.37 |
| 58340 | N | | Catheter for hysterography | | | | | |
| 58345 | T | | Reopen fallopian tube | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 58346 | T | | Insert heyman uteri capsule | 0192 | 2.7228 | $142.00 | $39.11 | $28.40 |
| 58350 | T | | Reopen fallopian tube | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 58353 | T | | Endometr ablate, thermal | 0193 | 14.4764 | $754.96 | $171.13 | $150.99 |
| 58400 | C | | Suspension of uterus | | | | | |
| 58410 | C | | Suspension of uterus | | | | | |
| 58520 | C | | Repair of ruptured uterus | | | | | |
| 58540 | C | | Revision of uterus | | | | | |
| 58545 | T | NI | Laparoscopic myomectomy | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 58546 | T | NI | Laparo-myomectomy, complex | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 58550 | T | | Laparo-asst vag hysterectomy | 0132 | 56.9948 | $2,972.34 | $1,239.22 | $594.47 |
| 58551 | T | DG | Laparoscopy, remove myoma | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 58552 | T | NI | Laparo-vag hyst incl t/o | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 58553 | T | NI | Laparo-vag hyst, complex | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 58554 | T | NI | Laparo-vag hyst w/t/o, compl | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 58555 | T | | Hysteroscopy, dx, sep proc | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 58558 | T | | Hysteroscopy, biopsy | 0190 | 19.0596 | $993.98 | $424.28 | $198.80 |
| 58559 | T | | Hysteroscopy, lysis | 0190 | 19.0596 | $993.98 | $424.28 | $198.80 |
| 58560 | T | | Hysteroscopy, resect septum | 0190 | 19.0596 | $993.98 | $424.28 | $198.80 |
| 58561 | T | | Hysteroscopy, remove myoma | 0190 | 19.0596 | $993.98 | $424.28 | $198.80 |
| 58562 | T | | Hysteroscopy, remove fb | 0190 | 19.0596 | $993.98 | $424.28 | $198.80 |
| 58563 | T | | Hysteroscopy, ablation | 0190 | 19.0596 | $993.98 | $424.28 | $198.80 |
| 58578 | T | | Laparo proc, uterus | 0190 | 19.0596 | $993.98 | $424.28 | $198.80 |
| 58579 | T | | Hysteroscope procedure | 0190 | 19.0596 | $993.98 | $424.28 | $198.80 |
| 58600 | T | | Division of fallopian tube | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 58605 | C | | Division of fallopian tube | | | | | |
| 58611 | C | | Ligate oviduct(s) add-on | | | | | |
| 58615 | T | | Occlude fallopian tube(s) | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 58660 | T | | Laparoscopy, lysis | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 58661 | T | | Laparoscopy, remove adnexa | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 58662 | T | | Laparoscopy, excise lesions | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 58670 | T | | Laparoscopy, tubal cautery | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 58671 | T | | Laparoscopy, tubal block | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 58672 | T | | Laparoscopy, fimbrioplasty | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 58673 | T | | Laparoscopy, salpingostomy | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 58679 | T | | Laparo proc, oviduct-ovary | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 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) | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 58805 | C | | Drainage of ovarian cyst(s) | | | | | |
| 58820 | T | | Drain ovary abscess, open | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 58822 | C | | Drain ovary abscess, percut | | | | | |
| 58823 | T | | Drain pelvic abscess, percut | 0193 | 14.4764 | $754.96 | $171.13 | $150.99 |
| 58825 | C | | Transposition, ovary(s) | | | | | |
| 58900 | T | | Biopsy of ovary(s) | 0195 | 23.7301 | $1,237.55 | $483.80 | $247.51 |
| 58920 | T | | Partial removal of ovary(s) | 0202 | 45.5610 | $2,376.05 | $1,164.26 | $475.21 |
| 58925 | T | | Removal of ovarian cyst(s) | 0202 | 45.5610 | $2,376.05 | $1,164.26 | $475.21 |
| 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 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 58974 | T | | Transfer of embryo | 0197 | 1.5697 | $81.86 | $33.06 | $16.37 |
| 58976 | T | | Transfer of embryo | 0197 | 1.5697 | $81.86 | $33.06 | $16.37 |
| 58999 | T | | Genital surgery procedure | 0191 | 0.2035 | $10.61 | $3.08 | $2.12 |
| 59000 | T | | Amniocentesis, diagnostic | 0198 | 1.2597 | $65.69 | $32.19 | $13.14 |
| 59001 | T | | Amniocentesis, therapeutic | 0198 | 1.2597 | $65.69 | $32.19 | $13.14 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 59012 | T | | Fetal cord puncture,prenatal | 0198 | 1.2597 | $65.69 | $32.19 | $13.14 |
| 59015 | T | | Chorion biopsy | 0198 | 1.2597 | $65.69 | $32.19 | $13.14 |
| 59020 | T | | Fetal contract stress test | 0198 | 1.2597 | $65.69 | $32.19 | $13.14 |
| 59025 | T | | Fetal non-stress test | 0198 | 1.2597 | $65.69 | $32.19 | $13.14 |
| 59030 | T | | Fetal scalp blood sample | 0198 | 1.2597 | $65.69 | $32.19 | $13.14 |
| 59050 | E | | Fetal monitor w/report | | | | | |
| 59051 | E | | Fetal monitor/interpret only | | | | | |
| 59100 | C | | Remove uterus lesion | | | | | |
| 59120 | C | | Treat ectopic pregnancy | | | | | |
| 59121 | C | | Treat ectopic pregnancy | | | | | |
| 59130 | C | | Treat ectopic pregnancy | | | | | |
| 59135 | C | | Treat ectopic pregnancy | | | | | |
| 59136 | C | | Treat ectopic pregnancy | | | | | |
| 59140 | C | | Treat ectopic pregnancy | | | | | |
| 59150 | T | | Treat ectopic pregnancy | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 59151 | T | | Treat ectopic pregnancy | 0131 | 40.2026 | $2,096.61 | $1,001.89 | $419.32 |
| 59160 | T | | D & c after delivery | 0196 | 15.5035 | $808.52 | $338.23 | $161.70 |
| 59200 | T | | Insert cervical dilator | 0189 | 1.5310 | $79.84 | $18.60 | $15.97 |
| 59300 | T | | Episiotomy or vaginal repair | 0193 | 14.4764 | $754.96 | $171.13 | $150.99 |
| 59320 | T | | Revision of cervix | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 59325 | C | | Revision of cervix | | | | | |
| 59350 | C | | Repair of uterus | | | | | |
| 59400 | E | | Obstetrical care | | | | | |
| 59409 | T | | Obstetrical care | 0199 | 3.9146 | $204.15 | $57.16 | $40.83 |
| 59410 | E | | Obstetrical care | | | | | |
| 59412 | T | | Antepartum manipulation | 0199 | 3.9146 | $204.15 | $57.16 | $40.83 |
| 59414 | T | | Deliver placenta | 0199 | 3.9146 | $204.15 | $57.16 | $40.83 |
| 59425 | E | | Antepartum care only | | | | | |
| 59426 | E | | Antepartum care only | | | | | |
| 59430 | E | | Care after delivery | | | | | |
| 59510 | E | | Cesarean delivery | | | | | |
| 59514 | C | | Cesarean delivery only | | | | | |
| 59515 | E | | Cesarean delivery | | | | | |
| 59525 | C | | Remove uterus after cesarean | | | | | |
| 59610 | E | | Vbac delivery | | | | | |
| 59612 | T | | Vbac delivery only | 0199 | 3.9146 | $204.15 | $57.16 | $40.83 |
| 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 | 15.3097 | $798.42 | $329.65 | $159.68 |
| 59820 | T | | Care of miscarriage | 0201 | 15.3097 | $798.42 | $329.65 | $159.68 |
| 59821 | T | | Treatment of miscarriage | 0201 | 15.3097 | $798.42 | $329.65 | $159.68 |
| 59830 | C | | Treat uterus infection | | | | | |
| 59840 | T | | Abortion | 0200 | 15.1838 | $791.85 | $307.83 | $158.37 |
| 59841 | T | | Abortion | 0200 | 15.1838 | $791.85 | $307.83 | $158.37 |
| 59850 | C | | Abortion | | | | | |
| 59851 | C | | Abortion | | | | | |
| 59852 | C | | Abortion | | | | | |
| 59855 | C | | Abortion | | | | | |
| 59856 | C | | Abortion | | | | | |
| 59857 | C | | Abortion | | | | | |
| 59866 | T | | Abortion (mpr) | 0198 | 1.2597 | $65.69 | $32.19 | $13.14 |
| 59870 | T | | Evacuate mole of uterus | 0201 | 15.3097 | $798.42 | $329.65 | $159.68 |
| 59871 | T | | Remove cerclage suture | 0194 | 18.0228 | $939.91 | $397.84 | $187.98 |
| 59898 | T | | Laparo proc, ob care/deliver | 0130 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 59899 | T | | Maternity care procedure | 0198 | 1.2597 | $65.69 | $32.19 | $13.14 |
| 60000 | T | | Drain thyroid/tongue cyst | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 60001 | T | | Aspirate/inject thyriod cyst | 0004 | 1.7441 | $90.96 | $23.47 | $18.19 |
| 60100 | T | | Biopsy of thyroid | 0004 | 1.7441 | $90.96 | $23.47 | $18.19 |
| 60200 | T | | Remove thyroid lesion | 0114 | 36.1135 | $1,883.36 | $485.91 | $376.67 |
| 60210 | T | | Partial thyroid excision | 0114 | 36.1135 | $1,883.36 | $485.91 | $376.67 |
| 60212 | T | | Partial thyroid excision | 0114 | 36.1135 | $1,883.36 | $485.91 | $376.67 |
| 60220 | T | | Partial removal of thyroid | 0114 | 36.1135 | $1,883.36 | $485.91 | $376.67 |
| 60225 | T | | Partial removal of thyroid | 0114 | 36.1135 | $1,883.36 | $485.91 | $376.67 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 60240 | T | | Removal of thyroid | 0114 | 36.1135 | $1,883.36 | $485.91 | $376.67 |
| 60252 | T | | Removal of thyroid | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 60254 | C | | Extensive thyroid surgery | | | | | |
| 60260 | T | | Repeat thyroid surgery | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 60270 | C | | Removal of thyroid | | | | | |
| 60271 | C | | Removal of thyroid | | | | | |
| 60280 | T | | Remove thyroid duct lesion | 0114 | 36.1135 | $1,883.36 | $485.91 | $376.67 |
| 60281 | T | | Remove thyroid duct lesion | 0114 | 36.1135 | $1,883.36 | $485.91 | $376.67 |
| 60500 | T | | Explore parathyroid glands | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 60502 | C | | Re-explore parathyroids | | | | | |
| 60505 | C | | Explore parathyroid glands | | | | | |
| 60512 | T | | Autotransplant parathyroid | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 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 | 30.4644 | $1,588.75 | $659.53 | $317.75 |
| 60699 | T | | Endocrine surgery procedure | 0114 | 36.1135 | $1,883.36 | $485.91 | $376.67 |
| 61000 | T | | Remove cranial cavity fluid | 0212 | 3.3139 | $172.82 | $79.53 | $34.56 |
| 61001 | T | | Remove cranial cavity fluid | 0212 | 3.3139 | $172.82 | $79.53 | $34.56 |
| 61020 | T | | Remove brain cavity fluid | 0212 | 3.3139 | $172.82 | $79.53 | $34.56 |
| 61026 | T | | Injection into brain canal | 0212 | 3.3139 | $172.82 | $79.53 | $34.56 |
| 61050 | T | | Remove brain canal fluid | 0212 | 3.3139 | $172.82 | $79.53 | $34.56 |
| 61055 | T | | Injection into brain canal | 0212 | 3.3139 | $172.82 | $79.53 | $34.56 |
| 61070 | T | | Brain canal shunt procedure | 0212 | 3.3139 | $172.82 | $79.53 | $34.56 |
| 61105 | C | | Twist drill hole | | | | | |
| 61107 | C | | Drill skull for implantation | | | | | |
| 61108 | C | | Drill skull for drainage | | | | | |
| 61120 | C | | Burr hole for puncture | | | | | |
| 61140 | C | | Pierce skull for biopsy | | | | | |
| 61150 | C | | Pierce skull for drainage | | | | | |
| 61151 | C | | Pierce skull for drainage | | | | | |
| 61154 | C | | Pierce skull & remove clot | | | | | |
| 61156 | C | | Pierce skull for drainage | | | | | |
| 61210 | C | | Pierce skull, implant device | | | | | |
| 61215 | T | | Insert brain-fluid device | 0224 | 34.0302 | $1,774.71 | $453.41 | $354.94 |
| 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 | N | NI | Implt cran bone flap to abdo | | | | | |
| 61320 | C | | Open skull for drainage | | | | | |
| 61321 | C | | Open skull for drainage | | | | | |
| 61322 | C | NI | Decompressive craniotomy | | | | | |
| 61323 | C | NI | Decompressive lobectomy | | | | | |
| 61330 | T | | Decompress eye socket | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 61480 | C | | Incise skull for surgery | | | | | |
| 61490 | C | | Incise skull for surgery | | | | | |
| 61500 | C | | Removal of skull lesion | | | | | |
| 61501 | C | | Remove infected skull bone | | | | | |
| 61510 | C | | Removal of brain lesion | | | | | |
| 61512 | C | | Remove brain lining lesion | | | | | |
| 61514 | C | | Removal of brain abscess | | | | | |
| 61516 | C | | Removal of brain lesion | | | | | |
| 61517 | N | NI | Implt brain chemotx add-on | | | | | |
| 61518 | C | | Removal of brain lesion | | | | | |
| 61519 | C | | Remove brain lining lesion | | | | | |
| 61520 | C | | Removal of brain lesion | | | | | |
| 61521 | C | | Removal of brain lesion | | | | | |
| 61522 | C | | Removal of brain abscess | | | | | |
| 61524 | C | | Removal of brain lesion | | | | | |
| 61526 | C | | Removal of brain lesion | | | | | |
| 61530 | C | | Removal of brain lesion | | | | | |
| 61531 | C | | Implant brain electrodes | | | | | |
| 61533 | C | | Implant brain electrodes | | | | | |
| 61534 | C | | Removal of brain lesion | | | | | |
| 61535 | C | | Remove brain electrodes | | | | | |
| 61536 | C | | Removal of brain lesion | | | | | |
| 61538 | C | | Removal of brain tissue | | | | | |
| 61539 | C | | Removal of brain tissue | | | | | |
| 61541 | C | | Incision of brain tissue | | | | | |
| 61542 | C | | Removal of brain tissue | | | | | |
| 61543 | C | | Removal of brain tissue | | | | | |
| 61544 | C | | Remove & treat brain lesion | | | | | |
| 61545 | C | | Excision of brain tumor | | | | | |
| 61546 | C | | Removal of pituitary gland | | | | | |
| 61548 | C | | Removal of pituitary gland | | | | | |
| 61550 | C | | Release of skull seams | | | | | |
| 61552 | C | | Release of skull seams | | | | | |
| 61556 | C | | Incise skull/sutures | | | | | |
| 61557 | C | | Incise skull/sutures | | | | | |
| 61558 | C | | Excision of skull/sutures | | | | | |
| 61559 | C | | Excision of skull/sutures | | | | | |
| 61563 | C | | Excision of skull tumor | | | | | |
| 61564 | C | | Excision of skull tumor | | | | | |
| 61570 | C | | Remove foreign body, brain | | | | | |
| 61571 | C | | Incise skull for brain wound | | | | | |
| 61575 | C | | Skull base/brainstem surgery | | | | | |
| 61576 | C | | Skull base/brainstem surgery | | | | | |
| 61580 | C | | Craniofacial approach, skull | | | | | |
| 61581 | C | | Craniofacial approach, skull | | | | | |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | NI | Endovasc tempory vessel occl | 0979 | | $1,625.00 | | $325.00 |
| 61624 | C | | Occlusion/embolization cath | | | | | |
| 61626 | T | | Transcath occlusion, non-cns | 0081 | 43.5067 | $2,268.92 | | $453.78 |
| 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 | 15.8136 | $824.70 | | $164.94 |
| 61791 | T | | Treat trigeminal tract | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 61793 | E | | Focus radiation beam | | | | | |
| 61795 | S | | Brain surgery using computer | 0302 | 9.2343 | $481.58 | $182.43 | $96.32 |
| 61850 | C | | Implant neuroelectrodes | | | | | |
| 61860 | C | | Implant neuroelectrodes | | | | | |
| 61862 | C | | Implant neurostimul, subcort | | | | | |
| 61870 | C | | Implant neuroelectrodes | | | | | |
| 61875 | C | | Implant neuroelectrodes | | | | | |
| 61880 | T | | Revise/remove neuroelectrode | 0687 | 25.8424 | $1,347.71 | $619.95 | $269.54 |
| 61885 | T | | Implant neurostim one array | 0222 | 227.7370 | $11,876.71 | | $2,375.34 |
| 61886 | T | | Implant neurostim arrays | 0222 | 227.7370 | $11,876.71 | | $2,375.34 |
| 61888 | T | | Revise/remove neuroreceiver | 0688 | 74.5719 | $3,889.00 | $1,905.61 | $777.80 |
| 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 | N | NI | Retr bone flap to fix skull | | | | | |
| 62160 | N | NI | Neuroendoscopy add-on | | | | | |
| 62161 | C | NI | Dissect brain w/scope | | | | | |
| 62162 | C | NI | Remove colloid cyst w/scope | | | | | |
| 62163 | C | NI | Neuroendoscopy w/fb removal | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 62164 | C | NI | Remove brain tumor w/scope | | | | | |
| 62165 | C | NI | 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 | 2.0833 | $108.65 | $43.80 | $21.73 |
| 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 | 0121 | 2.0833 | $108.65 | $43.80 | $21.73 |
| 62230 | T | | Replace/revise brain shunt | 0224 | 34.0302 | $1,774.71 | $453.41 | $354.94 |
| 62252 | S | | Csf shunt reprogram | 0691 | 2.9166 | $152.10 | $83.65 | $30.42 |
| 62256 | C | | Remove brain cavity shunt | | | | | |
| 62258 | C | | Replace brain cavity shunt | | | | | |
| 62263 | T | | Lysis epidural adhesions | 0203 | 11.7924 | $614.99 | $276.76 | $123.00 |
| 62264 | T | NI | Epidural lysis on single day | 0203 | 11.7924 | $614.99 | $276.76 | $123.00 |
| 62268 | T | | Drain spinal cord cyst | 0212 | 3.3139 | $172.82 | $79.53 | $34.56 |
| 62269 | T | | Needle biopsy, spinal cord | 0005 | 3.1201 | $162.72 | $71.59 | $32.54 |
| 62270 | T | | Spinal fluid tap, diagnostic | 0206 | 4.7867 | $249.63 | $75.55 | $49.93 |
| 62272 | T | | Drain cerebro spinal fluid | 0206 | 4.7867 | $249.63 | $75.55 | $49.93 |
| 62273 | T | | Treat epidural spine lesion | 0206 | 4.7867 | $249.63 | $75.55 | $49.93 |
| 62280 | T | | Treat spinal cord lesion | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 62281 | T | | Treat spinal cord lesion | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 62282 | T | | Treat spinal canal lesion | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 62284 | N | | Injection for myelogram | | | | | |
| 62287 | T | | Percutaneous diskectomy | 0220 | 15.8136 | $824.70 | | $164.94 |
| 62290 | N | | Inject for spine disk x-ray | | | | | |
| 62291 | N | | Inject for spine disk x-ray | | | | | |
| 62292 | T | | Injection into disk lesion | 0212 | 3.3139 | $172.82 | $79.53 | $34.56 |
| 62294 | T | | Injection into spinal artery | 0212 | 3.3139 | $172.82 | $79.53 | $34.56 |
| 62310 | T | | Inject spine c/t | 0206 | 4.7867 | $249.63 | $75.55 | $49.93 |
| 62311 | T | | Inject spine l/s (cd) | 0206 | 4.7867 | $249.63 | $75.55 | $49.93 |
| 62318 | T | | Inject spine w/cath, c/t | 0206 | 4.7867 | $249.63 | $75.55 | $49.93 |
| 62319 | T | | Inject spine w/cath l/s (cd) | 0206 | 4.7867 | $249.63 | $75.55 | $49.93 |
| 62350 | T | | Implant spinal canal cath | 0223 | 41.0262 | $2,139.56 | | $427.91 |
| 62351 | T | | Implant spinal canal cath | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 62355 | T | | Remove spinal canal catheter | 0203 | 11.7924 | $614.99 | $276.76 | $123.00 |
| 62360 | T | | Insert spine infusion device | 0226 | 144.3474 | $7,527.86 | | $1,505.57 |
| 62361 | T | | Implant spine infusion pump | 0227 | 144.5122 | $7,536.46 | | $1,507.29 |
| 62362 | T | | Implant spine infusion pump | 0227 | 144.5122 | $7,536.46 | | $1,507.29 |
| 62365 | T | | Remove spine infusion device | 0203 | 11.7924 | $614.99 | $276.76 | $123.00 |
| 62367 | S | | Analyze spine infusion pump | 0691 | 2.9166 | $152.10 | $83.65 | $30.42 |
| 62368 | S | | Analyze spine infusion pump | 0691 | 2.9166 | $152.10 | $83.65 | $30.42 |
| 63001 | T | | Removal of spinal lamina | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63003 | T | | Removal of spinal lamina | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63005 | T | | Removal of spinal lamina | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63011 | T | | Removal of spinal lamina | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63012 | T | | Removal of spinal lamina | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63015 | T | | Removal of spinal lamina | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63016 | T | | Removal of spinal lamina | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63017 | T | | Removal of spinal lamina | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63020 | T | | Neck spine disk surgery | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63030 | T | | Low back disk surgery | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63035 | T | | Spinal disk surgery add-on | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63040 | T | | Laminotomy, single cervical | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63042 | T | | Laminotomy, single lumbar | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63043 | C | | Laminotomy, addl cervical | | | | | |
| 63044 | C | | Laminotomy, addl lumbar | | | | | |
| 63045 | T | | Removal of spinal lamina | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63046 | T | | Removal of spinal lamina | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63047 | T | | Removal of spinal lamina | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63048 | T | | Remove spinal lamina add-on | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63055 | T | | Decompress spinal cord | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63056 | T | | Decompress spinal cord | 0208 | 38.4487 | $2,005.14 | | $401.03 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 63057 | T | | Decompress spine cord add-on | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63064 | T | | Decompress spinal cord | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63066 | T | | Decompress spine cord add-on | 0208 | 38.4487 | $2,005.14 | | $401.03 |
| 63075 | C | | Neck spine disk surgery | | | | | |
| 63076 | C | | Neck spine disk surgery | | | | | |
| 63077 | C | | Spine disk surgery, thorax | | | | | |
| 63078 | C | | Spine disk surgery, thorax | | | | | |
| 63081 | C | | Removal of vertebral body | | | | | |
| 63082 | C | | Remove vertebral body add-on | | | | | |
| 63085 | C | | Removal of vertebral body | | | | | |
| 63086 | C | | Remove vertebral body add-on | | | | | |
| 63087 | C | | Removal of vertebral body | | | | | |
| 63088 | C | | Remove vertebral body add-on | | | | | |
| 63090 | C | | Removal of vertebral body | | | | | |
| 63091 | C | | Remove vertebral body add-on | | | | | |
| 63170 | C | | Incise spinal cord tract(s) | | | | | |
| 63172 | C | | Drainage of spinal cyst | | | | | |
| 63173 | C | | Drainage of spinal cyst | | | | | |
| 63180 | C | | Revise spinal cord ligaments | | | | | |
| 63182 | C | | Revise spinal cord ligaments | | | | | |
| 63185 | C | | Incise spinal column/nerves | | | | | |
| 63190 | C | | Incise spinal column/nerves | | | | | |
| 63191 | C | | Incise spinal column/nerves | | | | | |
| 63194 | C | | Incise spinal column & cord | | | | | |
| 63195 | C | | Incise spinal column & cord | | | | | |
| 63196 | C | | Incise spinal column & cord | | | | | |
| 63197 | C | | Incise spinal column & cord | | | | | |
| 63198 | C | | Incise spinal column & cord | | | | | |
| 63199 | C | | Incise spinal column & cord | | | | | |
| 63200 | C | | Release of spinal cord | | | | | |
| 63250 | C | | Revise spinal cord vessels | | | | | |
| 63251 | C | | Revise spinal cord vessels | | | | | |
| 63252 | C | | Revise spinal cord vessels | | | | | |
| 63265 | C | | Excise intraspinal lesion | | | | | |
| 63266 | C | | Excise intraspinal lesion | | | | | |
| 63267 | C | | Excise intraspinal lesion | | | | | |
| 63268 | C | | Excise intraspinal lesion | | | | | |
| 63270 | C | | Excise intraspinal lesion | | | | | |
| 63271 | C | | Excise intraspinal lesion | | | | | |
| 63272 | C | | Excise intraspinal lesion | | | | | |
| 63273 | C | | Excise intraspinal lesion | | | | | |
| 63275 | C | | Biopsy/excise spinal tumor | | | | | |
| 63276 | C | | Biopsy/excise spinal tumor | | | | | |
| 63277 | C | | Biopsy/excise spinal tumor | | | | | |
| 63278 | C | | Biopsy/excise spinal tumor | | | | | |
| 63280 | C | | Biopsy/excise spinal tumor | | | | | |
| 63281 | C | | Biopsy/excise spinal tumor | | | | | |
| 63282 | C | | Biopsy/excise spinal tumor | | | | | |
| 63283 | C | | Biopsy/excise spinal tumor | | | | | |
| 63285 | C | | Biopsy/excise spinal tumor | | | | | |
| 63286 | C | | Biopsy/excise spinal tumor | | | | | |
| 63287 | C | | Biopsy/excise spinal tumor | | | | | |
| 63290 | C | | Biopsy/excise spinal tumor | | | | | |
| 63300 | C | | Removal of vertebral body | | | | | |
| 63301 | C | | Removal of vertebral body | | | | | |
| 63302 | C | | Removal of vertebral body | | | | | |
| 63303 | C | | Removal of vertebral body | | | | | |
| 63304 | C | | Removal of vertebral body | | | | | |
| 63305 | C | | Removal of vertebral body | | | | | |
| 63306 | C | | Removal of vertebral body | | | | | |
| 63307 | C | | Removal of vertebral body | | | | | |
| 63308 | C | | Remove vertebral body add-on | | | | | |
| 63600 | T | | Remove spinal cord lesion | 0220 | 15.8136 | $824.70 | | $164.94 |
| 63610 | T | | Stimulation of spinal cord | 0220 | 15.8136 | $824.70 | | $164.94 |
| 63615 | T | | Remove lesion of spinal cord | 0220 | 15.8136 | $824.70 | | $164.94 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 63650 | S | | Implant neuroelectrodes | 0225 | 139.3379 | $7,266.61 | | $1,453.32 |
| 63655 | S | | Implant neuroelectrodes | 0225 | 139.3379 | $7,266.61 | | $1,453.32 |
| 63660 | T | | Revise/remove neuroelectrode | 0687 | 25.8424 | $1,347.71 | $619.95 | $269.54 |
| 63685 | T | | Implant neuroreceiver | 0222 | 227.7370 | $11,876.71 | | $2,375.34 |
| 63688 | T | | Revise/remove neuroreceiver | 0688 | 74.5719 | $3,889.00 | $1,905.61 | $777.80 |
| 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 | 59.6207 | $3,109.28 | $696.46 | $621.86 |
| 63744 | T | | Revision of spinal shunt | 0228 | 59.6207 | $3,109.28 | $696.46 | $621.86 |
| 63746 | T | | Removal of spinal shunt | 0109 | 7.4708 | $389.61 | $131.49 | $77.92 |
| 64400 | T | | N block inj, trigeminal | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64402 | T | | N block inj, facial | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64405 | T | | N block inj, occipital | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64408 | T | | N block inj, vagus | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64410 | T | | N block inj, phrenic | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64412 | T | | N block inj, spinal accessor | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64413 | T | | N block inj, cervical plexus | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64415 | T | | Injection for nerve block | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64416 | T | NI | N block cont infuse, b plex | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64417 | T | | N block inj, axillary | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64418 | T | | N block inj, suprascapular | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64420 | T | | N block inj, intercost, sng | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 64421 | T | | N block inj, intercost, mlt | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 64425 | T | | N block inj ilio-ing/hypogi | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64430 | T | | N block inj, pudendal | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64435 | T | | N block inj, paracervical | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64445 | T | | Injection for nerve block | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64446 | T | NI | N blk inj, sciatic, cont inf | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64447 | T | NI | N block inj fem, single | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64448 | T | NI | N block inj fem, cont inf | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64450 | T | | N block, other peripheral | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64470 | T | | Inj paravertebral c/t | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 64472 | T | | Inj paravertebral c/t add-on | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 64475 | T | | Inj paravertebral l/s | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 64476 | T | | Inj paravertebral l/s add-on | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 64479 | T | | Inj foramen epidural c/t | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 64480 | T | | Inj foramen epidural add-on | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 64483 | T | | Inj foramen epidural l/s | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 64484 | T | | Inj foramen epidural add-on | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 64505 | T | | N block, spenopalatine gangl | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64508 | T | | N block, carotid sinus s/p | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64510 | T | | N block, stellate ganglion | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 64520 | T | | N block, lumbar/thoracic | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 64530 | T | | N block inj, celiac pelus | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 64550 | A | | Apply neurostimulator | | | | | |
| 64553 | S | | Implant neuroelectrodes | 0225 | 139.3379 | $7,266.61 | | $1,453.32 |
| 64555 | S | | Implant neuroelectrodes | 0225 | 139.3379 | $7,266.61 | | $1,453.32 |
| 64560 | S | | Implant neuroelectrodes | 0225 | 139.3379 | $7,266.61 | | $1,453.32 |
| 64561 | S | | Implant neuroelectrodes | 0225 | 139.3379 | $7,266.61 | | $1,453.32 |
| 64565 | S | | Implant neuroelectrodes | 0225 | 139.3379 | $7,266.61 | | $1,453.32 |
| 64573 | S | | Implant neuroelectrodes | 0225 | 139.3379 | $7,266.61 | | $1,453.32 |
| 64575 | S | | Implant neuroelectrodes | 0225 | 139.3379 | $7,266.61 | | $1,453.32 |
| 64577 | S | | Implant neuroelectrodes | 0225 | 139.3379 | $7,266.61 | | $1,453.32 |
| 64580 | S | | Implant neuroelectrodes | 0225 | 139.3379 | $7,266.61 | | $1,453.32 |
| 64581 | S | | Implant neuroelectrodes | 0225 | 139.3379 | $7,266.61 | | $1,453.32 |
| 64585 | T | | Revise/remove neuroelectrode | 0687 | 25.8424 | $1,347.71 | $619.95 | $269.54 |
| 64590 | T | | Implant neuroreceiver | 0222 | 227.7370 | $11,876.71 | | $2,375.34 |
| 64595 | T | | Revise/remove neuroreceiver | 0688 | 74.5719 | $3,889.00 | $1,905.61 | $777.80 |
| 64600 | T | | Injection treatment of nerve | 0203 | 11.7924 | $614.99 | $276.76 | $123.00 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 64605 | T | | Injection treatment of nerve | 0203 | 11.7924 | $614.99 | $276.76 | $123.00 |
| 64610 | T | | Injection treatment of nerve | 0203 | 11.7924 | $614.99 | $276.76 | $123.00 |
| 64612 | T | | Destroy nerve, face muscle | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64613 | T | | Destroy nerve, spine muscle | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64614 | T | | Destroy nerve, extrem musc | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 64620 | T | | Injection treatment of nerve | 0203 | 11.7924 | $614.99 | $276.76 | $123.00 |
| 64622 | T | | Destr paravertebrl nerve l/s | 0203 | 11.7924 | $614.99 | $276.76 | $123.00 |
| 64623 | T | | Destr paravertebral n add-on | 0203 | 11.7924 | $614.99 | $276.76 | $123.00 |
| 64626 | T | | Destr paravertebrl nerve c/t | 0203 | 11.7924 | $614.99 | $276.76 | $123.00 |
| 64627 | T | | Destr paravertebral n add-on | 0203 | 11.7924 | $614.99 | $276.76 | $123.00 |
| 64630 | T | | Injection treatment of nerve | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 64640 | T | | Injection treatment of nerve | 0207 | 5.7654 | $300.67 | $123.69 | $60.13 |
| 64680 | T | | Injection treatment of nerve | 0203 | 11.7924 | $614.99 | $276.76 | $123.00 |
| 64702 | T | | Revise finger/toe nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64704 | T | | Revise hand/foot nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64708 | T | | Revise arm/leg nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64712 | T | | Revision of sciatic nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64713 | T | | Revision of arm nerve(s) | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64714 | T | | Revise low back nerve(s) | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64716 | T | | Revision of cranial nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64718 | T | | Revise ulnar nerve at elbow | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64719 | T | | Revise ulnar nerve at wrist | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64721 | T | | Carpal tunnel surgery | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64722 | T | | Relieve pressure on nerve(s) | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64726 | T | | Release foot/toe nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64727 | T | | Internal nerve revision | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64732 | T | | Incision of brow nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64734 | T | | Incision of cheek nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64736 | T | | Incision of chin nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64738 | T | | Incision of jaw nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64740 | T | | Incision of tongue nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64742 | T | | Incision of facial nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64744 | T | | Incise nerve, back of head | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64746 | T | | Incise diaphragm nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 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 | 15.8136 | $824.70 | | $164.94 |
| 64763 | C | | Incise hip/thigh nerve | | | | | |
| 64766 | C | | Incise hip/thigh nerve | | | | | |
| 64771 | T | | Sever cranial nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64772 | T | | Incision of spinal nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64774 | T | | Remove skin nerve lesion | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64776 | T | | Remove digit nerve lesion | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64778 | T | | Digit nerve surgery add-on | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64782 | T | | Remove limb nerve lesion | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64783 | T | | Limb nerve surgery add-on | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64784 | T | | Remove nerve lesion | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64786 | T | | Remove sciatic nerve lesion | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64787 | T | | Implant nerve end | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64788 | T | | Remove skin nerve lesion | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64790 | T | | Removal of nerve lesion | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64792 | T | | Removal of nerve lesion | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64795 | T | | Biopsy of nerve | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64802 | T | | Remove sympathetic nerves | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64804 | C | | Remove sympathetic nerves | | | | | |
| 64809 | C | | Remove sympathetic nerves | | | | | |
| 64818 | C | | Remove sympathetic nerves | | | | | |
| 64820 | T | | Remove sympathetic nerves | 0220 | 15.8136 | $824.70 | | $164.94 |
| 64821 | T | | Remove sympathestic nerves | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 64822 | T | | Remove sympathetic nerves | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 64823 | T | | Remove sympathetic nerves | 0054 | 22.7223 | $1,184.99 | | $237.00 |
| 64831 | T | | Repair of digit nerve | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64832 | T | | Repair nerve add-on | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64834 | T | | Repair of hand or foot nerve | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 64835 | T | | Repair of hand or foot nerve | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64836 | T | | Repair of hand or foot nerve | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64837 | T | | Repair nerve add-on | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64840 | T | | Repair of leg nerve | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64856 | T | | Repair/transpose nerve | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64857 | T | | Repair arm/leg nerve | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64858 | T | | Repair sciatic nerve | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64859 | T | | Nerve surgery | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64861 | T | | Repair of arm nerves | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64862 | T | | Repair of low back nerves | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64864 | T | | Repair of facial nerve | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64865 | T | | Repair of facial nerve | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64866 | C | | Fusion of facial/other nerve | | | | | |
| 64868 | C | | Fusion of facial/other nerve | | | | | |
| 64870 | T | | Fusion of facial/other nerve | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64872 | T | | Subsequent repair of nerve | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64874 | T | | Repair & revise nerve add-on | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64876 | T | | Repair nerve/shorten bone | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64885 | T | | Nerve graft, head or neck | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64886 | T | | Nerve graft, head or neck | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64890 | T | | Nerve graft, hand or foot | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64891 | T | | Nerve graft, hand or foot | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64892 | T | | Nerve graft, arm or leg | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64893 | T | | Nerve graft, arm or leg | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64895 | T | | Nerve graft, hand or foot | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64896 | T | | Nerve graft, hand or foot | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64897 | T | | Nerve graft, arm or leg | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64898 | T | | Nerve graft, arm or leg | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64901 | T | | Nerve graft add-on | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64902 | T | | Nerve graft add-on | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64905 | T | | Nerve pedicle transfer | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64907 | T | | Nerve pedicle transfer | 0221 | 21.5208 | $1,122.33 | $463.62 | $224.47 |
| 64999 | T | | Nervous system surgery | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| 65091 | T | | Revise eye | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 65093 | T | | Revise eye with implant | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 65101 | T | | Removal of eye | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 65103 | T | | Remove eye/insert implant | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 65105 | T | | Remove eye/attach implant | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 65110 | T | | Removal of eye | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 65112 | T | | Remove eye/revise socket | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 65114 | T | | Remove eye/revise socket | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 65125 | T | | Revise ocular implant | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 65130 | T | | Insert ocular implant | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 65135 | T | | Insert ocular implant | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 65140 | T | | Attach ocular implant | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 65150 | T | | Revise ocular implant | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 65155 | T | | Reinsert ocular implant | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 65175 | T | | Removal of ocular implant | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 65205 | S | | Remove foreign body from eye | 0698 | 0.9205 | $48.00 | $18.72 | $9.60 |
| 65210 | S | | Remove foreign body from eye | 0231 | 2.1705 | $113.19 | $50.94 | $22.64 |
| 65220 | S | | Remove foreign body from eye | 0231 | 2.1705 | $113.19 | $50.94 | $22.64 |
| 65222 | S | | Remove foreign body from eye | 0231 | 2.1705 | $113.19 | $50.94 | $22.64 |
| 65235 | T | | Remove foreign body from eye | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 65260 | T | | Remove foreign body from eye | 0236 | 19.4278 | $1,013.18 | | $202.64 |
| 65265 | T | | Remove foreign body from eye | 0236 | 19.4278 | $1,013.18 | | $202.64 |
| 65270 | T | | Repair of eye wound | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 65272 | T | | Repair of eye wound | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 65273 | C | | Repair of eye wound | | | | | |
| 65275 | T | | Repair of eye wound | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 65280 | T | | Repair of eye wound | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 65285 | T | | Repair of eye wound | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 65286 | T | | Repair of eye wound | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 65290 | T | | Repair of eye socket wound | 0243 | 19.9705 | $1,041.48 | $431.39 | $208.30 |
| 65400 | T | | Removal of eye lesion | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 65410 | T | | Biopsy of cornea | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 65420 | T | | Removal of eye lesion | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 65426 | T | | Removal of eye lesion | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 65430 | S | | Corneal smear | 0230 | 0.7364 | $38.40 | $14.97 | $7.68 |
| 65435 | T | | Curette/treat cornea | 0239 | 6.8119 | $355.25 | $115.94 | $71.05 |
| 65436 | T | | Curette/treat cornea | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 65450 | S | | Treatment of corneal lesion | 0231 | 2.1705 | $113.19 | $50.94 | $22.64 |
| 65600 | T | | Revision of cornea | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 65710 | T | | Corneal transplant | 0244 | 35.6290 | $1,858.09 | $803.26 | $371.62 |
| 65730 | T | | Corneal transplant | 0244 | 35.6290 | $1,858.09 | $803.26 | $371.62 |
| 65750 | T | | Corneal transplant | 0244 | 35.6290 | $1,858.09 | $803.26 | $371.62 |
| 65755 | T | | Corneal transplant | 0244 | 35.6290 | $1,858.09 | $803.26 | $371.62 |
| 65760 | E | | Revision of cornea | | | | | |
| 65765 | E | | Revision of cornea | | | | | |
| 65767 | E | | Corneal tissue transplant | | | | | |
| 65770 | T | | Revise cornea with implant | 0244 | 35.6290 | $1,858.09 | $803.26 | $371.62 |
| 65771 | E | | Radial keratotomy | | | | | |
| 65772 | T | | Correction of astigmatism | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 65775 | T | | Correction of astigmatism | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 65800 | T | | Drainage of eye | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 65805 | T | | Drainage of eye | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 65810 | T | | Drainage of eye | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 65815 | T | | Drainage of eye | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 65820 | T | | Relieve inner eye pressure | 0232 | 4.4960 | $234.47 | $103.17 | $46.89 |
| 65850 | T | | Incision of eye | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 65855 | T | | Laser surgery of eye | 0247 | 4.7092 | $245.59 | $104.31 | $49.12 |
| 65860 | T | | Incise inner eye adhesions | 0247 | 4.7092 | $245.59 | $104.31 | $49.12 |
| 65865 | T | | Incise inner eye adhesions | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 65870 | T | | Incise inner eye adhesions | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 65875 | T | | Incise inner eye adhesions | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 65880 | T | | Incise inner eye adhesions | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 65900 | T | | Remove eye lesion | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 65920 | T | | Remove implant of eye | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 65930 | T | | Remove blood clot from eye | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 66020 | T | | Injection treatment of eye | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 66030 | T | | Injection treatment of eye | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 66130 | T | | Remove eye lesion | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 66150 | T | | Glaucoma surgery | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 66155 | T | | Glaucoma surgery | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 66160 | T | | Glaucoma surgery | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 66165 | T | | Glaucoma surgery | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 66170 | T | | Glaucoma surgery | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 66172 | T | | Incision of eye | 0673 | 25.9490 | $1,353.27 | $649.56 | $270.65 |
| 66180 | T | | Implant eye shunt | 0673 | 25.9490 | $1,353.27 | $649.56 | $270.65 |
| 66185 | T | | Revise eye shunt | 0673 | 25.9490 | $1,353.27 | $649.56 | $270.65 |
| 66220 | T | | Repair eye lesion | 0236 | 19.4278 | $1,013.18 | | $202.64 |
| 66225 | T | | Repair/graft eye lesion | 0673 | 25.9490 | $1,353.27 | $649.56 | $270.65 |
| 66250 | T | | Follow-up surgery of eye | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 66500 | T | | Incision of iris | 0232 | 4.4960 | $234.47 | $103.17 | $46.89 |
| 66505 | T | | Incision of iris | 0232 | 4.4960 | $234.47 | $103.17 | $46.89 |
| 66600 | T | | Remove iris and lesion | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 66605 | T | | Removal of iris | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 66625 | T | | Removal of iris | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 66630 | T | | Removal of iris | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 66635 | T | | Removal of iris | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 66680 | T | | Repair iris & ciliary body | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 66682 | T | | Repair iris & ciliary body | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 66700 | T | | Destruction, ciliary body | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 66710 | T | | Destruction, ciliary body | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 66720 | T | | Destruction, ciliary body | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 66740 | T | | Destruction, ciliary body | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 66761 | T | | Revision of iris | 0247 | 4.7092 | $245.59 | $104.31 | $49.12 |
| 66762 | T | | Revision of iris | 0247 | 4.7092 | $245.59 | $104.31 | $49.12 |
| 66770 | T | | Removal of inner eye lesion | 0247 | 4.7092 | $245.59 | $104.31 | $49.12 |
| 66820 | T | | Incision, secondary cataract | 0232 | 4.4960 | $234.47 | $103.17 | $46.89 |
| 66821 | T | | After cataract laser surgery | 0247 | 4.7092 | $245.59 | $104.31 | $49.12 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 66825 | T | | Reposition intraocular lens | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 66830 | T | | Removal of lens lesion | 0232 | 4.4960 | $234.47 | $103.17 | $46.89 |
| 66840 | T | | Removal of lens material | 0245 | 14.5442 | $758.49 | $251.21 | $151.70 |
| 66850 | T | | Removal of lens material | 0249 | 26.7242 | $1,393.69 | $524.67 | $278.74 |
| 66852 | T | | Removal of lens material | 0249 | 26.7242 | $1,393.69 | $524.67 | $278.74 |
| 66920 | T | | Extraction of lens | 0249 | 26.7242 | $1,393.69 | $524.67 | $278.74 |
| 66930 | T | | Extraction of lens | 0249 | 26.7242 | $1,393.69 | $524.67 | $278.74 |
| 66940 | T | | Extraction of lens | 0245 | 14.5442 | $758.49 | $251.21 | $151.70 |
| 66982 | T | | Cataract surgery, complex | 0246 | 22.2379 | $1,159.73 | $495.96 | $231.95 |
| 66983 | T | | Cataract surg w/iol, 1 stage | 0246 | 22.2379 | $1,159.73 | $495.96 | $231.95 |
| 66984 | T | | Cataract surg w/iol, 1 stage | 0246 | 22.2379 | $1,159.73 | $495.96 | $231.95 |
| 66985 | T | | Insert lens prosthesis | 0246 | 22.2379 | $1,159.73 | $495.96 | $231.95 |
| 66986 | T | | Exchange lens prosthesis | 0246 | 22.2379 | $1,159.73 | $495.96 | $231.95 |
| 66990 | N | NI | Ophthalmic endoscope add-on | | | | | |
| 66999 | T | | Eye surgery procedure | 0232 | 4.4960 | $234.47 | $103.17 | $46.89 |
| 67005 | T | | Partial removal of eye fluid | 0237 | 33.2647 | $1,734.79 | $818.54 | $346.96 |
| 67010 | T | | Partial removal of eye fluid | 0237 | 33.2647 | $1,734.79 | $818.54 | $346.96 |
| 67015 | T | | Release of eye fluid | 0237 | 33.2647 | $1,734.79 | $818.54 | $346.96 |
| 67025 | T | | Replace eye fluid | 0236 | 19.4278 | $1,013.18 | | $202.64 |
| 67027 | T | | Implant eye drug system | 0237 | 33.2647 | $1,734.79 | $818.54 | $346.96 |
| 67028 | T | | Injection eye drug | 0235 | 5.0871 | $265.30 | $73.44 | $53.06 |
| 67030 | T | | Incise inner eye strands | 0236 | 19.4278 | $1,013.18 | | $202.64 |
| 67031 | T | | Laser surgery, eye strands | 0247 | 4.7092 | $245.59 | $104.31 | $49.12 |
| 67036 | T | | Removal of inner eye fluid | 0237 | 33.2647 | $1,734.79 | $818.54 | $346.96 |
| 67038 | T | | Strip retinal membrane | 0237 | 33.2647 | $1,734.79 | $818.54 | $346.96 |
| 67039 | T | | Laser treatment of retina | 0237 | 33.2647 | $1,734.79 | $818.54 | $346.96 |
| 67040 | T | | Laser treatment of retina | 0672 | 37.9061 | $1,976.84 | $988.43 | $395.37 |
| 67101 | T | | Repair detached retina | 0235 | 5.0871 | $265.30 | $73.44 | $53.06 |
| 67105 | T | | Repair detached retina | 0248 | 4.2925 | $223.86 | $95.08 | $44.77 |
| 67107 | T | | Repair detached retina | 0672 | 37.9061 | $1,976.84 | $988.43 | $395.37 |
| 67108 | T | | Repair detached retina | 0672 | 37.9061 | $1,976.84 | $988.43 | $395.37 |
| 67110 | T | | Repair detached retina | 0235 | 5.0871 | $265.30 | $73.44 | $53.06 |
| 67112 | T | | Rerepair detached retina | 0672 | 37.9061 | $1,976.84 | $988.43 | $395.37 |
| 67115 | T | | Release encircling material | 0236 | 19.4278 | $1,013.18 | | $202.64 |
| 67120 | T | | Remove eye implant material | 0236 | 19.4278 | $1,013.18 | | $202.64 |
| 67121 | T | | Remove eye implant material | 0237 | 33.2647 | $1,734.79 | $818.54 | $346.96 |
| 67141 | T | | Treatment of retina | 0235 | 5.0871 | $265.30 | $73.44 | $53.06 |
| 67145 | T | | Treatment of retina | 0248 | 4.2925 | $223.86 | $95.08 | $44.77 |
| 67208 | T | | Treatment of retinal lesion | 0235 | 5.0871 | $265.30 | $73.44 | $53.06 |
| 67210 | T | | Treatment of retinal lesion | 0248 | 4.2925 | $223.86 | $95.08 | $44.77 |
| 67218 | T | | Treatment of retinal lesion | 0236 | 19.4278 | $1,013.18 | | $202.64 |
| 67220 | T | | Treatment of choroid lesion | 0235 | 5.0871 | $265.30 | $73.44 | $53.06 |
| 67221 | T | | Ocular photodynamic ther | 0235 | 5.0871 | $265.30 | $73.44 | $53.06 |
| 67225 | T | | Eye photodynamic ther add-on | 0235 | 5.0871 | $265.30 | $73.44 | $53.06 |
| 67227 | T | | Treatment of retinal lesion | 0235 | 5.0871 | $265.30 | $73.44 | $53.06 |
| 67228 | T | | Treatment of retinal lesion | 0248 | 4.2925 | $223.86 | $95.08 | $44.77 |
| 67250 | T | | Reinforce eye wall | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67255 | T | | Reinforce/graft eye wall | 0237 | 33.2647 | $1,734.79 | $818.54 | $346.96 |
| 67299 | T | | Eye surgery procedure | 0235 | 5.0871 | $265.30 | $73.44 | $53.06 |
| 67311 | T | | Revise eye muscle | 0243 | 19.9705 | $1,041.48 | $431.39 | $208.30 |
| 67312 | T | | Revise two eye muscles | 0243 | 19.9705 | $1,041.48 | $431.39 | $208.30 |
| 67314 | T | | Revise eye muscle | 0243 | 19.9705 | $1,041.48 | $431.39 | $208.30 |
| 67316 | T | | Revise two eye muscles | 0243 | 19.9705 | $1,041.48 | $431.39 | $208.30 |
| 67318 | T | | Revise eye muscle(s) | 0243 | 19.9705 | $1,041.48 | $431.39 | $208.30 |
| 67320 | T | | Revise eye muscle(s) add-on | 0243 | 19.9705 | $1,041.48 | $431.39 | $208.30 |
| 67331 | T | | Eye surgery follow-up add-on | 0243 | 19.9705 | $1,041.48 | $431.39 | $208.30 |
| 67332 | T | | Rerevise eye muscles add-on | 0243 | 19.9705 | $1,041.48 | $431.39 | $208.30 |
| 67334 | T | | Revise eye muscle w/suture | 0243 | 19.9705 | $1,041.48 | $431.39 | $208.30 |
| 67335 | T | | Eye suture during surgery | 0243 | 19.9705 | $1,041.48 | $431.39 | $208.30 |
| 67340 | T | | Revise eye muscle add-on | 0243 | 19.9705 | $1,041.48 | $431.39 | $208.30 |
| 67343 | T | | Release eye tissue | 0243 | 19.9705 | $1,041.48 | $431.39 | $208.30 |
| 67345 | T | | Destroy nerve of eye muscle | 0238 | 2.9747 | $155.13 | $58.96 | $31.03 |
| 67350 | T | | Biopsy eye muscle | 0699 | 3.7596 | $196.07 | $88.23 | $39.21 |
| 67399 | T | | Eye muscle surgery procedure | 0243 | 19.9705 | $1,041.48 | $431.39 | $208.30 |
| 67400 | T | | Explore/biopsy eye socket | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 67405 | T | | Explore/drain eye socket | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 67412 | T | | Explore/treat eye socket | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 67413 | T | | Explore/treat eye socket | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 67414 | T | | Explr/decompress eye socket | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 67415 | T | | Aspiration, orbital contents | 0239 | 6.8119 | $355.25 | $115.94 | $71.05 |
| 67420 | T | | Explore/treat eye socket | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 67430 | T | | Explore/treat eye socket | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 67440 | T | | Explore/drain eye socket | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 67445 | T | | Explr/decompress eye socket | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 67450 | T | | Explore/biopsy eye socket | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 67500 | S | | Inject/treat eye socket | 0231 | 2.1705 | $113.19 | $50.94 | $22.64 |
| 67505 | T | | Inject/treat eye socket | 0238 | 2.9747 | $155.13 | $58.96 | $31.03 |
| 67515 | T | | Inject/treat eye socket | 0239 | 6.8119 | $355.25 | $115.94 | $71.05 |
| 67550 | T | | Insert eye socket implant | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 67560 | T | | Revise eye socket implant | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 67570 | T | | Decompress optic nerve | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 67599 | T | | Orbit surgery procedure | 0239 | 6.8119 | $355.25 | $115.94 | $71.05 |
| 67700 | T | | Drainage of eyelid abscess | 0238 | 2.9747 | $155.13 | $58.96 | $31.03 |
| 67710 | T | | Incision of eyelid | 0239 | 6.8119 | $355.25 | $115.94 | $71.05 |
| 67715 | T | | Incision of eyelid fold | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67800 | T | | Remove eyelid lesion | 0238 | 2.9747 | $155.13 | $58.96 | $31.03 |
| 67801 | T | | Remove eyelid lesions | 0239 | 6.8119 | $355.25 | $115.94 | $71.05 |
| 67805 | T | | Remove eyelid lesions | 0238 | 2.9747 | $155.13 | $58.96 | $31.03 |
| 67808 | T | | Remove eyelid lesion(s) | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67810 | T | | Biopsy of eyelid | 0238 | 2.9747 | $155.13 | $58.96 | $31.03 |
| 67820 | S | | Revise eyelashes | 0230 | 0.7364 | $38.40 | $14.97 | $7.68 |
| 67825 | T | | Revise eyelashes | 0238 | 2.9747 | $155.13 | $58.96 | $31.03 |
| 67830 | T | | Revise eyelashes | 0239 | 6.8119 | $355.25 | $115.94 | $71.05 |
| 67835 | T | | Revise eyelashes | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67840 | T | | Remove eyelid lesion | 0239 | 6.8119 | $355.25 | $115.94 | $71.05 |
| 67850 | T | | Treat eyelid lesion | 0239 | 6.8119 | $355.25 | $115.94 | $71.05 |
| 67875 | T | | Closure of eyelid by suture | 0239 | 6.8119 | $355.25 | $115.94 | $71.05 |
| 67880 | T | | Revision of eyelid | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 67882 | T | | Revision of eyelid | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67900 | T | | Repair brow defect | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67901 | T | | Repair eyelid defect | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67902 | T | | Repair eyelid defect | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67903 | T | | Repair eyelid defect | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67904 | T | | Repair eyelid defect | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67906 | T | | Repair eyelid defect | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67908 | T | | Repair eyelid defect | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67909 | T | | Revise eyelid defect | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67911 | T | | Revise eyelid defect | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67914 | T | | Repair eyelid defect | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67915 | T | | Repair eyelid defect | 0239 | 6.8119 | $355.25 | $115.94 | $71.05 |
| 67916 | T | | Repair eyelid defect | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67917 | T | | Repair eyelid defect | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67921 | T | | Repair eyelid defect | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67922 | T | | Repair eyelid defect | 0239 | 6.8119 | $355.25 | $115.94 | $71.05 |
| 67923 | T | | Repair eyelid defect | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67924 | T | | Repair eyelid defect | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67930 | T | | Repair eyelid wound | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67935 | T | | Repair eyelid wound | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67938 | S | | Remove eyelid foreign body | 0698 | 0.9205 | $48.00 | $18.72 | $9.60 |
| 67950 | T | | Revision of eyelid | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67961 | T | | Revision of eyelid | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67966 | T | | Revision of eyelid | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67971 | T | | Reconstruction of eyelid | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 67973 | T | | Reconstruction of eyelid | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 67974 | T | | Reconstruction of eyelid | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 67975 | T | | Reconstruction of eyelid | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 67999 | T | | Revision of eyelid | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 68020 | T | | Incise/drain eyelid lining | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 68040 | S | | Treatment of eyelid lesions | 0698 | 0.9205 | $48.00 | $18.72 | $9.60 |
| 68100 | T | | Biopsy of eyelid lining | 0232 | 4.4960 | $234.47 | $103.17 | $46.89 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 68110 | T | | Remove eyelid lining lesion | 0699 | 3.7596 | $196.07 | $88.23 | $39.21 |
| 68115 | T | | Remove eyelid lining lesion | 0239 | 6.8119 | $355.25 | $115.94 | $71.05 |
| 68130 | T | | Remove eyelid lining lesion | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 68135 | T | | Remove eyelid lining lesion | 0239 | 6.8119 | $355.25 | $115.94 | $71.05 |
| 68200 | S | | Treat eyelid by injection | 0698 | 0.9205 | $48.00 | $18.72 | $9.60 |
| 68320 | T | | Revise/graft eyelid lining | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 68325 | T | | Revise/graft eyelid lining | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 68326 | T | | Revise/graft eyelid lining | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 68328 | T | | Revise/graft eyelid lining | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 68330 | T | | Revise eyelid lining | 0233 | 13.4202 | $699.88 | $266.33 | $139.98 |
| 68335 | T | | Revise/graft eyelid lining | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 68340 | T | | Separate eyelid adhesions | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 68360 | T | | Revise eyelid lining | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 68362 | T | | Revise eyelid lining | 0234 | 20.4259 | $1,065.23 | $511.31 | $213.05 |
| 68399 | T | | Eyelid lining surgery | 0239 | 6.8119 | $355.25 | $115.94 | $71.05 |
| 68400 | T | | Incise/drain tear gland | 0238 | 2.9747 | $155.13 | $58.96 | $31.03 |
| 68420 | T | | Incise/drain tear sac | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 68440 | T | | Incise tear duct opening | 0238 | 2.9747 | $155.13 | $58.96 | $31.03 |
| 68500 | T | | Removal of tear gland | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 68505 | T | | Partial removal, tear gland | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 68510 | T | | Biopsy of tear gland | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 68520 | T | | Removal of tear sac | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 68525 | T | | Biopsy of tear sac | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 68530 | T | | Clearance of tear duct | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 68540 | T | | Remove tear gland lesion | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 68550 | T | | Remove tear gland lesion | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 68700 | T | | Repair tear ducts | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 68705 | T | | Revise tear duct opening | 0238 | 2.9747 | $155.13 | $58.96 | $31.03 |
| 68720 | T | | Create tear sac drain | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 68745 | T | | Create tear duct drain | 0241 | 20.6294 | $1,075.84 | $384.47 | $215.17 |
| 68750 | T | | Create tear duct drain | 0242 | 28.0517 | $1,462.92 | $597.36 | $292.58 |
| 68760 | S | | Close tear duct opening | 0698 | 0.9205 | $48.00 | $18.72 | $9.60 |
| 68761 | S | | Close tear duct opening | 0231 | 2.1705 | $113.19 | $50.94 | $22.64 |
| 68770 | T | | Close tear system fistula | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 68801 | S | | Dilate tear duct opening | 0231 | 2.1705 | $113.19 | $50.94 | $22.64 |
| 68810 | T | | Probe nasolacrimal duct | 0699 | 3.7596 | $196.07 | $88.23 | $39.21 |
| 68811 | T | | Probe nasolacrimal duct | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 68815 | T | | Probe nasolacrimal duct | 0240 | 16.3078 | $850.47 | $315.31 | $170.09 |
| 68840 | T | | Explore/irrigate tear ducts | 0699 | 3.7596 | $196.07 | $88.23 | $39.21 |
| 68850 | N | | Injection for tear sac x-ray | | | | | |
| 68899 | T | | Tear duct system surgery | 0699 | 3.7596 | $196.07 | $88.23 | $39.21 |
| 69000 | T | | Drain external ear lesion | 0006 | 1.7926 | $93.49 | $24.12 | $18.70 |
| 69005 | T | | Drain external ear lesion | 0007 | 10.0191 | $522.51 | $108.89 | $104.50 |
| 69020 | T | | Drain outer ear canal lesion | 0006 | 1.7926 | $93.49 | $24.12 | $18.70 |
| 69090 | E | | Pierce earlobes | | | | | |
| 69100 | T | | Biopsy of external ear | 0019 | 3.7693 | $196.57 | $71.87 | $39.31 |
| 69105 | T | | Biopsy of external ear canal | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 69110 | T | | Remove external ear, partial | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 69120 | T | | Removal of external ear | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 69140 | T | | Remove ear canal lesion(s) | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 69145 | T | | Remove ear canal lesion(s) | 0021 | 13.9338 | $726.66 | $219.48 | $145.33 |
| 69150 | T | | Extensive ear canal surgery | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 69155 | C | | Extensive ear/neck surgery | | | | | |
| 69200 | X | | Clear outer ear canal | 0340 | 0.6492 | $33.86 | | $6.77 |
| 69205 | T | | Clear outer ear canal | 0022 | 17.3930 | $907.06 | $354.45 | $181.41 |
| 69210 | X | | Remove impacted ear wax | 0340 | 0.6492 | $33.86 | | $6.77 |
| 69220 | T | | Clean out mastoid cavity | 0012 | 0.7849 | $40.93 | $11.18 | $8.19 |
| 69222 | T | | Clean out mastoid cavity | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 69300 | T | | Revise external ear | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 69310 | T | | Rebuild outer ear canal | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69320 | T | | Rebuild outer ear canal | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69399 | T | | Outer ear surgery procedure | 0251 | 1.9089 | $99.55 | | $19.91 |
| 69400 | T | | Inflate middle ear canal | 0251 | 1.9089 | $99.55 | | $19.91 |
| 69401 | T | | Inflate middle ear canal | 0251 | 1.9089 | $99.55 | | $19.91 |
| 69405 | T | | Catheterize middle ear canal | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 69410 | T | | Inset middle ear (baffle) | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 69420 | T | | Incision of eardrum | 0251 | 1.9089 | $99.55 | | $19.91 |
| 69421 | T | | Incision of eardrum | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 69424 | T | | Remove ventilating tube | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 69433 | T | | Create eardrum opening | 0252 | 5.8041 | $302.69 | $113.41 | $60.54 |
| 69436 | T | | Create eardrum opening | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 69440 | T | | Exploration of middle ear | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 69450 | T | | Eardrum revision | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69501 | T | | Mastoidectomy | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69502 | T | | Mastoidectomy | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 69505 | T | | Remove mastoid structures | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69511 | T | | Extensive mastoid surgery | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69530 | T | | Extensive mastoid surgery | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69535 | C | | Remove part of temporal bone | | | | | |
| 69540 | T | | Remove ear lesion | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 69550 | T | | Remove ear lesion | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69552 | T | | Remove ear lesion | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69554 | C | | Remove ear lesion | | | | | |
| 69601 | T | | Mastoid surgery revision | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69602 | T | | Mastoid surgery revision | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69603 | T | | Mastoid surgery revision | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69604 | T | | Mastoid surgery revision | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69605 | T | | Mastoid surgery revision | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69610 | T | | Repair of eardrum | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 69620 | T | | Repair of eardrum | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 69631 | T | | Repair eardrum structures | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69632 | T | | Rebuild eardrum structures | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69633 | T | | Rebuild eardrum structures | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69635 | T | | Repair eardrum structures | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69636 | T | | Rebuild eardrum structures | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69637 | T | | Rebuild eardrum structures | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69641 | T | | Revise middle ear & mastoid | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69642 | T | | Revise middle ear & mastoid | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69643 | T | | Revise middle ear & mastoid | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69644 | T | | Revise middle ear & mastoid | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69645 | T | | Revise middle ear & mastoid | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69646 | T | | Revise middle ear & mastoid | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69650 | T | | Release middle ear bone | 0254 | 20.1158 | $1,049.06 | $321.35 | $209.81 |
| 69660 | T | | Revise middle ear bone | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69661 | T | | Revise middle ear bone | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69662 | T | | Revise middle ear bone | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69666 | T | | Repair middle ear structures | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69667 | T | | Repair middle ear structures | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69670 | T | | Remove mastoid air cells | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69676 | T | | Remove middle ear nerve | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69700 | T | | Close mastoid fistula | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69710 | E | | Implant/replace hearing aid | | | | | |
| 69711 | T | | Remove/repair hearing aid | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69714 | T | | Implant temple bone w/stimul | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69715 | T | | Temple bne implnt w/stimulat | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69717 | T | | Temple bone implant revision | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69718 | T | | Revise temple bone implant | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69720 | T | | Release facial nerve | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69725 | T | | Release facial nerve | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69740 | T | | Repair facial nerve | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69745 | T | | Repair facial nerve | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69799 | T | | Middle ear surgery procedure | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 69801 | T | | Incise inner ear | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69802 | T | | Incise inner ear | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69805 | T | | Explore inner ear | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69806 | T | | Explore inner ear | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69820 | T | | Establish inner ear window | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69840 | T | | Revise inner ear window | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69905 | T | | Remove inner ear | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69910 | T | | Remove inner ear & mastoid | 0256 | 34.0302 | $1,774.71 | | $354.94 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 69915 | T | | Incise inner ear nerve | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69930 | T | | Implant cochlear device | 0259 | 367.6466 | $19,173.14 | $9,394.83 | $3,834.63 |
| 69949 | T | | Inner ear surgery procedure | 0253 | 14.4473 | $753.44 | $282.29 | $150.69 |
| 69950 | C | | Incise inner ear nerve | | | | | |
| 69955 | T | | Release facial nerve | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69960 | T | | Release inner ear canal | 0256 | 34.0302 | $1,774.71 | | $354.94 |
| 69970 | C | | Remove inner ear lesion | | | | | |
| 69979 | T | | Temporal bone surgery | 0251 | 1.9089 | $99.55 | | $19.91 |
| 69990 | N | | Microsurgery add-on | | | | | |
| 70010 | S | | Contrast x-ray of brain | 0274 | 3.8759 | $202.13 | $96.54 | $40.43 |
| 70015 | S | | Contrast x-ray of brain | 0274 | 3.8759 | $202.13 | $96.54 | $40.43 |
| 70030 | X | | X-ray eye for foreign body | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70100 | X | | X-ray exam of jaw | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70110 | X | | X-ray exam of jaw | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70120 | X | | X-ray exam of mastoids | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70130 | X | | X-ray exam of mastoids | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70134 | X | | X-ray exam of middle ear | 0261 | 1.2887 | $67.21 | | $13.44 |
| 70140 | X | | X-ray exam of facial bones | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70150 | X | | X-ray exam of facial bones | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70160 | X | | X-ray exam of nasal bones | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70170 | X | | X-ray exam of tear duct | 0263 | 1.8992 | $99.05 | $43.58 | $19.81 |
| 70190 | X | | X-ray exam of eye sockets | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70200 | X | | X-ray exam of eye sockets | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70210 | X | | X-ray exam of sinuses | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70220 | X | | X-ray exam of sinuses | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70240 | X | | X-ray exam, pituitary saddle | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70250 | X | | X-ray exam of skull | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70260 | X | | X-ray exam of skull | 0261 | 1.2887 | $67.21 | | $13.44 |
| 70300 | X | | X-ray exam of teeth | 0262 | 0.5717 | $29.81 | $9.82 | $5.96 |
| 70310 | X | | X-ray exam of teeth | 0262 | 0.5717 | $29.81 | $9.82 | $5.96 |
| 70320 | X | | Full mouth x-ray of teeth | 0262 | 0.5717 | $29.81 | $9.82 | $5.96 |
| 70328 | X | | X-ray exam of jaw joint | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70330 | X | | X-ray exam of jaw joints | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70332 | S | | X-ray exam of jaw joint | 0275 | 2.9747 | $155.13 | $69.09 | $31.03 |
| 70336 | S | | Magnetic image, jaw joint | 0335 | 6.2983 | $328.46 | $151.46 | $65.69 |
| 70350 | X | | X-ray head for orthodontia | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70355 | X | | Panoramic x-ray of jaws | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70360 | X | | X-ray exam of neck | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70370 | X | | Throat x-ray & fluoroscopy | 0272 | 1.3372 | $69.74 | $38.36 | $13.95 |
| 70371 | X | | Speech evaluation, complex | 0272 | 1.3372 | $69.74 | $38.36 | $13.95 |
| 70373 | X | | Contrast x-ray of larynx | 0263 | 1.8992 | $99.05 | $43.58 | $19.81 |
| 70380 | X | | X-ray exam of salivary gland | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 70390 | X | | X-ray exam of salivary duct | 0264 | 2.8197 | $147.05 | $79.41 | $29.41 |
| 70450 | S | | Ct head/brain w/o dye | 0332 | 3.4398 | $179.39 | $91.27 | $35.88 |
| 70460 | S | | Ct head/brain w/dye | 0283 | 4.5057 | $234.98 | $126.27 | $47.00 |
| 70470 | S | | Ct head/brain w/o&w dye | 0333 | 5.3681 | $279.95 | $146.98 | $55.99 |
| 70480 | S | | Ct orbit/ear/fossa w/o dye | 0332 | 3.4398 | $179.39 | $91.27 | $35.88 |
| 70481 | S | | Ct orbit/ear/fossa w/dye | 0283 | 4.5057 | $234.98 | $126.27 | $47.00 |
| 70482 | S | | Ct orbit/ear/fossa w/o&w dye | 0333 | 5.3681 | $279.95 | $146.98 | $55.99 |
| 70486 | S | | Ct maxillofacial w/o dye | 0332 | 3.4398 | $179.39 | $91.27 | $35.88 |
| 70487 | S | | Ct maxillofacial w/dye | 0283 | 4.5057 | $234.98 | $126.27 | $47.00 |
| 70488 | S | | Ct maxillofacial w/o&w dye | 0333 | 5.3681 | $279.95 | $146.98 | $55.99 |
| 70490 | S | | Ct soft tissue neck w/o dye | 0332 | 3.4398 | $179.39 | $91.27 | $35.88 |
| 70491 | S | | Ct soft tissue neck w/dye | 0283 | 4.5057 | $234.98 | $126.27 | $47.00 |
| 70492 | S | | Ct sft tsue nck w/o & w/dye | 0333 | 5.3681 | $279.95 | $146.98 | $55.99 |
| 70496 | S | | Ct angiography, head | 0662 | 5.4553 | $284.50 | $156.47 | $56.90 |
| 70498 | S | | Ct angiography, neck | 0662 | 5.4553 | $284.50 | $156.47 | $56.90 |
| 70540 | S | | Mri orbit/face/neck w/o dye | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| 70542 | S | | Mri orbit/face/neck w/dye | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| 70543 | S | | Mri orbt/fac/nck w/o&w dye | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| 70544 | S | | Mr angiography head w/o dye | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| 70545 | S | | Mr angiography head w/dye | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| 70546 | S | | Mr angiograph head w/o&w dye | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| 70547 | S | | Mr angiography neck w/o dye | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| 70548 | S | | Mr angiography neck w/dye | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 70549 | S | | Mr angiograph neck w/o&w dye | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| 70551 | S | | Mri brain w/o dye | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| 70552 | S | | Mri brain w/dye | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| 70553 | S | | Mri brain w/o&w dye | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| 71010 | X | | Chest x-ray | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 71015 | X | | Chest x-ray | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 71020 | X | | Chest x-ray | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 71021 | X | | Chest x-ray | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 71022 | X | | Chest x-ray | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 71023 | X | | Chest x-ray and fluoroscopy | 0272 | 1.3372 | $69.74 | $38.36 | $13.95 |
| 71030 | X | | Chest x-ray | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 71034 | X | | Chest x-ray and fluoroscopy | 0272 | 1.3372 | $69.74 | $38.36 | $13.95 |
| 71035 | X | | Chest x-ray | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 71040 | X | | Contrast x-ray of bronchi | 0263 | 1.8992 | $99.05 | $43.58 | $19.81 |
| 71060 | X | | Contrast x-ray of bronchi | 0264 | 2.8197 | $147.05 | $79.41 | $29.41 |
| 71090 | X | | X-ray & pacemaker insertion | 0272 | 1.3372 | $69.74 | $38.36 | $13.95 |
| 71100 | X | | X-ray exam of ribs | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 71101 | X | | X-ray exam of ribs/chest | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 71110 | X | | X-ray exam of ribs | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 71111 | X | | X-ray exam of ribs/ chest | 0261 | 1.2887 | $67.21 | | $13.44 |
| 71120 | X | | X-ray exam of breastbone | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 71130 | X | | X-ray exam of breastbone | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 71250 | S | | Ct thorax w/o dye | 0332 | 3.4398 | $179.39 | $91.27 | $35.88 |
| 71260 | S | | Ct thorax w/dye | 0283 | 4.5057 | $234.98 | $126.27 | $47.00 |
| 71270 | S | | Ct thorax w/o&w dye | 0333 | 5.3681 | $279.95 | $146.98 | $55.99 |
| 71275 | S | | Ct angiography, chest | 0662 | 5.4553 | $284.50 | $156.47 | $56.90 |
| 71550 | S | | Mri chest w/o dye | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| 71551 | S | | Mri chest w/dye | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| 71552 | S | | Mri chest w/o&w/dye | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| 71555 | E | | Mri angio chest w or w/o dye | | | | | |
| 72010 | X | | X-ray exam of spine | 0261 | 1.2887 | $67.21 | | $13.44 |
| 72020 | X | | X-ray exam of spine | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 72040 | X | | X-ray exam of neck spine | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 72050 | X | | X-ray exam of neck spine | 0261 | 1.2887 | $67.21 | | $13.44 |
| 72052 | X | | X-ray exam of neck spine | 0261 | 1.2887 | $67.21 | | $13.44 |
| 72069 | X | | X-ray exam of trunk spine | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 72070 | X | | X-ray exam of thoracic spine | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 72072 | X | | X-ray exam of thoracic spine | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 72074 | X | | X-ray exam of thoracic spine | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 72080 | X | | X-ray exam of trunk spine | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 72090 | X | | X-ray exam of trunk spine | 0261 | 1.2887 | $67.21 | | $13.44 |
| 72100 | X | | X-ray exam of lower spine | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 72110 | X | | X-ray exam of lower spine | 0261 | 1.2887 | $67.21 | | $13.44 |
| 72114 | X | | X-ray exam of lower spine | 0261 | 1.2887 | $67.21 | | $13.44 |
| 72120 | X | | X-ray exam of lower spine | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 72125 | S | | Ct neck spine w/o dye | 0332 | 3.4398 | $179.39 | $91.27 | $35.88 |
| 72126 | S | | Ct neck spine w/dye | 0283 | 4.5057 | $234.98 | $126.27 | $47.00 |
| 72127 | S | | Ct neck spine w/o&w/dye | 0333 | 5.3681 | $279.95 | $146.98 | $55.99 |
| 72128 | S | | Ct chest spine w/o dye | 0332 | 3.4398 | $179.39 | $91.27 | $35.88 |
| 72129 | S | | Ct chest spine w/dye | 0283 | 4.5057 | $234.98 | $126.27 | $47.00 |
| 72130 | S | | Ct chest spine w/o&w/dye | 0333 | 5.3681 | $279.95 | $146.98 | $55.99 |
| 72131 | S | | Ct lumbar spine w/o dye | 0332 | 3.4398 | $179.39 | $91.27 | $35.88 |
| 72132 | S | | Ct lumbar spine w/dye | 0283 | 4.5057 | $234.98 | $126.27 | $47.00 |
| 72133 | S | | Ct lumbar spine w/o&w/dye | 0333 | 5.3681 | $279.95 | $146.98 | $55.99 |
| 72141 | S | | Mri neck spine w/o dye | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| 72142 | S | | Mri neck spine w/dye | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| 72146 | S | | Mri chest spine w/o dye | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| 72147 | S | | Mri chest spine w/dye | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| 72148 | S | | Mri lumbar spine w/o dye | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| 72149 | S | | Mri lumbar spine w/dye | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| 72156 | S | | Mri neck spine w/o&w/dye | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| 72157 | S | | Mri chest spine w/o&w/dye | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| 72158 | S | | Mri lumbar spine w/o&w/dye | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| 72159 | E | | Mr angio spine w/o&w/dye | | | | | |
| 72170 | X | | X-ray exam of pelvis | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| 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 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 72191 | S | | Ct angiograph pelv w/o&w/dye | 0662 | 5.4553 | $284.50 | $156.47 | $56.90 |
| 72192 | S | | Ct pelvis w/o dye | 0332 | 3.4398 | $179.39 | $91.27 | $35.88 |
| 72193 | S | | Ct pelvis w/dye | 0283 | 4.5057 | $234.98 | $126.27 | $47.00 |
| 72194 | S | | Ct pelvis w/o&w/dye | 0333 | 5.3681 | $279.95 | $146.98 | $55.99 |
| 72195 | S | | Mri pelvis w/o dye | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| 72196 | S | | Mri pelvis w/dye | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| 72197 | S | | Mri pelvis w/o & w/dye | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| 72198 | E | | Mr angio pelvis w/o&w/dye | | | | | |
| 72200 | X | | X-ray exam sacroiliac joints | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 72202 | X | | X-ray exam sacroiliac joints | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 72220 | X | | X-ray exam of tailbone | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 72240 | S | | Contrast x-ray of neck spine | 0274 | 3.8759 | $202.13 | $96.54 | $40.43 |
| 72255 | S | | Contrast x-ray, thorax spine | 0274 | 3.8759 | $202.13 | $96.54 | $40.43 |
| 72265 | S | | Contrast x-ray, lower spine | 0274 | 3.8759 | $202.13 | $96.54 | $40.43 |
| 72270 | S | | Contrast x-ray of spine | 0274 | 3.8759 | $202.13 | $96.54 | $40.43 |
| 72275 | S | | Epidurography | 0274 | 3.8759 | $202.13 | $96.54 | $40.43 |
| 72285 | S | | X-ray c/t spine disk | 0274 | 3.8759 | $202.13 | $96.54 | $40.43 |
| 72295 | S | | X-ray of lower spine disk | 0274 | 3.8759 | $202.13 | $96.54 | $40.43 |
| 73000 | X | | X-ray exam of collar bone | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73010 | X | | X-ray exam of shoulder blade | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73020 | X | | X-ray exam of shoulder | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73030 | X | | X-ray exam of shoulder | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73040 | S | | Contrast x-ray of shoulder | 0275 | 2.9747 | $155.13 | $69.09 | $31.03 |
| 73050 | X | | X-ray exam of shoulders | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73060 | X | | X-ray exam of humerus | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73070 | X | | X-ray exam of elbow | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73080 | X | | X-ray exam of elbow | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73085 | S | | Contrast x-ray of elbow | 0275 | 2.9747 | $155.13 | $69.09 | $31.03 |
| 73090 | X | | X-ray exam of forearm | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73092 | X | | X-ray exam of arm, infant | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73100 | X | | X-ray exam of wrist | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73110 | X | | X-ray exam of wrist | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73115 | S | | Contrast x-ray of wrist | 0275 | 2.9747 | $155.13 | $69.09 | $31.03 |
| 73120 | X | | X-ray exam of hand | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73130 | X | | X-ray exam of hand | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73140 | X | | X-ray exam of finger(s) | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73200 | S | | Ct upper extremity w/o dye | 0332 | 3.4398 | $179.39 | $91.27 | $35.88 |
| 73201 | S | | Ct upper extremity w/dye | 0283 | 4.5057 | $234.98 | $126.27 | $47.00 |
| 73202 | S | | Ct uppr extremity w/o&w/dye | 0333 | 5.3681 | $279.95 | $146.98 | $55.99 |
| 73206 | S | | Ct angio upr extrm w/o&w/dye | 0662 | 5.4553 | $284.50 | $156.47 | $56.90 |
| 73218 | S | | Mri upper extremity w/o dye | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| 73219 | S | | Mri upper extremity w/dye | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| 73220 | S | | Mri uppr extremity w/o&w/dye | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| 73221 | S | | Mri joint upr extrem w/o dye | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| 73222 | S | | Mri joint upr extrem w/dye | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| 73223 | S | | Mri joint upr extr w/o&w/dye | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| 73225 | E | | Mr angio upr extr w/o&w/dye | | | | | |
| 73500 | X | | X-ray exam of hip | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73510 | X | | X-ray exam of hip | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73520 | X | | X-ray exam of hips | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73525 | S | | Contrast x-ray of hip | 0275 | 2.9747 | $155.13 | $69.09 | $31.03 |
| 73530 | X | | X-ray exam of hip | 0261 | 1.2887 | $67.21 | | $13.44 |
| 73540 | X | | X-ray exam of pelvis & hips | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73542 | S | | X-ray exam, sacroiliac joint | 0275 | 2.9747 | $155.13 | $69.09 | $31.03 |
| 73550 | X | | X-ray exam of thigh | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73560 | X | | X-ray exam of knee, 1 or 2 | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73562 | X | | X-ray exam of knee, 3 | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73564 | X | | X-ray exam, knee, 4 or more | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73565 | X | | X-ray exam of knees | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73580 | S | | Contrast x-ray of knee joint | 0275 | 2.9747 | $155.13 | $69.09 | $31.03 |
| 73590 | X | | X-ray exam of lower leg | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73592 | X | | X-ray exam of leg, infant | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73600 | X | | X-ray exam of ankle | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73610 | X | | X-ray exam of ankle | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 73615 | S | | Contrast x-ray of ankle | 0275 | 2.9747 | $155.13 | $69.09 | $31.03 |
| 73620 | X | | X-ray exam of foot | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73630 | X | | X-ray exam of foot | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73650 | X | | X-ray exam of heel | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73660 | X | | X-ray exam of toe(s) | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 73700 | S | | Ct lower extremity w/o dye | 0332 | 3.4398 | $179.39 | $91.27 | $35.88 |
| 73701 | S | | Ct lower extremity w/dye | 0283 | 4.5057 | $234.98 | $126.27 | $47.00 |
| 73702 | S | | Ct lwr extremity w/o&w/dye | 0333 | 5.3681 | $279.95 | $146.98 | $55.99 |
| 73706 | S | | Ct angio lwr extr w/o&w/dye | 0662 | 5.4553 | $284.50 | $156.47 | $56.90 |
| 73718 | S | | Mri lower extremity w/o dye | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| 73719 | S | | Mri lower extremity w/dye | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| 73720 | S | | Mri lwr extremity w/o&w/dye | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| 73721 | S | | Mri jnt of lwr extre w/o dye | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| 73722 | S | | Mri joint of lwr extr w/dye | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| 73723 | S | | Mri joint lwr extr w/o&w/dye | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| 73725 | E | | Mr ang lwr ext w or w/o dye | | | | | |
| 74000 | X | | X-ray exam of abdomen | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 74010 | X | | X-ray exam of abdomen | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 74020 | X | | X-ray exam of abdomen | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 74022 | X | | X-ray exam series, abdomen | 0261 | 1.2887 | $67.21 | | $13.44 |
| 74150 | S | | Ct abdomen w/o dye | 0332 | 3.4398 | $179.39 | $91.27 | $35.88 |
| 74160 | S | | Ct abdomen w/dye | 0283 | 4.5057 | $234.98 | $126.27 | $47.00 |
| 74170 | S | | Ct abdomen w/o&w/dye | 0333 | 5.3681 | $279.95 | $146.98 | $55.99 |
| 74175 | S | | Ct angio abdom w/o&w/dye | 0662 | 5.4553 | $284.50 | $156.47 | $56.90 |
| 74181 | S | | Mri abdomen w/o dye | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| 74182 | S | | Mri abdomen w/dye | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| 74183 | S | | Mri abdomen w/o&w/dye | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| 74185 | E | | Mri angio, abdom w or w/o dy | | | | | |
| 74190 | X | | X-ray exam of peritoneum | 0263 | 1.8992 | $99.05 | $43.58 | $19.81 |
| 74210 | S | | Contrst x-ray exam of throat | 0276 | 1.5891 | $82.87 | $41.72 | $16.57 |
| 74220 | S | | Contrast x-ray, esophagus | 0276 | 1.5891 | $82.87 | $41.72 | $16.57 |
| 74230 | S | | Cine/vid x-ray, throat/esoph | 0276 | 1.5891 | $82.87 | $41.72 | $16.57 |
| 74235 | S | | Remove esophagus obstruction | 0296 | 2.4127 | $125.82 | $69.20 | $25.16 |
| 74240 | S | | X-ray exam, upper gi tract | 0276 | 1.5891 | $82.87 | $41.72 | $16.57 |
| 74241 | S | | X-ray exam, upper gi tract | 0276 | 1.5891 | $82.87 | $41.72 | $16.57 |
| 74245 | S | | X-ray exam, upper gi tract | 0277 | 2.3546 | $122.79 | $60.47 | $24.56 |
| 74246 | S | | Contrst x-ray uppr gi tract | 0276 | 1.5891 | $82.87 | $41.72 | $16.57 |
| 74247 | S | | Contrst x-ray uppr gi tract | 0276 | 1.5891 | $82.87 | $41.72 | $16.57 |
| 74249 | S | | Contrst x-ray uppr gi tract | 0277 | 2.3546 | $122.79 | $60.47 | $24.56 |
| 74250 | S | | X-ray exam of small bowel | 0276 | 1.5891 | $82.87 | $41.72 | $16.57 |
| 74251 | S | | X-ray exam of small bowel | 0277 | 2.3546 | $122.79 | $60.47 | $24.56 |
| 74260 | S | | X-ray exam of small bowel | 0277 | 2.3546 | $122.79 | $60.47 | $24.56 |
| 74270 | S | | Contrast x-ray exam of colon | 0276 | 1.5891 | $82.87 | $41.72 | $16.57 |
| 74280 | S | | Contrast x-ray exam of colon | 0277 | 2.3546 | $122.79 | $60.47 | $24.56 |
| 74283 | S | | Contrast x-ray exam of colon | 0276 | 1.5891 | $82.87 | $41.72 | $16.57 |
| 74290 | S | | Contrast x-ray, gallbladder | 0276 | 1.5891 | $82.87 | $41.72 | $16.57 |
| 74291 | S | | Contrast x-rays, gallbladder | 0276 | 1.5891 | $82.87 | $41.72 | $16.57 |
| 74300 | X | | X-ray bile ducts/pancreas | 0263 | 1.8992 | $99.05 | $43.58 | $19.81 |
| 74301 | X | | X-rays at surgery add-on | 0263 | 1.8992 | $99.05 | $43.58 | $19.81 |
| 74305 | X | | X-ray bile ducts/pancreas | 0263 | 1.8992 | $99.05 | $43.58 | $19.81 |
| 74320 | X | | Contrast x-ray of bile ducts | 0264 | 2.8197 | $147.05 | $79.41 | $29.41 |
| 74327 | S | | X-ray bile stone removal | 0296 | 2.4127 | $125.82 | $69.20 | $25.16 |
| 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 | 1.3372 | $69.74 | $38.36 | $13.95 |
| 74350 | X | | X-ray guide, stomach tube | 0263 | 1.8992 | $99.05 | $43.58 | $19.81 |
| 74355 | X | | X-ray guide, intestinal tube | 0263 | 1.8992 | $99.05 | $43.58 | $19.81 |
| 74360 | S | | X-ray guide, GI dilation | 0296 | 2.4127 | $125.82 | $69.20 | $25.16 |
| 74363 | S | | X-ray, bile duct dilation | 0297 | 7.6839 | $400.72 | $172.51 | $80.14 |
| 74400 | S | | Contrst x-ray, urinary tract | 0278 | 2.5290 | $131.89 | $66.07 | $26.38 |
| 74410 | S | | Contrst x-ray, urinary tract | 0278 | 2.5290 | $131.89 | $66.07 | $26.38 |
| 74415 | S | | Contrst x-ray, urinary tract | 0278 | 2.5290 | $131.89 | $66.07 | $26.38 |
| 74420 | S | | Contrst x-ray, urinary tract | 0278 | 2.5290 | $131.89 | $66.07 | $26.38 |
| 74425 | S | | Contrst x-ray, urinary tract | 0278 | 2.5290 | $131.89 | $66.07 | $26.38 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 74430 | S | | Contrast x-ray, bladder | 0278 | 2.5290 | $131.89 | $66.07 | $26.38 |
| 74440 | S | | X-ray, male genital tract | 0278 | 2.5290 | $131.89 | $66.07 | $26.38 |
| 74445 | S | | X-ray exam of penis | 0278 | 2.5290 | $131.89 | $66.07 | $26.38 |
| 74450 | S | | X-ray, urethra/bladder | 0278 | 2.5290 | $131.89 | $66.07 | $26.38 |
| 74455 | S | | X-ray, urethra/bladder | 0278 | 2.5290 | $131.89 | $66.07 | $26.38 |
| 74470 | X | | X-ray exam of kidney lesion | 0264 | 2.8197 | $147.05 | $79.41 | $29.41 |
| 74475 | S | | X-ray control, cath insert | 0297 | 7.6839 | $400.72 | $172.51 | $80.14 |
| 74480 | S | | X-ray control, cath insert | 0296 | 2.4127 | $125.82 | $69.20 | $25.16 |
| 74485 | S | | X-ray guide, GU dilation | 0296 | 2.4127 | $125.82 | $69.20 | $25.16 |
| 74710 | X | | X-ray measurement of pelvis | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 74740 | X | | X-ray, female genital tract | 0264 | 2.8197 | $147.05 | $79.41 | $29.41 |
| 74742 | X | | X-ray, fallopian tube | 0263 | 1.8992 | $99.05 | $43.58 | $19.81 |
| 74775 | S | | X-ray exam of perineum | 0278 | 2.5290 | $131.89 | $66.07 | $26.38 |
| 75552 | S | | Heart mri for morph w/o dye | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| 75553 | S | | Heart mri for morph w/dye | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| 75554 | S | | Cardiac MRI/function | 0335 | 6.2983 | $328.46 | $151.46 | $65.69 |
| 75555 | S | | Cardiac MRI/limited study | 0335 | 6.2983 | $328.46 | $151.46 | $65.69 |
| 75556 | E | | Cardiac MRI/flow mapping | | | | | |
| 75600 | S | | Contrast x-ray exam of aorta | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75605 | S | | Contrast x-ray exam of aorta | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75625 | S | | Contrast x-ray exam of aorta | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75630 | S | | X-ray aorta, leg arteries | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75635 | S | | Ct angio abdominal arteries | 0662 | 5.4553 | $284.50 | $156.47 | $56.90 |
| 75650 | S | | Artery x-rays, head & neck | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75658 | S | | Artery x-rays, arm | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75660 | S | | Artery x-rays, head & neck | 0279 | 8.6432 | $450.75 | $174.57 | $90.15 |
| 75662 | S | | Artery x-rays, head & neck | 0279 | 8.6432 | $450.75 | $174.57 | $90.15 |
| 75665 | S | | Artery x-rays, head & neck | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75671 | S | | Artery x-rays, head & neck | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75676 | S | | Artery x-rays, neck | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75680 | S | | Artery x-rays, neck | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75685 | S | | Artery x-rays, spine | 0279 | 8.6432 | $450.75 | $174.57 | $90.15 |
| 75705 | S | | Artery x-rays, spine | 0279 | 8.6432 | $450.75 | $174.57 | $90.15 |
| 75710 | S | | Artery x-rays, arm/leg | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75716 | S | | Artery x-rays, arms/legs | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75722 | S | | Artery x-rays, kidney | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75724 | S | | Artery x-rays, kidneys | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75726 | S | | Artery x-rays, abdomen | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75731 | S | | Artery x-rays, adrenal gland | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75733 | S | | Artery x-rays, adrenals | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75736 | S | | Artery x-rays, pelvis | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75741 | S | | Artery x-rays, lung | 0279 | 8.6432 | $450.75 | $174.57 | $90.15 |
| 75743 | S | | Artery x-rays, lungs | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75746 | S | | Artery x-rays, lung | 0279 | 8.6432 | $450.75 | $174.57 | $90.15 |
| 75756 | S | | Artery x-rays, chest | 0279 | 8.6432 | $450.75 | $174.57 | $90.15 |
| 75774 | S | | Artery x-ray, each vessel | 0668 | 10.3292 | $538.68 | $237.76 | $107.74 |
| 75790 | S | | Visualize A-V shunt | 0281 | 5.2227 | $272.37 | $115.16 | $54.47 |
| 75801 | X | | Lymph vessel x-ray, arm/leg | 0264 | 2.8197 | $147.05 | $79.41 | $29.41 |
| 75803 | X | | Lymph vessel x-ray,arms/legs | 0264 | 2.8197 | $147.05 | $79.41 | $29.41 |
| 75805 | X | | Lymph vessel x-ray, trunk | 0264 | 2.8197 | $147.05 | $79.41 | $29.41 |
| 75807 | X | | Lymph vessel x-ray, trunk | 0264 | 2.8197 | $147.05 | $79.41 | $29.41 |
| 75809 | X | | Nonvascular shunt, x-ray | 0263 | 1.8992 | $99.05 | $43.58 | $19.81 |
| 75810 | S | | Vein x-ray, spleen/liver | 0279 | 8.6432 | $450.75 | $174.57 | $90.15 |
| 75820 | S | | Vein x-ray, arm/leg | 0281 | 5.2227 | $272.37 | $115.16 | $54.47 |
| 75822 | S | | Vein x-ray, arms/legs | 0281 | 5.2227 | $272.37 | $115.16 | $54.47 |
| 75825 | S | | Vein x-ray, trunk | 0279 | 8.6432 | $450.75 | $174.57 | $90.15 |
| 75827 | S | | Vein x-ray, chest | 0279 | 8.6432 | $450.75 | $174.57 | $90.15 |
| 75831 | S | | Vein x-ray, kidney | 0287 | 6.9863 | $364.34 | $114.51 | $72.87 |
| 75833 | S | | Vein x-ray, kidneys | 0279 | 8.6432 | $450.75 | $174.57 | $90.15 |
| 75840 | S | | Vein x-ray, adrenal gland | 0287 | 6.9863 | $364.34 | $114.51 | $72.87 |
| 75842 | S | | Vein x-ray, adrenal glands | 0287 | 6.9863 | $364.34 | $114.51 | $72.87 |
| 75860 | S | | Vein x-ray, neck | 0287 | 6.9863 | $364.34 | $114.51 | $72.87 |
| 75870 | S | | Vein x-ray, skull | 0287 | 6.9863 | $364.34 | $114.51 | $72.87 |
| 75872 | S | | Vein x-ray, skull | 0287 | 6.9863 | $364.34 | $114.51 | $72.87 |
| 75880 | S | | Vein x-ray, eye socket | 0287 | 6.9863 | $364.34 | $114.51 | $72.87 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 75885 | S | | Vein x-ray, liver | 0279 | 8.6432 | $450.75 | $174.57 | $90.15 |
| 75887 | S | | Vein x-ray, liver | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75889 | S | | Vein x-ray, liver | 0279 | 8.6432 | $450.75 | $174.57 | $90.15 |
| 75891 | S | | Vein x-ray, liver | 0279 | 8.6432 | $450.75 | $174.57 | $90.15 |
| 75893 | N | | Venous sampling by catheter | | | | | |
| 75894 | S | | X-rays, transcath therapy | 0297 | 7.6839 | $400.72 | $172.51 | $80.14 |
| 75896 | S | | X-rays, transcath therapy | 0297 | 7.6839 | $400.72 | $172.51 | $80.14 |
| 75898 | X | | Follow-up angiography | 0264 | 2.8197 | $147.05 | $79.41 | $29.41 |
| 75900 | C | | Arterial catheter exchange | | | | | |
| 75901 | X | NI | Remove cva device obstruct | 0264 | 2.8197 | $147.05 | $79.41 | $29.41 |
| 75902 | X | NI | Remove cva lumen obstruct | 0263 | 1.8992 | $99.05 | $43.58 | $19.81 |
| 75940 | X | | X-ray placement, vein filter | 0187 | 3.9534 | $206.17 | $90.71 | $41.23 |
| 75945 | S | | Intravascular us | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 75946 | S | | Intravascular us add-on | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 75952 | C | | Endovasc repair abdom aorta | | | | | |
| 75953 | C | | Abdom aneurysm endovas rpr | | | | | |
| 75954 | C | NI | Iliac aneurysm endovas rpr | | | | | |
| 75960 | S | | Transcatheter intro, stent | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75961 | S | | Retrieval, broken catheter | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75962 | S | | Repair arterial blockage | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75964 | S | | Repair artery blockage, each | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75966 | S | | Repair arterial blockage | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75968 | S | | Repair artery blockage, each | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75970 | S | | Vascular biopsy | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75978 | S | | Repair venous blockage | 0668 | 10.3292 | $538.68 | $237.76 | $107.74 |
| 75980 | S | | Contrast xray exam bile duct | 0296 | 2.4127 | $125.82 | $69.20 | $25.16 |
| 75982 | S | | Contrast xray exam bile duct | 0297 | 7.6839 | $400.72 | $172.51 | $80.14 |
| 75984 | X | | Xray control catheter change | 0264 | 2.8197 | $147.05 | $79.41 | $29.41 |
| 75989 | N | | Abscess drainage under x-ray | | | | | |
| 75992 | S | | Atherectomy, x-ray exam | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75993 | S | | Atherectomy, x-ray exam | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75994 | S | | Atherectomy, x-ray exam | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75995 | S | | Atherectomy, x-ray exam | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 75996 | S | | Atherectomy, x-ray exam | 0280 | 15.2128 | $793.36 | $353.85 | $158.67 |
| 76000 | X | | Fluoroscope examination | 0272 | 1.3372 | $69.74 | $38.36 | $13.95 |
| 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 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 76010 | X | | X-ray, nose to rectum | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 76012 | S | | Percut vertebroplasty fluor | 0274 | 3.8759 | $202.13 | $96.54 | $40.43 |
| 76013 | S | | Percut vertebroplasty, ct | 0274 | 3.8759 | $202.13 | $96.54 | $40.43 |
| 76020 | X | | X-rays for bone age | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 76040 | X | | X-rays, bone evaluation | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 76061 | X | | X-rays, bone survey | 0261 | 1.2887 | $67.21 | | $13.44 |
| 76062 | X | | X-rays, bone survey | 0261 | 1.2887 | $67.21 | | $13.44 |
| 76065 | X | | X-rays, bone evaluation | 0261 | 1.2887 | $67.21 | | $13.44 |
| 76066 | X | | Joint survey, single view | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 76070 | E | | CT scan, bone density study | | | | | |
| 76071 | S | NI | Ct bone density, peripheral | 0282 | 1.6763 | $87.42 | $44.51 | $17.48 |
| 76075 | S | | Dexa, axial skeleton study | 0288 | 1.2984 | $67.71 | | $13.54 |
| 76076 | S | | Dexa, peripheral study | 0665 | 0.8236 | $42.95 | | $8.59 |
| 76078 | X | | Radiographic absorptiometry | 0261 | 1.2887 | $67.21 | | $13.44 |
| 76080 | X | | X-ray exam of fistula | 0263 | 1.8992 | $99.05 | $43.58 | $19.81 |
| 76085 | A | | Computer mammogram add-on | | | | | |
| 76086 | X | | X-ray of mammary duct | 0263 | 1.8992 | $99.05 | $43.58 | $19.81 |
| 76088 | X | | X-ray of mammary ducts | 0263 | 1.8992 | $99.05 | $43.58 | $19.81 |
| 76090 | S | | Mammogram, one breast | 0271 | 0.6492 | $33.86 | $16.80 | $6.77 |
| 76091 | S | | Mammogram, both breasts | 0271 | 0.6492 | $33.86 | $16.80 | $6.77 |
| 76092 | A | | Mammogram, screening | | | | | |
| 76093 | E | | Magnetic image, breast | | | | | |
| 76094 | E | | Magnetic image, both breasts | | | | | |
| 76095 | X | | Stereotactic breast biopsy | 0187 | 3.9534 | $206.17 | $90.71 | $41.23 |
| 76096 | X | | X-ray of needle wire, breast | 0289 | 1.8992 | $99.05 | $44.80 | $19.81 |
| 76098 | X | | X-ray exam, breast specimen | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 76100 | X | | X-ray exam of body section | 0261 | 1.2887 | $67.21 | | $13.44 |
| 76101 | X | | Complex body section x-ray | 0264 | 2.8197 | $147.05 | $79.41 | $29.41 |
| 76102 | X | | Complex body section x-rays | 0264 | 2.8197 | $147.05 | $79.41 | $29.41 |
| 76120 | X | | Cine/video x-rays | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 76125 | X | | Cine/video x-rays add-on | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 76140 | E | | X-ray consultation | | | | | |
| 76150 | X | | X-ray exam, dry process | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 76350 | N | | Special x-ray contrast study | | | | | |
| 76355 | S | | CAT scan for localization | 0283 | 4.5057 | $234.98 | $126.27 | $47.00 |
| 76360 | S | | CAT scan for needle biopsy | 0283 | 4.5057 | $234.98 | $126.27 | $47.00 |
| 76362 | N | | Cat scan for tissue ablation | | | | | |
| 76370 | S | | CAT scan for therapy guide | 0282 | 1.6763 | $87.42 | $44.51 | $17.48 |
| 76375 | S | | 3d/holograph reconstr add-on | 0282 | 1.6763 | $87.42 | $44.51 | $17.48 |
| 76380 | S | | CAT scan follow-up study | 0282 | 1.6763 | $87.42 | $44.51 | $17.48 |
| 76390 | E | | Mr spectroscopy | | | | | |
| 76393 | N | | Mr guidance for needle place | | | | | |
| 76394 | N | | Mri for tissue ablation | | | | | |
| 76400 | S | | Magnetic image, bone marrow | 0335 | 6.2983 | $328.46 | $151.46 | $65.69 |
| 76490 | N | | Us for tissue ablation | | | | | |
| 76496 | X | NI | Fluoroscopic procedure | 0272 | 1.3372 | $69.74 | $38.36 | $13.95 |
| 76497 | S | NI | Ct procedure | 0282 | 1.6763 | $87.42 | $44.51 | $17.48 |
| 76498 | S | NI | Mri procedure | 0335 | 6.2983 | $328.46 | $151.46 | $65.69 |
| 76499 | X | | Radiographic procedure | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 76506 | S | | Echo exam of head | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76511 | S | | Echo exam of eye | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76512 | S | | Echo exam of eye | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76513 | S | | Echo exam of eye, water bath | 0265 | 0.9787 | $51.04 | $28.07 | $10.21 |
| 76516 | S | | Echo exam of eye | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76519 | S | | Echo exam of eye | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76529 | S | | Echo exam of eye | 0265 | 0.9787 | $51.04 | $28.07 | $10.21 |
| 76536 | S | | Us exam of head and neck | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76604 | S | | Us exam, chest, b-scan | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76645 | S | | Us exam, breast(s) | 0265 | 0.9787 | $51.04 | $28.07 | $10.21 |
| 76700 | S | | Us exam, abdom, complete | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76705 | S | | Echo exam of abdomen | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76770 | S | | Us exam abdo back wall, comp | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76775 | S | | Us eam abdo back wall, lim | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76778 | S | | Us exam kidney transplant | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76800 | S | | Us exam, spinal canal | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76801 | S | NI | Ob us < 14 wks, single fetus | 0265 | 0.9787 | $51.04 | $28.07 | $10.21 |
| 76802 | S | NI | Ob us < 14 wks, addl fetus | 0265 | 0.9787 | $51.04 | $28.07 | $10.21 |
| 76805 | S | | Us exam, pg uterus, compl | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76810 | S | | Us exam, pg uterus, mult | 0265 | 0.9787 | $51.04 | $28.07 | $10.21 |
| 76811 | S | NI | Ob us, detailed, sngl fetus | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 76812 | S | NI | Ob us, detailed, addl fetus | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76815 | S | | Us exam, pg uterus limit | 0265 | 0.9787 | $51.04 | $28.07 | $10.21 |
| 76816 | S | | Us exam pg uterus repeat | 0265 | 0.9787 | $51.04 | $28.07 | $10.21 |
| 76817 | S | NI | Transvaginal us, obstetric | 0265 | 0.9787 | $51.04 | $28.07 | $10.21 |
| 76818 | S | | Fetal biophys profile w/nst | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76819 | S | | Fetal biophys profil w/o nst | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76825 | S | | Echo exam of fetal heart | 0671 | 2.3643 | $123.30 | $64.12 | $24.66 |
| 76826 | S | | Echo exam of fetal heart | 0697 | 1.5697 | $81.86 | $42.57 | $16.37 |
| 76827 | S | | Echo exam of fetal heart | 0671 | 2.3643 | $123.30 | $64.12 | $24.66 |
| 76828 | S | | Echo exam of fetal heart | 0697 | 1.5697 | $81.86 | $42.57 | $16.37 |
| 76830 | S | | Transvaginal us, non-ob | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76831 | S | | Echo exam, uterus | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76856 | S | | Us exam, pelvic, complete | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76857 | S | | Us exam, pelvic, limited | 0265 | 0.9787 | $51.04 | $28.07 | $10.21 |
| 76870 | S | | Us exam, scrotum | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76872 | S | | Echo exam, transrectal | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76873 | S | | Echograp trans r, pros study | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76880 | S | | Us exam, extremity | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76885 | S | | Us exam infant hips, dynamic | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76886 | S | | Us exam infant hips, static | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76930 | S | | Echo guide, cardiocentesis | 0268 | 1.3856 | $72.26 | | $14.45 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 76932 | S | | Echo guide for heart biopsy | 0268 | 1.3856 | $72.26 | | $14.45 |
| 76936 | S | | Echo guide for artery repair | 0268 | 1.3856 | $72.26 | | $14.45 |
| 76941 | S | | Echo guide for transfusion | 0268 | 1.3856 | $72.26 | | $14.45 |
| 76942 | S | | Echo guide for biopsy | 0268 | 1.3856 | $72.26 | | $14.45 |
| 76945 | S | | Echo guide, villus sampling | 0268 | 1.3856 | $72.26 | | $14.45 |
| 76946 | S | | Echo guide for amniocentesis | 0268 | 1.3856 | $72.26 | | $14.45 |
| 76948 | S | | Echo guide, ova aspiration | 0268 | 1.3856 | $72.26 | | $14.45 |
| 76950 | S | | Echo guidance radiotherapy | 0268 | 1.3856 | $72.26 | | $14.45 |
| 76965 | S | | Echo guidance radiotherapy | 0268 | 1.3856 | $72.26 | | $14.45 |
| 76970 | S | | Ultrasound exam follow-up | 0265 | 0.9787 | $51.04 | $28.07 | $10.21 |
| 76975 | S | | GI endoscopic ultrasound | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76977 | S | | Us bone density measure | 0265 | 0.9787 | $51.04 | $28.07 | $10.21 |
| 76986 | S | | Ultrasound guide intraoper | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 76999 | S | | Echo examination procedure | 0265 | 0.9787 | $51.04 | $28.07 | $10.21 |
| 77261 | E | | Radiation therapy planning | | | | | |
| 77262 | E | | Radiation therapy planning | | | | | |
| 77263 | E | | Radiation therapy planning | | | | | |
| 77280 | X | | Set radiation therapy field | 0304 | 1.6182 | $84.39 | $41.52 | $16.88 |
| 77285 | X | | Set radiation therapy field | 0305 | 3.6530 | $190.51 | $91.38 | $38.10 |
| 77290 | X | | Set radiation therapy field | 0305 | 3.6530 | $190.51 | $91.38 | $38.10 |
| 77295 | X | | Set radiation therapy field | 0310 | 13.6625 | $712.51 | $325.27 | $142.50 |
| 77299 | E | | Radiation therapy planning | | | | | |
| 77300 | X | | Radiation therapy dose plan | 0304 | 1.6182 | $84.39 | $41.52 | $16.88 |
| 77301 | S | | Radiotherapy dose plan, imrt | 0712 | | $875.00 | | $175.00 |
| 77305 | X | | Teletx isodose plan simple | 0304 | 1.6182 | $84.39 | $41.52 | $16.88 |
| 77310 | X | | Teletx isodose plan intermed | 0304 | 1.6182 | $84.39 | $41.52 | $16.88 |
| 77315 | X | | Teletx isodose plan complex | 0305 | 3.6530 | $190.51 | $91.38 | $38.10 |
| 77321 | X | | Special teletx port plan | 0305 | 3.6530 | $190.51 | $91.38 | $38.10 |
| 77326 | X | | Radiation therapy dose plan | 0305 | 3.6530 | $190.51 | $91.38 | $38.10 |
| 77327 | X | | Brachytx isodose calc interm | 0305 | 3.6530 | $190.51 | $91.38 | $38.10 |
| 77328 | X | | Brachytx isodose plan compl | 0305 | 3.6530 | $190.51 | $91.38 | $38.10 |
| 77331 | X | | Special radiation dosimetry | 0304 | 1.6182 | $84.39 | $41.52 | $16.88 |
| 77332 | X | | Radiation treatment aid(s) | 0303 | 2.8391 | $148.06 | $66.95 | $29.61 |
| 77333 | X | | Radiation treatment aid(s) | 0303 | 2.8391 | $148.06 | $66.95 | $29.61 |
| 77334 | X | | Radiation treatment aid(s) | 0303 | 2.8391 | $148.06 | $66.95 | $29.61 |
| 77336 | X | | Radiation physics consult | 0304 | 1.6182 | $84.39 | $41.52 | $16.88 |
| 77370 | X | | Radiation physics consult | 0305 | 3.6530 | $190.51 | $91.38 | $38.10 |
| 77399 | X | | External radiation dosimetry | 0304 | 1.6182 | $84.39 | $41.52 | $16.88 |
| 77401 | S | | Radiation treatment delivery | 0300 | 1.5794 | $82.37 | | $16.47 |
| 77402 | S | | Radiation treatment delivery | 0300 | 1.5794 | $82.37 | | $16.47 |
| 77403 | S | | Radiation treatment delivery | 0300 | 1.5794 | $82.37 | | $16.47 |
| 77404 | S | | Radiation treatment delivery | 0300 | 1.5794 | $82.37 | | $16.47 |
| 77406 | S | | Radiation treatment delivery | 0300 | 1.5794 | $82.37 | | $16.47 |
| 77407 | S | | Radiation treatment delivery | 0300 | 1.5794 | $82.37 | | $16.47 |
| 77408 | S | | Radiation treatment delivery | 0300 | 1.5794 | $82.37 | | $16.47 |
| 77409 | S | | Radiation treatment delivery | 0300 | 1.5794 | $82.37 | | $16.47 |
| 77411 | S | | Radiation treatment delivery | 0300 | 1.5794 | $82.37 | | $16.47 |
| 77412 | S | | Radiation treatment delivery | 0301 | 3.1588 | $164.73 | | $32.95 |
| 77413 | S | | Radiation treatment delivery | 0301 | 3.1588 | $164.73 | | $32.95 |
| 77414 | S | | Radiation treatment delivery | 0301 | 3.1588 | $164.73 | | $32.95 |
| 77416 | S | | Radiation treatment delivery | 0301 | 3.1588 | $164.73 | | $32.95 |
| 77417 | X | | Radiology port film(s) | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| 77418 | S | | Radiation tx delivery, imrt | 0710 | | $400.00 | | $80.00 |
| 77427 | E | | Radiation tx management, x5 | | | | | |
| 77431 | E | | Radiation therapy management | | | | | |
| 77432 | E | | Stereotactic radiation trmt | | | | | |
| 77470 | S | | Special radiation treatment | 0299 | 5.9785 | $311.78 | | $62.36 |
| 77499 | E | | Radiation therapy management | | | | | |
| 77520 | S | | Proton trmt, simple w/o comp | 0664 | 10.0482 | $524.02 | | $104.80 |
| 77522 | S | | Proton trmt, simple w/comp | 0664 | 10.0482 | $524.02 | | $104.80 |
| 77523 | S | | Proton trmt, intermediate | 0650 | 12.0152 | $626.60 | | $125.32 |
| 77525 | S | | Proton treatment, complex | 0650 | 12.0152 | $626.60 | | $125.32 |
| 77600 | S | | Hyperthermia treatment | 0314 | 4.1763 | $217.80 | $101.77 | $43.56 |
| 77605 | S | | Hyperthermia treatment | 0314 | 4.1763 | $217.80 | $101.77 | $43.56 |
| 77610 | S | | Hyperthermia treatment | 0314 | 4.1763 | $217.80 | $101.77 | $43.56 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 77615 | S | | Hyperthermia treatment | 0314 | 4.1763 | $217.80 | $101.77 | $43.56 |
| 77620 | S | | Hyperthermia treatment | 0314 | 4.1763 | $217.80 | $101.77 | $43.56 |
| 77750 | S | | Infuse radioactive materials | 0300 | 1.5794 | $82.37 | | $16.47 |
| 77761 | S | | Apply intrcav radiat simple | 0312 | 52.8864 | $2,758.08 | | $551.62 |
| 77762 | S | | Apply intrcav radiat interm | 0312 | 52.8864 | $2,758.08 | | $551.62 |
| 77763 | S | | Apply intrcav radiat compl | 0312 | 52.8864 | $2,758.08 | | $551.62 |
| 77776 | S | | Apply interstit radiat simpl | 0312 | 52.8864 | $2,758.08 | | $551.62 |
| 77777 | S | | Apply interstit radiat inter | 0312 | 52.8864 | $2,758.08 | | $551.62 |
| 77778 | S | | Apply interstit radiat compl | 0651 | 54.7177 | $2,853.58 | | $570.72 |
| 77781 | S | | High intensity brachytherapy | 0313 | 21.0363 | $1,097.06 | | $219.41 |
| 77782 | S | | High intensity brachytherapy | 0313 | 21.0363 | $1,097.06 | | $219.41 |
| 77783 | S | | High intensity brachytherapy | 0313 | 21.0363 | $1,097.06 | | $219.41 |
| 77784 | S | | High intensity brachytherapy | 0313 | 21.0363 | $1,097.06 | | $219.41 |
| 77789 | S | | Apply surface radiation | 0300 | 1.5794 | $82.37 | | $16.47 |
| 77790 | N | | Radiation handling | | | | | |
| 77799 | S | | Radium/radioisotope therapy | 0313 | 21.0363 | $1,097.06 | | $219.41 |
| 78000 | S | | Thyroid, single uptake | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78001 | S | | Thyroid, multiple uptakes | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78003 | S | | Thyroid suppress/stimul | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78006 | S | | Thyroid imaging with uptake | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78007 | S | | Thyroid image, mult uptakes | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78010 | S | | Thyroid imaging | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78011 | S | | Thyroid imaging with flow | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78015 | S | | Thyroid met imaging | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78016 | S | | Thyroid met imaging/studies | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78018 | S | | Thyroid met imaging, body | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78020 | S | | Thyroid met uptake | 0666 | 2.9650 | $154.63 | $85.05 | $30.93 |
| 78070 | S | | Parathyroid nuclear imaging | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78075 | S | | Adrenal nuclear imaging | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78099 | S | | Endocrine nuclear procedure | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78102 | S | | Bone marrow imaging, ltd | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78103 | S | | Bone marrow imaging, mult | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78104 | S | | Bone marrow imaging, body | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78110 | S | | Plasma volume, single | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78111 | S | | Plasma volume, multiple | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78120 | S | | Red cell mass, single | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78121 | S | | Red cell mass, multiple | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78122 | S | | Blood volume | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78130 | S | | Red cell survival study | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78135 | S | | Red cell survival kinetics | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78140 | S | | Red cell sequestration | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78160 | S | | Plasma iron turnover | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78162 | S | | Radioiron absorption exam | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78170 | S | | Red cell iron utilization | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78172 | S | | Total body iron estimation | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78185 | S | | Spleen imaging | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78190 | S | | Platelet survival, kinetics | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78191 | S | | Platelet survival | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78195 | S | | Lymph system imaging | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78199 | S | | Blood/lymph nuclear exam | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78201 | S | | Liver imaging | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78202 | S | | Liver imaging with flow | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78205 | S | | Liver imaging (3D) | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78206 | S | | Liver image (3d) with flow | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78215 | S | | Liver and spleen imaging | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78216 | S | | Liver & spleen image/flow | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78220 | S | | Liver function study | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78223 | S | | Hepatobiliary imaging | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78230 | S | | Salivary gland imaging | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78231 | S | | Serial salivary imaging | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78232 | S | | Salivary gland function exam | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78258 | S | | Esophageal motility study | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78261 | S | | Gastric mucosa imaging | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78262 | S | | Gastroesophageal reflux exam | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78264 | S | | Gastric emptying study | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 78267 | A | | Breath tst attain/anal c-14 | | | | | |
| 78268 | A | | Breath test analysis, c-14 | | | | | |
| 78270 | S | | Vit B-12 absorption exam | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78271 | S | | Vit b-12 absrp exam, int fac | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78272 | S | | Vit B-12 absorp, combined | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78278 | S | | Acute GI blood loss imaging | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78282 | S | | GI protein loss exam | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78290 | S | | Meckel's divert exam | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78291 | S | | Leveen/shunt patency exam | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78299 | S | | GI nuclear procedure | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78300 | S | | Bone imaging, limited area | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78305 | S | | Bone imaging, multiple areas | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78306 | S | | Bone imaging, whole body | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78315 | S | | Bone imaging, 3 phase | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78320 | S | | Bone imaging (3D) | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78350 | X | | Bone mineral, single photon | 0261 | 1.2887 | $67.21 | | $13.44 |
| 78351 | E | | Bone mineral, dual photon | | | | | |
| 78399 | S | | Musculoskeletal nuclear exam | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78414 | S | | Non-imaging heart function | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78428 | S | | Cardiac shunt imaging | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78445 | S | | Vascular flow imaging | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78455 | S | | Venous thrombosis study | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78456 | S | | Acute venous thrombus image | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78457 | S | | Venous thrombosis imaging | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78458 | S | | Ven thrombosis images, bilat | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78459 | E | | Heart muscle imaging (PET) | | | | | |
| 78460 | S | | Heart muscle blood, single | 0286 | 6.5309 | $340.59 | $187.32 | $68.12 |
| 78461 | S | | Heart muscle blood, multiple | 0286 | 6.5309 | $340.59 | $187.32 | $68.12 |
| 78464 | S | | Heart image (3d), single | 0286 | 6.5309 | $340.59 | $187.32 | $68.12 |
| 78465 | S | | Heart image (3d), multiple | 0286 | 6.5309 | $340.59 | $187.32 | $68.12 |
| 78466 | S | | Heart infarct image | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78468 | S | | Heart infarct image (ef) | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78469 | S | | Heart infarct image (3D) | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78472 | S | | Gated heart, planar, single | 0286 | 6.5309 | $340.59 | $187.32 | $68.12 |
| 78473 | S | | Gated heart, multiple | 0286 | 6.5309 | $340.59 | $187.32 | $68.12 |
| 78478 | S | | Heart wall motion add-on | 0666 | 2.9650 | $154.63 | $85.05 | $30.93 |
| 78480 | S | | Heart function add-on | 0666 | 2.9650 | $154.63 | $85.05 | $30.93 |
| 78481 | S | | Heart first pass, single | 0286 | 6.5309 | $340.59 | $187.32 | $68.12 |
| 78483 | S | | Heart first pass, multiple | 0286 | 6.5309 | $340.59 | $187.32 | $68.12 |
| 78491 | E | | Heart image (pet), single | | | | | |
| 78492 | E | | Heart image (pet), multiple | | | | | |
| 78494 | S | | Heart image, spect | 0286 | 6.5309 | $340.59 | $187.32 | $68.12 |
| 78496 | S | | Heart first pass add-on | 0666 | 2.9650 | $154.63 | $85.05 | $30.93 |
| 78499 | S | | Cardiovascular nuclear exam | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78580 | S | | Lung perfusion imaging | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78584 | S | | Lung V/Q image single breath | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78585 | S | | Lung V/Q imaging | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78586 | S | | Aerosol lung image, single | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78587 | S | | Aerosol lung image, multiple | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78588 | S | | Perfusion lung image | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78591 | S | | Vent image, 1 breath, 1 proj | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78593 | S | | Vent image, 1 proj, gas | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78594 | S | | Vent image, mult proj, gas | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78596 | S | | Lung differential function | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78599 | S | | Respiratory nuclear exam | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78600 | S | | Brain imaging, ltd static | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78601 | S | | Brain imaging, ltd w/ flow | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78605 | S | | Brain imaging, complete | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78606 | S | | Brain imaging, compl w/flow | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78607 | S | | Brain imaging (3D) | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78608 | E | | Brain imaging (PET) | | | | | |
| 78609 | E | | Brain imaging (PET) | | | | | |
| 78610 | S | | Brain flow imaging only | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78615 | S | | Cerebral vascular flow image | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78630 | S | | Cerebrospinal fluid scan | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 78635 | S | | CSF ventriculography | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78645 | S | | CSF shunt evaluation | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78647 | S | | Cerebrospinal fluid scan | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78650 | S | | CSF leakage imaging | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78660 | S | | Nuclear exam of tear flow | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78699 | S | | Nervous system nuclear exam | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78700 | S | | Kidney imaging, static | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78701 | S | | Kidney imaging with flow | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78704 | S | | Imaging renogram | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78707 | S | | Kidney flow/function image | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78708 | S | | Kidney flow/function image | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78709 | S | | Kidney flow/function image | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78710 | S | | Kidney imaging (3D) | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78715 | S | | Renal vascular flow exam | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78725 | S | | Kidney function study | 0290 | 2.0251 | $105.61 | $53.17 | $21.12 |
| 78730 | S | | Urinary bladder retention | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78740 | S | | Ureteral reflux study | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78760 | S | | Testicular imaging | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78761 | S | | Testicular imaging/flow | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78799 | S | | Genitourinary nuclear exam | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 78800 | S | | Tumor imaging, limited area | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78801 | S | | Tumor imaging, mult areas | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78802 | S | | Tumor imaging, whole body | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78803 | S | | Tumor imaging (3D) | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78805 | S | | Abscess imaging, ltd area | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78806 | S | | Abscess imaging, whole body | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78807 | S | | Nuclear localization/abscess | 0292 | 4.2925 | $223.86 | $112.69 | $44.77 |
| 78810 | E | | Tumor imaging (PET) | | | | | |
| 78890 | N | | Nuclear medicine data proc | | | | | |
| 78891 | N | | Nuclear med data proc | | | | | |
| 78990 | N | | Provide diag radionuclide(s) | | | | | |
| 78999 | S | | Nuclear diagnostic exam | 0291 | 3.9825 | $207.69 | $104.55 | $41.54 |
| 79000 | S | | Init hyperthyroid therapy | 0294 | 4.0794 | $212.74 | $117.01 | $42.55 |
| 79001 | S | | Repeat hyperthyroid therapy | 0294 | 4.0794 | $212.74 | $117.01 | $42.55 |
| 79020 | S | | Thyroid ablation | 0294 | 4.0794 | $212.74 | $117.01 | $42.55 |
| 79030 | S | | Thyroid ablation, carcinoma | 0294 | 4.0794 | $212.74 | $117.01 | $42.55 |
| 79035 | S | | Thyroid metastatic therapy | 0294 | 4.0794 | $212.74 | $117.01 | $42.55 |
| 79100 | S | | Hematopoetic nuclear therapy | 0294 | 4.0794 | $212.74 | $117.01 | $42.55 |
| 79200 | S | | Intracavitary nuclear trmt | 0294 | 4.0794 | $212.74 | $117.01 | $42.55 |
| 79300 | S | | Interstitial nuclear therapy | 0294 | 4.0794 | $212.74 | $117.01 | $42.55 |
| 79400 | S | | Nonhemato nuclear therapy | 0294 | 4.0794 | $212.74 | $117.01 | $42.55 |
| 79420 | S | | Intravascular nuclear ther | 0294 | 4.0794 | $212.74 | $117.01 | $42.55 |
| 79440 | S | | Nuclear joint therapy | 0294 | 4.0794 | $212.74 | $117.01 | $42.55 |
| 79900 | N | | Provide ther radiopharm(s) | | | | | |
| 79999 | S | | Nuclear medicine therapy | 0294 | 4.0794 | $212.74 | $117.01 | $42.55 |
| 80048 | A | | Basic metabolic panel | | | | | |
| 80050 | A | | General health panel | | | | | |
| 80051 | A | | Electrolyte panel | | | | | |
| 80053 | A | | Comprehen metabolic panel | | | | | |
| 80055 | A | | Obstetric panel | | | | | |
| 80061 | A | | Lipid panel | | | | | |
| 80069 | A | | Renal function panel | | | | | |
| 80074 | A | | Acute hepatitis panel | | | | | |
| 80076 | A | | Hepatic function panel | | | | | |
| 80090 | A | DG | Torch antibody 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | | | | | |
| 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 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 80502 | X | | Lab pathology consultation | 0342 | 0.2132 | $11.12 | $5.88 | $2.22 |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | | | | | |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | | | | | |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | | | | | |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | | | | | |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | NI | Natriuretic peptide | | | | | |
| 83883 | A | | Assay, nephelometry not spec | | | | | |
| 83885 | A | | Assay of nickel | | | | | |
| 83887 | A | | Assay of nicotine | | | | | |
| 83890 | A | | Molecule isolate | | | | | |
| 83891 | A | | Molecule isolate nucleic | | | | | |
| 83892 | A | | Molecular diagnostics | | | | | |
| 83893 | A | | Molecule dot/slot/blot | | | | | |
| 83894 | A | | Molecule gel electrophor | | | | | |
| 83896 | A | | Molecular diagnostics | | | | | |
| 83897 | A | | Molecule nucleic transfer | | | | | |
| 83898 | A | | Molecule nucleic ampli | | | | | |
| 83901 | A | | Molecule nucleic ampli | | | | | |
| 83902 | A | | Molecular diagnostics | | | | | |
| 83903 | A | | Molecule mutation scan | | | | | |
| 83904 | A | | Molecule mutation identify | | | | | |
| 83905 | A | | Molecule mutation identify | | | | | |
| 83906 | A | | Molecule mutation identify | | | | | |
| 83912 | A | | Genetic examination | | | | | |
| 83915 | A | | Assay of nucleotidase | | | | | |
| 83916 | A | | Oligoclonal bands | | | | | |
| 83918 | A | | Organic acids, total, quant | | | | | |
| 83919 | A | | Organic acids, qual, each | | | | | |
| 83921 | A | | Organic acid, single, quant | | | | | |
| 83925 | A | | Assay of opiates | | | | | |
| 83930 | A | | Assay of blood osmolality | | | | | |
| 83935 | A | | Assay of urine osmolality | | | | | |
| 83937 | A | | Assay of osteocalcin | | | | | |
| 83945 | A | | Assay of oxalate | | | | | |
| 83950 | A | | Oncoprotein, her-2/neu | | | | | |
| 83970 | A | | Assay of parathormone | | | | | |
| 83986 | A | | Assay of body fluid acidity | | | | | |
| 83992 | A | | Assay for phencyclidine | | | | | |
| 84022 | A | | Assay of phenothiazine | | | | | |
| 84030 | A | | Assay of blood pku | | | | | |
| 84035 | A | | Assay of phenylketones | | | | | |
| 84060 | A | | Assay acid phosphatase | | | | | |
| 84061 | A | | Phosphatase, forensic exam | | | | | |
| 84066 | A | | Assay prostate phosphatase | | | | | |
| 84075 | A | | Assay alkaline phosphatase | | | | | |
| 84078 | A | | Assay alkaline phosphatase | | | | | |
| 84080 | A | | Assay alkaline phosphatases | | | | | |
| 84081 | A | | Amniotic fluid enzyme test | | | | | |
| 84085 | A | | Assay of rbc pg6d enzyme | | | | | |
| 84087 | A | | Assay phosphohexose enzymes | | | | | |
| 84100 | A | | Assay of phosphorus | | | | | |
| 84105 | A | | Assay of urine phosphorus | | | | | |
| 84106 | A | | Test for porphobilinogen | | | | | |
| 84110 | A | | Assay of porphobilinogen | | | | | |
| 84119 | A | | Test urine for porphyrins | | | | | |
| 84120 | A | | Assay of urine porphyrins | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | | | | | |
| 84160 | A | | Assay of serum protein | | | | | |
| 84165 | A | | Assay of serum proteins | | | | | |
| 84181 | A | | Western blot test | | | | | |
| 84182 | A | | Protein, western blot test | | | | | |
| 84202 | A | | Assay RBC protoporphyrin | | | | | |
| 84203 | A | | Test RBC protoporphyrin | | | | | |
| 84206 | A | | Assay of proinsulin | | | | | |
| 84207 | A | | Assay of vitamin b-6 | | | | | |
| 84210 | A | | Assay of pyruvate | | | | | |
| 84220 | A | | Assay of pyruvate kinase | | | | | |
| 84228 | A | | Assay of quinine | | | | | |
| 84233 | A | | Assay of estrogen | | | | | |
| 84234 | A | | Assay of progesterone | | | | | |
| 84235 | A | | Assay of endocrine hormone | | | | | |
| 84238 | A | | Assay, nonendocrine receptor | | | | | |
| 84244 | A | | Assay of renin | | | | | |
| 84252 | A | | Assay of vitamin b-2 | | | | | |
| 84255 | A | | Assay of selenium | | | | | |
| 84260 | A | | Assay of serotonin | | | | | |
| 84270 | A | | Assay of sex hormone globul | | | | | |
| 84275 | A | | Assay of sialic acid | | | | | |
| 84285 | A | | Assay of silica | | | | | |
| 84295 | A | | Assay of serum sodium | | | | | |
| 84300 | A | | Assay of urine sodium | | | | | |
| 84302 | A | NI | 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) | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 84460 | A | | Alanine amino (ALT) (SGPT) | | | | | |
| 84466 | A | | Assay of transferrin | | | | | |
| 84478 | A | | Assay of triglycerides | | | | | |
| 84479 | A | | Assay of thyroid (t3 or t4) | | | | | |
| 84480 | A | | Assay, triiodothyronine (t3) | | | | | |
| 84481 | A | | Free assay (FT-3) | | | | | |
| 84482 | A | | T3 reverse | | | | | |
| 84484 | A | | Assay of troponin, quant | | | | | |
| 84485 | A | | Assay duodenal fluid trypsin | | | | | |
| 84488 | A | | Test feces for trypsin | | | | | |
| 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 | NI | 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 | | | | | |
| 85021 | A | DG | Automated hemogram | | | | | |
| 85022 | A | DG | Automated hemogram | | | | | |
| 85023 | A | DG | Automated hemogram | | | | | |
| 85024 | A | DG | Automated hemogram | | | | | |
| 85025 | A | | Automated hemogram | | | | | |
| 85027 | A | | Automated hemogram | | | | | |
| 85031 | A | DG | Manual hemogram, cbc | | | | | |
| 85032 | A | NI | 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 | NI | Automated platelet count | | | | | |
| 85060 | X | | Blood smear interpretation | 0342 | 0.2132 | $11.12 | $5.88 | $2.22 |
| 85097 | X | | Bone marrow interpretation | 0343 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 85130 | A | | Chromogenic substrate assay | | | | | |
| 85170 | A | | Blood clot retraction | | | | | |
| 85175 | A | | Blood clot lysis time | | | | | |
| 85210 | A | | Blood clot factor II test | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 85220 | A | | Blood clot factor V test | | | | | |
| 85230 | A | | Blood clot factor VII test | | | | | |
| 85240 | A | | Blood clot factor VIII test | | | | | |
| 85244 | A | | Blood clot factor VIII test | | | | | |
| 85245 | A | | Blood clot factor VIII test | | | | | |
| 85246 | A | | Blood clot factor VIII test | | | | | |
| 85247 | A | | Blood clot factor VIII test | | | | | |
| 85250 | A | | Blood clot factor IX test | | | | | |
| 85260 | A | | Blood clot factor X test | | | | | |
| 85270 | A | | Blood clot factor XI test | | | | | |
| 85280 | A | | Blood clot factor XII test | | | | | |
| 85290 | A | | Blood clot factor XIII test | | | | | |
| 85291 | A | | Blood clot factor XIII test | | | | | |
| 85292 | A | | Blood clot factor assay | | | | | |
| 85293 | A | | Blood clot factor assay | | | | | |
| 85300 | A | | Antithrombin III test | | | | | |
| 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 | NI | Fibrin degradation, vte | | | | | |
| 85384 | A | | Fibrinogen | | | | | |
| 85385 | A | | Fibrinogen | | | | | |
| 85390 | A | | Fibrinolysins screen | | | | | |
| 85400 | A | | Fibrinolytic plasmin | | | | | |
| 85410 | A | | Fibrinolytic antiplasmin | | | | | |
| 85415 | A | | Fibrinolytic plasminogen | | | | | |
| 85420 | A | | Fibrinolytic plasminogen | | | | | |
| 85421 | A | | Fibrinolytic plasminogen | | | | | |
| 85441 | A | | Heinz bodies, direct | | | | | |
| 85445 | A | | Heinz bodies, induced | | | | | |
| 85460 | A | | Hemoglobin, fetal | | | | | |
| 85461 | A | | Hemoglobin, fetal | | | | | |
| 85475 | A | | Hemolysin | | | | | |
| 85520 | A | | Heparin assay | | | | | |
| 85525 | A | | Heparin neutralization | | | | | |
| 85530 | A | | Heparin-protamine tolerance | | | | | |
| 85536 | A | | Iron stain peripheral blood | | | | | |
| 85540 | A | | Wbc alkaline phosphatase | | | | | |
| 85547 | A | | RBC mechanical fragility | | | | | |
| 85549 | A | | Muramidase | | | | | |
| 85555 | A | | RBC osmotic fragility | | | | | |
| 85557 | A | | RBC osmotic fragility | | | | | |
| 85576 | A | | Blood platelet aggregation | | | | | |
| 85585 | A | DG | Blood platelet estimation | | | | | |
| 85590 | A | DG | Platelet count, manual | | | | | |
| 85595 | A | DG | Platelet count, automated | | | | | |
| 85597 | A | | Platelet neutralization | | | | | |
| 85610 | A | | Prothrombin time | | | | | |
| 85611 | A | | Prothrombin test | | | | | |
| 85612 | A | | Viper venom prothrombin time | | | | | |
| 85613 | A | | Russell viper venom, diluted | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | X | | Physician blood bank service | 0343 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 86078 | X | | Physician blood bank service | 0344 | 0.6201 | $32.34 | $17.46 | $6.47 |
| 86079 | X | | Physician blood bank service | 0344 | 0.6201 | $32.34 | $17.46 | $6.47 |
| 86140 | A | | C-reactive protein | | | | | |
| 86141 | A | | C-reactive protein, hs | | | | | |
| 86146 | A | | Glycoprotein antibody | | | | | |
| 86147 | A | | Cardiolipin antibody | | | | | |
| 86148 | A | | Phospholipid antibody | | | | | |
| 86155 | A | | Chemotaxis assay | | | | | |
| 86156 | A | | Cold agglutinin, screen | | | | | |
| 86157 | A | | Cold agglutinin, titer | | | | | |
| 86160 | A | | Complement, antigen | | | | | |
| 86161 | A | | Complement/function activity | | | | | |
| 86162 | A | | Complement, total (CH50) | | | | | |
| 86171 | A | | Complement fixation, each | | | | | |
| 86185 | A | | Counterimmunoelectrophoresis | | | | | |
| 86215 | A | | Deoxyribonuclease, antibody | | | | | |
| 86225 | A | | DNA antibody | | | | | |
| 86226 | A | | DNA antibody, single strand | | | | | |
| 86235 | A | | Nuclear antigen antibody | | | | | |
| 86243 | A | | Fc receptor | | | | | |
| 86255 | A | | Fluorescent antibody, screen | | | | | |
| 86256 | A | | Fluorescent antibody, titer | | | | | |
| 86277 | A | | Growth hormone antibody | | | | | |
| 86280 | A | | Hemagglutination inhibition | | | | | |
| 86294 | A | | Immunoassay, tumor qual | | | | | |
| 86300 | A | | Immunoassay, tumor ca 15-3 | | | | | |
| 86301 | A | | Immunoassay, tumor ca 19-9 | | | | | |
| 86304 | A | | Immunoassay, tumor, ca 125 | | | | | |
| 86308 | A | | Heterophile antibodies | | | | | |
| 86309 | A | | Heterophile antibodies | | | | | |
| 86310 | A | | Heterophile antibodies | | | | | |
| 86316 | A | | Immunoassay, tumor other | | | | | |
| 86317 | A | | Immunoassay,infectious agent | | | | | |
| 86318 | A | | Immunoassay,infectious agent | | | | | |
| 86320 | A | | Serum immunoelectrophoresis | | | | | |
| 86325 | A | | Other immunoelectrophoresis | | | | | |
| 86327 | A | | Immunoelectrophoresis assay | | | | | |
| 86329 | A | | Immunodiffusion | | | | | |
| 86331 | A | | Immunodiffusion ouchterlony | | | | | |
| 86332 | A | | Immune complex assay | | | | | |
| 86334 | A | | Immunofixation procedure | | | | | |
| 86336 | A | | Inhibin A | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | 0.1453 | $7.58 | $3.08 | $1.52 |
| 86490 | X | | Coccidioidomycosis skin test | 0341 | 0.1453 | $7.58 | $3.08 | $1.52 |
| 86510 | X | | Histoplasmosis skin test | 0341 | 0.1453 | $7.58 | $3.08 | $1.52 |
| 86580 | X | | TB intradermal test | 0341 | 0.1453 | $7.58 | $3.08 | $1.52 |
| 86585 | X | | TB tine test | 0341 | 0.1453 | $7.58 | $3.08 | $1.52 |
| 86586 | X | | Skin test, unlisted | 0341 | 0.1453 | $7.58 | $3.08 | $1.52 |
| 86590 | A | | Streptokinase, antibody | | | | | |
| 86592 | A | | Blood serology, qualitative | | | | | |
| 86593 | A | | Blood serology, quantitative | | | | | |
| 86602 | A | | Antinomyces antibody | | | | | |
| 86603 | A | | Adenovirus antibody | | | | | |
| 86606 | A | | Aspergillus antibody | | | | | |
| 86609 | A | | Bacterium antibody | | | | | |
| 86611 | A | | Bartonella antibody | | | | | |
| 86612 | A | | Blastomyces antibody | | | | | |
| 86615 | A | | Bordetella antibody | | | | | |
| 86617 | A | | Lyme disease antibody | | | | | |
| 86618 | A | | Lyme disease antibody | | | | | |
| 86619 | A | | Borrelia antibody | | | | | |
| 86622 | A | | Brucella antibody | | | | | |
| 86625 | A | | Campylobacter antibody | | | | | |
| 86628 | A | | Candida antibody | | | | | |
| 86631 | A | | Chlamydia antibody | | | | | |
| 86632 | A | | Chlamydia igm antibody | | | | | |
| 86635 | A | | Coccidioides antibody | | | | | |
| 86638 | A | | Q fever antibody | | | | | |
| 86641 | A | | Cryptococcus antibody | | | | | |
| 86644 | A | | CMV antibody | | | | | |
| 86645 | A | | CMV antibody, IgM | | | | | |
| 86648 | A | | Diphtheria antibody | | | | | |
| 86651 | A | | Encephalitis antibody | | | | | |
| 86652 | A | | Encephalitis antibody | | | | | |
| 86653 | A | | Encephalitis antibody | | | | | |
| 86654 | A | | Encephalitis antibody | | | | | |
| 86658 | A | | Enterovirus antibody | | | | | |
| 86663 | A | | Epstein-barr antibody | | | | | |
| 86664 | A | | Epstein-barr antibody | | | | | |
| 86665 | A | | Epstein-barr antibody | | | | | |
| 86666 | A | | Ehrlichia antibody | | | | | |
| 86668 | A | | Francisella tularensis | | | | | |
| 86671 | A | | Fungus antibody | | | | | |
| 86674 | A | | Giardia lamblia antibody | | | | | |
| 86677 | A | | Helicobacter pylori | | | | | |
| 86682 | A | | Helminth antibody | | | | | |
| 86684 | A | | Hemophilus influenza | | | | | |
| 86687 | A | | Htlv-i antibody | | | | | |
| 86688 | A | | Htlv-ii antibody | | | | | |
| 86689 | A | | HTLV/HIV confirmatory test | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | | | | | |
| 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 | 0.1938 | $10.11 | $3.10 | $2.02 |
| 86860 | X | | RBC antibody elution | 0346 | 0.5136 | $26.78 | $6.75 | $5.36 |
| 86870 | X | | RBC antibody identification | 0346 | 0.5136 | $26.78 | $6.75 | $5.36 |
| 86880 | X | | Coombs test, direct | 0341 | 0.1453 | $7.58 | $3.08 | $1.52 |
| 86885 | X | | Coombs test, indirect, qual | 0341 | 0.1453 | $7.58 | $3.08 | $1.52 |
| 86886 | X | | Coombs test, indirect, titer | 0341 | 0.1453 | $7.58 | $3.08 | $1.52 |
| 86890 | X | | Autologous blood process | 0347 | 1.1240 | $58.62 | $14.76 | $11.72 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 86891 | X | | Autologous blood, op salvage | 0345 | 0.1938 | $10.11 | $3.10 | $2.02 |
| 86900 | X | | Blood typing, ABO | 0341 | 0.1453 | $7.58 | $3.08 | $1.52 |
| 86901 | X | | Blood typing, Rh (D) | 0345 | 0.1938 | $10.11 | $3.10 | $2.02 |
| 86903 | X | | Blood typing, antigen screen | 0345 | 0.1938 | $10.11 | $3.10 | $2.02 |
| 86904 | X | | Blood typing, patient serum | 0345 | 0.1938 | $10.11 | $3.10 | $2.02 |
| 86905 | X | | Blood typing, RBC antigens | 0345 | 0.1938 | $10.11 | $3.10 | $2.02 |
| 86906 | X | | Blood typing, Rh phenotype | 0345 | 0.1938 | $10.11 | $3.10 | $2.02 |
| 86910 | E | | Blood typing, paternity test | | | | | |
| 86911 | E | | Blood typing, antigen system | | | | | |
| 86915 | S | DG | Bone marrow/stem cell prep | 0110 | 4.0309 | $210.22 | | $42.04 |
| 86920 | X | | Compatibility test | 0346 | 0.5136 | $26.78 | $6.75 | $5.36 |
| 86921 | X | | Compatibility test | 0345 | 0.1938 | $10.11 | $3.10 | $2.02 |
| 86922 | X | | Compatibility test | 0346 | 0.5136 | $26.78 | $6.75 | $5.36 |
| 86927 | X | | Plasma, fresh frozen | 0346 | 0.5136 | $26.78 | $6.75 | $5.36 |
| 86930 | X | | Frozen blood prep | 0347 | 1.1240 | $58.62 | $14.76 | $11.72 |
| 86931 | X | | Frozen blood thaw | 0347 | 1.1240 | $58.62 | $14.76 | $11.72 |
| 86932 | X | | Frozen blood freeze/thaw | 0347 | 1.1240 | $58.62 | $14.76 | $11.72 |
| 86940 | A | | Hemolysins/agglutinins, auto | | | | | |
| 86941 | A | | Hemolysins/agglutinins | | | | | |
| 86945 | X | | Blood product/irradiation | 0346 | 0.5136 | $26.78 | $6.75 | $5.36 |
| 86950 | X | | Leukacyte transfusion | 0347 | 1.1240 | $58.62 | $14.76 | $11.72 |
| 86965 | X | | Pooling blood platelets | 0346 | 0.5136 | $26.78 | $6.75 | $5.36 |
| 86970 | X | | RBC pretreatment | 0345 | 0.1938 | $10.11 | $3.10 | $2.02 |
| 86971 | X | | RBC pretreatment | 0345 | 0.1938 | $10.11 | $3.10 | $2.02 |
| 86972 | X | | RBC pretreatment | 0345 | 0.1938 | $10.11 | $3.10 | $2.02 |
| 86975 | X | | RBC pretreatment, serum | 0345 | 0.1938 | $10.11 | $3.10 | $2.02 |
| 86976 | X | | RBC pretreatment, serum | 0345 | 0.1938 | $10.11 | $3.10 | $2.02 |
| 86977 | X | | RBC pretreatment, serum | 0345 | 0.1938 | $10.11 | $3.10 | $2.02 |
| 86978 | X | | RBC pretreatment, serum | 0345 | 0.1938 | $10.11 | $3.10 | $2.02 |
| 86985 | X | | Split blood or products | 0347 | 1.1240 | $58.62 | $14.76 | $11.72 |
| 86999 | X | | Transfusion procedure | 0345 | 0.1938 | $10.11 | $3.10 | $2.02 |
| 87001 | A | | Small animal inoculation | | | | | |
| 87003 | A | | Small animal inoculation | | | | | |
| 87015 | A | | Specimen concentration | | | | | |
| 87040 | A | | Blood culture for bacteria | | | | | |
| 87045 | A | | Feces culture, bacteria | | | | | |
| 87046 | A | | Stool cultr, bacteria, each | | | | | |
| 87070 | A | | Culture, bacteria, other | | | | | |
| 87071 | A | | Culture bacteri aerobic othr | | | | | |
| 87073 | A | | Culture bacteria anaerobic | | | | | |
| 87075 | A | | Culture bacteria anaerobic | | | | | |
| 87076 | A | | Culture anaerobe ident, each | | | | | |
| 87077 | A | | Culture aerobic identify | | | | | |
| 87081 | A | | Culture screen only | | | | | |
| 87084 | A | | Culture of specimen by kit | | | | | |
| 87086 | A | | Urine culture/colony count | | | | | |
| 87088 | A | | Urine bacteria culture | | | | | |
| 87101 | A | | Skin fungi culture | | | | | |
| 87102 | A | | Fungus isolation culture | | | | | |
| 87103 | A | | Blood fungus culture | | | | | |
| 87106 | A | | Fungi identification, yeast | | | | | |
| 87107 | A | | Fungi identification, mold | | | | | |
| 87109 | A | | Mycoplasma | | | | | |
| 87110 | A | | Chlamydia culture | | | | | |
| 87116 | A | | Mycobacteria culture | | | | | |
| 87118 | A | | Mycobacteric identification | | | | | |
| 87140 | A | | Culture type immunofluoresc | | | | | |
| 87143 | A | | Culture typing, glc/hplc | | | | | |
| 87147 | A | | Culture type, immunologic | | | | | |
| 87149 | A | | Culture type, nucleic acid | | | | | |
| 87152 | A | | Culture type pulse field gel | | | | | |
| 87158 | A | | Culture typing, added method | | | | | |
| 87164 | A | | Dark field examination | | | | | |
| 87166 | A | | Dark field examination | | | | | |
| 87168 | A | | Macroscopic exam arthropod | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | | | | | |
| 87198 | A | DG | Cytomegalovirus antibody dfa | | | | | |
| 87199 | A | DG | Enterovirus antibody, dfa | | | | | |
| 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 | NI | Genet virus isolate, hsv | | | | | |
| 87260 | A | | Adenovirus ag, if | | | | | |
| 87265 | A | | Pertussis ag, if | | | | | |
| 87267 | A | NI | Enterovirus antibody, dfa | | | | | |
| 87270 | A | | Chlamydia trachomatis ag, if | | | | | |
| 87271 | A | NI | Cryptosporidum/gardia ag, if | | | | | |
| 87272 | A | | Cryptosporidum/gardia ag, if | | | | | |
| 87273 | A | | Herpes simplex 2, ag, if | | | | | |
| 87274 | A | | Herpes simplex 1, ag, if | | | | | |
| 87275 | A | | Influenza b, ag, if | | | | | |
| 87276 | A | | Influenza a, ag, if | | | | | |
| 87277 | A | | Legionella micdadei, ag, if | | | | | |
| 87278 | A | | Legion pneumophilia ag, if | | | | | |
| 87279 | A | | Parainfluenza, ag, if | | | | | |
| 87280 | A | | Respiratory syncytial ag, if | | | | | |
| 87281 | A | | Pneumocystis carinii, ag, if | | | | | |
| 87283 | A | | Rubeola, ag, if | | | | | |
| 87285 | A | | Treponema pallidum, ag, if | | | | | |
| 87290 | A | | Varicella zoster, ag, if | | | | | |
| 87299 | A | | Antibody detection, nos, if | | | | | |
| 87300 | A | | Ag detection, polyval, if | | | | | |
| 87301 | A | | Adenovirus ag, eia | | | | | |
| 87320 | A | | Chylmd trach ag, eia | | | | | |
| 87324 | A | | Clostridium ag, eia | | | | | |
| 87327 | A | | Cryptococcus neoform ag, eia | | | | | |
| 87328 | A | | Cryptospor ag, eia | | | | | |
| 87332 | A | | Cytomegalovirus ag, eia | | | | | |
| 87335 | A | | E coli 0157 ag, eia | | | | | |
| 87336 | A | | Entamoeb hist dispr, ag, eia | | | | | |
| 87337 | A | | Entamoeb hist group, ag, eia | | | | | |
| 87338 | A | | Hpylori, stool, eia | | | | | |
| 87339 | A | | H pylori ag, eia | | | | | |
| 87340 | A | | Hepatitis b surface ag, eia | | | | | |
| 87341 | A | | Hepatitis b surface, ag, eia | | | | | |
| 87350 | A | | Hepatitis be ag, eia | | | | | |
| 87380 | A | | Hepatitis delta ag, eia | | | | | |
| 87385 | A | | Histoplasma capsul ag, eia | | | | | |
| 87390 | A | | Hiv-1 ag, eia | | | | | |
| 87391 | A | | Hiv-2 ag, eia | | | | | |
| 87400 | A | | Influenza a/b, ag, eia | | | | | |
| 87420 | A | | Resp syncytial ag, eia | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 87425 | A | | Rotavirus ag, eia | | | | | |
| 87427 | A | | Shiga-like toxin ag, eia | | | | | |
| 87430 | A | | Strep a ag, eia | | | | | |
| 87449 | A | | Ag detect nos, eia, mult | | | | | |
| 87450 | A | | Ag detect nos, eia, single | | | | | |
| 87451 | A | | Ag detect polyval, eia, mult | | | | | |
| 87470 | A | | Bartonella, dna, dir probe | | | | | |
| 87471 | A | | Bartonella, dna, amp probe | | | | | |
| 87472 | A | | Bartonella, dna, quant | | | | | |
| 87475 | A | | Lyme dis, dna, dir probe | | | | | |
| 87476 | A | | Lyme dis, dna, amp probe | | | | | |
| 87477 | A | | Lyme dis, dna, quant | | | | | |
| 87480 | A | | Candida, dna, dir probe | | | | | |
| 87481 | A | | Candida, dna, amp probe | | | | | |
| 87482 | A | | Candida, dna, quant | | | | | |
| 87485 | A | | Chylmd pneum, dna, dir probe | | | | | |
| 87486 | A | | Chylmd pneum, dna, amp probe | | | | | |
| 87487 | A | | Chylmd pneum, dna, quant | | | | | |
| 87490 | A | | Chylmd trach, dna, dir probe | | | | | |
| 87491 | A | | Chylmd trach, dna, amp probe | | | | | |
| 87492 | A | | Chylmd trach, dna, quant | | | | | |
| 87495 | A | | Cytomeg, dna, dir probe | | | | | |
| 87496 | A | | Cytomeg, dna, amp probe | | | | | |
| 87497 | A | | Cytomeg, dna, quant | | | | | |
| 87510 | A | | Gardner vag, dna, dir probe | | | | | |
| 87511 | A | | Gardner vag, dna, amp probe | | | | | |
| 87512 | A | | Gardner vag, dna, quant | | | | | |
| 87515 | A | | Hepatitis b, dna, dir probe | | | | | |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 87592 | A | | N.gonorrhoeae, dna, quant | | | | | |
| 87620 | A | | Hpv, dna, dir probe | | | | | |
| 87621 | A | | Hpv, dna, amp probe | | | | | |
| 87622 | A | | Hpv, dna, quant | | | | | |
| 87650 | A | | Strep a, dna, dir probe | | | | | |
| 87651 | A | | Strep a, dna, amp probe | | | | | |
| 87652 | A | | Strep a, dna, quant | | | | | |
| 87797 | A | | Detect agent nos, dna, dir | | | | | |
| 87798 | A | | Detect agent nos, dna, amp | | | | | |
| 87799 | A | | Detect agent nos, dna, quant | | | | | |
| 87800 | A | | Detect agnt mult, dna, direc | | | | | |
| 87801 | A | | Detect agnt mult, dna, ampli | | | | | |
| 87802 | A | | Strep b assay w/optic | | | | | |
| 87803 | A | | Clostridium toxin a w/optic | | | | | |
| 87804 | A | | Influenza assay w/optic | | | | | |
| 87810 | A | | Chylmd trach assay w/optic | | | | | |
| 87850 | A | | N. gonorrhoeae assay w/optic | | | | | |
| 87880 | A | | Strep a assay w/optic | | | | | |
| 87899 | A | | Agent nos assay w/optic | | | | | |
| 87901 | A | | Genotype, dna, hiv reverse t | | | | | |
| 87902 | A | | Genotype, dna, hepatitis C | | | | | |
| 87903 | A | | Phenotype, dna hiv w/culture | | | | | |
| 87904 | A | | Phenotype, dna hiv w/clt add | | | | | |
| 87999 | A | | Microbiology procedure | | | | | |
| 88000 | E | | Autopsy (necropsy), gross | | | | | |
| 88005 | E | | Autopsy (necropsy), gross | | | | | |
| 88007 | E | | Autopsy (necropsy), gross | | | | | |
| 88012 | E | | Autopsy (necropsy), gross | | | | | |
| 88014 | E | | Autopsy (necropsy), gross | | | | | |
| 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 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 88106 | X | | Cytopathology, fluids | 0343 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 88107 | X | | Cytopathology, fluids | 0343 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 88108 | X | | Cytopath, concentrate tech | 0343 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 88125 | X | | Forensic cytopathology | 0342 | 0.2132 | $11.12 | $5.88 | $2.22 |
| 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 | | | | | |
| 88144 | A | DG | Cytopath, c/v, thin lyr redo | | | | | |
| 88145 | A | DG | Cytopath, c/v, thin lyr sel | | | | | |
| 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 | 0.2132 | $11.12 | $5.88 | $2.22 |
| 88161 | X | | Cytopath smear, other source | 0343 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 88162 | X | | Cytopath smear, other source | 0343 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 88164 | A | | Cytopath tbs, c/v, manual | | | | | |
| 88165 | A | | Cytopath tbs, c/v, redo | | | | | |
| 88166 | A | | Cytopath tbs, c/v, auto redo | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 88167 | A | | Cytopath tbs, c/v, select | | | | | |
| 88172 | X | | Cytopathology eval of fna | 0343 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 88173 | X | | Cytopath eval, fna, report | 0343 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 88174 | A | NI | Cytopath, c/v auto, in fluid | | | | | |
| 88175 | A | NI | Cytopath c/v auto fluid redo | | | | | |
| 88180 | X | | Cell marker study | 0343 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 88182 | X | | Cell marker study | 0344 | 0.6201 | $32.34 | $17.46 | $6.47 |
| 88199 | A | | Cytopathology procedure | | | | | |
| 88230 | A | | Tissue culture, lymphocyte | | | | | |
| 88233 | A | | Tissue culture, skin/biopsy | | | | | |
| 88235 | A | | Tissue culture, placenta | | | | | |
| 88237 | A | | Tissue culture, bone marrow | | | | | |
| 88239 | A | | Tissue culture, tumor | | | | | |
| 88240 | A | | Cell cryopreserve/storage | | | | | |
| 88241 | A | | Frozen cell preparation | | | | | |
| 88245 | A | | Chromosome analysis, 20-25 | | | | | |
| 88248 | A | | Chromosome analysis, 50-100 | | | | | |
| 88249 | A | | Chromosome analysis, 100 | | | | | |
| 88261 | A | | Chromosome analysis, 5 | | | | | |
| 88262 | A | | Chromosome analysis, 15-20 | | | | | |
| 88263 | A | | Chromosome analysis, 45 | | | | | |
| 88264 | A | | Chromosome analysis, 20-25 | | | | | |
| 88267 | A | | Chromosome analys, placenta | | | | | |
| 88269 | A | | Chromosome analys, amniotic | | | | | |
| 88271 | A | | Cytogenetics, dna probe | | | | | |
| 88272 | A | | Cytogenetics, 3-5 | | | | | |
| 88273 | A | | Cytogenetics, 10-30 | | | | | |
| 88274 | A | | Cytogenetics, 25-99 | | | | | |
| 88275 | A | | Cytogenetics, 100-300 | | | | | |
| 88280 | A | | Chromosome karyotype study | | | | | |
| 88283 | A | | Chromosome banding study | | | | | |
| 88285 | A | | Chromosome count, additional | | | | | |
| 88289 | A | | Chromosome study, additional | | | | | |
| 88291 | A | | Cyto/molecular report | | | | | |
| 88299 | X | | Cytogenetic study | 0342 | 0.2132 | $11.12 | $5.88 | $2.22 |
| 88300 | X | | Surgical path, gross | 0342 | 0.2132 | $11.12 | $5.88 | $2.22 |
| 88302 | X | | Tissue exam by pathologist | 0342 | 0.2132 | $11.12 | $5.88 | $2.22 |
| 88304 | X | | Tissue exam by pathologist | 0343 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 88305 | X | | Tissue exam by pathologist | 0343 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 88307 | X | | Tissue exam by pathologist | 0344 | 0.6201 | $32.34 | $17.46 | $6.47 |
| 88309 | X | | Tissue exam by pathologist | 0344 | 0.6201 | $32.34 | $17.46 | $6.47 |
| 88311 | X | | Decalcify tissue | 0342 | 0.2132 | $11.12 | $5.88 | $2.22 |
| 88312 | X | | Special stains | 0342 | 0.2132 | $11.12 | $5.88 | $2.22 |
| 88313 | X | | Special stains | 0342 | 0.2132 | $11.12 | $5.88 | $2.22 |
| 88314 | X | | Histochemical stain | 0342 | 0.2132 | $11.12 | $5.88 | $2.22 |
| 88318 | X | | Chemical histochemistry | 0342 | 0.2132 | $11.12 | $5.88 | $2.22 |
| 88319 | X | | Enzyme histochemistry | 0342 | 0.2132 | $11.12 | $5.88 | $2.22 |
| 88321 | X | | Microslide consultation | 0342 | 0.2132 | $11.12 | $5.88 | $2.22 |
| 88323 | X | | Microslide consultation | 0343 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 88325 | X | | Comprehensive review of data | 0344 | 0.6201 | $32.34 | $17.46 | $6.47 |
| 88329 | X | | Path consult introp | 0342 | 0.2132 | $11.12 | $5.88 | $2.22 |
| 88331 | X | | Path consult intraop, 1 bloc | 0343 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 88332 | X | | Path consult intraop, addl | 0342 | 0.2132 | $11.12 | $5.88 | $2.22 |
| 88342 | X | | Immunocytochemistry | 0344 | 0.6201 | $32.34 | $17.46 | $6.47 |
| 88346 | X | | Immunofluorescent study | 0343 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 88347 | X | | Immunofluorescent study | 0344 | 0.6201 | $32.34 | $17.46 | $6.47 |
| 88348 | X | | Electron microscopy | 0661 | 3.5077 | $182.93 | $100.61 | $36.59 |
| 88349 | X | | Scanning electron microscopy | 0661 | 3.5077 | $182.93 | $100.61 | $36.59 |
| 88355 | X | | Analysis, skeletal muscle | 0344 | 0.6201 | $32.34 | $17.46 | $6.47 |
| 88356 | X | | Analysis, nerve | 0344 | 0.6201 | $32.34 | $17.46 | $6.47 |
| 88358 | X | | Analysis, tumor | 0344 | 0.6201 | $32.34 | $17.46 | $6.47 |
| 88362 | X | | Nerve teasing preparations | 0343 | 0.4457 | $23.24 | $12.55 | $4.65 |
| 88365 | X | | Tissue hybridization | 0344 | 0.6201 | $32.34 | $17.46 | $6.47 |
| 88371 | A | | Protein, western blot tissue | | | | | |
| 88372 | A | | Protein analysis w/probe | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | NI | Leukocyte count, fecal | | | | | |
| 89060 | A | | Exam,synovial fluid crystals | | | | | |
| 89100 | X | | Sample intestinal contents | 0360 | 1.6279 | $84.90 | $42.45 | $16.98 |
| 89105 | X | | Sample intestinal contents | 0360 | 1.6279 | $84.90 | $42.45 | $16.98 |
| 89125 | A | | Specimen fat stain | | | | | |
| 89130 | X | | Sample stomach contents | 0360 | 1.6279 | $84.90 | $42.45 | $16.98 |
| 89132 | X | | Sample stomach contents | 0360 | 1.6279 | $84.90 | $42.45 | $16.98 |
| 89135 | X | | Sample stomach contents | 0360 | 1.6279 | $84.90 | $42.45 | $16.98 |
| 89136 | X | | Sample stomach contents | 0360 | 1.6279 | $84.90 | $42.45 | $16.98 |
| 89140 | X | | Sample stomach contents | 0360 | 1.6279 | $84.90 | $42.45 | $16.98 |
| 89141 | X | | Sample stomach contents | 0360 | 1.6279 | $84.90 | $42.45 | $16.98 |
| 89160 | A | | Exam feces for meat fibers | | | | | |
| 89190 | A | | Nasal smear for eosinophils | | | | | |
| 89250 | X | | Fertilization of oocyte | 0348 | 0.5523 | $28.80 | | $5.76 |
| 89251 | X | | Culture oocyte w/embryos | 0348 | 0.5523 | $28.80 | | $5.76 |
| 89252 | X | | Assist oocyte fertilization | 0348 | 0.5523 | $28.80 | | $5.76 |
| 89253 | X | | Embryo hatching | 0348 | 0.5523 | $28.80 | | $5.76 |
| 89254 | X | | Oocyte identification | 0348 | 0.5523 | $28.80 | | $5.76 |
| 89255 | X | | Prepare embryo for transfer | 0348 | 0.5523 | $28.80 | | $5.76 |
| 89256 | X | | Prepare cryopreserved embryo | 0348 | 0.5523 | $28.80 | | $5.76 |
| 89257 | X | | Sperm identification | 0348 | 0.5523 | $28.80 | | $5.76 |
| 89258 | X | | Cryopreservation, embryo | 0348 | 0.5523 | $28.80 | | $5.76 |
| 89259 | X | | Cryopreservation, sperm | 0348 | 0.5523 | $28.80 | | $5.76 |
| 89260 | X | | Sperm isolation, simple | 0348 | 0.5523 | $28.80 | | $5.76 |
| 89261 | X | | Sperm isolation, complex | 0348 | 0.5523 | $28.80 | | $5.76 |
| 89264 | X | | Identify sperm tissue | 0348 | 0.5523 | $28.80 | | $5.76 |
| 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 | | | | | |
| 89350 | X | | Sputum specimen collection | 0344 | 0.6201 | $32.34 | $17.46 | $6.47 |
| 89355 | A | | Exam feces for starch | | | | | |
| 89360 | X | | Collect sweat for test | 0344 | 0.6201 | $32.34 | $17.46 | $6.47 |
| 89365 | A | | Water load test | | | | | |
| 89399 | A | | Pathology lab procedure | | | | | |
| 90281 | E | | Human ig, im | | | | | |
| 90283 | E | | Human ig, iv | | | | | |
| 90287 | E | | Botulinum antitoxin | | | | | |
| 90288 | E | | Botulism ig, iv | | | | | |
| 90291 | E | | Cmv ig, iv | | | | | |
| 90296 | K | | Diphtheria antitoxin | 0356 | 0.7655 | $39.92 | | $7.98 |
| 90371 | E | | Hep b ig, im | | | | | |
| 90375 | K | | Rabies ig, im/sc | 0356 | 0.7655 | $39.92 | | $7.98 |
| 90376 | K | | Rabies ig, heat treated | 0356 | 0.7655 | $39.92 | | $7.98 |
| 90378 | E | | Rsv ig, im, 50mg | | | | | |
| 90379 | K | | Rsv ig, iv | 0356 | 0.7655 | $39.92 | | $7.98 |
| 90384 | E | | Rh ig, full-dose, im | | | | | |
| 90385 | N | | Rh ig, minidose, im | | | | | |
| 90386 | E | | Rh ig, iv | | | | | |
| 90389 | N | | Tetanus ig, im | | | | | |
| 90393 | N | | Vaccina ig, im | | | | | |
| 90396 | N | | Varicella-zoster ig, im | | | | | |
| 90399 | E | | Immune globulin | | | | | |
| 90471 | N | | Immunization admin | | | | | |
| 90472 | N | | Immunization admin, each add | | | | | |
| 90473 | E | | Immune admin oral/nasal | | | | | |
| 90474 | E | | Immune admin oral/nasal addl | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 90476 | N | | Adenovirus vaccine, type 4 | | | | | |
| 90477 | N | | Adenovirus vaccine, type 7 | | | | | |
| 90581 | K | | Anthrax vaccine, sc | 0356 | 0.7655 | $39.92 | | $7.98 |
| 90585 | N | | Bcg vaccine, percut | | | | | |
| 90586 | N | | Bcg vaccine, intravesical | | | | | |
| 90632 | N | | Hep a vaccine, adult im | | | | | |
| 90633 | N | | Hep a vacc, ped/adol, 2 dose | | | | | |
| 90634 | N | | Hep a vacc, ped/adol, 3 dose | | | | | |
| 90636 | K | | Hep a/hep b vacc, adult im | 0355 | 0.2132 | $11.12 | | $2.22 |
| 90645 | N | | Hib vaccine, hboc, im | | | | | |
| 90646 | N | | Hib vaccine, prp-d, im | | | | | |
| 90647 | N | | Hib vaccine, prp-omp, im | | | | | |
| 90648 | N | | Hib vaccine, prp-t, im | | | | | |
| 90657 | L | | Flu vaccine, 6-35 mo, im | | | | | |
| 90658 | L | | Flu vaccine, 3 yrs, im | | | | | |
| 90659 | L | | Flu vaccine, whole, im | | | | | |
| 90660 | E | | Flu vaccine, nasal | | | | | |
| 90665 | N | | Lyme disease vaccine, im | | | | | |
| 90669 | E | | Pneumococcal vacc, ped <5 | | | | | |
| 90675 | N | | Rabies vaccine, im | | | | | |
| 90676 | N | | Rabies vaccine, id | | | | | |
| 90680 | N | | Rotovirus vaccine, oral | | | | | |
| 90690 | N | | Typhoid vaccine, oral | | | | | |
| 90691 | N | | Typhoid vaccine, im | | | | | |
| 90692 | N | | Typhoid vaccine, h-p, sc/id | | | | | |
| 90693 | K | | Typhoid vaccine, akd, sc | 0356 | 0.7655 | $39.92 | | $7.98 |
| 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 | | | | | |
| 90709 | K | DG | Rubella & mumps vaccine, sc | 0356 | 0.7655 | $39.92 | | $7.98 |
| 90710 | N | | Mmrv vaccine, sc | | | | | |
| 90712 | N | | Oral poliovirus vaccine | | | | | |
| 90713 | N | | Poliovirus, ipv, sc | | | | | |
| 90716 | N | | Chicken pox vaccine, sc | | | | | |
| 90717 | N | | Yellow fever vaccine, sc | | | | | |
| 90718 | N | | Td vaccine > 7, im | | | | | |
| 90719 | N | | Diphtheria vaccine, im | | | | | |
| 90720 | N | | Dtp/hib vaccine, im | | | | | |
| 90721 | N | | Dtap/hib vaccine, im | | | | | |
| 90723 | K | | Dtap-hep b-ipv vaccine, im | 0356 | 0.7655 | $39.92 | | $7.98 |
| 90725 | N | | Cholera vaccine, injectable | | | | | |
| 90727 | N | | Plague vaccine, im | | | | | |
| 90732 | L | | Pneumococcal vaccine | | | | | |
| 90733 | N | | Meningococcal vaccine, sc | | | | | |
| 90735 | N | | Encephalitis vaccine, sc | | | | | |
| 90740 | E | | Hepb vacc, ill pat 3 dose im | | | | | |
| 90743 | E | | Hep b vacc, adol, 2 dose, im | | | | | |
| 90744 | E | | Hepb vacc ped/adol 3 dose im | | | | | |
| 90746 | E | | Hep b vaccine, adult, im | | | | | |
| 90747 | E | | Hepb vacc, ill pat 4 dose im | | | | | |
| 90748 | E | | Hep b/hib vaccine, im | | | | | |
| 90749 | N | | Vaccine toxoid | | | | | |
| 90780 | E | | IV infusion therapy, 1 hour | | | | | |
| 90781 | E | | IV infusion, additional hour | | | | | |
| 90782 | X | | Injection, sc/im | 0353 | 0.3973 | $20.72 | | $4.14 |
| 90783 | X | | Injection, ia | 0359 | 1.1337 | $59.12 | | $11.82 |
| 90784 | X | | Injection, iv | 0359 | 1.1337 | $59.12 | | $11.82 |
| 90788 | X | | Injection of antibiotic | 0359 | 1.1337 | $59.12 | | $11.82 |
| 90799 | X | | Ther/prophylactic/dx inject | 0352 | 0.2229 | $11.62 | | $2.32 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 90801 | S | | Psy dx interview | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90802 | S | | Intac psy dx interview | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90804 | S | | Psytx, office, 20-30 min | 0322 | 1.3275 | $69.23 | $12.40 | $13.85 |
| 90805 | S | | Psytx, off, 20-30 min w/e&m | 0322 | 1.3275 | $69.23 | $12.40 | $13.85 |
| 90806 | S | | Psytx, off, 45-50 min | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90807 | S | | Psytx, off, 45-50 min w/e&m | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90808 | S | | Psytx, office, 75-80 min | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90809 | S | | Psytx, off, 75-80, w/e&m | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90810 | S | | Intac psytx, off, 20-30 min | 0322 | 1.3275 | $69.23 | $12.40 | $13.85 |
| 90811 | S | | Intac psytx, 20-30, w/e&m | 0322 | 1.3275 | $69.23 | $12.40 | $13.85 |
| 90812 | S | | Intac psytx, off, 45-50 min | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90813 | S | | Intac psytx, 45-50 min w/e&m | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90814 | S | | Intac psytx, off, 75-80 min | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90815 | S | | Intac psytx, 75-80 w/e&m | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90816 | S | | Psytx, hosp, 20-30 min | 0322 | 1.3275 | $69.23 | $12.40 | $13.85 |
| 90817 | S | | Psytx, hosp, 20-30 min w/e&m | 0322 | 1.3275 | $69.23 | $12.40 | $13.85 |
| 90818 | S | | Psytx, hosp, 45-50 min | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90819 | S | | Psytx, hosp, 45-50 min w/e&m | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90821 | S | | Psytx, hosp, 75-80 min | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90822 | S | | Psytx, hosp, 75-80 min w/e&m | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90823 | S | | Intac psytx, hosp, 20-30 min | 0322 | 1.3275 | $69.23 | $12.40 | $13.85 |
| 90824 | S | | Intac psytx, hsp 20-30 w/e&m | 0322 | 1.3275 | $69.23 | $12.40 | $13.85 |
| 90826 | S | | Intac psytx, hosp, 45-50 min | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90827 | S | | Intac psytx, hsp 45-50 w/e&m | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90828 | S | | Intac psytx, hosp, 75-80 min | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90829 | S | | Intac psytx, hsp 75-80 w/e&m | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90845 | S | | Psychoanalysis | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90846 | S | | Family psytx w/o patient | 0324 | 2.4612 | $128.35 | | $25.67 |
| 90847 | S | | Family psytx w/patient | 0324 | 2.4612 | $128.35 | | $25.67 |
| 90849 | S | | Multiple family group psytx | 0325 | 1.4244 | $74.28 | $18.27 | $14.86 |
| 90853 | S | | Group psychotherapy | 0325 | 1.4244 | $74.28 | $18.27 | $14.86 |
| 90857 | S | | Intac group psytx | 0325 | 1.4244 | $74.28 | $18.27 | $14.86 |
| 90862 | X | | Medication management | 0374 | 1.1434 | $59.63 | $9.97 | $11.93 |
| 90865 | S | | Narcosynthesis | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 90870 | S | | Electroconvulsive therapy | 0320 | 4.2635 | $222.35 | $80.06 | $44.47 |
| 90871 | S | | Electroconvulsive therapy | 0320 | 4.2635 | $222.35 | $80.06 | $44.47 |
| 90875 | E | | Psychophysiological therapy | | | | | |
| 90876 | E | | Psychophysiological therapy | | | | | |
| 90880 | S | | Hypnotherapy | 0323 | 1.8410 | $96.01 | $21.26 | $19.20 |
| 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 | 1.3275 | $69.23 | $12.40 | $13.85 |
| 90901 | S | | Biofeedback train, any meth | 0321 | 1.2112 | $63.17 | $21.78 | $12.63 |
| 90911 | S | | Biofeedback peri/uro/rectal | 0321 | 1.2112 | $63.17 | $21.78 | $12.63 |
| 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 | 4.8352 | $252.16 | | $50.43 |
| 90937 | E | | Hemodialysis, repeated eval | | | | | |
| 90939 | N | | Hemodialysis study, transcut | | | | | |
| 90940 | N | | Hemodialysis access study | | | | | |
| 90945 | S | | Dialysis, one evaluation | 0170 | 4.8352 | $252.16 | | $50.43 |
| 90947 | E | | Dialysis, repeated eval | | | | | |
| 90989 | E | | Dialysis training, complete | | | | | |
| 90993 | E | | Dialysis training, incompl | | | | | |
| 90997 | E | | Hemoperfusion | | | | | |
| 90999 | E | | Dialysis procedure | | | | | |
| 91000 | X | | Esophageal intubation | 0361 | 3.3914 | $176.86 | $83.23 | $35.37 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 91010 | X | | Esophagus motility study | 0361 | 3.3914 | $176.86 | $83.23 | $35.37 |
| 91011 | X | | Esophagus motility study | 0361 | 3.3914 | $176.86 | $83.23 | $35.37 |
| 91012 | X | | Esophagus motility study | 0361 | 3.3914 | $176.86 | $83.23 | $35.37 |
| 91020 | X | | Gastric motility | 0361 | 3.3914 | $176.86 | $83.23 | $35.37 |
| 91030 | X | | Acid perfusion of esophagus | 0361 | 3.3914 | $176.86 | $83.23 | $35.37 |
| 91032 | X | | Esophagus, acid reflux test | 0361 | 3.3914 | $176.86 | $83.23 | $35.37 |
| 91033 | X | | Prolonged acid reflux test | 0361 | 3.3914 | $176.86 | $83.23 | $35.37 |
| 91052 | X | | Gastric analysis test | 0361 | 3.3914 | $176.86 | $83.23 | $35.37 |
| 91055 | X | | Gastric intubation for smear | 0360 | 1.6279 | $84.90 | $42.45 | $16.98 |
| 91060 | X | | Gastric saline load test | 0360 | 1.6279 | $84.90 | $42.45 | $16.98 |
| 91065 | X | | Breath hydrogen test | 0360 | 1.6279 | $84.90 | $42.45 | $16.98 |
| 91100 | X | | Pass intestine bleeding tube | 0360 | 1.6279 | $84.90 | $42.45 | $16.98 |
| 91105 | X | | Gastric intubation treatment | 0360 | 1.6279 | $84.90 | $42.45 | $16.98 |
| 91122 | T | | Anal pressure record | 0156 | 2.9747 | $155.13 | $46.55 | $31.03 |
| 91123 | N | | Irrigate fecal impaction | | | | | |
| 91132 | X | | Electrogastrography | 0360 | 1.6279 | $84.90 | $42.45 | $16.98 |
| 91133 | X | | Electrogastrography w/test | 0360 | 1.6279 | $84.90 | $42.45 | $16.98 |
| 91299 | X | | Gastroenterology procedure | 0360 | 1.6279 | $84.90 | $42.45 | $16.98 |
| 92002 | V | | Eye exam, new patient | 0601 | 0.9690 | $50.53 | | $10.11 |
| 92004 | V | | Eye exam, new patient | 0602 | 1.4631 | $76.30 | | $15.26 |
| 92012 | V | | Eye exam established pat | 0600 | 0.8430 | $43.96 | | $8.79 |
| 92014 | V | | Eye exam & treatment | 0602 | 1.4631 | $76.30 | | $15.26 |
| 92015 | E | | Refraction | | | | | |
| 92018 | T | | New eye exam & treatment | 0699 | 3.7596 | $196.07 | $88.23 | $39.21 |
| 92019 | S | | Eye exam & treatment | 0698 | 0.9205 | $48.00 | $18.72 | $9.60 |
| 92020 | S | | Special eye evaluation | 0230 | 0.7364 | $38.40 | $14.97 | $7.68 |
| 92060 | S | | Special eye evaluation | 0230 | 0.7364 | $38.40 | $14.97 | $7.68 |
| 92065 | S | | Orthoptic/pleoptic training | 0230 | 0.7364 | $38.40 | $14.97 | $7.68 |
| 92070 | N | | Fitting of contact lens | | | | | |
| 92081 | S | | Visual field examination(s) | 0230 | 0.7364 | $38.40 | $14.97 | $7.68 |
| 92082 | S | | Visual field examination(s) | 0698 | 0.9205 | $48.00 | $18.72 | $9.60 |
| 92083 | S | | Visual field examination(s) | 0698 | 0.9205 | $48.00 | $18.72 | $9.60 |
| 92100 | N | | Serial tonometry exam(s) | | | | | |
| 92120 | S | | Tonography & eye evaluation | 0230 | 0.7364 | $38.40 | $14.97 | $7.68 |
| 92130 | S | | Water provocation tonography | 0698 | 0.9205 | $48.00 | $18.72 | $9.60 |
| 92135 | S | | Opthalmic dx imaging | 0230 | 0.7364 | $38.40 | $14.97 | $7.68 |
| 92136 | S | | Ophthalmic biometry | 0230 | 0.7364 | $38.40 | $14.97 | $7.68 |
| 92140 | S | | Glaucoma provocative tests | 0698 | 0.9205 | $48.00 | $18.72 | $9.60 |
| 92225 | S | | Special eye exam, initial | 0698 | 0.9205 | $48.00 | $18.72 | $9.60 |
| 92226 | S | | Special eye exam, subsequent | 0698 | 0.9205 | $48.00 | $18.72 | $9.60 |
| 92230 | T | | Eye exam with photos | 0699 | 3.7596 | $196.07 | $88.23 | $39.21 |
| 92235 | T | | Eye exam with photos | 0699 | 3.7596 | $196.07 | $88.23 | $39.21 |
| 92240 | S | | Icg angiography | 0231 | 2.1705 | $113.19 | $50.94 | $22.64 |
| 92250 | S | | Eye exam with photos | 0230 | 0.7364 | $38.40 | $14.97 | $7.68 |
| 92260 | S | | Ophthalmoscopy/dynamometry | 0230 | 0.7364 | $38.40 | $14.97 | $7.68 |
| 92265 | S | | Eye muscle evaluation | 0231 | 2.1705 | $113.19 | $50.94 | $22.64 |
| 92270 | S | | Electro-oculography | 0698 | 0.9205 | $48.00 | $18.72 | $9.60 |
| 92275 | S | | Electroretinography | 0231 | 2.1705 | $113.19 | $50.94 | $22.64 |
| 92283 | S | | Color vision examination | 0230 | 0.7364 | $38.40 | $14.97 | $7.68 |
| 92284 | S | | Dark adaptation eye exam | 0698 | 0.9205 | $48.00 | $18.72 | $9.60 |
| 92285 | S | | Eye photography | 0230 | 0.7364 | $38.40 | $14.97 | $7.68 |
| 92286 | S | | Internal eye photography | 0698 | 0.9205 | $48.00 | $18.72 | $9.60 |
| 92287 | S | | Internal eye photography | 0231 | 2.1705 | $113.19 | $50.94 | $22.64 |
| 92310 | E | | Contact lens fitting | | | | | |
| 92311 | X | | Contact lens fitting | 0362 | 2.8391 | $148.06 | | $29.61 |
| 92312 | X | | Contact lens fitting | 0362 | 2.8391 | $148.06 | | $29.61 |
| 92313 | X | | Contact lens fitting | 0362 | 2.8391 | $148.06 | | $29.61 |
| 92314 | E | | Prescription of contact lens | | | | | |
| 92315 | X | | Prescription of contact lens | 0362 | 2.8391 | $148.06 | | $29.61 |
| 92316 | X | | Prescription of contact lens | 0362 | 2.8391 | $148.06 | | $29.61 |
| 92317 | X | | Prescription of contact lens | 0362 | 2.8391 | $148.06 | | $29.61 |
| 92325 | X | | Modification of contact lens | 0362 | 2.8391 | $148.06 | | $29.61 |
| 92326 | X | | Replacement of contact lens | 0362 | 2.8391 | $148.06 | | $29.61 |
| 92330 | S | | Fitting of artificial eye | 0230 | 0.7364 | $38.40 | $14.97 | $7.68 |
| 92335 | N | | Fitting of artificial eye | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 92340 | E | | Fitting of spectacles | | | | | |
| 92341 | E | | Fitting of spectacles | | | | | |
| 92342 | E | | Fitting of spectacles | | | | | |
| 92352 | X | | Special spectacles fitting | 0362 | 2.8391 | $148.06 | | $29.61 |
| 92353 | X | | Special spectacles fitting | 0362 | 2.8391 | $148.06 | | $29.61 |
| 92354 | X | | Special spectacles fitting | 0362 | 2.8391 | $148.06 | | $29.61 |
| 92355 | X | | Special spectacles fitting | 0362 | 2.8391 | $148.06 | | $29.61 |
| 92358 | X | | Eye prosthesis service | 0362 | 2.8391 | $148.06 | | $29.61 |
| 92370 | E | | Repair & adjust spectacles | | | | | |
| 92371 | X | | Repair & adjust spectacles | 0362 | 2.8391 | $148.06 | | $29.61 |
| 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 | 0.7364 | $38.40 | $14.97 | $7.68 |
| 92502 | T | | Ear and throat examination | 0251 | 1.9089 | $99.55 | | $19.91 |
| 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 | 0.9205 | $48.00 | $12.89 | $9.60 |
| 92512 | X | | Nasal function studies | 0363 | 1.0852 | $56.59 | $20.94 | $11.32 |
| 92516 | X | | Facial nerve function test | 0660 | 1.5891 | $82.87 | $30.66 | $16.57 |
| 92520 | X | | Laryngeal function studies | 0660 | 1.5891 | $82.87 | $30.66 | $16.57 |
| 92525 | A | DG | Oral function evaluation | | | | | |
| 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 | 1.0852 | $56.59 | $20.94 | $11.32 |
| 92542 | X | | Positional nystagmus test | 0363 | 1.0852 | $56.59 | $20.94 | $11.32 |
| 92543 | X | | Caloric vestibular test | 0660 | 1.5891 | $82.87 | $30.66 | $16.57 |
| 92544 | X | | Optokinetic nystagmus test | 0363 | 1.0852 | $56.59 | $20.94 | $11.32 |
| 92545 | X | | Oscillating tracking test | 0363 | 1.0852 | $56.59 | $20.94 | $11.32 |
| 92546 | X | | Sinusoidal rotational test | 0660 | 1.5891 | $82.87 | $30.66 | $16.57 |
| 92547 | X | | Supplemental electrical test | 0363 | 1.0852 | $56.59 | $20.94 | $11.32 |
| 92548 | X | | Posturography | 0660 | 1.5891 | $82.87 | $30.66 | $16.57 |
| 92551 | E | | Pure tone hearing test, air | | | | | |
| 92552 | X | | Pure tone audiometry, air | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 92553 | X | | Audiometry, air & bone | 0365 | 1.2112 | $63.17 | $18.95 | $12.63 |
| 92555 | X | | Speech threshold audiometry | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 92556 | X | | Speech audiometry, complete | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 92557 | X | | Comprehensive hearing test | 0365 | 1.2112 | $63.17 | $18.95 | $12.63 |
| 92559 | E | | Group audiometric testing | | | | | |
| 92560 | E | | Bekesy audiometry, screen | | | | | |
| 92561 | X | | Bekesy audiometry, diagnosis | 0365 | 1.2112 | $63.17 | $18.95 | $12.63 |
| 92562 | X | | Loudness balance test | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 92563 | X | | Tone decay hearing test | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 92564 | X | | Sisi hearing test | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 92565 | X | | Stenger test, pure tone | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 92567 | X | | Tympanometry | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 92568 | X | | Acoustic reflex testing | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 92569 | X | | Acoustic reflex decay test | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 92571 | X | | Filtered speech hearing test | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 92572 | X | | Staggered spondaic word test | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 92573 | X | | Lombard test | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 92575 | X | | Sensorineural acuity test | 0365 | 1.2112 | $63.17 | $18.95 | $12.63 |
| 92576 | X | | Synthetic sentence test | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 92577 | X | | Stenger test, speech | 0365 | 1.2112 | $63.17 | $18.95 | $12.63 |
| 92579 | X | | Visual audiometry (vra) | 0365 | 1.2112 | $63.17 | $18.95 | $12.63 |
| 92582 | X | | Conditioning play audiometry | 0365 | 1.2112 | $63.17 | $18.95 | $12.63 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 92583 | X | | Select picture audiometry | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 92584 | X | | Electrocochleography | 0660 | 1.5891 | $82.87 | $30.66 | $16.57 |
| 92585 | S | | Auditor evoke potent, compre | 0216 | 2.8972 | $151.09 | $67.98 | $30.22 |
| 92586 | S | | Auditor evoke potent, limit | 0218 | 1.0077 | $52.55 | | $10.51 |
| 92587 | X | | Evoked auditory test | 0363 | 1.0852 | $56.59 | $20.94 | $11.32 |
| 92588 | X | | Evoked auditory test | 0660 | 1.5891 | $82.87 | $30.66 | $16.57 |
| 92589 | X | | Auditory function test(s) | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 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 | 1.2112 | $63.17 | $18.95 | $12.63 |
| 92597 | E | | Voice Prosthetic Evaluation | | | | | |
| 92598 | E | DG | Voice Prosthetic Modification | | | | | |
| 92599 | X | DG | ENT procedure/service | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 92601 | A | NI | Cochlear implt f/up exam < 7 | | | | | |
| 92602 | A | NI | Reprogram cochlear implt < 7 | | | | | |
| 92603 | A | NI | Cochlear implt f/up exam 7 > | | | | | |
| 92604 | A | NI | Reprogram cochlear implt 7 > | | | | | |
| 92605 | A | NI | Eval for nonspeech device rx | | | | | |
| 92606 | A | NI | Non-speech device service | | | | | |
| 92607 | A | NI | Ex for speech device rx, 1hr | | | | | |
| 92608 | A | NI | Ex for speech device rx addl | | | | | |
| 92609 | A | NI | Use of speech device service | | | | | |
| 92610 | A | NI | Evaluate swallowing function | | | | | |
| 92611 | A | NI | Motion fluoroscopy/swallow | | | | | |
| 92612 | A | NI | Endoscopy swallow tst (fees) | | | | | |
| 92613 | E | NI | Endoscopy swallow tst (fees) | | | | | |
| 92614 | A | NI | Laryngoscopic sensory test | | | | | |
| 92615 | E | NI | Eval laryngoscopy sense tst | | | | | |
| 92616 | A | NI | Fees w/laryngeal sense test | | | | | |
| 92617 | E | NI | Interprt fees/laryngeal test | | | | | |
| 92700 | X | NI | Ent procedure/service | 0364 | 0.4457 | $23.24 | $9.06 | $4.65 |
| 92950 | S | | Heart/lung resuscitation cpr | 0094 | 3.8371 | $200.11 | $67.63 | $40.02 |
| 92953 | S | | Temporary external pacing | 0094 | 3.8371 | $200.11 | $67.63 | $40.02 |
| 92960 | S | | Cardioversion electric, ext | 0679 | 5.4069 | $281.98 | $95.30 | $56.40 |
| 92961 | S | | Cardioversion, electric, int | 0679 | 5.4069 | $281.98 | $95.30 | $56.40 |
| 92970 | C | | Cardioassist, internal | | | | | |
| 92971 | C | | Cardioassist, external | | | | | |
| 92973 | T | | Percut coronary thrombectomy | 0973 | | $250.00 | | $50.00 |
| 92974 | T | | Cath place, cardio brachytx | 0981 | | $2,250.00 | | $450.00 |
| 92975 | C | | Dissolve clot, heart vessel | | | | | |
| 92977 | T | | Dissolve clot, heart vessel | 0676 | 4.1278 | $215.27 | $58.21 | $43.05 |
| 92978 | S | | Intravasc us, heart add-on | 0670 | 30.2416 | $1,577.13 | $571.17 | $315.43 |
| 92979 | S | | Intravasc us, heart add-on | 0670 | 30.2416 | $1,577.13 | $571.17 | $315.43 |
| 92980 | T | | Insert intracoronary stent | 0104 | 76.5486 | $3,992.09 | | $798.42 |
| 92981 | T | | Insert intracoronary stent | 0104 | 76.5486 | $3,992.09 | | $798.42 |
| 92982 | T | | Coronary artery dilation | 0083 | 51.9755 | $2,710.57 | | $542.11 |
| 92984 | T | | Coronary artery dilation | 0083 | 51.9755 | $2,710.57 | | $542.11 |
| 92986 | T | | Revision of aortic valve | 0083 | 51.9755 | $2,710.57 | | $542.11 |
| 92987 | T | | Revision of mitral valve | 0083 | 51.9755 | $2,710.57 | | $542.11 |
| 92990 | T | | Revision of pulmonary valve | 0083 | 51.9755 | $2,710.57 | | $542.11 |
| 92992 | C | | Revision of heart chamber | | | | | |
| 92993 | C | | Revision of heart chamber | | | | | |
| 92995 | T | | Coronary atherectomy | 0082 | 86.4321 | $4,507.52 | $1,293.59 | $901.50 |
| 92996 | T | | Coronary atherectomy add-on | 0082 | 86.4321 | $4,507.52 | $1,293.59 | $901.50 |
| 92997 | T | | Pul art balloon repr, percut | 0081 | 43.5067 | $2,268.92 | | $453.78 |
| 92998 | T | | Pul art balloon repr, percut | 0081 | 43.5067 | $2,268.92 | | $453.78 |
| 93000 | E | | Electrocardiogram, complete | | | | | |
| 93005 | S | | Electrocardiogram, tracing | 0099 | 0.3682 | $19.20 | | $3.84 |
| 93010 | A | | Electrocardiogram report | | | | | |
| 93012 | N | | Transmission of ecg | | | | | |
| 93014 | E | | Report on transmitted ecg | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 93015 | E | | Cardiovascular stress test | | | | | |
| 93016 | E | | Cardiovascular stress test | | | | | |
| 93017 | X | | Cardiovascular stress test | 0100 | 1.6085 | $83.88 | $41.44 | $16.78 |
| 93018 | E | | Cardiovascular stress test | | | | | |
| 93024 | X | | Cardiac drug stress test | 0100 | 1.6085 | $83.88 | $41.44 | $16.78 |
| 93025 | X | | Microvolt t-wave assess | 0100 | 1.6085 | $83.88 | $41.44 | $16.78 |
| 93040 | E | | Rhythm ECG with report | | | | | |
| 93041 | S | | Rhythm ECG, tracing | 0099 | 0.3682 | $19.20 | | $3.84 |
| 93042 | E | | Rhythm ECG, report | | | | | |
| 93224 | E | | ECG monitor/report, 24 hrs | | | | | |
| 93225 | X | | ECG monitor/record, 24 hrs | 0097 | 1.0077 | $52.55 | $23.80 | $10.51 |
| 93226 | X | | ECG monitor/report, 24 hrs | 0097 | 1.0077 | $52.55 | $23.80 | $10.51 |
| 93227 | E | | ECG monitor/review, 24 hrs | | | | | |
| 93230 | E | | ECG monitor/report, 24 hrs | | | | | |
| 93231 | X | | Ecg monitor/record, 24 hrs | 0097 | 1.0077 | $52.55 | $23.80 | $10.51 |
| 93232 | X | | ECG monitor/report, 24 hrs | 0097 | 1.0077 | $52.55 | $23.80 | $10.51 |
| 93233 | E | | ECG monitor/review, 24 hrs | | | | | |
| 93235 | E | | ECG monitor/report, 24 hrs | | | | | |
| 93236 | X | | ECG monitor/report, 24 hrs | 0097 | 1.0077 | $52.55 | $23.80 | $10.51 |
| 93237 | E | | ECG monitor/review, 24 hrs | | | | | |
| 93268 | E | | ECG record/review | | | | | |
| 93270 | X | | ECG recording | 0097 | 1.0077 | $52.55 | $23.80 | $10.51 |
| 93271 | X | | Ecg/monitoring and analysis | 0097 | 1.0077 | $52.55 | $23.80 | $10.51 |
| 93272 | E | | Ecg/review, interpret only | | | | | |
| 93278 | S | | ECG/signal-averaged | 0099 | 0.3682 | $19.20 | | $3.84 |
| 93303 | S | | Echo transthoracic | 0269 | 3.2170 | $167.77 | $87.24 | $33.55 |
| 93304 | S | | Echo transthoracic | 0697 | 1.5697 | $81.86 | $42.57 | $16.37 |
| 93307 | S | | Echo exam of heart | 0269 | 3.2170 | $167.77 | $87.24 | $33.55 |
| 93308 | S | | Echo exam of heart | 0697 | 1.5697 | $81.86 | $42.57 | $16.37 |
| 93312 | S | | Echo transesophageal | 0270 | 5.3003 | $276.42 | $146.79 | $55.28 |
| 93313 | S | | Echo transesophageal | 0270 | 5.3003 | $276.42 | $146.79 | $55.28 |
| 93314 | N | | Echo transesophageal | | | | | |
| 93315 | S | | Echo transesophageal | 0270 | 5.3003 | $276.42 | $146.79 | $55.28 |
| 93316 | S | | Echo transesophageal | 0270 | 5.3003 | $276.42 | $146.79 | $55.28 |
| 93317 | N | | Echo transesophageal | | | | | |
| 93318 | S | | Echo transesophageal intraop | 0270 | 5.3003 | $276.42 | $146.79 | $55.28 |
| 93320 | S | | Doppler echo exam, heart | 0671 | 2.3643 | $123.30 | $64.12 | $24.66 |
| 93321 | S | | Doppler echo exam, heart | 0697 | 1.5697 | $81.86 | $42.57 | $16.37 |
| 93325 | S | | Doppler color flow add-on | 0697 | 1.5697 | $81.86 | $42.57 | $16.37 |
| 93350 | S | | Echo transthoracic | 0269 | 3.2170 | $167.77 | $87.24 | $33.55 |
| 93501 | T | | Right heart catheterization | 0080 | 35.2996 | $1,840.91 | $838.92 | $368.18 |
| 93503 | T | | Insert/place heart catheter | 0103 | 11.8408 | $617.51 | $223.63 | $123.50 |
| 93505 | T | | Biopsy of heart lining | 0103 | 11.8408 | $617.51 | $223.63 | $123.50 |
| 93508 | T | | Cath placement, angiography | 0080 | 35.2996 | $1,840.91 | $838.92 | $368.18 |
| 93510 | T | | Left heart catheterization | 0080 | 35.2996 | $1,840.91 | $838.92 | $368.18 |
| 93511 | T | | Left heart catheterization | 0080 | 35.2996 | $1,840.91 | $838.92 | $368.18 |
| 93514 | T | | Left heart catheterization | 0080 | 35.2996 | $1,840.91 | $838.92 | $368.18 |
| 93524 | T | | Left heart catheterization | 0080 | 35.2996 | $1,840.91 | $838.92 | $368.18 |
| 93526 | T | | Rt & Lt heart catheters | 0080 | 35.2996 | $1,840.91 | $838.92 | $368.18 |
| 93527 | T | | Rt & Lt heart catheters | 0080 | 35.2996 | $1,840.91 | $838.92 | $368.18 |
| 93528 | T | | Rt & Lt heart catheters | 0080 | 35.2996 | $1,840.91 | $838.92 | $368.18 |
| 93529 | T | | Rt, lt heart catheterization | 0080 | 35.2996 | $1,840.91 | $838.92 | $368.18 |
| 93530 | T | | Rt heart cath, congenital | 0080 | 35.2996 | $1,840.91 | $838.92 | $368.18 |
| 93531 | T | | R & l heart cath, congenital | 0080 | 35.2996 | $1,840.91 | $838.92 | $368.18 |
| 93532 | T | | R & l heart cath, congenital | 0080 | 35.2996 | $1,840.91 | $838.92 | $368.18 |
| 93533 | T | | R & l heart cath, congenital | 0080 | 35.2996 | $1,840.91 | $838.92 | $368.18 |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 93561 | N | | Cardiac output measurement | | | | | |
| 93562 | N | | Cardiac output measurement | | | | | |
| 93571 | N | | Heart flow reserve measure | | | | | |
| 93572 | N | | Heart flow reserve measure | | | | | |
| 93580 | T | NI | Transcath closure of asd | 0981 | | $2,250.00 | | $450.00 |
| 93581 | T | NI | Transcath closure of vsd | 0981 | | $2,250.00 | | $450.00 |
| 93600 | T | | Bundle of His recording | 0087 | 39.3983 | $2,054.66 | | $410.93 |
| 93602 | T | | Intra-atrial recording | 0087 | 39.3983 | $2,054.66 | | $410.93 |
| 93603 | T | | Right ventricular recording | 0087 | 39.3983 | $2,054.66 | | $410.93 |
| 93609 | T | | Map tachycardia, add-on | 0087 | 39.3983 | $2,054.66 | | $410.93 |
| 93610 | T | | Intra-atrial pacing | 0087 | 39.3983 | $2,054.66 | | $410.93 |
| 93612 | T | | Intraventricular pacing | 0087 | 39.3983 | $2,054.66 | | $410.93 |
| 93613 | T | | Electrophys map 3d, add-on | 0087 | 39.3983 | $2,054.66 | | $410.93 |
| 93615 | T | | Esophageal recording | 0087 | 39.3983 | $2,054.66 | | $410.93 |
| 93616 | T | | Esophageal recording | 0087 | 39.3983 | $2,054.66 | | $410.93 |
| 93618 | T | | Heart rhythm pacing | 0087 | 39.3983 | $2,054.66 | | $410.93 |
| 93619 | T | | Electrophysiology evaluation | 0085 | 41.7238 | $2,175.94 | $480.03 | $435.19 |
| 93620 | T | | Electrophysiology evaluation | 0085 | 41.7238 | $2,175.94 | $480.03 | $435.19 |
| 93621 | T | | Electrophysiology evaluation | 0085 | 41.7238 | $2,175.94 | $480.03 | $435.19 |
| 93622 | T | | Electrophysiology evaluation | 0085 | 41.7238 | $2,175.94 | $480.03 | $435.19 |
| 93623 | T | | Stimulation, pacing heart | 0087 | 39.3983 | $2,054.66 | | $410.93 |
| 93624 | S | | Electrophysiologic study | 0084 | 9.3312 | $486.63 | | $97.33 |
| 93631 | T | | Heart pacing, mapping | 0087 | 39.3983 | $2,054.66 | | $410.93 |
| 93640 | S | | Evaluation heart device | 0084 | 9.3312 | $486.63 | | $97.33 |
| 93641 | S | | Electrophysiology evaluation | 0084 | 9.3312 | $486.63 | | $97.33 |
| 93642 | S | | Electrophysiology evaluation | 0084 | 9.3312 | $486.63 | | $97.33 |
| 93650 | T | | Ablate heart dysrhythm focus | 0086 | 52.8282 | $2,755.04 | $936.35 | $551.01 |
| 93651 | T | | Ablate heart dysrhythm focus | 0086 | 52.8282 | $2,755.04 | $936.35 | $551.01 |
| 93652 | T | | Ablate heart dysrhythm focus | 0086 | 52.8282 | $2,755.04 | $936.35 | $551.01 |
| 93660 | S | | Tilt table evaluation | 0101 | 4.2247 | $220.32 | $105.27 | $44.06 |
| 93662 | S | | Intracardiac ecg (ice) | 0670 | 30.2416 | $1,577.13 | $571.17 | $315.43 |
| 93668 | E | | Peripheral vascular rehab | | | | | |
| 93701 | S | | Bioimpedance, thoracic | 0099 | 0.3682 | $19.20 | | $3.84 |
| 93720 | E | | Total body plethysmography | | | | | |
| 93721 | X | | Plethysmography tracing | 0368 | 1.0562 | $55.08 | $27.55 | $11.02 |
| 93722 | E | | Plethysmography report | | | | | |
| 93724 | S | | Analyze pacemaker system | 0690 | 0.4263 | $22.23 | $10.63 | $4.45 |
| 93727 | S | | Analyze ilr system | 0690 | 0.4263 | $22.23 | $10.63 | $4.45 |
| 93731 | S | | Analyze pacemaker system | 0690 | 0.4263 | $22.23 | $10.63 | $4.45 |
| 93732 | S | | Analyze pacemaker system | 0690 | 0.4263 | $22.23 | $10.63 | $4.45 |
| 93733 | S | | Telephone analy, pacemaker | 0690 | 0.4263 | $22.23 | $10.63 | $4.45 |
| 93734 | S | | Analyze pacemaker system | 0690 | 0.4263 | $22.23 | $10.63 | $4.45 |
| 93735 | S | | Analyze pacemaker system | 0690 | 0.4263 | $22.23 | $10.63 | $4.45 |
| 93736 | S | | Telephone analy, pacemaker | 0690 | 0.4263 | $22.23 | $10.63 | $4.45 |
| 93740 | X | | Temperature gradient studies | 0367 | 0.5814 | $30.32 | $15.16 | $6.06 |
| 93741 | S | | Analyze ht pace device sngl | 0689 | 0.5814 | $30.32 | | $6.06 |
| 93742 | S | | Analyze ht pace device sngl | 0689 | 0.5814 | $30.32 | | $6.06 |
| 93743 | S | | Analyze ht pace device dual | 0689 | 0.5814 | $30.32 | | $6.06 |
| 93744 | S | | Analyze ht pace device dual | 0689 | 0.5814 | $30.32 | | $6.06 |
| 93760 | E | | Cephalic thermogram | | | | | |
| 93762 | E | | Peripheral thermogram | | | | | |
| 93770 | N | | Measure venous pressure | | | | | |
| 93784 | E | | Ambulatory BP monitoring | | | | | |
| 93786 | X | | Ambulatory BP recording | 0097 | 1.0077 | $52.55 | $23.80 | $10.51 |
| 93788 | E | | Ambulatory BP analysis | | | | | |
| 93790 | E | | Review/report BP recording | | | | | |
| 93797 | S | | Cardiac rehab | 0095 | 0.6105 | $31.84 | $16.73 | $6.37 |
| 93798 | S | | Cardiac rehab/monitor | 0095 | 0.6105 | $31.84 | $16.73 | $6.37 |
| 93799 | S | | Cardiovascular procedure | 0096 | 1.7054 | $88.94 | $48.15 | $17.79 |
| 93875 | S | | Extracranial study | 0096 | 1.7054 | $88.94 | $48.15 | $17.79 |
| 93880 | S | | Extracranial study | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 93882 | S | | Extracranial study | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 93886 | S | | Intracranial study | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 93888 | S | | Intracranial study | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 93922 | S | | Extremity study | 0096 | 1.7054 | $88.94 | $48.15 | $17.79 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 93923 | S | | Extremity study | 0096 | 1.7054 | $88.94 | $48.15 | $17.79 |
| 93924 | S | | Extremity study | 0096 | 1.7054 | $88.94 | $48.15 | $17.79 |
| 93925 | S | | Lower extremity study | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 93926 | S | | Lower extremity study | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 93930 | S | | Upper extremity study | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 93931 | S | | Upper extremity study | 0266 | 1.5988 | $83.38 | $45.86 | $16.68 |
| 93965 | S | | Extremity study | 0096 | 1.7054 | $88.94 | $48.15 | $17.79 |
| 93970 | S | | Extremity study | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 93971 | S | | Extremity study | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 93975 | S | | Vascular study | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 93976 | S | | Vascular study | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 93978 | S | | Vascular study | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 93979 | S | | Vascular study | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 93980 | S | | Penile vascular study | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 93981 | S | | Penile vascular study | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 93990 | S | | Doppler flow testing | 0267 | 2.4418 | $127.34 | $65.52 | $25.47 |
| 94010 | X | | Breathing capacity test | 0368 | 1.0562 | $55.08 | $27.55 | $11.02 |
| 94014 | X | | Patient recorded spirometry | 0367 | 0.5814 | $30.32 | $15.16 | $6.06 |
| 94015 | X | | Patient recorded spirometry | 0367 | 0.5814 | $30.32 | $15.16 | $6.06 |
| 94016 | A | | Review patient spirometry | | | | | |
| 94060 | X | | Evaluation of wheezing | 0368 | 1.0562 | $55.08 | $27.55 | $11.02 |
| 94070 | X | | Evaluation of wheezing | 0369 | 2.5871 | $134.92 | $44.18 | $26.98 |
| 94150 | X | | Vital capacity test | 0367 | 0.5814 | $30.32 | $15.16 | $6.06 |
| 94200 | X | | Lung function test (MBC/MVV) | 0367 | 0.5814 | $30.32 | $15.16 | $6.06 |
| 94240 | X | | Residual lung capacity | 0368 | 1.0562 | $55.08 | $27.55 | $11.02 |
| 94250 | X | | Expired gas collection | 0367 | 0.5814 | $30.32 | $15.16 | $6.06 |
| 94260 | X | | Thoracic gas volume | 0368 | 1.0562 | $55.08 | $27.55 | $11.02 |
| 94350 | X | | Lung nitrogen washout curve | 0368 | 1.0562 | $55.08 | $27.55 | $11.02 |
| 94360 | X | | Measure airflow resistance | 0367 | 0.5814 | $30.32 | $15.16 | $6.06 |
| 94370 | X | | Breath airway closing volume | 0367 | 0.5814 | $30.32 | $15.16 | $6.06 |
| 94375 | X | | Respiratory flow volume loop | 0367 | 0.5814 | $30.32 | $15.16 | $6.06 |
| 94400 | X | | CO2 breathing response curve | 0367 | 0.5814 | $30.32 | $15.16 | $6.06 |
| 94450 | X | | Hypoxia response curve | 0367 | 0.5814 | $30.32 | $15.16 | $6.06 |
| 94620 | X | | Pulmonary stress test/simple | 0368 | 1.0562 | $55.08 | $27.55 | $11.02 |
| 94621 | X | | Pulm stress test/complex | 0369 | 2.5871 | $134.92 | $44.18 | $26.98 |
| 94640 | S | | Airway inhalation treatment | 0077 | 0.2907 | $15.16 | $8.34 | $3.03 |
| 94642 | S | | Aerosol inhalation treatment | 0078 | 0.6492 | $33.86 | $14.55 | $6.77 |
| 94650 | S | DG | Pressure breathing (IPPB) | 0077 | 0.2907 | $15.16 | $8.34 | $3.03 |
| 94651 | S | DG | Pressure breathing (IPPB) | 0077 | 0.2907 | $15.16 | $8.34 | $3.03 |
| 94652 | C | DG | Pressure breathing (IPPB) | | | | | |
| 94656 | S | | Initial ventilator mgmt | 0079 | 1.6376 | $85.40 | | $17.08 |
| 94657 | S | | Continued ventilator mgmt | 0079 | 1.6376 | $85.40 | | $17.08 |
| 94660 | S | | Pos airway pressure, CPAP | 0068 | 2.0736 | $108.14 | $59.48 | $21.63 |
| 94662 | S | | Neg press ventilation, cnp | 0079 | 1.6376 | $85.40 | | $17.08 |
| 94664 | S | | Aerosol or vapor inhalations | 0077 | 0.2907 | $15.16 | $8.34 | $3.03 |
| 94665 | S | DG | Aerosol or vapor inhalations | 0077 | 0.2907 | $15.16 | $8.34 | $3.03 |
| 94667 | S | | Chest wall manipulation | 0077 | 0.2907 | $15.16 | $8.34 | $3.03 |
| 94668 | S | | Chest wall manipulation | 0077 | 0.2907 | $15.16 | $8.34 | $3.03 |
| 94680 | X | | Exhaled air analysis, o2 | 0367 | 0.5814 | $30.32 | $15.16 | $6.06 |
| 94681 | X | | Exhaled air analysis, o2/co2 | 0368 | 1.0562 | $55.08 | $27.55 | $11.02 |
| 94690 | X | | Exhaled air analysis | 0367 | 0.5814 | $30.32 | $15.16 | $6.06 |
| 94720 | X | | Monoxide diffusing capacity | 0368 | 1.0562 | $55.08 | $27.55 | $11.02 |
| 94725 | X | | Membrane diffusion capacity | 0368 | 1.0562 | $55.08 | $27.55 | $11.02 |
| 94750 | X | | Pulmonary compliance study | 0367 | 0.5814 | $30.32 | $15.16 | $6.06 |
| 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 | 0.5814 | $30.32 | $15.16 | $6.06 |
| 94772 | X | | Breath recording, infant | 0369 | 2.5871 | $134.92 | $44.18 | $26.98 |
| 94799 | X | | Pulmonary service/procedure | 0367 | 0.5814 | $30.32 | $15.16 | $6.06 |
| 95004 | X | | Percut allergy skin tests | 0370 | 0.7752 | $40.43 | $11.58 | $8.09 |
| 95010 | X | | Percut allergy titrate test | 0370 | 0.7752 | $40.43 | $11.58 | $8.09 |
| 95015 | X | | Id allergy titrate-drug/bug | 0370 | 0.7752 | $40.43 | $11.58 | $8.09 |
| 95024 | X | | Id allergy test, drug/bug | 0370 | 0.7752 | $40.43 | $11.58 | $8.09 |
| 95027 | X | | Skin end point titration | 0370 | 0.7752 | $40.43 | $11.58 | $8.09 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 95028 | X | ..... | Id allergy test-delayed type | 0370 | 0.7752 | $40.43 | $11.58 | $8.09 |
| 95044 | X | ..... | Allergy patch tests | 0370 | 0.7752 | $40.43 | $11.58 | $8.09 |
| 95052 | X | ..... | Photo patch test | 0370 | 0.7752 | $40.43 | $11.58 | $8.09 |
| 95056 | X | ..... | Photosensitivity tests | 0370 | 0.7752 | $40.43 | $11.58 | $8.09 |
| 95060 | X | ..... | Eye allergy tests | 0370 | 0.7752 | $40.43 | $11.58 | $8.09 |
| 95065 | X | ..... | Nose allergy test | 0370 | 0.7752 | $40.43 | $11.58 | $8.09 |
| 95070 | X | ..... | Bronchial allergy tests | 0369 | 2.5871 | $134.92 | $44.18 | $26.98 |
| 95071 | X | ..... | Bronchial allergy tests | 0369 | 2.5871 | $134.92 | $44.18 | $26.98 |
| 95075 | X | ..... | Ingestion challenge test | 0361 | 3.3914 | $176.86 | $83.23 | $35.37 |
| 95078 | X | ..... | Provocative testing | 0370 | 0.7752 | $40.43 | $11.58 | $8.09 |
| 95115 | X | ..... | Immunotherapy, one injection | 0352 | 0.2229 | $11.62 | ..... | $2.32 |
| 95117 | X | ..... | Immunotherapy injections | 0353 | 0.3973 | $20.72 | ..... | $4.14 |
| 95120 | E | ..... | Immunotherapy, one injection | ..... | ..... | ..... | ..... | ..... |
| 95125 | E | ..... | Immunotherapy, many antigens | ..... | ..... | ..... | ..... | ..... |
| 95130 | E | ..... | Immunotherapy, insect venom | ..... | ..... | ..... | ..... | ..... |
| 95131 | E | ..... | Immunotherapy, insect venoms | ..... | ..... | ..... | ..... | ..... |
| 95132 | E | ..... | Immunotherapy, insect venoms | ..... | ..... | ..... | ..... | ..... |
| 95133 | E | ..... | Immunotherapy, insect venoms | ..... | ..... | ..... | ..... | ..... |
| 95134 | E | ..... | Immunotherapy, insect venoms | ..... | ..... | ..... | ..... | ..... |
| 95144 | X | ..... | Antigen therapy services | 0371 | 0.5039 | $26.28 | ..... | $5.26 |
| 95145 | X | ..... | Antigen therapy services | 0371 | 0.5039 | $26.28 | ..... | $5.26 |
| 95146 | X | ..... | Antigen therapy services | 0371 | 0.5039 | $26.28 | ..... | $5.26 |
| 95147 | X | ..... | Antigen therapy services | 0371 | 0.5039 | $26.28 | ..... | $5.26 |
| 95148 | X | ..... | Antigen therapy services | 0371 | 0.5039 | $26.28 | ..... | $5.26 |
| 95149 | X | ..... | Antigen therapy services | 0371 | 0.5039 | $26.28 | ..... | $5.26 |
| 95165 | X | ..... | Antigen therapy services | 0371 | 0.5039 | $26.28 | ..... | $5.26 |
| 95170 | X | ..... | Antigen therapy services | 0371 | 0.5039 | $26.28 | ..... | $5.26 |
| 95180 | X | ..... | Rapid desensitization | 0370 | 0.7752 | $40.43 | $11.58 | $8.09 |
| 95199 | X | ..... | Allergy immunology services | 0370 | 0.7752 | $40.43 | $11.58 | $8.09 |
| 95250 | T | ..... | Glucose monitoring, cont | 0972 | ..... | $150.00 | ..... | $30.00 |
| 95805 | S | ..... | Multiple sleep latency test | 0209 | 11.3369 | $591.23 | $280.58 | $118.25 |
| 95806 | S | ..... | Sleep study, unattended | 0213 | 3.2557 | $169.79 | $70.41 | $33.96 |
| 95807 | S | ..... | Sleep study, attended | 0209 | 11.3369 | $591.23 | $280.58 | $118.25 |
| 95808 | S | ..... | Polysomnography, 1-3 | 0209 | 11.3369 | $591.23 | $280.58 | $118.25 |
| 95810 | S | ..... | Polysomnography, 4 or more | 0209 | 11.3369 | $591.23 | $280.58 | $118.25 |
| 95811 | S | ..... | Polysomnography w/cpap | 0209 | 11.3369 | $591.23 | $280.58 | $118.25 |
| 95812 | S | ..... | Electroencephalogram (EEG) | 0213 | 3.2557 | $169.79 | $70.41 | $33.96 |
| 95813 | S | ..... | Eeg, over 1 hour | 0213 | 3.2557 | $169.79 | $70.41 | $33.96 |
| 95816 | S | ..... | Electroencephalogram (EEG) | 0214 | 2.2286 | $116.22 | $58.12 | $23.24 |
| 95819 | S | ..... | Electroencephalogram (EEG) | 0214 | 2.2286 | $116.22 | $58.12 | $23.24 |
| 95822 | S | ..... | Sleep electroencephalogram | 0214 | 2.2286 | $116.22 | $58.12 | $23.24 |
| 95824 | S | ..... | Eeg, cerebral death only | 0214 | 2.2286 | $116.22 | $58.12 | $23.24 |
| 95827 | S | ..... | Night electroencephalogram | 0209 | 11.3369 | $591.23 | $280.58 | $118.25 |
| 95829 | S | ..... | Surgery electrocorticogram | 0214 | 2.2286 | $116.22 | $58.12 | $23.24 |
| 95830 | E | ..... | Insert electrodes for EEG | ..... | ..... | ..... | ..... | ..... |
| 95831 | N | ..... | Limb muscle testing, manual | ..... | ..... | ..... | ..... | ..... |
| 95832 | N | ..... | Hand muscle testing, manual | ..... | ..... | ..... | ..... | ..... |
| 95833 | N | ..... | Body muscle testing, manual | ..... | ..... | ..... | ..... | ..... |
| 95834 | N | ..... | Body muscle testing, manual | ..... | ..... | ..... | ..... | ..... |
| 95851 | N | ..... | Range of motion measurements | ..... | ..... | ..... | ..... | ..... |
| 95852 | N | ..... | Range of motion measurements | ..... | ..... | ..... | ..... | ..... |
| 95857 | S | ..... | Tensilon test | 0218 | 1.0077 | $52.55 | ..... | $10.51 |
| 95858 | S | ..... | Tensilon test & myogram | 0218 | 1.0077 | $52.55 | ..... | $10.51 |
| 95860 | S | ..... | Muscle test, one limb | 0218 | 1.0077 | $52.55 | ..... | $10.51 |
| 95861 | S | ..... | Muscle test, 2 limbs | 0218 | 1.0077 | $52.55 | ..... | $10.51 |
| 95863 | S | ..... | Muscle test, 3 limbs | 0218 | 1.0077 | $52.55 | ..... | $10.51 |
| 95864 | S | ..... | Muscle test, 4 limbs | 0218 | 1.0077 | $52.55 | ..... | $10.51 |
| 95867 | S | ..... | Muscle test, head or neck | 0218 | 1.0077 | $52.55 | ..... | $10.51 |
| 95868 | S | ..... | Muscle test cran nerve bilat | 0218 | 1.0077 | $52.55 | ..... | $10.51 |
| 95869 | S | ..... | Muscle test, thor paraspinal | 0215 | 0.5814 | $30.32 | $15.76 | $6.06 |
| 95870 | S | ..... | Muscle test, nonparaspinal | 0218 | 1.0077 | $52.55 | ..... | $10.51 |
| 95872 | S | ..... | Muscle test, one fiber | 0218 | 1.0077 | $52.55 | ..... | $10.51 |
| 95875 | S | ..... | Limb exercise test | 0215 | 0.5814 | $30.32 | $15.76 | $6.06 |
| 95900 | S | ..... | Motor nerve conduction test | 0218 | 1.0077 | $52.55 | ..... | $10.51 |
| 95903 | S | ..... | Motor nerve conduction test | 0218 | 1.0077 | $52.55 | ..... | $10.51 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 95904 | S | | Sense nerve conduction test | 0215 | 0.5814 | $30.32 | $15.76 | $6.06 |
| 95920 | S | | Intraop nerve test add-on | 0216 | 2.8972 | $151.09 | $67.98 | $30.22 |
| 95921 | S | | Autonomic nerv function test | 0218 | 1.0077 | $52.55 | | $10.51 |
| 95922 | S | | Autonomic nerv function test | 0218 | 1.0077 | $52.55 | | $10.51 |
| 95923 | S | | Autonomic nerv function test | 0215 | 0.5814 | $30.32 | $15.76 | $6.06 |
| 95925 | S | | Somatosensory testing | 0216 | 2.8972 | $151.09 | $67.98 | $30.22 |
| 95926 | S | | Somatosensory testing | 0216 | 2.8972 | $151.09 | $67.98 | $30.22 |
| 95927 | S | | Somatosensory testing | 0216 | 2.8972 | $151.09 | $67.98 | $30.22 |
| 95930 | S | | Visual evoked potential test | 0218 | 1.0077 | $52.55 | | $10.51 |
| 95933 | S | | Blink reflex test | 0215 | 0.5814 | $30.32 | $15.76 | $6.06 |
| 95934 | S | | H-reflex test | 0215 | 0.5814 | $30.32 | $15.76 | $6.06 |
| 95936 | S | | H-reflex test | 0215 | 0.5814 | $30.32 | $15.76 | $6.06 |
| 95937 | S | | Neuromuscular junction test | 0218 | 1.0077 | $52.55 | | $10.51 |
| 95950 | S | | Ambulatory eeg monitoring | 0213 | 3.2557 | $169.79 | $70.41 | $33.96 |
| 95951 | S | | EEG monitoring/videorecord | 0209 | 11.3369 | $591.23 | $280.58 | $118.25 |
| 95953 | S | | EEG monitoring/computer | 0209 | 11.3369 | $591.23 | $280.58 | $118.25 |
| 95954 | S | | EEG monitoring/giving drugs | 0214 | 2.2286 | $116.22 | $58.12 | $23.24 |
| 95955 | S | | EEG during surgery | 0214 | 2.2286 | $116.22 | $58.12 | $23.24 |
| 95956 | S | | Eeg monitoring, cable/radio | 0214 | 2.2286 | $116.22 | $58.12 | $23.24 |
| 95957 | S | | EEG digital analysis | 0214 | 2.2286 | $116.22 | $58.12 | $23.24 |
| 95958 | S | | EEG monitoring/function test | 0213 | 3.2557 | $169.79 | $70.41 | $33.96 |
| 95961 | S | | Electrode stimulation, brain | 0216 | 2.8972 | $151.09 | $67.98 | $30.22 |
| 95962 | S | | Electrode stim, brain add-on | 0216 | 2.8972 | $151.09 | $67.98 | $30.22 |
| 95965 | S | | Meg, spontaneous | 0717 | | $2,250.00 | | $450.00 |
| 95966 | S | | Meg, evoked, single | 0714 | | $1,375.00 | | $275.00 |
| 95967 | S | | Meg, evoked, each addl | 0712 | | $875.00 | | $175.00 |
| 95970 | S | | Analyze neurostim, no prog | 0692 | 6.2595 | $326.44 | $179.54 | $65.29 |
| 95971 | S | | Analyze neurostim, simple | 0692 | 6.2595 | $326.44 | $179.54 | $65.29 |
| 95972 | S | | Analyze neurostim, complex | 0692 | 6.2595 | $326.44 | $179.54 | $65.29 |
| 95973 | S | | Analyze neurostim, complex | 0692 | 6.2595 | $326.44 | $179.54 | $65.29 |
| 95974 | S | | Cranial neurostim, complex | 0692 | 6.2595 | $326.44 | $179.54 | $65.29 |
| 95975 | S | | Cranial neurostim, complex | 0692 | 6.2595 | $326.44 | $179.54 | $65.29 |
| 95990 | T | NI | Spin/brain pump refil & main | 0125 | 2.0639 | $107.63 | | $21.53 |
| 95999 | S | | Neurological procedure | 0215 | 0.5814 | $30.32 | $15.76 | $6.06 |
| 96000 | S | | Motion analysis, video/3d | 0708 | | $150.00 | | $30.00 |
| 96001 | S | | Motion test w/ft press meas | 0708 | | $150.00 | | $30.00 |
| 96002 | S | | Dynamic surface emg | 0708 | | $150.00 | | $30.00 |
| 96003 | S | | Dynamic fine wire emg | 0708 | | $150.00 | | $30.00 |
| 96004 | E | | Phys review of motion tests | | | | | |
| 96100 | X | | Psychological testing | 0373 | 2.2577 | $117.74 | | $23.55 |
| 96105 | X | | Assessment of aphasia | 0373 | 2.2577 | $117.74 | | $23.55 |
| 96110 | X | | Developmental test, lim | 0373 | 2.2577 | $117.74 | | $23.55 |
| 96111 | X | | Developmental test, extend | 0373 | 2.2577 | $117.74 | | $23.55 |
| 96115 | X | | Neurobehavior status exam | 0373 | 2.2577 | $117.74 | | $23.55 |
| 96117 | X | | Neuropsych test battery | 0373 | 2.2577 | $117.74 | | $23.55 |
| 96150 | S | | Assess lth/behave, init | 0322 | 1.3275 | $69.23 | $12.40 | $13.85 |
| 96151 | S | | Assess hlth/behave, subseq | 0322 | 1.3275 | $69.23 | $12.40 | $13.85 |
| 96152 | S | | Intervene hlth/behave, indiv | 0322 | 1.3275 | $69.23 | $12.40 | $13.85 |
| 96153 | S | | Intervene hlth/behave, group | 0322 | 1.3275 | $69.23 | $12.40 | $13.85 |
| 96154 | S | | Interv hlth/behav, fam w/pt | 0322 | 1.3275 | $69.23 | $12.40 | $13.85 |
| 96155 | S | | Interv hlth/behav fam no pt | 0322 | 1.3275 | $69.23 | $12.40 | $13.85 |
| 96400 | E | | Chemotherapy, sc/im | | | | | |
| 96405 | E | | Intralesional chemo admin | | | | | |
| 96406 | E | | Intralesional chemo admin | | | | | |
| 96408 | E | | Chemotherapy, push technique | | | | | |
| 96410 | E | | Chemotherapy,infusion method | | | | | |
| 96412 | E | | Chemo, infuse method add-on | | | | | |
| 96414 | E | | Chemo, infuse method add-on | | | | | |
| 96420 | E | | Chemotherapy, push technique | | | | | |
| 96422 | E | | Chemotherapy,infusion method | | | | | |
| 96423 | E | | Chemo, infuse method add-on | | | | | |
| 96425 | E | | Chemotherapy,infusion method | | | | | |
| 96440 | E | | Chemotherapy, intracavitary | | | | | |
| 96445 | E | | Chemotherapy, intracavitary | | | | | |
| 96450 | E | | Chemotherapy, into CNS | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 96520 | T | | Port pump refill & main | 0125 | 2.0639 | $107.63 | | $21.53 |
| 96530 | T | | Pump refilling, maintenance | 0125 | 2.0639 | $107.63 | | $21.53 |
| 96542 | E | | Chemotherapy injection | | | | | |
| 96545 | E | | Provide chemotherapy agent | | | | | |
| 96549 | E | | Chemotherapy, unspecified | | | | | |
| 96567 | T | | Photodynamic tx, skin | 0972 | | $150.00 | | $30.00 |
| 96570 | T | | Photodynamic tx, 30 min | 0973 | | $250.00 | | $50.00 |
| 96571 | T | | Photodynamic tx, addl 15 min | 0973 | | $250.00 | | $50.00 |
| 96900 | S | | Ultraviolet light therapy | 0001 | 0.3779 | $19.71 | $7.09 | $3.94 |
| 96902 | N | | Trichogram | | | | | |
| 96910 | S | | Photochemotherapy with UV-B | 0001 | 0.3779 | $19.71 | $7.09 | $3.94 |
| 96912 | S | | Photochemotherapy with UV-A | 0001 | 0.3779 | $19.71 | $7.09 | $3.94 |
| 96913 | S | | Photochemotherapy, UV-A or B | 0683 | 1.8992 | $99.05 | $35.65 | $19.81 |
| 96920 | T | NI | Laser tx, skin < 250 sq cm | 0012 | 0.7849 | $40.93 | $11.18 | $8.19 |
| 96921 | T | NI | Laser tx, skin 250-500 sq cm | 0012 | 0.7849 | $40.93 | $11.18 | $8.19 |
| 96922 | T | NI | Laser tx, skin > 500 sq cm | 0013 | 1.0756 | $56.09 | $14.20 | $11.22 |
| 96999 | T | | Dermatological procedure | 0010 | 0.6589 | $34.36 | $10.08 | $6.87 |
| 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 | A | | Electric stimulation therapy | | | | | |
| 97016 | A | | Vasopneumatic device therapy | | | | | |
| 97018 | A | | Paraffin bath therapy | | | | | |
| 97020 | A | | Microwave therapy | | | | | |
| 97022 | A | | Whirlpool therapy | | | | | |
| 97024 | A | | Diathermy treatment | | | | | |
| 97026 | A | | Infrared therapy | | | | | |
| 97028 | A | | Ultraviolet therapy | | | | | |
| 97032 | A | | Electrical stimulation | | | | | |
| 97033 | A | | Electric current therapy | | | | | |
| 97034 | A | | Contrast bath therapy | | | | | |
| 97035 | A | | Ultrasound therapy | | | | | |
| 97036 | A | | Hydrotherapy | | | | | |
| 97039 | A | | Physical therapy treatment | | | | | |
| 97110 | A | | Therapeutic exercises | | | | | |
| 97112 | A | | Neuromuscular reeducation | | | | | |
| 97113 | A | | Aquatic therapy/exercises | | | | | |
| 97116 | A | | Gait training therapy | | | | | |
| 97124 | A | | Massage therapy | | | | | |
| 97139 | A | | Physical medicine procedure | | | | | |
| 97140 | A | | Manual therapy | | | | | |
| 97150 | A | | Group therapeutic procedures | | | | | |
| 97504 | A | | Orthotic training | | | | | |
| 97520 | A | | Prosthetic training | | | | | |
| 97530 | A | | Therapeutic activities | | | | | |
| 97532 | A | | Cognitive skills development | | | | | |
| 97533 | A | | Sensory integration | | | | | |
| 97535 | A | | Self care mngment training | | | | | |
| 97537 | A | | Community/work reintegration | | | | | |
| 97542 | A | | Wheelchair mngment training | | | | | |
| 97545 | A | | Work hardening | | | | | |
| 97546 | A | | Work hardening add-on | | | | | |
| 97601 | A | | Wound(s) care, selective | | | | | |
| 97602 | N | | Wound(s) care non-selective | | | | | |
| 97703 | A | | Prosthetic checkout | | | | | |
| 97750 | A | | Physical performance test | | | | | |
| 97780 | E | | Acupuncture w/o stimul | | | | | |
| 97781 | E | | Acupuncture w/stimul | | | | | |
| 97799 | A | | Physical medicine procedure | | | | | |
| 97802 | A | | Medical nutrition, indiv, in | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 97803 | A | | Med nutrition, indiv, subseq | | | | | |
| 97804 | A | | Medical nutrition, group | | | | | |
| 98925 | S | | Osteopathic manipulation | 0060 | 0.3294 | $17.18 | | $3.44 |
| 98926 | S | | Osteopathic manipulation | 0060 | 0.3294 | $17.18 | | $3.44 |
| 98927 | S | | Osteopathic manipulation | 0060 | 0.3294 | $17.18 | | $3.44 |
| 98928 | S | | Osteopathic manipulation | 0060 | 0.3294 | $17.18 | | $3.44 |
| 98929 | S | | Osteopathic manipulation | 0060 | 0.3294 | $17.18 | | $3.44 |
| 98940 | S | | Chiropractic manipulation | 0060 | 0.3294 | $17.18 | | $3.44 |
| 98941 | S | | Chiropractic manipulation | 0060 | 0.3294 | $17.18 | | $3.44 |
| 98942 | S | | Chiropractic manipulation | 0060 | 0.3294 | $17.18 | | $3.44 |
| 98943 | E | | Chiropractic manipulation | | | | | |
| 99000 | E | | Specimen handling | | | | | |
| 99001 | E | | Specimen handling | | | | | |
| 99002 | E | | Device handling | | | | | |
| 99024 | E | | Postop follow-up visit | | | | | |
| 99025 | E | | Initial surgical evaluation | | | | | |
| 99026 | E | NI | In-hospital on call service | | | | | |
| 99027 | E | NI | Out-of-hosp on call service | | | | | |
| 99050 | E | | Medical services after hrs | | | | | |
| 99052 | E | | Medical services at night | | | | | |
| 99054 | E | | Medical servcs, unusual hrs | | | | | |
| 99056 | E | | Non-office medical services | | | | | |
| 99058 | E | | Office emergency care | | | | | |
| 99070 | E | | Special supplies | | | | | |
| 99071 | E | | Patient education materials | | | | | |
| 99075 | E | | Medical testimony | | | | | |
| 99078 | N | | Group health education | | | | | |
| 99080 | E | | Special reports or forms | | | | | |
| 99082 | E | | Unusual physician travel | | | | | |
| 99090 | E | | Computer data analysis | | | | | |
| 99091 | E | | Collect/review data from pt | | | | | |
| 99100 | E | | Special anesthesia service | | | | | |
| 99116 | E | | Anesthesia with hypothermia | | | | | |
| 99135 | E | | Special anesthesia procedure | | | | | |
| 99140 | E | | Emergency anesthesia | | | | | |
| 99141 | N | | Sedation, iv/im or inhalant | | | | | |
| 99142 | N | | Sedation, oral/rectal/nasal | | | | | |
| 99170 | T | | Anogenital exam, child | 0191 | 0.2035 | $10.61 | $3.08 | $2.12 |
| 99172 | E | | Ocular function screen | | | | | |
| 99173 | E | | Visual acuity screen | | | | | |
| 99175 | N | | Induction of vomiting | | | | | |
| 99183 | E | | Hyperbaric oxygen therapy | | | | | |
| 99185 | N | | Regional hypothermia | | | | | |
| 99186 | N | | Total body hypothermia | | | | | |
| 99190 | C | | Special pump services | | | | | |
| 99191 | C | | Special pump services | | | | | |
| 99192 | C | | Special pump services | | | | | |
| 99195 | X | | Phlebotomy | 0372 | 0.5329 | $27.79 | $10.09 | $5.56 |
| 99199 | E | | Special service/proc/report | | | | | |
| 99201 | V | | Office/outpatient visit, new | 0600 | 0.8430 | $43.96 | | $8.79 |
| 99202 | V | | Office/outpatient visit, new | 0600 | 0.8430 | $43.96 | | $8.79 |
| 99203 | V | | Office/outpatient visit, new | 0601 | 0.9690 | $50.53 | | $10.11 |
| 99204 | V | | Office/outpatient visit, new | 0602 | 1.4631 | $76.30 | | $15.26 |
| 99205 | V | | Office/outpatient visit, new | 0602 | 1.4631 | $76.30 | | $15.26 |
| 99211 | V | | Office/outpatient visit, est | 0600 | 0.8430 | $43.96 | | $8.79 |
| 99212 | V | | Office/outpatient visit, est | 0600 | 0.8430 | $43.96 | | $8.79 |
| 99213 | V | | Office/outpatient visit, est | 0601 | 0.9690 | $50.53 | | $10.11 |
| 99214 | V | | Office/outpatient visit, est | 0602 | 1.4631 | $76.30 | | $15.26 |
| 99215 | V | | Office/outpatient visit, est | 0602 | 1.4631 | $76.30 | | $15.26 |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | 0.8430 | $43.96 | | $8.79 |
| 99242 | V | | Office consultation | 0600 | 0.8430 | $43.96 | | $8.79 |
| 99243 | V | | Office consultation | 0601 | 0.9690 | $50.53 | | $10.11 |
| 99244 | V | | Office consultation | 0602 | 1.4631 | $76.30 | | $15.26 |
| 99245 | V | | Office consultation | 0602 | 1.4631 | $76.30 | | $15.26 |
| 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 | 0.8430 | $43.96 | | $8.79 |
| 99272 | V | | Confirmatory consultation | 0600 | 0.8430 | $43.96 | | $8.79 |
| 99273 | V | | Confirmatory consultation | 0601 | 0.9690 | $50.53 | | $10.11 |
| 99274 | V | | Confirmatory consultation | 0602 | 1.4631 | $76.30 | | $15.26 |
| 99275 | V | | Confirmatory consultation | 0602 | 1.4631 | $76.30 | | $15.26 |
| 99281 | V | | Emergency dept visit | 0610 | 1.4147 | $73.78 | $19.57 | $14.76 |
| 99282 | V | | Emergency dept visit | 0610 | 1.4147 | $73.78 | $19.57 | $14.76 |
| 99283 | V | | Emergency dept visit | 0611 | 2.5290 | $131.89 | $36.47 | $26.38 |
| 99284 | V | | Emergency dept visit | 0612 | 4.3410 | $226.39 | $54.14 | $45.28 |
| 99285 | V | | Emergency dept visit | 0612 | 4.3410 | $226.39 | $54.14 | $45.28 |
| 99288 | E | | Direct advanced life support | | | | | |
| 99289 | N | | Pt transport, 30-74 min | | | | | |
| 99290 | N | | Pt transport, addl 30 min | | | | | |
| 99291 | S | | Critical care, first hour | 0620 | 9.9610 | $519.48 | $150.55 | $103.90 |
| 99292 | N | | Critical care, addl 30 min | | | | | |
| 99293 | C | NI | Ped critical care, initial | | | | | |
| 99294 | C | NI | Ped critical care, subseq | | | | | |
| 99295 | C | | Neonatal critical care | | | | | |
| 99296 | C | | Neonatal critical care | | | | | |
| 99297 | C | DG | Neonatal critical care | | | | | |
| 99298 | C | | Neonatal critical care | | | | | |
| 99299 | C | NI | Ic, lbw infant 1500-2500 gm | | | | | |
| 99301 | E | | Nursing facility care | | | | | |
| 99302 | E | | Nursing facility care | | | | | |
| 99303 | E | | Nursing facility care | | | | | |
| 99311 | E | | Nursing fac care, subseq | | | | | |
| 99312 | E | | Nursing fac care, subseq | | | | | |
| 99313 | E | | Nursing fac care, subseq | | | | | |
| 99315 | E | | Nursing fac discharge day | | | | | |
| 99316 | E | | Nursing fac discharge day | | | | | |
| 99321 | E | | Rest home visit, new patient | | | | | |
| 99322 | E | | Rest home visit, new patient | | | | | |
| 99323 | E | | Rest home visit, new patient | | | | | |
| 99331 | E | | Rest home visit, est pat | | | | | |
| 99332 | E | | Rest home visit, est pat | | | | | |
| 99333 | E | | Rest home visit, est pat | | | | | |
| 99341 | E | | Home visit, new patient | | | | | |
| 99342 | E | | Home visit, new patient | | | | | |
| 99343 | E | | Home visit, new patient | | | | | |
| 99344 | E | | Home visit, new patient | | | | | |
| 99345 | E | | Home visit, new patient | | | | | |
| 99347 | E | | Home visit, est patient | | | | | |
| 99348 | E | | Home visit, est patient | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 99349 | E | | Home visit, est patient | | | | | |
| 99350 | E | | Home visit, est patient | | | | | |
| 99354 | N | | Prolonged service, office | | | | | |
| 99355 | N | | Prolonged service, office | | | | | |
| 99356 | C | | Prolonged service, inpatient | | | | | |
| 99357 | C | | Prolonged service, inpatient | | | | | |
| 99358 | N | | Prolonged serv, w/o contact | | | | | |
| 99359 | N | | Prolonged serv, w/o contact | | | | | |
| 99360 | E | | Physician standby services | | | | | |
| 99361 | E | | Physician/team conference | | | | | |
| 99362 | E | | Physician/team conference | | | | | |
| 99371 | E | | Physician phone consultation | | | | | |
| 99372 | E | | Physician phone consultation | | | | | |
| 99373 | E | | Physician phone consultation | | | | | |
| 99374 | E | | Home health care supervision | | | | | |
| 99377 | E | | Hospice care supervision | | | | | |
| 99379 | E | | Nursing fac care supervision | | | | | |
| 99380 | E | | Nursing fac care supervision | | | | | |
| 99381 | E | | Prev visit, new, infant | | | | | |
| 99382 | E | | Prev visit, new, age 1-4 | | | | | |
| 99383 | E | | Prev visit, new, age 5-11 | | | | | |
| 99384 | E | | Prev visit, new, age 12-17 | | | | | |
| 99385 | E | | Prev visit, new, age 18-39 | | | | | |
| 99386 | E | | Prev visit, new, age 40-64 | | | | | |
| 99387 | E | | Prev visit, new, 65 & over | | | | | |
| 99391 | E | | Prev visit, est, infant | | | | | |
| 99392 | E | | Prev visit, est, age 1-4 | | | | | |
| 99393 | E | | Prev visit, est, age 5-11 | | | | | |
| 99394 | E | | Prev visit, est, age 12-17 | | | | | |
| 99395 | E | | Prev visit, est, age 18-39 | | | | | |
| 99396 | E | | Prev visit, est, age 40-64 | | | | | |
| 99397 | E | | Prev visit, est, 65 & over | | | | | |
| 99401 | E | | Preventive counseling, indiv | | | | | |
| 99402 | E | | Preventive counseling, indiv | | | | | |
| 99403 | E | | Preventive counseling, indiv | | | | | |
| 99404 | E | | Preventive counseling, indiv | | | | | |
| 99411 | E | | Preventive counseling, group | | | | | |
| 99412 | E | | Preventive counseling, group | | | | | |
| 99420 | E | | Health risk assessment test | | | | | |
| 99429 | E | | Unlisted preventive service | | | | | |
| 99431 | V | | Initial care, normal newborn | 0600 | 0.8430 | $43.96 | | $8.79 |
| 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 | 3.8371 | $200.11 | $67.63 | $40.02 |
| 99450 | E | | Life/disability evaluation | | | | | |
| 99455 | E | | Disability examination | | | | | |
| 99456 | E | | Disability examination | | | | | |
| 99499 | E | | Unlisted e&m service | | | | | |
| 99500 | E | | Home visit, prenatal | | | | | |
| 99501 | E | | Home visit, postnatal | | | | | |
| 99502 | E | | Home visit, nb care | | | | | |
| 99503 | E | | Home visit, resp therapy | | | | | |
| 99504 | E | | Home visit mech ventilator | | | | | |
| 99505 | E | | Home visit, stoma care | | | | | |
| 99506 | E | | Home visit, im injection | | | | | |
| 99507 | E | | Home visit, cath maintain | | | | | |
| 99508 | E | DG | Home visit, sleep studies | | | | | |
| 99509 | E | | Home visit day life activity | | | | | |
| 99510 | E | | Home visit, sing/m/fam couns | | | | | |
| 99511 | E | | Home visit, fecal/enema mgmt | | | | | |
| 99512 | E | | Home visit, hemodialysis | | | | | |
| 99539 | E | DG | Home visit, nos | | | | | |
| 99551 | E | | Home infus, pain mgmt, iv/sc | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 99552 | E | | Hm infus pain mgmt, epid/ith | | | | | |
| 99553 | E | | Home infuse, tocolytic tx | | | | | |
| 99554 | E | | Home infus, hormone/platelet | | | | | |
| 99555 | E | | Home infuse, chemotheraphy | | | | | |
| 99556 | E | | Home infus, antibio/fung/vir | | | | | |
| 99557 | E | | Home infuse, anticoagulant | | | | | |
| 99558 | E | | Home infuse, immunotherapy | | | | | |
| 99559 | E | | Home infus, periton dialysis | | | | | |
| 99560 | E | | Home infus, entero nutrition | | | | | |
| 99561 | E | | Home infuse, hydration tx | | | | | |
| 99562 | E | | Home infus, parent nutrition | | | | | |
| 99563 | E | | Home admin, pentamidine | | | | | |
| 99564 | E | | Hme infus, antihemophil agnt | | | | | |
| 99565 | E | | Home infus, proteinase inhib | | | | | |
| 99566 | E | | Home infuse, iv therapy | | | | | |
| 99567 | E | | Home infuse, sympath agent | | | | | |
| 99568 | E | | Home infus, misc drug, daily | | | | | |
| 99569 | E | | Home infuse, each addl tx | | | | | |
| 99600 | E | NI | Home visit nos | | | | | |
| A0021 | E | | Outside state ambulance serv | | | | | |
| A0080 | E | | Noninterest escort in non er | | | | | |
| A0090 | E | | Interest escort in non er | | | | | |
| A0100 | E | | Nonemergency transport taxi | | | | | |
| A0110 | E | | Nonemergency transport bus | | | | | |
| A0120 | E | | Noner transport mini-bus | | | | | |
| A0130 | E | | Noner transport wheelch van | | | | | |
| A0140 | E | | Nonemergency transport air | | | | | |
| A0160 | E | | Noner transport case worker | | | | | |
| A0170 | E | | Noner transport parking fees | | | | | |
| A0180 | E | | Noner transport lodgng recip | | | | | |
| A0190 | E | | Noner transport meals recip | | | | | |
| A0200 | E | | Noner transport lodgng escrt | | | | | |
| A0210 | E | | Noner transport meals escort | | | | | |
| A0225 | A | | Neonatal emergency transport | | | | | |
| A0380 | A | | Basic life support mileage | | | | | |
| A0382 | A | | Basic support routine suppls | | | | | |
| A0384 | A | | Bls defibrillation supplies | | | | | |
| A0390 | A | | Advanced life support mileag | | | | | |
| A0392 | A | | Als defibrillation supplies | | | | | |
| A0394 | A | | Als IV drug therapy supplies | | | | | |
| A0396 | A | | Als esophageal intub suppls | | | | | |
| A0398 | A | | Als routine disposble suppls | | | | | |
| A0420 | A | | Ambulance waiting 1/2 hr | | | | | |
| A0422 | A | | Ambulance 02 life sustaining | | | | | |
| A0424 | A | | Extra ambulance attendant | | | | | |
| A0425 | A | | Ground mileage | | | | | |
| A0426 | A | | Als 1 | | | | | |
| A0427 | A | | ALS1-emergency | | | | | |
| A0428 | A | | bls | | | | | |
| A0429 | A | | BLS-emergency | | | | | |
| A0430 | A | | Fixed wing air transport | | | | | |
| A0431 | A | | Rotary wing air transport | | | | | |
| A0432 | A | | PI volunteer ambulance co | | | | | |
| A0433 | A | | als 2 | | | | | |
| A0434 | A | | Specialty care transport | | | | | |
| A0435 | A | | Fixed wing air mileage | | | | | |
| A0436 | A | | Rotary wing air mileage | | | | | |
| A0888 | E | | Noncovered ambulance mileage | | | | | |
| A0999 | A | | Unlisted ambulance service | | | | | |
| A4206 | A | | 1 CC sterile syringe&needle | | | | | |
| A4207 | A | | 2 CC sterile syringe&needle | | | | | |
| A4208 | A | | 3 CC sterile syringe&needle | | | | | |
| A4209 | E | | 5+ CC sterile syringe&needle | | | | | |
| A4210 | E | | Nonneedle injection device | | | | | |
| A4211 | E | | Supp for self-adm injections | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| A4212 | E | | Non coring needle or stylet | | | | | |
| A4213 | E | | 20+ CC syringe only | | | | | |
| A4214 | A | | 30 CC sterile water/saline | | | | | |
| A4215 | E | | Sterile needle | | | | | |
| A4220 | A | | Infusion pump refill kit | | | | | |
| A4221 | A | | Maint drug infus cath per wk | | | | | |
| A4222 | A | | Drug infusion pump supplies | | | | | |
| A4230 | A | | Infus insulin pump non needl | | | | | |
| A4231 | A | | Infusion insulin pump needle | | | | | |
| A4232 | A | | Syringe w/needle insulin 3cc | | | | | |
| A4244 | E | | Alcohol or peroxide per pint | | | | | |
| A4245 | E | | Alcohol wipes per box | | | | | |
| A4246 | E | | Betadine/phisohex solution | | | | | |
| A4247 | E | | Betadine/iodine swabs/wipes | | | | | |
| A4250 | E | | Urine reagent strips/tablets | | | | | |
| A4253 | A | | Blood glucose/reagent strips | | | | | |
| A4254 | A | | Battery for glucose monitor | | | | | |
| A4255 | A | | Glucose monitor platforms | | | | | |
| A4256 | A | | Calibrator solution/chips | | | | | |
| A4257 | A | | Replace Lensshield Cartridge | | | | | |
| A4258 | A | | Lancet device each | | | | | |
| A4259 | A | | Lancets per box | | | | | |
| A4260 | E | | Levonorgestrel implant | | | | | |
| A4261 | E | | Cervical cap contraceptive | | | | | |
| A4262 | N | | Temporary tear duct plug | | | | | |
| A4263 | N | | Permanent tear duct plug | | | | | |
| A4265 | A | | Paraffin | | | | | |
| A4266 | E | NI | Diaphragm | | | | | |
| A4267 | E | NI | Male condom | | | | | |
| A4268 | E | NI | Female condom | | | | | |
| A4269 | E | NI | Spermicide | | | | | |
| A4270 | A | | Disposable endoscope sheath | | | | | |
| A4280 | A | | Brst prsths adhsv attchmnt | | | | | |
| A4281 | E | NI | Replacement breastpump tube | | | | | |
| A4282 | E | NI | Replacement breastpump adpt | | | | | |
| A4283 | E | NI | Replacement breastpump cap | | | | | |
| A4284 | E | NI | Replcmnt breast pump shield | | | | | |
| A4285 | E | NI | Replcmnt breast pump bottle | | | | | |
| A4286 | E | NI | Replcmnt breastpump lok ring | | | | | |
| A4290 | E | | Sacral nerve stim test lead | | | | | |
| A4300 | N | | Cath impl vasc access portal | | | | | |
| A4301 | N | | Implantable access syst perc | | | | | |
| A4305 | A | | Drug delivery system >=50 ML | | | | | |
| A4306 | A | | Drug delivery system <=5 ML | | | | | |
| A4310 | A | | Insert tray w/o bag/cath | | | | | |
| A4311 | A | | Catheter w/o bag 2-way latex | | | | | |
| A4312 | A | | Cath w/o bag 2-way silicone | | | | | |
| A4313 | A | | Catheter w/bag 3-way | | | | | |
| A4314 | A | | Cath w/drainage 2-way latex | | | | | |
| A4315 | A | | Cath w/drainage 2-way silcne | | | | | |
| A4316 | A | | Cath w/drainage 3-way | | | | | |
| A4319 | A | | Sterile H2O irrigation solut | | | | | |
| A4320 | A | | Irrigation tray | | | | | |
| A4321 | A | | Cath therapeutic irrig agent | | | | | |
| A4322 | A | | Irrigation syringe | | | | | |
| A4323 | A | | Saline irrigation solution | | | | | |
| A4324 | A | | Male ext cath w/adh coating | | | | | |
| A4325 | A | | Male ext cath w/adh strip | | | | | |
| A4326 | A | | Male external catheter | | | | | |
| A4327 | A | | Fem urinary collect dev cup | | | | | |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | | | | | |
| A4360 | A | DG | Adult incontinence garment | | | | | |
| A4361 | A | | Ostomy face plate | | | | | |
| A4362 | A | | Solid skin barrier | | | | | |
| A4364 | A | | Adhesive, liquid or equal | | | | | |
| A4365 | A | | Adhesive remover wipes | | | | | |
| A4367 | A | | Ostomy belt | | | | | |
| A4368 | A | | Ostomy filter | | | | | |
| A4369 | A | | Skin barrier liquid per oz | | | | | |
| A4370 | A | DG | Skin barrier paste per oz | | | | | |
| A4371 | A | | Skin barrier powder per oz | | | | | |
| A4372 | A | | Skin barrier solid 4x4 equiv | | | | | |
| A4373 | A | | Skin barrier with flange | | | | | |
| A4374 | A | DG | Skin barrier extended wear | | | | | |
| A4375 | A | | Drainable plastic pch w fcpl | | | | | |
| A4376 | A | | Drainable rubber pch w fcplt | | | | | |
| A4377 | A | | Drainable plstic pch w/o fp | | | | | |
| A4378 | A | | Drainable rubber pch w/o fp | | | | | |
| A4379 | A | | Urinary plastic pouch w fcpl | | | | | |
| A4380 | A | | Urinary rubber pouch w fcplt | | | | | |
| A4381 | A | | Urinary plastic pouch w/o fp | | | | | |
| A4382 | A | | Urinary hvy plstc pch w/o fp | | | | | |
| A4383 | A | | Urinary rubber pouch w/o fp | | | | | |
| A4384 | A | | Ostomy faceplt/silicone ring | | | | | |
| A4385 | A | | Ost skn barrier sld ext wear | | | | | |
| A4386 | A | DG | Ost skn barrier w flng ex wr | | | | | |
| 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 | NI | Nonpectin based ostomy paste | | | | | |
| A4406 | A | NI | Pectin based ostomy paste | | | | | |
| A4407 | A | NI | Ext wear ost skn barr <=4sq≧ | | | | | |
| A4408 | A | NI | Ext wear ost skn barr >4sq≧ | | | | | |
| A4409 | A | NI | Ost skn barr w flng <=4 sq≧ | | | | | |
| A4410 | A | NI | Ost skn barr w flng >4sq≧ | | | | | |
| A4413 | A | NI | 2 pc drainable ost pouch | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| A4414 | A | NI | Ostomy sknbarr w flng <=4sq≧ | | | | | |
| A4415 | A | NI | Ostomy skn barr w flng >4sq≧ | | | | | |
| A4421 | A | | Ostomy supply misc | | | | | |
| A4422 | A | NI | Ost pouch absorbent material | | | | | |
| A4450 | A | NI | Non-waterproof tape | | | | | |
| A4452 | A | NI | Waterproof tape | | | | | |
| A4454 | A | DG | Tape all types all sizes | | | | | |
| A4455 | A | | Adhesive remover per ounce | | | | | |
| A4458 | E | NI | Reusable enema bag | | | | | |
| A4460 | A | DG | Elastic compression bandage | | | | | |
| A4462 | A | | Abdmnl drssng holder/binder | | | | | |
| A4464 | A | DG | Joint support device/garment | | | | | |
| 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 | NI | Adult size diaper sm each | | | | | |
| A4522 | E | NI | Adult size diaper med each | | | | | |
| A4523 | E | NI | Adult size diaper lg each | | | | | |
| A4524 | E | NI | Adult size diaper xl each | | | | | |
| A4525 | E | NI | Adult size brief sm each | | | | | |
| A4526 | E | NI | Adult size brief med each | | | | | |
| A4527 | E | NI | Adult size brief lg each | | | | | |
| A4528 | E | NI | Adult size brief xl each | | | | | |
| A4529 | E | NI | Child size diaper sm/med ea | | | | | |
| A4530 | E | NI | Child size diaper lg each | | | | | |
| A4531 | E | NI | Child size brief sm/med each | | | | | |
| A4532 | E | NI | Child size brief lg each | | | | | |
| A4533 | E | NI | Youth size diaper each | | | | | |
| A4534 | E | NI | Youth size brief each | | | | | |
| A4535 | E | NI | Disp incont liner/shield ea | | | | | |
| A4536 | E | NI | Prot underwr wshbl any sz ea | | | | | |
| A4537 | E | NI | Under pad reusable any sz ea | | | | | |
| A4538 | E | NI | Diaper sv ea reusable diaper | | | | | |
| A4550 | E | | Surgical trays | | | | | |
| A4554 | E | | Disposable underpads | | | | | |
| A4556 | A | | Electrodes, pair | | | | | |
| A4557 | A | | Lead wires, pair | | | | | |
| A4558 | A | | Conductive paste or gel | | | | | |
| A4561 | N | | Pessary rubber, any type | | | | | |
| A4562 | N | | Pessary, non rubber,any type | | | | | |
| A4565 | A | | Slings | | | | | |
| A4570 | N | | Splint | | | | | |
| A4572 | A | DG | Rib belt | | | | | |
| A4575 | E | | Hyperbaric o2 chamber disps | | | | | |
| A4580 | N | | Cast supplies (plaster) | | | | | |
| A4590 | N | | Special casting material | | | | | |
| A4595 | A | | TENS suppl 2 lead per month | | | | | |
| A4606 | A | NI | Oxygen probe used w oximeter | | | | | |
| A4608 | A | | Transtracheal oxygen cath | | | | | |
| A4609 | A | NI | Trach suction cath clsed sys | | | | | |
| A4610 | A | NI | 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| A4619 | A | | Face tent | | | | | |
| A4620 | A | | Variable concentration mask | | | | | |
| A4621 | A | | Tracheotomy mask or collar | | | | | |
| A4622 | A | | Tracheostomy or larngectomy | | | | | |
| A4623 | A | | Tracheostomy inner cannula | | | | | |
| A4624 | A | | Tracheal suction tube | | | | | |
| A4625 | A | | Trach care kit for new trach | | | | | |
| A4626 | A | | Tracheostomy cleaning brush | | | | | |
| A4627 | E | | Spacer bag/reservoir | | | | | |
| A4628 | A | | Oropharyngeal suction cath | | | | | |
| A4629 | A | | Tracheostomy care kit | | | | | |
| A4630 | A | | Repl bat t.e.n.s. own by pt | | | | | |
| A4631 | A | | Wheelchair battery | | | | | |
| A4632 | A | NI | Infus pump rplcemnt battery | | | | | |
| A4633 | A | NI | Uvl replacement bulb | | | | | |
| A4634 | A | NI | Replacement bulb th lightbox | | | | | |
| A4635 | A | | Underarm crutch pad | | | | | |
| A4636 | A | | Handgrip for cane etc | | | | | |
| A4637 | A | | Repl tip cane/crutch/walker | | | | | |
| A4639 | A | NI | Infrared ht sys replcmnt pad | | | | | |
| A4640 | A | | Alternating pressure pad | | | | | |
| A4641 | N | | Diagnostic imaging agent | | | | | |
| A4642 | N | | Satumomab pendetide per dose | | | | | |
| A4643 | N | | High dose contrast MRI | | | | | |
| A4644 | N | | Contrast 100-199 MGs iodine | | | | | |
| A4645 | N | | Contrast 200-299 MGs iodine | | | | | |
| A4646 | N | | Contrast 300-399 MGs iodine | | | | | |
| A4647 | N | | Supp- paramagnetic contr mat | | | | | |
| A4649 | A | | Surgical supplies | | | | | |
| A4651 | A | | Calibrated microcap tube | | | | | |
| A4652 | A | | Microcapillary tube sealant | | | | | |
| A4653 | A | NI | PD catheter anchor belt | | | | | |
| A4656 | A | | Dialysis needle | | | | | |
| A4657 | A | | Dialysis syringe w/wo needle | | | | | |
| A4660 | A | | Sphyg/bp app w cuff and stet | | | | | |
| A4663 | A | | Dialysis blood pressure cuff | | | | | |
| A4670 | E | | Automatic bp monitor, dial | | | | | |
| A4680 | A | | Activated carbon filter, ea | | | | | |
| A4690 | A | | Dialyzer, each | | | | | |
| A4706 | A | | Bicarbonate conc sol per gal | | | | | |
| A4707 | A | | Bicarbonate conc pow per pac | | | | | |
| A4708 | A | | Acetate conc sol per gallon | | | | | |
| A4709 | A | | Acid conc sol per gallon | | | | | |
| A4712 | A | | Sterile water inj per 10 ml | | | | | |
| A4714 | A | | Treated water per gallon | | | | | |
| A4719 | A | | ≧Y set≧ tubing | | | | | |
| A4720 | A | | Dialysat sol fld vol > 249cc | | | | | |
| A4721 | A | | Dialysat sol fld vol > 999cc | | | | | |
| A4722 | A | | Dialys sol fld vol > 1999cc | | | | | |
| A4723 | A | | Dialys sol fld vol > 2999cc | | | | | |
| A4724 | A | | Dialys sol fld vol > 3999cc | | | | | |
| A4725 | A | | Dialys sol fld vol > 4999cc | | | | | |
| A4726 | A | | Dialys sol fld vol > 5999cc | | | | | |
| A4730 | A | | Fistula cannulation set, ea | | | | | |
| A4736 | A | | Topical anesthetic, per gram | | | | | |
| A4737 | A | | Inj anesthetic per 10 ml | | | | | |
| A4740 | A | | Shunt accessory | | | | | |
| A4750 | A | | Art or venous blood tubing | | | | | |
| A4755 | A | | Comb art/venous blood tubing | | | | | |
| A4760 | A | | Dialysate sol test kit, each | | | | | |
| A4765 | A | | Dialysate conc pow per pack | | | | | |
| A4766 | A | | Dialysate conc sol add 10 ml | | | | | |
| A4770 | A | | Blood collection tube/vacuum | | | | | |
| A4771 | A | | Serum clotting time tube | | | | | |
| A4772 | A | | Blood glucose test strips | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| A4773 | A | | Occult blood test strips | | | | | |
| A4774 | A | | Ammonia test strips | | | | | |
| A4801 | A | DG | Heparin per 1000 units | | | | | |
| 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 | NI | Sterile, gloves per pair | | | | | |
| A4931 | A | NI | Reusable oral thermometer | | | | | |
| A4932 | E | NI | 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 | | | | | |
| A5123 | A | DG | Skin barrier with flange | | | | | |
| A5126 | A | | Disk/foam pad +or- adhesive | | | | | |
| A5131 | A | | Appliance cleaner | | | | | |
| A5200 | A | | Percutaneous catheter anchor | | | | | |
| A5500 | A | | Diab shoe for density insert | | | | | |
| A5501 | A | | Diabetic custom molded shoe | | | | | |
| A5503 | A | | Diabetic shoe w/roller/rockr | | | | | |
| A5504 | A | | Diabetic shoe with wedge | | | | | |
| A5505 | A | | Diab shoe w/metatarsal bar | | | | | |
| A5506 | A | | Diabetic shoe w/off set heel | | | | | |
| A5507 | A | | Modification diabetic shoe | | | | | |
| A5508 | A | | Diabetic deluxe shoe | | | | | |
| A5509 | A | | Direct heat form shoe insert | | | | | |
| A5510 | A | | Compression form shoe insert | | | | | |
| A5511 | A | | Custom fab molded shoe inser | | | | | |
| A6000 | E | | Wound warming wound cover | | | | | |
| A6010 | A | | Collagen based wound filler | | | | | |
| A6011 | A | NI | 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | | | | | |
| A6260 | A | | Wound cleanser any type/size | | | | | |
| A6261 | A | | Wound filler gel/paste /oz | | | | | |
| A6262 | A | | Wound filler dry form / gram | | | | | |
| A6263 | A | DG | Non-sterile elastic gauze/yd | | | | | |
| A6264 | A | DG | Non-sterile no elastic gauze | | | | | |
| A6265 | A | DG | Tape per 18 sq inches | | | | | |
| A6266 | A | | Impreg gauze no h20/sal/yard | | | | | |
| A6402 | A | | Sterile gauze <= 16 sq in | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| A6403 | A | | Sterile gauze>16 <= 48 sq in | | | | | |
| A6404 | A | | Sterile gauze > 48 sq in | | | | | |
| A6405 | A | DG | Sterile elastic gauze /yd | | | | | |
| A6406 | A | DG | Sterile non-elastic gauze/yd | | | | | |
| A6410 | A | NI | Sterile eye pad | | | | | |
| A6411 | A | NI | Non-sterile eye pad | | | | | |
| A6412 | E | NI | Occlusive eye patch | | | | | |
| A6421 | A | NI | Pad bandage >=3 <5in w /roll | | | | | |
| A6422 | A | NI | Conf bandage ns >=3<5≧w/roll | | | | | |
| A6424 | A | NI | Conf bandage ns >=5≧w /roll | | | | | |
| A6426 | A | NI | Conf bandage s >=3<5≧ w/roll | | | | | |
| A6428 | A | NI | Conf bandage s >=5≧ w /roll | | | | | |
| A6430 | A | NI | Lt compres bdg >=3<5≧w /roll | | | | | |
| A6432 | A | NI | Lt compres bdg >=5≧w /roll | | | | | |
| A6434 | A | NI | Mo compres bdg >=3<5≧w /roll | | | | | |
| A6436 | A | NI | Hi compres bdg >=3<5≧w /roll | | | | | |
| A6438 | A | NI | Self-adher bdg >=3<5≧w /roll | | | | | |
| A6440 | A | NI | Zinc paste bdg >=3<5≧w /roll | | | | | |
| A6501 | A | NI | Compres burngarment bodysuit | | | | | |
| A6502 | A | NI | Compres burngarment chinstrp | | | | | |
| A6503 | A | NI | Compres burngarment facehood | | | | | |
| A6504 | A | NI | Cmprsburngarment glove-wrist | | | | | |
| A6505 | A | NI | Cmprsburngarment glove-elbow | | | | | |
| A6506 | A | NI | Cmprsburngrmnt glove-axilla | | | | | |
| A6507 | A | NI | Cmprs burngarment foot-knee | | | | | |
| A6508 | A | NI | Cmprs burngarment foot-thigh | | | | | |
| A6509 | A | NI | Compres burn garment jacket | | | | | |
| A6510 | A | NI | Compres burn garment leotard | | | | | |
| A6511 | A | NI | Compres burn garment panty | | | | | |
| A6512 | A | NI | Compres burn garment, noc | | | | | |
| A7000 | A | | Disposable canister for pump | | | | | |
| A7001 | A | | Nondisposable pump canister | | | | | |
| A7002 | A | | Tubing used w suction pump | | | | | |
| A7003 | A | | Nebulizer administration set | | | | | |
| A7004 | A | | Disposable nebulizer sml vol | | | | | |
| A7005 | A | | Nondisposable nebulizer set | | | | | |
| A7006 | A | | Filtered nebulizer admin set | | | | | |
| A7007 | A | | Lg vol nebulizer disposable | | | | | |
| A7008 | A | | Disposable nebulizer prefill | | | | | |
| A7009 | A | | Nebulizer reservoir bottle | | | | | |
| A7010 | A | | Disposable corrugated tubing | | | | | |
| A7011 | A | | Nondispos corrugated tubing | | | | | |
| A7012 | A | | Nebulizer water collec devic | | | | | |
| A7013 | A | | Disposable compressor filter | | | | | |
| A7014 | A | | Compressor nondispos filter | | | | | |
| A7015 | A | | Aerosol mask used w nebulize | | | | | |
| A7016 | A | | Nebulizer dome & mouthpiece | | | | | |
| A7017 | A | | Nebulizer not used w oxygen | | | | | |
| A7018 | A | | Water distilled w/nebulizer | | | | | |
| A7019 | A | | Saline solution dispenser | | | | | |
| A7020 | A | | Sterile H2O or NSS w lgv neb | | | | | |
| A7025 | A | NI | Replace chest compress vest | | | | | |
| A7026 | A | NI | Replace chst cmprss sys hose | | | | | |
| A7030 | A | NI | CPAP full face mask | | | | | |
| A7031 | A | NI | Replacement facemask interfa | | | | | |
| A7032 | A | NI | Replacement nasal cushion | | | | | |
| A7033 | A | NI | Replacement nasal pillows | | | | | |
| A7034 | A | NI | Nasal application device | | | | | |
| A7035 | A | NI | Pos airway press headgear | | | | | |
| A7036 | A | NI | Pos airway press chinstrap | | | | | |
| A7037 | A | NI | Pos airway pressure tubing | | | | | |
| A7038 | A | NI | Pos airway pressure filter | | | | | |
| A7039 | A | NI | Filter, non disposable w pap | | | | | |
| A7042 | A | NI | Implanted pleural catheter | | | | | |
| A7043 | A | NI | Vacuum drainagebottle/tubing | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| A7044 | A | NI | PAP oral interface | | | | | |
| A7501 | A | | Tracheostoma valve w diaphra | | | | | |
| A7502 | A | | Replacement diaphragm/fplate | | | | | |
| A7503 | A | | HMES filter holder or cap | | | | | |
| A7504 | A | | Tracheostoma HMES filter | | | | | |
| A7505 | A | | HMES or trach valve housing | | | | | |
| A7506 | A | | HMES/trachvalve adhesivedisk | | | | | |
| A7507 | A | | Integrated filter & holder | | | | | |
| A7508 | A | | Housing & Integrated Adhesiv | | | | | |
| A7509 | A | | Heat & moisture exchange sys | | | | | |
| A9150 | E | | Misc/exper non-prescript dru | | | | | |
| A9270 | E | | Non-covered item or service | | | | | |
| A9300 | E | | Exercise equipment | | | | | |
| A9500 | N | | Technetium TC 99m sestamibi | | | | | |
| A9502 | N | | Technetium TC99M tetrofosmin | | | | | |
| A9503 | N | | Technetium TC 99m medronate | | | | | |
| A9504 | N | | Technetium tc 99m apcitide | | | | | |
| A9505 | N | | Thallous chloride TL 201/mci | | | | | |
| A9507 | K | | Indium/111 capromab pendetid | 1604 | 16.4434 | $857.54 | | $171.51 |
| A9508 | K | | Iobenguane sulfate I-131 | 1045 | 1.5697 | $81.86 | | $16.37 |
| A9510 | N | | Technetium TC99m Disofenin | | | | | |
| A9511 | K | | Technetium TC 99m depreotide | 1095 | 5.6006 | $292.08 | | $58.42 |
| A9512 | N | NI | Technetium tc99m pertechnetate | | | | | |
| A9513 | N | NI | Technetium tc-99m mebrofenin | | | | | |
| A9514 | N | NI | Technetium tc99m pyrophosphate | | | | | |
| A9515 | N | NI | Technetium tc-99m pentetate | | | | | |
| A9516 | N | NI | I-123 sodium iodide capsule | | | | | |
| A9517 | N | NI | I-131 sodium iodide capsule | | | | | |
| A9518 | K | NI | I-131 sodium iodide solution | 1348 | 0.9399 | $49.02 | | $9.80 |
| A9519 | N | NI | Technetium tc-99m macroag albu | | | | | |
| A9520 | N | NI | Technetium tc-99m sulfur clld | | | | | |
| A9521 | K | NI | Technetium tc-99m exametazine | 1096 | 4.4379 | $231.44 | | $46.29 |
| A9522 | E | NI | Indium111ibritumomabtiuxetan | | | | | |
| A9523 | E | NI | Yttrium90ibritumomabtiuxetan | | | | | |
| A9524 | N | NI | Iodinated I-131 serumalbumin | | | | | |
| A9600 | K | | Strontium-89 chloride | 0701 | 8.9920 | $468.94 | | $93.79 |
| A9603 | N | NI | I-131sodiumiodidecap per mci | | | | | |
| A9605 | K | | Samarium sm153 lexidronamm | 0702 | 14.6218 | $762.54 | | $152.51 |
| A9699 | N | NI | Noc therapeutic radiopharm | | | | | |
| A9700 | G | | Echocardiography Contrast | 9016 | | $118.75 | | $17.75 |
| A9900 | A | | Supply/accessory/service | | | | | |
| A9901 | A | | Delivery/set up/dispensing | | | | | |
| B4034 | A | | Enter feed supkit syr by day | | | | | |
| B4035 | A | | Enteral feed supp pump per d | | | | | |
| B4036 | A | | Enteral feed sup kit grav by | | | | | |
| B4081 | A | | Enteral ng tubing w/ stylet | | | | | |
| B4082 | A | | Enteral ng tubing w/o stylet | | | | | |
| B4083 | A | | Enteral stomach tube levine | | | | | |
| B4086 | A | | Gastrostomy/jejunostomy tube | | | | | |
| B4100 | E | NI | 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% | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | | Blood, L/R, CMV-NEG | 1010 | 2.3352 | $121.78 | | $24.36 |
| C1011 | K | | Platelets, HLA-m, L/R, unit | 1011 | 9.5831 | $499.77 | | $99.95 |
| C1012 | K | DG | PLATELET CONC, L/R, Irrad | 0954 | 2.2868 | $119.26 | | $23.85 |
| C1013 | K | DG | PLATELET CONC, L/R, Unit | 1013 | 0.9496 | $49.52 | | $9.90 |
| C1014 | K | DG | Platelet,Aph/Pher, L/R, unit | 9501 | 7.8390 | $408.81 | | $81.76 |
| C1015 | K | NI | Plt, pher,L/R,CMV, irrad | 1020 | 9.4959 | $495.22 | | $99.04 |
| C1016 | K | | BLOOD,L/R,FROZ/DEGLY/Washed | 1016 | 5.7848 | $301.68 | | $60.34 |
| C1017 | K | | Plt, APH/PHER,L/R,CMV-NEG | 1017 | 7.5386 | $393.15 | | $78.63 |
| C1018 | K | | Blood, L/R, IRRADIATED | 1018 | 2.5387 | $132.40 | | $26.48 |
| C1020 | K | NI | RBC, frz/deg/wsh, L/R, irrad | 1021 | 6.4436 | $336.04 | | $67.21 |
| C1021 | K | NI | RBC, L/R, CMV neg, irrad | 1022 | 3.8565 | $201.12 | | $40.22 |
| C1022 | K | NI | Plasma, frz within 24 hour | 0955 | 1.8217 | $95.00 | | $19.00 |
| C1058 | N | DG | TC 99M oxidronate, per vial | | | | | |
| C1064 | N | DG | I-131 cap, each add mCi | | | | | |
| C1065 | N | DG | I-131 sol, each add mCi | | | | | |
| C1066 | N | DG | IN 111 satumomab pendetide | | | | | |
| C1079 | N | | CO 57/58 per 0.5 uCi | | | | | |
| C1087 | N | DG | I-123 per 100 uCi | | | | | |
| C1088 | T | | LASER OPTIC TR Sys | 0980 | | $1,875.00 | | $375.00 |
| C1091 | K | | IN111 oxyquinoline,per0.5mCi | 1091 | 4.7092 | $245.59 | | $49.12 |
| C1092 | K | | IN 111 pentetate per 0.5 mCi | 1092 | 4.4379 | $231.44 | | $46.29 |
| C1094 | N | DG | TC99Malbumin aggr,per 1.0mCi | | | | | |
| C1096 | K | DG | TC 99M EXAMETAZIME, PER Dose | 1096 | 4.4379 | $231.44 | | $46.29 |
| C1097 | N | DG | TC 99M MEBROFENIN, PER Vial | | | | | |
| C1098 | N | DG | TC 99M PENTETATE, PER Vial | | | | | |
| C1099 | N | DG | TC 99M PYROPHOSPHATE,PER Via. | | | | | |
| C1122 | K | | Tc 99M ARCITUMOMAB PER VIAL | 1122 | 11.4726 | $598.31 | | $119.66 |
| C1166 | N | | CYTARABINE LIPOSOMAL, 10 mg | | | | | |
| C1167 | K | | EPIRUBICIN HCL, 2 mg | 1167 | 0.3294 | $17.18 | | $3.44 |
| C1178 | K | | BUSULFAN IV, 6 Mg | 1178 | 0.4845 | $25.27 | | $5.05 |
| C1188 | N | DG | I-131 cap, per 1-5 mCi | | | | | |
| C1200 | N | | TC 99M Sodium Glucoheptonat | | | | | |
| C1201 | N | | TC 99M SUCCIMER, PER Vial | | | | | |
| C1202 | N | DG | TC 99M SULFUR COLLOID, Vial | | | | | |
| C1207 | K | DG | OCTREOTIDE ACETATE DEPOT 1mg. | 1207 | 1.4244 | $74.28 | | $14.86 |
| C1300 | S | | HYPERBARIC Oxygen | 0659 | 3.2364 | $168.78 | | $33.76 |
| C1305 | K | | Apligraf | 1305 | 13.0520 | $680.67 | | $136.13 |
| C1348 | K | DG | I-131 sol, per 1-6 mCi | 1348 | 0.9399 | $49.02 | | $9.80 |
| C1713 | D | DNG | Anchor/screw bn/bn,tis/bn | | | | | |
| C1714 | D | DNG | Cath, trans atherectomy, dir | | | | | |
| C1715 | D | DNG | Brachytherapy needle | | | | | |
| C1716 | K | | Brachytx seed, Gold 198 | 1716 | 0.4360 | $22.74 | | $4.55 |
| C1717 | D | DNG | Brachytx seed, HDR Ir-192 | | | | | |
| C1718 | K | | Brachytx seed, Iodine 125 | 1718 | 0.6008 | $31.33 | | $6.27 |
| C1719 | K | | Brachytx seed,Non-HDR Ir-192 | 1719 | 0.5232 | $27.29 | | $5.46 |
| C1720 | K | | Brachytx seed, Palladium 103 | 1720 | 0.8430 | $43.96 | | $8.79 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| C1721 | D | DNG | AICD, dual chamber | | | | | |
| C1722 | D | DNG | AICD, single chamber | | | | | |
| C1724 | D | DNG | Cath, trans atherec,rotation | | | | | |
| C1725 | D | DNG | Cath, translumin non-laser | | | | | |
| C1726 | D | DNG | Cath, bal dil, non-vascular | | | | | |
| C1727 | D | DNG | Cath, bal tis dis, non-vas | | | | | |
| C1728 | D | DNG | Cath, brachytx seed adm | | | | | |
| C1729 | D | DNG | Cath, drainage | | | | | |
| C1730 | D | DNG | Cath, EP, 19 or few elect | | | | | |
| C1731 | D | DNG | Cath, EP, 20 or more elec | | | | | |
| C1732 | D | DNG | Cath, EP, diag/abl, 3D/vect | | | | | |
| C1733 | D | DNG | Cath, EP, othr than cool-tip | | | | | |
| C1750 | D | DNG | Cath, hemodialysis,long-term | | | | | |
| C1751 | D | DNG | Cath, inf, per/cent/midline | | | | | |
| C1752 | D | DNG | Cath,hemodialysis,short-term | | | | | |
| C1753 | D | DNG | Cath, intravas ultrasound | | | | | |
| C1754 | D | DNG | Catheter, intradiscal | | | | | |
| C1755 | D | DNG | Catheter, intraspinal | | | | | |
| C1756 | D | DNG | Cath, pacing, transesoph | | | | | |
| C1757 | D | DNG | Cath, thrombectomy/embolect | | | | | |
| C1758 | D | DNG | Catheter, ureteral | | | | | |
| C1759 | D | DNG | Cath, intra echocardiography | | | | | |
| C1760 | D | DNG | Closure dev, vasc | | | | | |
| C1762 | D | DNG | Conn tiss, human(inc fascia) | | | | | |
| C1763 | D | DNG | Conn tiss, non-human | | | | | |
| C1764 | D | DNG | Event recorder, cardiac | | | | | |
| C1765 | H | | Adhesion barrier | 1765 | | | | |
| C1766 | D | DNG | Intro/sheath,strble,non-peel | | | | | |
| C1767 | D | DNG | Generator, neurostim, imp | | | | | |
| C1768 | D | DNG | Graft, vascular | | | | | |
| C1769 | D | DNG | Guide wire | | | | | |
| C1770 | D | DNG | Imaging coil, MR, insertable | | | | | |
| C1771 | D | DNG | Rep dev, urinary, w/sling | | | | | |
| C1772 | D | DNG | Infusion pump, programmable | | | | | |
| C1773 | D | DNG | Ret dev, insertable | | | | | |
| C1774 | K | | Darbepoetin alfa, 1 mcg | 0734 | 0.0454 | $2.37 | | $.47 |
| C1775 | K | | FDG, per dose (4-40 mCi/ml) | 1775 | 7.5289 | $392.64 | | $78.53 |
| C1776 | D | DNG | Joint device (implantable) | | | | | |
| C1777 | D | DNG | Lead, AICD, endo single coil | | | | | |
| C1778 | D | DNG | Lead, neurostimulator | | | | | |
| C1779 | D | DNG | Lead, pmkr, transvenous VDD | | | | | |
| C1780 | D | DNG | Lens, intraocular (new tech) | | | | | |
| C1781 | D | DNG | Mesh (implantable) | | | | | |
| C1782 | D | DNG | Morcellator | | | | | |
| C1783 | H | | Ocular imp, aqueous drain dev | 1783 | | | | |
| C1784 | D | DNG | Ocular dev, intraop, det ret | | | | | |
| C1785 | D | DNG | Pmkr, dual, rate-resp | | | | | |
| C1786 | D | DNG | Pmkr, single, rate-resp | | | | | |
| C1787 | D | DNG | Patient progr, neurostim | | | | | |
| C1788 | D | DNG | Port, indwelling, imp | | | | | |
| C1789 | D | DNG | Prosthesis, breast, imp | | | | | |
| C1813 | D | DNG | Prosthesis, penile, inflatab | | | | | |
| C1815 | D | DNG | Pros, urinary sph, imp | | | | | |
| C1816 | D | DNG | Receiver/transmitter, neuro | | | | | |
| C1817 | D | DNG | Septal defect imp sys | | | | | |
| C1874 | D | DNG | Stent, coated/cov w/del sys | | | | | |
| C1875 | D | DNG | Stent, coated/cov w/o del sy | | | | | |
| C1876 | D | DNG | Stent, non-coa/non-cov w/del | | | | | |
| C1877 | D | DNG | Stent, non-coat/cov w/o del | | | | | |
| C1878 | D | DNG | Matrl for vocal cord | | | | | |
| C1879 | D | DNG | Tissue marker, implantable | | | | | |
| C1880 | D | DNG | Vena cava filter | | | | | |
| C1881 | D | DNG | Dialysis access system | | | | | |
| C1882 | D | DNG | AICD, other than sing/dual | | | | | |
| C1883 | D | DNG | Adapt/ext, pacing/neuro lead | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| C1885 | D | DNG | Cath, translumin angio laser | | | | | |
| C1887 | D | DNG | Catheter, guiding | | | | | |
| C1888 | H | | Endovas non-cardiac abl cath | 1888 | | | | |
| C1891 | D | DNG | Infusion pump,non-prog, perm | | | | | |
| C1892 | D | DNG | Intro/sheath,fixed,peel-away | | | | | |
| C1893 | D | DNG | Intro/sheath, fixed,non-peel | | | | | |
| C1894 | D | DNG | Intro/sheath, non-laser | | | | | |
| C1895 | D | DNG | Lead, AICD, endo dual coil | | | | | |
| C1896 | D | DNG | Lead, AICD, non sing/dual | | | | | |
| C1897 | D | DNG | Lead, neurostim test kit | | | | | |
| C1898 | D | DNG | Lead, pmkr, other than trans | | | | | |
| C1899 | D | DNG | Lead, pmkr/AICD combination | | | | | |
| C1900 | H | | Lead coronary venous | 1900 | | | | |
| C2614 | H | NI | Probe, perc lumb disc | 2614 | | | | |
| C2615 | D | DNG | Sealant, pulmonary, liquid | | | | | |
| C2616 | K | | Brachytx seed, Yttrium-90 | 2616 | 8.8370 | $460.86 | | $92.17 |
| C2617 | D | DNG | Stent, non-cor, tem w/o del | | | | | |
| C2618 | H | | Probe, cryoablation | 2618 | | | | |
| C2619 | D | DNG | Pmkr, dual, non rate-resp | | | | | |
| C2620 | D | DNG | Pmkr, single, non rate-resp | | | | | |
| C2621 | D | DNG | Pmkr, other than sing/dual | | | | | |
| C2622 | D | DNG | Prosthesis, penile, non-inf | | | | | |
| C2625 | D | DNG | Stent, non-cor, tem w/del sy | | | | | |
| C2626 | D | DNG | Infusion pump, non-prog,temp | | | | | |
| C2627 | D | DNG | Cath, suprapubic/cystoscopic | | | | | |
| C2628 | D | DNG | Catheter, occlusion | | | | | |
| C2629 | D | DNG | Intro/sheath, laser | | | | | |
| C2630 | D | DNG | Cath, EP, cool-tip | | | | | |
| C2631 | D | DNG | Rep dev, urinary, w/o sling | | | | | |
| C2632 | H | NI | Brachytx sol, I-125, per mCi | 2632 | | | | |
| C8900 | S | | MRA w/cont, abd | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| C8901 | S | | MRA w/o cont, abd | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| C8902 | S | | MRA w/o fol w/cont, abd | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| C8903 | S | | MRI w/cont, breast, uni | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| C8904 | S | | MRI w/o cont, breast, uni | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| C8905 | S | | MRI w/o fol w/cont, brst, un | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| C8906 | S | | MRI w/cont, breast, bi | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| C8907 | S | | MRI w/o cont, breast, bi | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| C8908 | S | | MRI w/o fol w/cont, breast, | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| C8909 | S | | MRA w/cont, chest | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| C8910 | S | | MRA w/o cont, chest | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| C8911 | S | | MRA w/o fol w/cont, chest | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| C8912 | S | | MRA w/cont, lwr ext | 0284 | 7.2382 | $377.48 | $201.02 | $75.50 |
| C8913 | S | | MRA w/o cont, lwr ext | 0336 | 6.5987 | $344.13 | $176.94 | $68.83 |
| C8914 | S | | MRA w/o fol w/cont, lwr ext | 0337 | 9.2440 | $482.08 | $240.77 | $96.42 |
| C9000 | K | | Na chromateCr51, per 0.25mCi | 9000 | 1.8798 | $98.03 | | $19.61 |
| C9003 | K | | Palivizumab, per 50 mg | 9003 | 8.5657 | $446.71 | | $89.34 |
| C9007 | N | | Baclofen Intrathecal kit-1am | | | | | |
| C9008 | N | | Baclofen Refill Kit-500mcg | | | | | |
| C9009 | K | | Baclofen Refill Kit-2000mcg | 9009 | 0.7267 | $37.90 | | $7.58 |
| C9010 | K | | Baclofen Refill Kit--4000mcg | 9010 | 0.9205 | $48.00 | | $9.60 |
| C9013 | N | | Co 57 cobaltous chloride | | | | | |
| C9019 | G | DG | Caspofungin acetate, 5 mg | 9019 | | $34.20 | | $5.11 |
| C9020 | K | DG | Sirolimussolution, 1 mg | 9020 | 0.0581 | $3.03 | | $.61 |
| C9100 | N | DG | Iodinated I-131 Albumin | | | | | |
| C9102 | N | | 51 Na Chromate, 50mCi | | | | | |
| C9103 | N | | Na Iothalamate I-125, 10 uCi | | | | | |
| C9105 | K | | Hep B imm glob, per 1 ml | 9105 | 1.5116 | $78.83 | | $15.77 |
| C9108 | K | DG | Thyrotropin alfa, 1.1 mg | 9108 | 7.5870 | $395.67 | | $79.13 |
| C9109 | K | | Tirofiban hcl, 6.25 mg | 9109 | 2.1996 | $114.71 | | $22.94 |
| C9110 | G | DG | Alemtuzumab, per 10mg/ml | 9110 | | $511.22 | | $76.41 |
| C9111 | G | | Inj, bivalirudin, 250mg vial | 9111 | | $397.81 | | $56.46 |
| C9112 | G | | Perflutren lipid micro, 2ml | 9112 | | $4.94 | | $.74 |
| C9113 | G | | Inj pantoprazole sodium, via | 9113 | | $22.80 | | $3.41 |
| C9114 | G | DG | Nesiritide, per 1.5 mg vial | 9114 | | $433.20 | | $64.75 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| C9115 | G | DG | Inj, zoledronic acid, 2 mg | 9115 | | $406.78 | | $60.80 |
| C9116 | G | NI | Ertapenem sodium, per 1 gm | 9116 | | $45.31 | | $6.77 |
| C9117 | E | DG | Y-90 ibritumomab tiuxetan | | | | | |
| C9118 | E | DG | IN-111 ibritumomab tiuxetan | | | | | |
| C9119 | G | NI | Injection, pegfilgrastim | 9119 | | $2,802.50 | | $418.90 |
| C9120 | G | NI | Injection, fulvestrant | 9120 | | $87.58 | | $13.09 |
| C9121 | G | NI | Injection, argatroban | 9121 | | $14.25 | | $2.13 |
| 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 |
| C9503 | K | | Fresh frozen plasma, ea unit | 9503 | 1.3372 | $69.74 | | $13.95 |
| C9701 | T | | Stretta System | 0980 | | $1,875.00 | | $375.00 |
| C9703 | T | | Bard Endoscopic Suturing Sys | 0979 | | $1,625.00 | | $325.00 |
| C9708 | T | DG | Preview Tx Planning Software | 0975 | | $625.00 | | $125.00 |
| C9711 | T | | H.E.L.P. Apheresis System | 0978 | | $1,375.00 | | $275.00 |
| D0120 | E | | Periodic oral evaluation | | | | | |
| D0140 | E | | Limit oral eval problm focus | | | | | |
| D0150 | S | | Comprehensve oral evaluation | 0330 | 4.7770 | $249.13 | | $49.83 |
| D0160 | E | | Extensv oral eval prob focus | | | | | |
| D0170 | E | | Re-eval,est pt,problem focus | | | | | |
| D0180 | E | NI | 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 | 4.7770 | $249.13 | | $49.83 |
| D0250 | S | | Extraoral first film | 0330 | 4.7770 | $249.13 | | $49.83 |
| D0260 | S | | Extraoral ea additional film | 0330 | 4.7770 | $249.13 | | $49.83 |
| D0270 | S | | Dental bitewing single film | 0330 | 4.7770 | $249.13 | | $49.83 |
| D0272 | S | | Dental bitewings two films | 0330 | 4.7770 | $249.13 | | $49.83 |
| D0274 | S | | Dental bitewings four films | 0330 | 4.7770 | $249.13 | | $49.83 |
| D0277 | S | | Vert bitewings-sev to eight | 0330 | 4.7770 | $249.13 | | $49.83 |
| 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 | 4.7770 | $249.13 | | $49.83 |
| D0470 | E | | Diagnostic casts | | | | | |
| D0472 | S | | Gross exam, prep & report | 0330 | 4.7770 | $249.13 | | $49.83 |
| D0473 | S | | Micro exam, prep & report | 0330 | 4.7770 | $249.13 | | $49.83 |
| D0474 | S | | Micro w exam of surg margins | 0330 | 4.7770 | $249.13 | | $49.83 |
| D0480 | S | | Cytopath smear prep & report | 0330 | 4.7770 | $249.13 | | $49.83 |
| D0501 | S | DG | Histopathologic examinations | 0330 | 4.7770 | $249.13 | | $49.83 |
| D0502 | S | | Other oral pathology procedu | 0330 | 4.7770 | $249.13 | | $49.83 |
| D0999 | S | | Unspecified diagnostic proce | 0330 | 4.7770 | $249.13 | | $49.83 |
| 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 | 4.7770 | $249.13 | | $49.83 |
| D1515 | S | | Fixed bilat space maintainer | 0330 | 4.7770 | $249.13 | | $49.83 |
| D1520 | S | | Remove unilat space maintain | 0330 | 4.7770 | $249.13 | | $49.83 |
| D1525 | S | | Remove bilat space maintain | 0330 | 4.7770 | $249.13 | | $49.83 |
| D1550 | S | | Recement space maintainer | 0330 | 4.7770 | $249.13 | | $49.83 |
| D2110 | E | DG | Amalgam one surface primary | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| D2120 | E | DG | Amalgam two surfaces primary | | | | | |
| D2130 | E | DG | Amalgam three surfaces prima | | | | | |
| D2131 | E | DG | Amalgam four/more surf prima | | | | | |
| 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 | | | | | |
| D2336 | E | DG | Composite resin crown | | | | | |
| D2337 | E | DG | Compo resin crown ant-perm | | | | | |
| D2380 | E | DG | Resin one surf poster primar | | | | | |
| D2381 | E | DG | Resin two surf poster primar | | | | | |
| D2382 | E | DG | Resin three/more surf post p | | | | | |
| D2385 | E | DG | Resin one surf poster perman | | | | | |
| D2386 | E | DG | Resin two surf poster perman | | | | | |
| D2387 | E | DG | Resin three/more surf post p | | | | | |
| D2388 | E | DG | Resin four/more, post perm | | | | | |
| D2390 | E | NI | Ant resin-based cmpst crown | | | | | |
| D2391 | E | NI | Post 1 srfc resinbased cmpst | | | | | |
| D2392 | E | NI | Post 2 srfc resinbased cmpst | | | | | |
| D2393 | E | NI | Post 3 srfc resinbased cmpst | | | | | |
| D2394 | E | NI | Post >=4srfc resinbase cmpst | | | | | |
| D2410 | E | | Dental gold foil one surface | | | | | |
| D2420 | E | | Dental gold foil two surface | | | | | |
| D2430 | E | | Dental gold foil three surfa | | | | | |
| D2510 | E | | Dental inlay metalic 1 surf | | | | | |
| D2520 | E | | Dental inlay metallic 2 surf | | | | | |
| D2530 | E | | Dental inlay metl 3/more sur | | | | | |
| D2542 | E | | Dental onlay metallic 2 surf | | | | | |
| D2543 | E | | Dental onlay metallic 3 surf | | | | | |
| D2544 | E | | Dental onlay metl 4/more sur | | | | | |
| D2610 | E | | Inlay porcelain/ceramic 1 su | | | | | |
| D2620 | E | | Inlay porcelain/ceramic 2 su | | | | | |
| D2630 | E | | Dental onlay porc 3/more sur | | | | | |
| D2642 | E | | Dental onlay porcelin 2 surf | | | | | |
| D2643 | E | | Dental onlay porcelin 3 surf | | | | | |
| D2644 | E | | Dental onlay porc 4/more sur | | | | | |
| D2650 | E | | Inlay composite/resin one su | | | | | |
| D2651 | E | | Inlay composite/resin two su | | | | | |
| D2652 | E | | Dental inlay resin 3/mre sur | | | | | |
| D2662 | E | | Dental onlay resin 2 surface | | | | | |
| D2663 | E | | Dental onlay resin 3 surface | | | | | |
| D2664 | E | | Dental onlay resin 4/mre sur | | | | | |
| D2710 | E | | Crown resin laboratory | | | | | |
| D2720 | E | | Crown resin w/ high noble me | | | | | |
| D2721 | E | | Crown resin w/ base metal | | | | | |
| D2722 | E | | Crown resin w/ noble metal | | | | | |
| D2740 | E | | Crown porcelain/ceramic subs | | | | | |
| D2750 | E | | Crown porcelain w/ h noble m | | | | | |
| D2751 | E | | Crown porcelain fused base m | | | | | |
| D2752 | E | | Crown porcelain w/ noble met | | | | | |
| D2780 | E | | Crown 3/4 cast hi noble met | | | | | |
| D2781 | E | | Crown 3/4 cast base metal | | | | | |
| D2782 | E | | Crown 3/4 cast noble metal | | | | | |
| D2783 | E | | Crown 3/4 porcelain/ceramic | | | | | |
| D2790 | E | | Crown full cast high noble m | | | | | |
| D2791 | E | | Crown full cast base metal | | | | | |
| D2792 | E | | Crown full cast noble metal | | | | | |
| D2799 | E | | Provisional crown | | | | | |
| D2910 | E | | Dental recement inlay | | | | | |
| D2920 | E | | Dental recement crown | | | | | |
| D2930 | E | | Prefab stnlss steel crwn pri | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | 4.7770 | $249.13 | | $49.83 |
| D2980 | E | | Crown repair | | | | | |
| D2999 | S | | Dental unspec restorative pr | 0330 | 4.7770 | $249.13 | | $49.83 |
| 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 | 4.7770 | $249.13 | | $49.83 |
| 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 | 4.7770 | $249.13 | | $49.83 |
| D4210 | E | | Gingivectomy/plasty per quad | | | | | |
| D4211 | E | | Gingivectomy/plasty per toot | | | | | |
| D4220 | E | DG | Gingival curettage per quadr | | | | | |
| D4240 | E | | Gingival flap proc w/ planin | | | | | |
| D4241 | E | NI | 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 | 4.7770 | $249.13 | | $49.83 |
| D4261 | E | NI | Osseous surgl-3teethperquad | | | | | |
| D4263 | S | | Bone replce graft first site | 0330 | 4.7770 | $249.13 | | $49.83 |
| D4264 | S | | Bone replce graft each add | 0330 | 4.7770 | $249.13 | | $49.83 |
| D4265 | E | NI | 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 | 4.7770 | $249.13 | | $49.83 |
| D4270 | S | | Pedicle soft tissue graft pr | 0330 | 4.7770 | $249.13 | | $49.83 |
| D4271 | S | | Free soft tissue graft proc | 0330 | 4.7770 | $249.13 | | $49.83 |
| D4273 | S | | Subepithelial tissue graft | 0330 | 4.7770 | $249.13 | | $49.83 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| D4274 | E | | Distal/proximal wedge proc | | | | | |
| D4275 | E | NI | Soft tissue allograft | | | | | |
| D4276 | E | NI | Con tissue w dble ped graft | | | | | |
| D4320 | E | | Provision splnt intracoronal | | | | | |
| D4321 | E | | Provisional splint extracoro | | | | | |
| D4341 | E | | Periodontal scaling & root | | | | | |
| D4342 | E | NI | Periodontal scaling 1-3teeth | | | | | |
| D4355 | S | | Full mouth debridement | 0330 | 4.7770 | $249.13 | | $49.83 |
| D4381 | S | | Localized chemo delivery | 0330 | 4.7770 | $249.13 | | $49.83 |
| 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 | NI | Replc tth&acrlc on mtl frmwk | | | | | |
| D5671 | E | NI | Replc tth&acrlc mandibular | | | | | |
| D5710 | E | | Dentures rebase cmplt maxil | | | | | |
| D5711 | E | | Dentures rebase cmplt mand | | | | | |
| D5720 | E | | Dentures rebase part maxill | | | | | |
| D5721 | E | | Dentures rebase part mandbl | | | | | |
| D5730 | E | | Denture reln cmplt maxil ch | | | | | |
| D5731 | E | | Denture reln cmplt mand chr | | | | | |
| D5740 | E | | Denture reln part maxil chr | | | | | |
| D5741 | E | | Denture reln part mand chr | | | | | |
| D5750 | E | | Denture reln cmplt max lab | | | | | |
| D5751 | E | | Denture reln cmplt mand lab | | | | | |
| D5760 | E | | Denture reln part maxil lab | | | | | |
| D5761 | E | | Denture reln part mand lab | | | | | |
| D5810 | E | | Denture interm cmplt maxill | | | | | |
| D5811 | E | | Denture interm cmplt mandbl | | | | | |
| D5820 | E | | Denture interm part maxill | | | | | |
| D5821 | E | | Denture interm part mandbl | | | | | |
| D5850 | E | | Denture tiss conditn maxill | | | | | |
| D5851 | E | | Denture tiss condtin mandbl | | | | | |
| D5860 | E | | Overdenture complete | | | | | |
| D5861 | E | | Overdenture partial | | | | | |
| D5862 | E | | Precision attachment | | | | | |
| D5867 | E | | Replacement of precision att | | | | | |
| D5875 | E | | Prosthesis modification | | | | | |
| D5899 | E | | Removable prosthodontic proc | | | | | |
| D5911 | S | | Facial moulage sectional | 0330 | 4.7770 | $249.13 | | $49.83 |
| D5912 | S | | Facial moulage complete | 0330 | 4.7770 | $249.13 | | $49.83 |
| D5913 | E | | Nasal prosthesis | | | | | |
| D5914 | E | | Auricular prosthesis | | | | | |
| D5915 | E | | Orbital prosthesis | | | | | |
| D5916 | E | | Ocular prosthesis | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | 4.7770 | $249.13 | | $49.83 |
| D5984 | S | | Radiation shield | 0330 | 4.7770 | $249.13 | | $49.83 |
| D5985 | S | | Radiation cone locator | 0330 | 4.7770 | $249.13 | | $49.83 |
| D5986 | E | | Fluoride applicator | | | | | |
| D5987 | S | | Commissure splint | 0330 | 4.7770 | $249.13 | | $49.83 |
| 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 | NI | Implnt/abtmnt spprt remv dnt | | | | | |
| D6054 | E | NI | 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| D6095 | E | | Odontics repr abutment | | | | | |
| D6100 | E | | Removal of implant | | | | | |
| D6199 | E | | Implant procedure | | | | | |
| D6210 | E | | Prosthodont high noble metal | | | | | |
| D6211 | E | | Bridge base metal cast | | | | | |
| D6212 | E | | Bridge noble metal cast | | | | | |
| D6240 | E | | Bridge porcelain high noble | | | | | |
| D6241 | E | | Bridge porcelain base metal | | | | | |
| D6242 | E | | Bridge porcelain nobel metal | | | | | |
| D6245 | E | | Bridge porcelain/ceramic | | | | | |
| D6250 | E | | Bridge resin w/high noble | | | | | |
| D6251 | E | | Bridge resin base metal | | | | | |
| D6252 | E | | Bridge resin w/noble metal | | | | | |
| D6253 | E | NI | Provisional pontic | | | | | |
| D6519 | E | DG | Inlay/onlay porce/ceramic | | | | | |
| D6520 | E | DG | Dental retainer two surfaces | | | | | |
| D6530 | E | DG | Retainer metallic 3+ surface | | | | | |
| D6543 | E | DG | Dental retainr onlay 3 surf | | | | | |
| D6544 | E | DG | Dental retainr onlay 4/more | | | | | |
| D6545 | E | | Dental retainr cast metl | | | | | |
| D6548 | E | | Porcelain/ceramic retainer | | | | | |
| D6600 | E | NI | Porcelain/ceramic inlay 2srf | | | | | |
| D6601 | E | NI | Porc/ceram inlay >= 3 surfac | | | | | |
| D6602 | E | NI | Cst hgh nble mtl inlay 2 srf | | | | | |
| D6603 | E | NI | Cst hgh nble mtl inlay >=3sr | | | | | |
| D6604 | E | NI | Cst bse mtl inlay 2 surfaces | | | | | |
| D6605 | E | NI | Cst bse mtl inlay >= 3 surfa | | | | | |
| D6606 | E | NI | Cast noble metal inlay 2 sur | | | | | |
| D6607 | E | NI | Cst noble mtl inlay >=3 surf | | | | | |
| D6608 | E | NI | Onlay porc/crmc 2 surfaces | | | | | |
| D6609 | E | NI | Onlay porc/crmc >=3 surfaces | | | | | |
| D6610 | E | NI | Onlay cst hgh nbl mtl 2 srfc | | | | | |
| D6611 | E | NI | Onlay cst hgh nbl mtl >=3srf | | | | | |
| D6612 | E | NI | Onlay cst base mtl 2 surface | | | | | |
| D6613 | E | NI | Onlay cst base mtl >=3 surfa | | | | | |
| D6614 | E | NI | Onlay cst nbl mtl 2 surfaces | | | | | |
| D6615 | E | NI | 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 | NI | Provisional retainer crown | | | | | |
| D6920 | S | | Dental connector bar | 0330 | 4.7770 | $249.13 | | $49.83 |
| 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 | NI | Pediatric partial denture fx | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| D6999 | E | | Fixed prosthodontic proc | | | | | |
| D7110 | S | DG | Oral surgery single tooth | 0330 | 4.7770 | $249.13 | | $49.83 |
| D7111 | S | NI | Coronal remnants deciduous t | 0330 | 4.7770 | $249.13 | | $49.83 |
| D7120 | S | DG | Each add tooth extraction | 0330 | 4.7770 | $249.13 | | $49.83 |
| D7130 | S | DG | Tooth root removal | 0330 | 4.7770 | $249.13 | | $49.83 |
| D7140 | S | NI | Extraction erupted tooth/exr | 0330 | 4.7770 | $249.13 | | $49.83 |
| D7210 | S | | Rem imp tooth w mucoper flp | 0330 | 4.7770 | $249.13 | | $49.83 |
| D7220 | S | | Impact tooth remov soft tiss | 0330 | 4.7770 | $249.13 | | $49.83 |
| D7230 | S | | Impact tooth remov part bony | 0330 | 4.7770 | $249.13 | | $49.83 |
| D7240 | S | | Impact tooth remov comp bony | 0330 | 4.7770 | $249.13 | | $49.83 |
| D7241 | S | | Impact tooth rem bony w/comp | 0330 | 4.7770 | $249.13 | | $49.83 |
| D7250 | S | | Tooth root removal | 0330 | 4.7770 | $249.13 | | $49.83 |
| D7260 | S | | Oral antral fistula closure | 0330 | 4.7770 | $249.13 | | $49.83 |
| D7261 | S | NI | Primary closure sinus perf | 0330 | 4.7770 | $249.13 | | $49.83 |
| D7270 | E | | Tooth reimplantation | | | | | |
| D7272 | E | | Tooth transplantation | | | | | |
| D7280 | E | | Exposure impact tooth orthod | | | | | |
| D7281 | E | | Exposure tooth aid eruption | | | | | |
| D7282 | E | NI | Mobilize erupted/malpos toot | | | | | |
| D7285 | E | | Biopsy of oral tissue hard | | | | | |
| D7286 | E | | Biopsy of oral tissue soft | | | | | |
| D7287 | E | NI | Cytology sample collection | | | | | |
| D7290 | E | | Repositioning of teeth | | | | | |
| D7291 | S | | Transseptal fiberotomy | 0330 | 4.7770 | $249.13 | | $49.83 |
| 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 | NI | Excision benign lesion>1.25c | | | | | |
| D7412 | E | NI | Excision benign lesion compl | | | | | |
| D7413 | E | NI | Excision malig lesion<=1.25c | | | | | |
| D7414 | E | NI | Excision malig lesion>1.25cm | | | | | |
| D7415 | E | NI | Excision malig les complicat | | | | | |
| D7420 | E | DG | Lesion > 1.25 cm | | | | | |
| D7430 | E | DG | Exc benign tumor to 1.25 cm | | | | | |
| D7431 | E | DG | Benign tumor exc > 1.25 cm | | | | | |
| 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 | NI | Removal of torus palatinus | | | | | |
| D7473 | E | NI | Remove torus mandibularis | | | | | |
| D7480 | E | DG | Partial ostectomy | | | | | |
| D7485 | E | NI | 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 | NI | Alveolus open reduction | | | | | |
| D7680 | E | | Reduct simple facial bone fx | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | NI | 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 | 4.7770 | $249.13 | | $49.83 |
| 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 | NI | 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | NI | Case presentation tx plan | | | | | |
| D9610 | E | | Dent therapeutic drug inject | | | | | |
| D9630 | S | | Other drugs/medicaments | 0330 | 4.7770 | $249.13 | | $49.83 |
| D9910 | E | | Dent appl desensitizing med | | | | | |
| D9911 | E | | Appl desensitizing resin | | | | | |
| D9920 | E | | Behavior management | | | | | |
| D9930 | S | | Treatment of complications | 0330 | 4.7770 | $249.13 | | $49.83 |
| D9940 | S | | Dental occlusal guard | 0330 | 4.7770 | $249.13 | | $49.83 |
| D9941 | E | | Fabrication athletic guard | | | | | |
| D9950 | S | | Occlusion analysis | 0330 | 4.7770 | $249.13 | | $49.83 |
| D9951 | S | | Limited occlusal adjustment | 0330 | 4.7770 | $249.13 | | $49.83 |
| D9952 | S | | Complete occlusal adjustment | 0330 | 4.7770 | $249.13 | | $49.83 |
| D9970 | E | | Enamel microabrasion | | | | | |
| D9971 | E | | Odontoplasty 1-2 teeth | | | | | |
| D9972 | E | | Extrnl bleaching per arch | | | | | |
| D9973 | E | | Extrnl bleaching per tooth | | | | | |
| D9974 | E | | Intrnl bleaching per tooth | | | | | |
| D9999 | E | | Adjunctive procedure | | | | | |
| E0100 | A | | Cane adjust/fixed with tip | | | | | |
| E0105 | A | | Cane adjust/fixed quad/3 pro | | | | | |
| E0110 | A | | Crutch forearm pair | | | | | |
| E0111 | A | | Crutch forearm each | | | | | |
| E0112 | A | | Crutch underarm pair wood | | | | | |
| E0113 | A | | Crutch underarm each wood | | | | | |
| E0114 | A | | Crutch underarm pair no wood | | | | | |
| E0116 | A | | Crutch underarm each no wood | | | | | |
| E0117 | A | NI | Underarm springassist crutch | | | | | |
| E0130 | A | | Walker rigid adjust/fixed ht | | | | | |
| E0135 | A | | Walker folding adjust/fixed | | | | | |
| E0141 | A | | Rigid walker wheeled wo seat | | | | | |
| E0142 | A | | Walker rigid wheeled with se | | | | | |
| E0143 | A | | Walker folding wheeled w/o s | | | | | |
| E0144 | A | | Enclosed walker w rear seat | | | | | |
| E0145 | A | | Walker whled seat/crutch att | | | | | |
| E0146 | A | | Folding walker wheels w seat | | | | | |
| E0147 | A | | Walker variable wheel resist | | | | | |
| E0148 | A | | Heavyduty walker no wheels | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| E0149 | A | | Heavy duty wheeled walker | | | | | |
| E0153 | A | | Forearm crutch platform atta | | | | | |
| E0154 | A | | Walker platform attachment | | | | | |
| E0155 | A | | Walker wheel attachment,pair | | | | | |
| E0156 | A | | Walker seat attachment | | | | | |
| E0157 | A | | Walker crutch attachment | | | | | |
| E0158 | A | | Walker leg extenders set of4 | | | | | |
| E0159 | A | | Brake for wheeled walker | | | | | |
| E0160 | A | | Sitz type bath or equipment | | | | | |
| E0161 | A | | Sitz bath/equipment w/faucet | | | | | |
| E0162 | A | | Sitz bath chair | | | | | |
| E0163 | A | | Commode chair stationry fxd | | | | | |
| E0164 | A | | Commode chair mobile fixed a | | | | | |
| E0165 | A | | Commode chair stationry det | | | | | |
| E0166 | A | | Commode chair mobile detach | | | | | |
| E0167 | A | | Commode chair pail or pan | | | | | |
| E0168 | A | | Heavyduty/wide commode chair | | | | | |
| E0169 | A | | Seatlift incorp commodechair | | | | | |
| E0175 | A | | Commode chair foot rest | | | | | |
| E0176 | A | | Air pressre pad/cushion nonp | | | | | |
| E0177 | A | | Water press pad/cushion nonp | | | | | |
| E0178 | A | | Gel pressre pad/cushion nonp | | | | | |
| E0179 | A | | Dry pressre pad/cushion nonp | | | | | |
| E0180 | A | | Press pad alternating w pump | | | | | |
| E0181 | A | | Press pad alternating w/ pum | | | | | |
| E0182 | A | | Pressure pad alternating pum | | | | | |
| E0184 | A | | Dry pressure mattress | | | | | |
| E0185 | A | | Gel pressure mattress pad | | | | | |
| E0186 | A | | Air pressure mattress | | | | | |
| E0187 | A | | Water pressure mattress | | | | | |
| E0188 | E | | Synthetic sheepskin pad | | | | | |
| E0189 | E | | Lambswool sheepskin pad | | | | | |
| E0191 | A | | Protector heel or elbow | | | | | |
| E0192 | A | | Pad wheelchr low press/posit | | | | | |
| 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 | NI | Therapeutic lightbox tabletp | | | | | |
| E0205 | A | | Heat lamp with stand | | | | | |
| E0210 | A | | Electric heat pad standard | | | | | |
| E0215 | A | | Electric heat pad moist | | | | | |
| E0217 | A | | Water circ heat pad w pump | | | | | |
| E0218 | E | | Water circ cold pad w pump | | | | | |
| E0220 | A | | Hot water bottle | | | | | |
| E0221 | A | | Infrared heating pad system | | | | | |
| E0225 | A | | Hydrocollator unit | | | | | |
| E0230 | A | | Ice cap or collar | | | | | |
| E0231 | E | | Wound warming device | | | | | |
| E0232 | E | | Warming card for NWT | | | | | |
| E0235 | A | | Paraffin bath unit portable | | | | | |
| E0236 | A | | Pump for water circulating p | | | | | |
| E0238 | A | | Heat pad non-electric moist | | | | | |
| E0239 | A | | Hydrocollator unit portable | | | | | |
| E0241 | E | | Bath tub wall rail | | | | | |
| E0242 | E | | Bath tub rail floor | | | | | |
| E0243 | E | | Toilet rail | | | | | |
| E0244 | E | | Toilet seat raised | | | | | |
| E0245 | E | | Tub stool or bench | | | | | |
| E0246 | E | | Transfer tub rail attachment | | | | | |
| E0249 | A | | Pad water circulating heat u | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| E0250 | A | | Hosp bed fixed ht w/ mattres | | | | | |
| E0251 | A | | Hosp bed fixd ht w/o mattres | | | | | |
| E0255 | A | | Hospital bed var ht w/ mattr | | | | | |
| E0256 | A | | Hospital bed var ht w/o matt | | | | | |
| E0260 | A | | Hosp bed semi-electr w/ matt | | | | | |
| E0261 | A | | Hosp bed semi-electr w/o mat | | | | | |
| E0265 | A | | Hosp bed total electr w/ mat | | | | | |
| E0266 | A | | Hosp bed total elec w/o matt | | | | | |
| E0270 | E | | Hospital bed institutional t | | | | | |
| E0271 | A | | Mattress innerspring | | | | | |
| E0272 | A | | Mattress foam rubber | | | | | |
| E0273 | E | | Bed board | | | | | |
| E0274 | E | | Over-bed table | | | | | |
| E0275 | A | | Bed pan standard | | | | | |
| E0276 | A | | Bed pan fracture | | | | | |
| E0277 | A | | Powered pres-redu air mattrs | | | | | |
| E0280 | A | | Bed cradle | | | | | |
| E0290 | A | | Hosp bed fx ht w/o rails w/m | | | | | |
| E0291 | A | | Hosp bed fx ht w/o rail w/o | | | | | |
| E0292 | A | | Hosp bed var ht w/o rail w/o | | | | | |
| E0293 | A | | Hosp bed var ht w/o rail w/ | | | | | |
| E0294 | A | | Hosp bed semi-elect w/ mattr | | | | | |
| E0295 | A | | Hosp bed semi-elect w/o matt | | | | | |
| E0296 | A | | Hosp bed total elect w/ matt | | | | | |
| E0297 | A | | Hosp bed total elect w/o mat | | | | | |
| E0305 | A | | Rails bed side half length | | | | | |
| E0310 | A | | Rails bed side full length | | | | | |
| E0315 | E | | Bed accessory brd/tbl/supprt | | | | | |
| E0316 | A | | Bed safety enclosure | | | | | |
| E0325 | A | | Urinal male jug-type | | | | | |
| E0326 | A | | Urinal female jug-type | | | | | |
| E0350 | E | | Control unit bowel system | | | | | |
| E0352 | E | | Disposable pack w/bowel syst | | | | | |
| E0370 | E | | Air elevator for heel | | | | | |
| E0371 | A | | Nonpower mattress overlay | | | | | |
| 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 | NI | Oximeter non-invasive | | | | | |
| E0450 | A | | Volume vent stationary/porta | | | | | |
| E0454 | A | NI | Pressure ventilator | | | | | |
| E0455 | A | | Oxygen tent excl croup/ped t | | | | | |
| E0457 | A | | Chest shell | | | | | |
| E0459 | A | | Chest wrap | | | | | |
| E0460 | A | | Neg press vent portabl/statn | | | | | |
| E0461 | A | NI | Vol vent noninvasive interfa | | | | | |
| E0462 | A | | Rocking bed w/ or w/o side r | | | | | |
| E0480 | A | | Percussor elect/pneum home m | | | | | |
| E0481 | A | | Intrpulmnry percuss vent sys | | | | | |
| E0482 | A | | Cough stimulating device | | | | | |
| E0483 | A | NI | Chest compression gen system | | | | | |
| E0484 | A | NI | Non-elec oscillatory pep dvc | | | | | |
| E0500 | A | | Ippb all types | | | | | |
| E0550 | A | | Humidif extens supple w ippb | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| E0555 | A | | Humidifier for use w/ regula | | | | | |
| E0560 | A | | Humidifier supplemental w/ i | | | | | |
| E0565 | A | | Compressor air power source | | | | | |
| E0570 | A | | Nebulizer with compression | | | | | |
| E0571 | A | | Aerosol compressor for svneb | | | | | |
| E0572 | A | | Aerosol compressor adjust pr | | | | | |
| E0574 | A | | Ultrasonic generator w svneb | | | | | |
| E0575 | A | | Nebulizer ultrasonic | | | | | |
| E0580 | A | | Nebulizer for use w/ regulat | | | | | |
| E0585 | A | | Nebulizer w/ compressor & he | | | | | |
| E0590 | A | | Dispensing fee dme neb drug | | | | | |
| E0600 | A | | Suction pump portab hom modl | | | | | |
| E0601 | A | | Cont airway pressure device | | | | | |
| E0602 | E | | Manual breast pump | | | | | |
| E0603 | A | | Electric breast pump | | | | | |
| E0604 | A | | Hosp grade elec breast pump | | | | | |
| E0605 | A | | Vaporizer room type | | | | | |
| E0606 | A | | Drainage board postural | | | | | |
| E0607 | A | | Blood glucose monitor home | | | | | |
| E0608 | A | DG | Apnea monitor | | | | | |
| E0610 | A | | Pacemaker monitr audible/vis | | | | | |
| E0615 | A | | Pacemaker monitr digital/vis | | | | | |
| E0616 | N | | Cardiac event recorder | | | | | |
| E0617 | A | | Automatic ext defibrillator | | | | | |
| E0618 | A | NI | Apnea monitor | | | | | |
| E0619 | A | NI | 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 | NI | PT support & positioning sys | | | | | |
| 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 | | | | | |
| E0690 | A | DG | Ultraviolet cabinet | | | | | |
| E0691 | A | NI | Uvl pnl 2 sq ft or less | | | | | |
| E0692 | A | NI | Uvl sys panel 4 ft | | | | | |
| E0693 | A | NI | Uvl sys panel 6 ft | | | | | |
| E0694 | A | NI | Uvl md cabinet sys 6 ft | | | | | |
| E0700 | E | | Safety equipment | | | | | |
| E0701 | A | NI | Helmet w face guard prefab | | | | | |
| E0710 | E | | Restraints any type | | | | | |
| E0720 | A | | Tens two lead | | | | | |
| E0730 | A | | Tens four lead | | | | | |
| E0731 | A | | Conductive garment for tens/ | | | | | |
| E0740 | E | | Incontinence treatment systm | | | | | |
| E0744 | A | | Neuromuscular stim for scoli | | | | | |
| E0745 | A | | Neuromuscular stim for shock | | | | | |
| E0746 | E | | Electromyograph biofeedback | | | | | |
| E0747 | A | | Elec osteogen stim not spine | | | | | |
| E0748 | A | | Elec osteogen stim spinal | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| E0749 | N | | Elec osteogen stim implanted | | | | | |
| E0752 | E | | Neurostimulator electrode | | | | | |
| E0754 | A | | Pulsegenerator pt programmer | | | | | |
| E0755 | E | | Electronic salivary reflex s | | | | | |
| E0756 | E | | Implantable pulse generator | | | | | |
| E0757 | E | | Implantable RF receiver | | | | | |
| E0758 | A | | External RF transmitter | | | | | |
| E0759 | A | | Replace rdfrquncy transmittr | | | | | |
| E0760 | E | | Osteogen ultrasound stimltor | | | | | |
| E0761 | E | NI | 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 | E | | Non-programble infusion pump | | | | | |
| E0783 | E | | Programmable infusion pump | | | | | |
| E0784 | A | | Ext amb infusn pump insulin | | | | | |
| E0785 | E | | Replacement impl pump cathet | | | | | |
| E0786 | E | | Implantable pump replacement | | | | | |
| E0791 | A | | Parenteral infusion pump sta | | | | | |
| E0830 | N | | Ambulatory traction device | | | | | |
| E0840 | A | | Tract frame attach headboard | | | | | |
| E0850 | A | | Traction stand free standing | | | | | |
| E0855 | A | | Cervical traction equipment | | | | | |
| E0860 | A | | Tract equip cervical tract | | | | | |
| E0870 | A | | Tract frame attach footboard | | | | | |
| E0880 | A | | Trac stand free stand extrem | | | | | |
| E0890 | A | | Traction frame attach pelvic | | | | | |
| E0900 | A | | Trac stand free stand pelvic | | | | | |
| E0910 | A | | Trapeze bar attached to bed | | | | | |
| E0920 | A | | Fracture frame attached to b | | | | | |
| E0930 | A | | Fracture frame free standing | | | | | |
| E0935 | A | | Exercise device passive moti | | | | | |
| E0940 | A | | Trapeze bar free standing | | | | | |
| E0941 | A | | Gravity assisted traction de | | | | | |
| E0942 | A | | Cervical head harness/halter | | | | | |
| E0943 | A | | Cervical pillow | | | | | |
| E0944 | A | | Pelvic belt/harness/boot | | | | | |
| E0945 | A | | Belt/harness extremity | | | | | |
| E0946 | A | | Fracture frame dual w cross | | | | | |
| E0947 | A | | Fracture frame attachmnts pe | | | | | |
| E0948 | A | | Fracture frame attachmnts ce | | | | | |
| E0950 | E | | Tray | | | | | |
| E0951 | E | | Loop heel | | | | | |
| E0952 | E | | Loop tie | | | | | |
| E0953 | E | | Pneumatic tire | | | | | |
| E0954 | E | | Wheelchair semi-pneumatic ca | | | | | |
| E0958 | A | | Whlchr att- conv 1 arm drive | | | | | |
| E0959 | E | | Amputee adapter | | | | | |
| E0961 | E | | Wheelchair brake extension | | | | | |
| E0962 | A | | Wheelchair 1 inch cushion | | | | | |
| E0963 | A | | Wheelchair 2 inch cushion | | | | | |
| E0964 | A | | Wheelchair 3 inch cushion | | | | | |
| E0965 | A | | Wheelchair 4 inch cushion | | | | | |
| E0966 | E | | Wheelchair head rest extensi | | | | | |
| E0967 | E | | Wheelchair hand rims | | | | | |
| E0968 | A | | Wheelchair commode seat | | | | | |
| E0969 | E | | Wheelchair narrowing device | | | | | |
| E0970 | E | | Wheelchair no. 2 footplates | | | | | |
| E0971 | E | | Wheelchair anti-tipping devi | | | | | |
| E0972 | A | | Transfer board or device | | | | | |
| E0973 | E | | Wheelchair adjustabl height | | | | | |
| E0974 | E | | Wheelchair grade-aid | | | | | |
| E0975 | E | | Wheelchair reinforced seat u | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| E0976 | E | | Wheelchair reinforced back u | | | | | |
| E0977 | E | | Wheelchair wedge cushion | | | | | |
| E0978 | E | | Wheelchair belt w/airplane b | | | | | |
| E0979 | E | | Wheelchair belt with velcro | | | | | |
| E0980 | E | | Wheelchair safety vest | | | | | |
| E0990 | E | | Whellchair elevating leg res | | | | | |
| E0991 | E | | Wheelchair upholstry seat | | | | | |
| E0992 | E | | Wheelchair solid seat insert | | | | | |
| E0993 | E | | Wheelchair back upholstery | | | | | |
| E0994 | E | | Wheelchair arm rest | | | | | |
| E0995 | E | | Wheelchair calf rest | | | | | |
| E0996 | E | | Wheelchair tire solid | | | | | |
| E0997 | E | | Wheelchair caster w/ a fork | | | | | |
| E0998 | E | | Wheelchair caster w/o a fork | | | | | |
| E0999 | E | | Wheelchr pneumatic tire w/wh | | | | | |
| E1000 | E | | Wheelchair tire pneumatic ca | | | | | |
| E1001 | E | | Wheelchair wheel | | | | | |
| E1011 | A | NI | Ped wc modify width adjustm | | | | | |
| E1012 | A | NI | Int seat sys planar ped w/c | | | | | |
| E1013 | A | NI | Int seat sys contour ped w/c | | | | | |
| E1014 | A | NI | Reclining back add ped w/c | | | | | |
| E1015 | A | NI | Shock absorber for man w/c | | | | | |
| E1016 | A | NI | Shock absorber for power w/c | | | | | |
| E1017 | A | NI | HD shck absrbr for hd man wc | | | | | |
| E1018 | A | NI | HD shck absrber for hd powwc | | | | | |
| E1020 | A | NI | Residual limb support system | | | | | |
| E1025 | A | NI | Pedwc lat/thor sup nocontour | | | | | |
| E1026 | A | NI | Pedwc contoured lat/thor sup | | | | | |
| E1027 | A | NI | Ped wc lat/ant support | | | | | |
| E1031 | A | | Rollabout chair with casters | | | | | |
| E1035 | E | | Patient transfer system | | | | | |
| E1037 | A | NI | Transport chair, ped size | | | | | |
| E1038 | A | NI | Transport chair, adult size | | | | | |
| E1050 | A | | Whelchr fxd full length arms | | | | | |
| E1060 | A | | Wheelchair detachable arms | | | | | |
| E1065 | E | | Wheelchair power attachment | | | | | |
| E1066 | E | | Wheelchair battery charger | | | | | |
| E1069 | E | | Wheelchair deep cycle batter | | | | | |
| E1070 | A | | Wheelchair detachable foot r | | | | | |
| E1083 | A | | Hemi-wheelchair fixed arms | | | | | |
| E1084 | A | | Hemi-wheelchair detachable a | | | | | |
| E1085 | A | | Hemi-wheelchair fixed arms | | | | | |
| E1086 | A | | Hemi-wheelchair detachable a | | | | | |
| E1087 | A | | Wheelchair lightwt fixed arm | | | | | |
| E1088 | A | | Wheelchair lightweight det a | | | | | |
| E1089 | A | | Wheelchair lightwt fixed arm | | | | | |
| E1090 | A | | Wheelchair lightweight det a | | | | | |
| E1091 | A | | Wheelchair youth | | | | | |
| E1092 | A | | Wheelchair wide w/ leg rests | | | | | |
| E1093 | A | | Wheelchair wide w/ foot rest | | | | | |
| E1100 | A | | Whchr s-recl fxd arm leg res | | | | | |
| E1110 | A | | Wheelchair semi-recl detach | | | | | |
| E1130 | A | | Whlchr stand fxd arm ft rest | | | | | |
| E1140 | A | | Wheelchair standard detach a | | | | | |
| E1150 | A | | Wheelchair standard w/ leg r | | | | | |
| E1160 | A | | Wheelchair fixed arms | | | | | |
| E1161 | A | NI | 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| E1211 | A | | Wheelchair motorized w/ det | | | | | |
| E1212 | A | | Wheelchair motorized w full | | | | | |
| E1213 | A | | Wheelchair motorized w/ det | | | | | |
| E1220 | A | | Whlchr special size/constrc | | | | | |
| E1221 | A | | Wheelchair spec size w foot | | | | | |
| E1222 | A | | Wheelchair spec size w/ leg | | | | | |
| E1223 | A | | Wheelchair spec size w foot | | | | | |
| E1224 | A | | Wheelchair spec size w/ leg | | | | | |
| E1225 | A | | Wheelchair spec sz semi-recl | | | | | |
| E1226 | E | | Wheelchair spec sz full-recl | | | | | |
| E1227 | E | | Wheelchair spec sz spec ht a | | | | | |
| E1228 | A | | Wheelchair spec sz spec ht b | | | | | |
| E1230 | A | | Power operated vehicle | | | | | |
| E1231 | A | NI | Rigid ped w/c tilt-in-space | | | | | |
| E1232 | A | NI | Folding ped wc tilt-in-space | | | | | |
| E1233 | A | NI | Rig ped wc tltnspc w/o seat | | | | | |
| E1234 | A | NI | Fld ped wc tltnspc w/o seat | | | | | |
| E1235 | A | NI | Rigid ped wc adjustable | | | | | |
| E1236 | A | NI | Folding ped wc adjustable | | | | | |
| E1237 | A | NI | Rgd ped wc adjstabl w/o seat | | | | | |
| E1238 | A | NI | Fld ped wc adjstabl w/o seat | | | | | |
| E1240 | A | | Whchr litwt det arm leg rest | | | | | |
| E1250 | A | | Wheelchair lightwt fixed arm | | | | | |
| E1260 | A | | Wheelchair lightwt foot rest | | | | | |
| E1270 | A | | Wheelchair lightweight leg r | | | | | |
| E1280 | A | | Whchr h-duty det arm leg res | | | | | |
| E1285 | A | | Wheelchair heavy duty fixed | | | | | |
| E1290 | A | | Wheelchair hvy duty detach a | | | | | |
| E1295 | A | | Wheelchair heavy duty fixed | | | | | |
| E1296 | A | | Wheelchair special seat heig | | | | | |
| E1297 | A | | Wheelchair special seat dept | | | | | |
| E1298 | A | | Wheelchair spec seat depth/w | | | | | |
| E1300 | E | | Whirlpool portable | | | | | |
| E1310 | A | | Whirlpool non-portable | | | | | |
| E1340 | A | | Repair for DME, per 15 min | | | | | |
| E1353 | A | | Oxygen supplies regulator | | | | | |
| E1355 | A | | Oxygen supplies stand/rack | | | | | |
| E1372 | A | | Oxy suppl heater for nebuliz | | | | | |
| E1390 | A | | Oxygen concentrator | | | | | |
| E1399 | A | | Durable medical equipment mi | | | | | |
| E1405 | A | | O2/water vapor enrich w/heat | | | | | |
| E1406 | A | | O2/water vapor enrich w/o he | | | | | |
| E1500 | A | | Centrifuge | | | | | |
| E1510 | A | | Kidney dialysate delivry sys | | | | | |
| E1520 | A | | Heparin infusion pump | | | | | |
| E1530 | A | | Replacement air bubble detec | | | | | |
| E1540 | A | | Replacement pressure alarm | | | | | |
| E1550 | A | | Bath conductivity meter | | | | | |
| E1560 | A | | Replace blood leak detector | | | | | |
| E1570 | A | | Adjustable chair for esrd pt | | | | | |
| E1575 | A | | Transducer protect/fld bar | | | | | |
| E1580 | A | | Unipuncture control system | | | | | |
| E1590 | A | | Hemodialysis machine | | | | | |
| E1592 | A | | Auto interm peritoneal dialy | | | | | |
| E1594 | A | | Cycler dialysis machine | | | | | |
| E1600 | A | | Deli/install chrg hemo equip | | | | | |
| E1610 | A | | Reverse osmosis h2o puri sys | | | | | |
| E1615 | A | | Deionizer H2O puri system | | | | | |
| E1620 | A | | Replacement blood pump | | | | | |
| E1625 | A | | Water softening system | | | | | |
| E1630 | A | | Reciprocating peritoneal dia | | | | | |
| E1632 | A | | Wearable artificial kidney | | | | | |
| E1635 | A | | Compact travel hemodialyzer | | | | | |
| E1636 | A | | Sorbent cartridges per 10 | | | | | |
| E1637 | A | | Hemostats for dialysis, each | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| E1638 | A | DG | Peri dialysis heating pad | | | | | |
| 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 | NI | Adjst forearm pro/sup device | | | | | |
| E1805 | A | | Adjust wrist ext/flex device | | | | | |
| E1806 | A | | SPS wrist device | | | | | |
| E1810 | A | | Adjust knee ext/flex device | | | | | |
| E1811 | A | | SPS knee device | | | | | |
| E1815 | A | | Adjust ankle ext/flex device | | | | | |
| E1816 | A | | SPS ankle device | | | | | |
| E1818 | A | | SPS forearm device | | | | | |
| E1820 | A | | Soft interface material | | | | | |
| E1821 | A | | Replacement interface SPSD | | | | | |
| E1825 | A | | Adjust finger ext/flex devc | | | | | |
| E1830 | A | | Adjust toe ext/flex device | | | | | |
| E1840 | A | | Adj shoulder ext/flex device | | | | | |
| E1902 | A | | AAC non-electronic board | | | | | |
| E2000 | A | | Gastric suction pump hme mdl | | | | | |
| E2100 | A | | Bld glucose monitor w voice | | | | | |
| E2101 | A | | Bld glucose monitor w lance | | | | | |
| G0001 | A | | Drawing blood for specimen | | | | | |
| G0002 | X | DG | Temporary urinary catheter | 0340 | 0.6492 | $33.86 | | $6.77 |
| G0004 | E | DG | ECG transm phys review & int | | | | | |
| G0005 | X | DG | ECG 24 hour recording | 0097 | 1.0077 | $52.55 | $23.80 | $10.51 |
| G0006 | X | DG | ECG transmission & analysis | 0097 | 1.0077 | $52.55 | $23.80 | $10.51 |
| G0007 | N | DG | ECG phy review & interpret | | | | | |
| G0008 | L | | Admin influenza virus vac | | | | | |
| G0009 | L | | Admin pneumococcal vaccine | | | | | |
| G0010 | K | | Admin hepatitis b vaccine | 0355 | 0.2132 | $11.12 | | $2.22 |
| G0015 | X | DG | Post symptom ECG tracing | 0097 | 1.0077 | $52.55 | $23.80 | $10.51 |
| G0025 | N | | Collagen skin test kit | | | | | |
| G0026 | A | DG | Fecal leukocyte examination | | | | | |
| G0027 | A | DG | Semen analysis | | | | | |
| G0030 | S | | PET imaging prev PET single | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0031 | S | | PET imaging prev PET multple | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0032 | S | | PET follow SPECT 78464 singl | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0033 | S | | PET follow SPECT 78464 mult | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0034 | S | | PET follow SPECT 76865 singl | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0035 | S | | PET follow SPECT 78465 mult | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0036 | S | | PET follow cornry angio sing | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0037 | S | | PET follow cornry angio mult | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0038 | S | | PET follow myocard perf sing | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0039 | S | | PET follow myocard perf mult | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0040 | S | | PET follow stress echo singl | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0041 | S | | PET follow stress echo mult | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0042 | S | | PET follow ventriculogm sing | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0043 | S | | PET follow ventriculogm mult | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0044 | S | | PET following rest ECG singl | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0045 | S | | PET following rest ECG mult | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0046 | S | | PET follow stress ECG singl | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0047 | S | | PET follow stress ECG mult | 0285 | 18.1294 | $945.47 | $409.56 | $189.09 |
| G0050 | S | DG | Residual urine by ultrasound | 0265 | 0.9787 | $51.04 | $28.07 | $10.21 |
| G0101 | V | | CA screen;pelvic/breast exam | 0600 | 0.8430 | $43.96 | | $8.79 |
| G0102 | N | | Prostate ca screening; dre | | | | | |
| G0103 | A | | Psa, total screening | | | | | |
| G0104 | S | | CA screen;flexi sigmoidscope | 0159 | 2.3255 | $121.28 | | $30.32 |
| G0105 | T | | Colorectal scrn; hi risk ind | 0158 | 7.0638 | $368.38 | | $92.10 |
| G0106 | S | | Colon CA screen;barium enema | 0157 | 2.5387 | $132.40 | | $26.48 |
| G0107 | A | | CA screen; fecal blood test | | | | | |
| G0108 | A | | Diab manage trn per indiv | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| G0109 | A | | Diab manage trn ind/group | | | | | |
| G0110 | A | | Nett pulm-rehab educ; ind | | | | | |
| G0111 | A | | Nett pulm-rehab educ; group | | | | | |
| G0112 | A | | Nett;nutrition guid, initial | | | | | |
| G0113 | A | | Nett;nutrition guid,subseqnt | | | | | |
| G0114 | A | | Nett; psychosocial consult | | | | | |
| G0115 | A | | Nett; psychological testing | | | | | |
| G0116 | A | | Nett; psychosocial counsel | | | | | |
| G0117 | S | | Glaucoma scrn hgh risk direc | 0230 | 0.7364 | $38.40 | $14.97 | $7.68 |
| G0118 | S | | Glaucoma scrn hgh risk direc | 0230 | 0.7364 | $38.40 | $14.97 | $7.68 |
| G0120 | S | | Colon ca scrn; barium enema | 0157 | 2.5387 | $132.40 | | $26.48 |
| G0121 | T | | Colon ca scrn not hi rsk ind | 0158 | 7.0638 | $368.38 | | $92.10 |
| 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 | 0714 | | $1,375.00 | | $275.00 |
| G0127 | T | | Trim nail(s) | 0009 | 0.6298 | $32.84 | $8.34 | $6.57 |
| G0128 | E | | CORF skilled nursing service | | | | | |
| G0129 | P | | Partial hosp prog service | 0033 | 4.6026 | $240.03 | $48.17 | $48.01 |
| G0130 | X | | Single energy x-ray study | 0260 | 0.7655 | $39.92 | $21.95 | $7.98 |
| G0131 | S | DG | CT scan, bone density study | 0288 | 1.2984 | $67.71 | | $13.54 |
| G0132 | S | DG | CT scan, bone density study | 0665 | 0.8236 | $42.95 | | $8.59 |
| G0141 | E | | Scr c/v cyto,autosys and md | | | | | |
| G0143 | A | | Scr c/v cyto,thinlayer,rescr | | | | | |
| G0144 | A | | Scr c/v cyto,thinlayer,rescr | | | | | |
| G0145 | A | | Scr c/v cyto,thinlayer,rescr | | | | | |
| G0147 | A | | Scr c/v cyto, automated sys | | | | | |
| G0148 | A | | Scr c/v cyto, autosys, rescr | | | | | |
| G0151 | E | | HHCP-serv of pt,ea 15 min | | | | | |
| G0152 | E | | HHCP-serv of ot,ea 15 min | | | | | |
| G0153 | E | | HHCP-svs of s/l path,ea 15mn | | | | | |
| G0154 | E | | HHCP-svs of rn,ea 15 min | | | | | |
| G0155 | E | | HHCP-svs of csw,ea 15 min | | | | | |
| G0156 | E | | HHCP-svs of aide,ea 15 min | | | | | |
| G0166 | T | | Extrnl counterpulse, per tx | 0678 | 2.2189 | $115.72 | | $23.14 |
| G0167 | E | | Hyperbaric oz tx;no md reqrd | | | | | |
| G0168 | X | | Wound closure by adhesive | 0340 | 0.6492 | $33.86 | | $6.77 |
| G0173 | S | | Stereo radoisurgery,complete | 0721 | | $5,500.00 | | $1,100.00 |
| G0175 | V | | OPPS Service,sched team conf | 0602 | 1.4631 | $76.30 | | $15.26 |
| G0176 | P | | OPPS/PHP;activity therapy | 0033 | 4.6026 | $240.03 | $48.17 | $48.01 |
| G0177 | P | | OPPS/PHP; train & educ serv | 0033 | 4.6026 | $240.03 | $48.17 | $48.01 |
| G0179 | E | | MD recertification HHA PT | | | | | |
| G0180 | E | | MD certification HHA patient | | | | | |
| G0181 | E | | Home health care supervision | | | | | |
| G0182 | E | | Hospice care supervision | | | | | |
| G0185 | T | DG | Transpuppillary thermotx | 0235 | 5.0871 | $265.30 | $73.44 | $53.06 |
| G0186 | T | | Dstry eye lesn,fdr vssl tech | 0235 | 5.0871 | $265.30 | $73.44 | $53.06 |
| G0187 | T | DG | Dstry mclr drusen,photocoag | 0235 | 5.0871 | $265.30 | $73.44 | $53.06 |
| G0192 | N | DG | Immunization oral/intranasal | | | | | |
| G0193 | A | DG | Endoscopicstudyswallowfunctn | | | | | |
| G0194 | A | DG | Sensorytestingendoscopicstud | | | | | |
| G0195 | A | DG | Clinicalevalswallowingfunct | | | | | |
| G0196 | A | DG | Evalofswallowingwithradioopa | | | | | |
| G0197 | A | DG | Evalofptforprescipspeechdevi | | | | | |
| G0198 | A | DG | Patientadapation&trainforspe | | | | | |
| G0199 | A | DG | Reevaluationofpatientusespec | | | | | |
| G0200 | A | DG | Evalofpatientprescipofvoicep | | | | | |
| G0201 | A | DG | Modifortraininginusevoicepro | | | | | |
| G0202 | A | | Screeningmammographydigital | | | | | |
| G0204 | S | | Diagnosticmammographydigital | 0669 | 0.8915 | $46.49 | | $9.30 |
| G0206 | S | | Diagnosticmammographydigital | 0669 | 0.8915 | $46.49 | | $9.30 |
| G0210 | S | | PET img whbd ring dxlung ca | 0714 | | $1,375.00 | | $275.00 |
| G0211 | S | | PET img whbd ring init lung | 0714 | | $1,375.00 | | $275.00 |
| G0212 | S | | PET img whbd ring restag lun | 0714 | | $1,375.00 | | $275.00 |
| G0213 | S | | PET img whbd ring dx colorec | 0714 | | $1,375.00 | | $275.00 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| G0214 | S | | PET img whbd ring init colre | 0714 | | $1,375.00 | | $275.00 |
| G0215 | S | | PET img whbd restag col | 0714 | | $1,375.00 | | $275.00 |
| G0216 | S | | PET img whbd ring dx melanom | 0714 | | $1,375.00 | | $275.00 |
| G0217 | S | | PET img whbd ring init melan | 0714 | | $1,375.00 | | $275.00 |
| G0218 | S | | PET img whbd ring restag mel | 0714 | | $1,375.00 | | $275.00 |
| G0219 | E | | PET img whbd ring noncov ind | | | | | |
| G0220 | S | | PET img whbd ring dx lymphom | 0714 | | $1,375.00 | | $275.00 |
| G0221 | S | | PET img whbd ring init lymph | 0714 | | $1,375.00 | | $275.00 |
| G0222 | S | | PET img whbd ring resta lymp | 0714 | | $1,375.00 | | $275.00 |
| G0223 | S | | PET img whbd reg ring dx hea | 0714 | | $1,375.00 | | $275.00 |
| G0224 | S | | PETimg whbd reg ring ini hea | 0714 | | $1,375.00 | | $275.00 |
| G0225 | S | | PET img whbd ring restag hea | 0714 | | $1,375.00 | | $275.00 |
| G0226 | S | | PET img whbd dx esophag | 0714 | | $1,375.00 | | $275.00 |
| G0227 | S | | PET img whbd ring ini esopha | 0714 | | $1,375.00 | | $275.00 |
| G0228 | S | | PET img whbd ring restg esop | 0714 | | $1,375.00 | | $275.00 |
| G0229 | S | | PET img metabolic brain ring | 0714 | | $1,375.00 | | $275.00 |
| G0230 | S | | PET myocard viability ring | 0714 | | $1,375.00 | | $275.00 |
| G0231 | S | | PET WhBD colorec; gamma cam | 0714 | | $1,375.00 | | $275.00 |
| G0232 | S | | PET whbd lymphoma; gamma cam | 0714 | | $1,375.00 | | $275.00 |
| G0233 | S | | PET whbd melanoma; gamma cam | 0714 | | $1,375.00 | | $275.00 |
| G0234 | S | | PET WhBD pulm nod; gamma cam | 0714 | | $1,375.00 | | $275.00 |
| G0236 | S | | Digital film convert diag ma | 0706 | | $25.00 | | $5.00 |
| G0237 | T | | Therapeutic procd strg endur | 0970 | | $25.00 | | $5.00 |
| G0238 | T | | Oth resp proc, indiv | 0970 | | $25.00 | | $5.00 |
| G0239 | T | | Oth resp proc, group | 0970 | | $25.00 | | $5.00 |
| G0240 | A | DG | Critic care by MD transport | | | | | |
| G0241 | A | DG | Each additional 30 minutes | | | | | |
| G0242 | S | | Multisource photon ster plan | 0714 | | $1,375.00 | | $275.00 |
| G0243 | S | | Multisour photon stero treat | 0721 | | $5,500.00 | | $1,100.00 |
| G0244 | S | | Observ care by facility topt | 0339 | 7.2188 | $376.47 | | $75.29 |
| G0245 | V | | Initial Foot Exam PTLOPS | 0600 | 0.8430 | $43.96 | | $8.79 |
| G0246 | V | | Follow-up Eval of Foot PTLOPS | 0600 | 0.8430 | $43.96 | | $8.79 |
| G0247 | T | | Routine footcare w LOPS | 0009 | 0.6298 | $32.84 | $8.34 | $6.57 |
| G0248 | S | | Demonstrate use home INR mon | 0708 | | $150.00 | | $30.00 |
| G0249 | S | | Provide test material,equipm | 0708 | | $150.00 | | $30.00 |
| G0250 | E | | MD review interpret of test | | | | | |
| G0251 | S | NI | Linear acc based stero radio | 0713 | | $1,125.00 | | $225.00 |
| G0252 | S | NI | PET imaging initial dx | 0714 | | $1,375.00 | | $275.00 |
| G0253 | S | NI | PET image brst dection recur | 0714 | | $1,375.00 | | $275.00 |
| G0254 | S | NI | PET image brst eval to tx | 0714 | | $1,375.00 | | $275.00 |
| G0255 | E | NI | Current percep threshold tst | | | | | |
| G0256 | T | NF | Prostate brachy w palladium | 0649 | 115.0167 | $5,998.24 | | $1,199.65 |
| G0257 | S | NF | Unsched dialysis ESRD pt hos | 0170 | 4.8352 | $252.16 | | $50.43 |
| G0258 | X | DG | IV infusion during obs stay | 0340 | 0.6492 | $33.86 | | $6.77 |
| G0259 | N | NF | Inject for sacroiliac joint | | | | | |
| G0260 | T | NF | Inj for sacroiliac jt anesth | 0204 | 2.0251 | $105.61 | $40.13 | $21.12 |
| G0261 | T | NF | Prostate brachy w iodine see | 0684 | 98.8349 | $5,154.34 | | $1,030.87 |
| G0262 | S | NI | Sm intestinal image capsule | 0711 | | $625.00 | | $125.00 |
| G0263 | N | NF | Adm with CHF, CP, asthma | | | | | |
| G0264 | V | NF | Assmt otr CHF, CP, asthma | 0600 | 0.8430 | $43.96 | | $8.79 |
| G0265 | A | NI | Cryopresevation Freeze+stora | | | | | |
| G0266 | A | NI | Thawing + expansion froz cel | | | | | |
| G0267 | A | NI | Bone marrow or psc harvest | | | | | |
| G0268 | X | NI | Removal of impacted wax md | 0340 | 0.6492 | $33.86 | | $6.77 |
| G0269 | N | NI | Occlusive device in vein art | | | | | |
| G0270 | A | NI | MNT subs tx for change dx | | | | | |
| G0271 | A | NI | Group MNT 2 or more 30 mins | | | | | |
| G0272 | X | NI | Naso/oro gastric tube pl MD | 0272 | 1.3372 | $69.74 | $38.36 | $13.95 |
| G0273 | S | NI | Pretx planning, non-Hodgkins | 0718 | | $2,750.00 | | $550.00 |
| G0274 | S | NI | Radiopharm tx, non-Hodgkins | 0725 | | $20,000.00 | | $4,000.00 |
| G0275 | N | NI | Renal angio, cardiac cath | | | | | |
| G0278 | N | NI | Iliac art angio,cardiac cath | | | | | |
| G0279 | A | NI | Excorp shock tx, elbow epi | | | | | |
| G0280 | A | NI | Excorp shock tx other than | | | | | |
| G0281 | A | NI | Elec stim unattend for press | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| G0282 | A | NI | Elect stim wound care not pd | | | | | |
| G0283 | A | NI | Elec stim other than wound | | | | | |
| G0288 | T | NI | Recon, CTA for surg plan | 0975 | | $625.00 | | $125.00 |
| G0289 | N | NI | Arthro, loose body + chondro | | | | | |
| G0290 | E | NF | Drug-eluting stents, single | | | | | |
| G0291 | E | NF | Drug-eluting stents,each add | | | | | |
| G0292 | S | NI | Adm exp drugs,clinical trial | 0708 | | $150.00 | | $30.00 |
| G0293 | S | NI | Non-cov surg proc,clin trial | 0710 | | $400.00 | | $80.00 |
| G0294 | S | NI | Non-cov proc, clinical trial | 0707 | | $75.00 | | $15.00 |
| G0295 | E | NI | Electromagnetic therapy onc | | | | | |
| G9001 | E | | MCCD, initial rate | | | | | |
| G9002 | E | | MCCD,maintenance rate | | | | | |
| G9003 | E | | MCCD, risk adj hi, initial | | | | | |
| G9004 | E | | MCCD, risk adj lo, initial | | | | | |
| G9005 | E | | MCCD, risk adj, maintenance | | | | | |
| G9006 | E | | MCCD, Home monitoring | | | | | |
| G9007 | E | | MCCD, sch team conf | | | | | |
| G9008 | E | | Mccd,phys coor-care ovrsght | | | | | |
| G9009 | E | | MCCD, risk adj, level 3 | | | | | |
| G9010 | E | | MCCD, risk adj, level 4 | | | | | |
| G9011 | E | | MCCD, risk adj, level 5 | | | | | |
| G9012 | E | | Other Specified Case Mgmt | | | | | |
| G9016 | A | | Demo-smoking cessation coun | | | | | |
| H0001 | E | | Alcohol and/or drug assess | | | | | |
| H0002 | E | | Alcohol and/or drug screenin | | | | | |
| H0003 | E | | Alcohol and/or drug screenin | | | | | |
| H0004 | E | | Alcohol and/or drug services | | | | | |
| H0005 | E | | Alcohol and/or drug services | | | | | |
| H0006 | E | | Alcohol and/or drug services | | | | | |
| H0007 | E | | Alcohol and/or drug services | | | | | |
| H0008 | E | | Alcohol and/or drug services | | | | | |
| H0009 | E | | Alcohol and/or drug services | | | | | |
| H0010 | E | | Alcohol and/or drug services | | | | | |
| H0011 | E | | Alcohol and/or drug services | | | | | |
| H0012 | E | | Alcohol and/or drug services | | | | | |
| H0013 | E | | Alcohol and/or drug services | | | | | |
| H0014 | E | | Alcohol and/or drug services | | | | | |
| H0015 | E | | Alcohol and/or drug services | | | | | |
| H0016 | E | | Alcohol and/or drug services | | | | | |
| H0017 | E | | Alcohol and/or drug services | | | | | |
| H0018 | E | | Alcohol and/or drug services | | | | | |
| H0019 | E | | Alcohol and/or drug services | | | | | |
| H0020 | E | | Alcohol and/or drug services | | | | | |
| H0021 | E | | Alcohol and/or drug training | | | | | |
| H0022 | E | | Alcohol and/or drug interven | | | | | |
| H0023 | E | | Alcohol and/or drug outreach | | | | | |
| H0024 | E | | Alcohol and/or drug preventi | | | | | |
| H0025 | E | | Alcohol and/or drug preventi | | | | | |
| H0026 | E | | Alcohol and/or drug preventi | | | | | |
| H0027 | E | | Alcohol and/or drug preventi | | | | | |
| H0028 | E | | Alcohol and/or drug preventi | | | | | |
| H0029 | E | | Alcohol and/or drug preventi | | | | | |
| H0030 | E | | Alcohol and/or drug hotline | | | | | |
| H0031 | E | NI | MH health assess by non-md | | | | | |
| H0032 | E | NI | MH svc plan dev by non-md | | | | | |
| H0033 | E | NI | Oral med adm direct observe | | | | | |
| H0034 | E | NI | Med trng & support per 15min | | | | | |
| H0035 | E | NI | MH partial hosp tx under 24h | | | | | |
| H0036 | E | NI | Comm psy face-face per 15min | | | | | |
| H0037 | E | NI | Comm psy sup tx pgm per diem | | | | | |
| H0038 | E | NI | Self-help/peer svc per 15min | | | | | |
| H0039 | E | NI | Asser com tx face-face/15min | | | | | |
| H0040 | E | NI | Assert comm tx pgm per diem | | | | | |
| H0041 | E | NI | Fos c chld non-ther per diem | | | | | |
| H0042 | E | NI | Fos c chld non-ther per mon | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| H0043 | E | NI | Supported housing, per diem | | | | | |
| H0044 | E | NI | Supported housing, per month | | | | | |
| H0045 | E | NI | Respite not-in-home per diem | | | | | |
| H0046 | E | NI | Mental health service, nos | | | | | |
| H0047 | E | NI | Alcohol/drug abuse svc nos | | | | | |
| H0048 | E | NI | Spec coll non-blood:a/d test | | | | | |
| H1000 | A | | Prenatal care atrisk assessm | | | | | |
| H1001 | A | | Antepartum management | | | | | |
| H1002 | A | | Carecoordination prenatal | | | | | |
| H1003 | A | | Prenatal at risk education | | | | | |
| H1004 | A | | Follow up home visit/prental | | | | | |
| H1005 | A | | Prenatalcare enhanced srv pk | | | | | |
| H1010 | E | NI | Nonmed family planning ed | | | | | |
| H1011 | E | NI | Family assessment | | | | | |
| H2000 | E | NI | Comp multidisipln evaluation | | | | | |
| H2001 | E | NI | Rehabilitation program 1/2 d | | | | | |
| J0120 | N | | Tetracyclin injection | | | | | |
| J0130 | K | | Abciximab injection | 1605 | 5.8526 | $305.22 | | $61.04 |
| J0150 | N | | Injection adenosine 6 MG | | | | | |
| J0151 | K | | Adenosine injection | 0917 | 3.1986 | $166.81 | | $33.36 |
| J0170 | N | | Adrenalin epinephrin inject | | | | | |
| J0190 | N | | Inj biperiden lactate/5 mg | | | | | |
| J0200 | N | | Alatrofloxacin mesylate | | | | | |
| J0205 | F | | Alglucerase injection | | | | | |
| J0207 | K | | Amifostine | 7000 | 4.5057 | $234.98 | | $47.00 |
| J0210 | N | | Methyldopate hcl injection | | | | | |
| J0256 | F | | Alpha 1 proteinase inhibitor | | | | | |
| J0270 | E | | Alprostadil for injection | | | | | |
| J0275 | E | | Alprostadil urethral suppos | | | | | |
| J0280 | N | | Aminophyllin 250 MG inj | | | | | |
| J0282 | N | | Amiodarone HCl | | | | | |
| J0285 | N | | Amphotericin B | | | | | |
| J0286 | K | DG | Amphotericin B lipid complex | 7001 | 2.3449 | $122.29 | | $24.46 |
| J0287 | K | NI | Amphotericin b lipid complex | 9024 | 0.4167 | $21.73 | | $4.35 |
| J0288 | N | NI | Ampho b cholesteryl sulfate | | | | | |
| J0289 | N | NI | Amphotericin b liposome inj | | | | | |
| J0290 | N | | Ampicillin 500 MG inj | | | | | |
| J0295 | N | | Ampicillin sodium per 1.5 gm | | | | | |
| J0300 | N | | Amobarbital 125 MG inj | | | | | |
| J0330 | N | | Succinycholine chloride inj | | | | | |
| J0350 | N | | Injection anistreplase 30 u | | | | | |
| J0360 | N | | Hydralazine hcl injection | | | | | |
| J0380 | N | | Inj metaraminol bitartrate | | | | | |
| J0390 | N | | Chloroquine injection | | | | | |
| J0395 | N | | Arbutamine HCl injection | | | | | |
| J0456 | N | | Azithromycin | | | | | |
| J0460 | N | | Atropine sulfate injection | | | | | |
| J0470 | N | | Dimecaprol injection | | | | | |
| J0475 | N | | Baclofen 10 MG injection | | | | | |
| J0476 | E | | Baclofen intrathecal trial | | | | | |
| J0500 | N | | Dicyclomine injection | | | | | |
| J0515 | N | | Inj benztropine mesylate | | | | | |
| J0520 | N | | Bethanechol chloride inject | | | | | |
| J0530 | N | | Penicillin g benzathine inj | | | | | |
| J0540 | N | | Penicillin g benzathine inj | | | | | |
| J0550 | N | | Penicillin g benzathine inj | | | | | |
| J0560 | N | | Penicillin g benzathine inj | | | | | |
| J0570 | N | | Penicillin g benzathine inj | | | | | |
| J0580 | N | | Penicillin g benzathine inj | | | | | |
| J0585 | K | | Botulinum toxin a per unit | 0902 | 0.0484 | $2.52 | | $.50 |
| J0587 | G | | Botulinum toxin type B | 9018 | | $8.79 | | $1.31 |
| J0592 | N | NI | Buprenorphine hydrochloride | | | | | |
| J0600 | N | | Edetate calcium disodium inj | | | | | |
| J0610 | N | | Calcium gluconate injection | | | | | |
| J0620 | N | | Calcium glycer & lact/10 ML | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| J0630 | N | | Calcitonin salmon injection | | | | | |
| J0635 | N | DG | Calcitriol injection | | | | | |
| J0636 | N | NI | Inj calcitriol per 0.1 mcg | | | | | |
| J0637 | G | NI | Caspofungin acetate | 9019 | | $34.20 | | $5.11 |
| 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 | 4.7383 | $247.11 | | $49.42 |
| J0880 | E | NI | 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 | | | | | |
| J1050 | N | DG | Medroxyprogesterone inj | | | | | |
| J1051 | N | NI | 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 | NI | Inj dexamethasone acetate | | | | | |
| J1095 | N | DG | 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 | 2.2577 | $117.74 | | $23.55 |
| J1200 | N | | Diphenhydramine hcl injectio | | | | | |
| J1205 | N | | Chlorothiazide sodium inj | | | | | |
| J1212 | N | | Dimethyl sulfoxide 50% 50 ML | | | | | |
| J1230 | N | | Methadone injection | | | | | |
| J1240 | N | | Dimenhydrinate injection | | | | | |
| J1245 | N | | Dipyridamole injection | | | | | |
| J1250 | N | | Inj dobutamine HCL/250 mg | | | | | |
| J1260 | N | | Dolasetron mesylate | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| 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 | N | | Eptifibatide injection | | | | | |
| J1330 | N | | Ergonovine maleate injection | | | | | |
| J1364 | N | | Erythro lactobionate /500 MG | | | | | |
| J1380 | N | | Estradiol valerate 10 MG inj | | | | | |
| J1390 | N | | Estradiol valerate 20 MG inj | | | | | |
| J1410 | N | | Inj estrogen conjugate 25 MG | | | | | |
| J1435 | N | | Injection estrone per 1 MG | | | | | |
| J1436 | N | | Etidronate disodium inj | | | | | |
| J1438 | N | | Etanercept injection | | | | | |
| J1440 | K | | Filgrastim 300 mcg injection | 0728 | 2.1027 | $109.66 | | $21.93 |
| J1441 | K | | Filgrastim 480 mcg injection | 7049 | 3.2267 | $168.28 | | $33.66 |
| J1450 | N | | Fluconazole | | | | | |
| J1452 | N | | Intraocular Fomivirsen na | | | | | |
| J1455 | N | | Foscarnet sodium injection | | | | | |
| J1460 | N | | Gamma globulin 1 CC inj | | | | | |
| J1470 | E | | Gamma globulin 2 CC inj | | | | | |
| J1480 | E | | Gamma globulin 3 CC inj | | | | | |
| J1490 | E | | Gamma globulin 4 CC inj | | | | | |
| J1500 | E | | Gamma globulin 5 CC inj | | | | | |
| J1510 | E | | Gamma globulin 6 CC inj | | | | | |
| J1520 | E | | Gamma globulin 7 CC inj | | | | | |
| J1530 | E | | Gamma globulin 8 CC inj | | | | | |
| J1540 | E | | Gamma globulin 9 CC inj | | | | | |
| J1550 | E | | Gamma globulin 10 CC inj | | | | | |
| J1560 | E | | Gamma globulin > 10 CC inj | | | | | |
| J1561 | K | DG | Immune globulin 500 mg | 0905 | 0.8333 | $43.46 | | $8.69 |
| J1563 | E | | IV immune globulin | | | | | |
| J1564 | K | NI | Immune globulin 10 mg | 9021 | 0.0097 | $.51 | | $.10 |
| J1565 | K | | RSV-ivig | 0906 | 0.5911 | $30.83 | | $6.17 |
| J1570 | N | | Ganciclovir sodium injection | | | | | |
| J1580 | N | | Garamycin gentamicin inj | | | | | |
| J1590 | N | | Gatifloxacin injection | | | | | |
| J1600 | N | | Gold sodium thiomaleate inj | | | | | |
| J1610 | N | | Glucagon hydrochloride/1 MG | | | | | |
| J1620 | N | | Gonadorelin hydroch/ 100 mcg | | | | | |
| J1626 | N | | Granisetron HCl injection | | | | | |
| J1630 | N | | Haloperidol injection | | | | | |
| J1631 | N | | Haloperidol decanoate inj | | | | | |
| J1642 | N | | Inj heparin sodium per 10 u | | | | | |
| J1644 | N | | Inj heparin sodium per 1000u | | | | | |
| J1645 | N | | Dalteparin sodium | | | | | |
| J1650 | N | | Inj enoxaparin sodium | | | | | |
| J1652 | N | NI | 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 | 0.7364 | $38.40 | | $7.68 |
| J1750 | N | | Iron dextran | | | | | |
| J1755 | N | DG | Iron sucrose injection | | | | | |
| J1756 | N | NI | Iron sucrose injection | | | | | |
| J1785 | K | | Injection imiglucerase /unit | 0916 | 0.0484 | $2.52 | | $.50 |
| J1790 | N | | Droperidol injection | | | | | |
| J1800 | N | | Propranolol injection | | | | | |
| J1810 | E | | Droperidol/fentanyl inj | | | | | |
| J1815 | N | NI | Insulin injection | | | | | |
| J1817 | N | NI | Insulin for insulin pump use | | | | | |
| J1820 | N | DG | Insulin injection | | | | | |
| J1825 | K | | Interferon beta-1a | 0909 | 2.7906 | $145.53 | | $29.11 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| J1830 | K | | Interferon beta-1b / .25 MG | 0910 | 1.9864 | $103.59 | | $20.72 |
| J1835 | N | | Itraconazole injection | | | | | |
| J1840 | N | | Kanamycin sulfate 500 MG inj | | | | | |
| J1850 | N | | Kanamycin sulfate 75 MG inj | | | | | |
| J1885 | N | | Ketorolac tromethamine inj | | | | | |
| J1890 | N | | Cephalothin sodium injection | | | | | |
| J1910 | N | | Kutapressin injection | | | | | |
| J1940 | N | | Furosemide injection | | | | | |
| J1950 | K | | Leuprolide acetate /3.75 MG | 0800 | 3.7984 | $198.09 | | $39.62 |
| J1955 | E | | Inj levocarnitine per 1 gm | | | | | |
| J1956 | N | | Levofloxacin injection | | | | | |
| J1960 | N | | Levorphanol tartrate inj | | | | | |
| J1980 | N | | Hyoscyamine sulfate inj | | | | | |
| J1990 | N | | Chlordiazepoxide injection | | | | | |
| J2000 | N | | Lidocaine injection | | | | | |
| J2010 | N | | Lincomycin injection | | | | | |
| J2020 | N | | Linezolid injection | | | | | |
| J2060 | N | | Lorazepam injection | | | | | |
| J2150 | N | | Mannitol injection | | | | | |
| J2175 | N | | Meperidine hydrochl /100 MG | | | | | |
| J2180 | N | | Meperidine/promethazine inj | | | | | |
| J2210 | N | | Methylergonovin maleate inj | | | | | |
| J2250 | N | | Inj midazolam hydrochloride | | | | | |
| J2260 | N | | Inj milrinone lactate / 5 ML | | | | | |
| J2270 | N | | Morphine sulfate injection | | | | | |
| J2271 | N | | Morphine so4 injection 100mg | | | | | |
| J2275 | N | | Morphine sulfate injection | | | | | |
| J2300 | N | | Inj nalbuphine hydrochloride | | | | | |
| J2310 | N | | Inj naloxone hydrochloride | | | | | |
| J2320 | N | | Nandrolone decanoate 50 MG | | | | | |
| J2321 | N | | Nandrolone decanoate 100 MG | | | | | |
| J2322 | N | | Nandrolone decanoate 200 MG | | | | | |
| J2324 | G | NI | Nesiritide | 9114 | | $433.20 | | $64.75 |
| J2352 | K | | Octreotide acetate injection | 7031 | 1.2694 | $66.20 | | $13.24 |
| J2355 | K | | Oprelvekin injection | 7011 | 2.7325 | $142.50 | | $28.50 |
| 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 | 3.2654 | $170.29 | | $34.06 |
| J2440 | N | | Papaverin hcl injection | | | | | |
| J2460 | N | | Oxytetracycline injection | | | | | |
| J2500 | N | DG | Paricalcitol | | | | | |
| J2501 | N | NI | Paricalcitol | | | | | |
| J2510 | N | | Penicillin g procaine inj | | | | | |
| J2515 | N | | Pentobarbital sodium inj | | | | | |
| J2540 | N | | Penicillin g potassium inj | | | | | |
| J2543 | N | | Piperacillin/tazobactam | | | | | |
| J2545 | A | | Pentamidine isethionte/300mg | | | | | |
| J2550 | N | | Promethazine hcl injection | | | | | |
| J2560 | N | | Phenobarbital sodium inj | | | | | |
| J2590 | N | | Oxytocin injection | | | | | |
| J2597 | N | | Inj desmopressin acetate | | | | | |
| J2650 | N | | Prednisolone acetate inj | | | | | |
| J2670 | N | | Totazoline hcl injection | | | | | |
| J2675 | N | | Inj progesterone per 50 MG | | | | | |
| J2680 | N | | Fluphenazine decanoate 25 MG | | | | | |
| J2690 | N | | Procainamide hcl injection | | | | | |
| J2700 | N | | Oxacillin sodium injeciton | | | | | |
| J2710 | N | | Neostigmine methylslfte inj | | | | | |
| J2720 | N | | Inj protamine sulfate/10 MG | | | | | |
| J2725 | N | | Inj protirelin per 250 mcg | | | | | |
| J2730 | N | | Pralidoxime chloride inj | | | | | |
| J2760 | N | | Phentolaine mesylate inj | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| J2765 | N | | Metoclopramide hcl injection | | | | | |
| J2770 | N | | Quinupristin/dalfopristin | | | | | |
| J2780 | N | | Ranitidine hydrochloride inj | | | | | |
| J2788 | K | NI | Rho d immune globulin 50 mcg | 9023 | 0.0484 | $2.52 | | $.50 |
| J2790 | N | | Rho d immune globulin inj | | | | | |
| J2792 | K | | Rho(D) immune globulin h, sd | 1609 | 0.2229 | $11.62 | | $2.32 |
| J2795 | N | | Ropivacaine HCl injection | | | | | |
| J2800 | N | | Methocarbamol injection | | | | | |
| J2810 | N | | Inj theophylline per 40 MG | | | | | |
| J2820 | N | | Sargramostim injection | | | | | |
| J2910 | N | | Aurothioglucose injeciton | | | | | |
| J2912 | N | | Sodium chloride injection | | | | | |
| J2915 | N | DG | NA Ferric Gluconate Complex | | | | | |
| J2916 | N | NI | Na ferric gluconate complex | | | | | |
| J2920 | N | | Methylprednisolone injection | | | | | |
| J2930 | N | | Methylprednisolone injection | | | | | |
| J2940 | N | | Somatrem injection | | | | | |
| J2941 | K | | Somatropin injection | 7034 | 0.7170 | $37.39 | | $7.48 |
| J2950 | N | | Promazine hcl injection | | | | | |
| J2993 | K | | Reteplase injection | 9005 | 12.6547 | $659.96 | | $131.99 |
| J2995 | N | | Inj streptokinase /250000 IU | | | | | |
| J2997 | N | | Alteplase recombinant | | | | | |
| J3000 | N | | Streptomycin injection | | | | | |
| J3010 | N | | Fentanyl citrate injeciton | | | | | |
| J3030 | N | | Sumatriptan succinate / 6 MG | | | | | |
| J3070 | N | | Pentazocine hcl injection | | | | | |
| J3100 | K | | Tenecteplase injection | 9002 | 27.5963 | $1,439.17 | | $287.83 |
| 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 | 7.5870 | $395.67 | | $79.13 |
| J3245 | K | | Tirofiban hydrochloride | 7041 | 4.9417 | $257.71 | | $51.54 |
| 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 | 1.3081 | $68.22 | | $13.64 |
| J3310 | N | | Perphenazine injeciton | | | | | |
| J3315 | E | NI | Triptorelin pamoate | | | | | |
| J3320 | N | | Spectinomycn di-hcl inj | | | | | |
| J3350 | N | | Urea injection | | | | | |
| J3360 | N | | Diazepam injection | | | | | |
| J3364 | N | | Urokinase 5000 IU injection | | | | | |
| J3365 | N | | Urokinase 250,000 IU inj | | | | | |
| J3370 | N | | Vancomycin hcl injection | | | | | |
| J3395 | K | | Verteporfin injection | 1203 | 16.5209 | $861.58 | | $172.32 |
| J3400 | N | | Triflupromazine hcl inj | | | | | |
| J3410 | N | | Hydroxyzine hcl injection | | | | | |
| J3420 | N | | Vitamin b12 injection | | | | | |
| J3430 | N | | Vitamin k phytonadione inj | | | | | |
| J3470 | N | | Hyaluronidase injection | | | | | |
| J3475 | N | | Inj magnesium sulfate | | | | | |
| J3480 | N | | Inj potassium chloride | | | | | |
| J3485 | N | | Zidovudine | | | | | |
| J3487 | G | NI | Zoledronic acid | 9115 | | $406.78 | | $60.80 |
| J3490 | N | | Drugs unclassified injection | | | | | |
| J3520 | | | Edetate disodium per 150 mg | | | | | |
| J3530 | N | | Nasal vaccine inhalation | | | | | |
| J3535 | E | | Metered dose inhaler drug | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| J3570 | E | | Laetrile amygdalin vit B17 | | | | | |
| J3590 | N | NI | 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 | 0.0097 | $.51 | | $.10 |
| J7191 | K | | Factor VIII (porcine) | 0926 | 0.0291 | $1.52 | | $.30 |
| J7192 | K | | Factor viii recombinant | 0927 | 0.0194 | $1.01 | | $.20 |
| J7193 | K | | Factor IX non-recombinant | 0931 | 0.0097 | $.51 | | $.10 |
| J7194 | K | | Factor ix complex | 0928 | 0.0097 | $.51 | | $.10 |
| J7195 | K | | Factor IX recombinant | 0932 | 0.0194 | $1.01 | | $.20 |
| J7197 | K | | Antithrombin iii injection | 0930 | 0.0194 | $1.01 | | $.20 |
| J7198 | K | | Anti-inhibitor | 0929 | 0.0194 | $1.01 | | $.20 |
| J7199 | E | | Hemophilia clot factor noc | | | | | |
| J7300 | E | | Intraut copper contraceptive | | | | | |
| J7302 | E | | Levonorgestrel iu contracept | | | | | |
| J7308 | N | | Aminolevulinic acid hcl top | | | | | |
| J7310 | N | | Ganciclovir long act implant | | | | | |
| J7316 | N | DG | Sodium hyaluronate injection | | | | | |
| J7317 | N | NI | Sodium hyaluronate injection | | | | | |
| J7320 | K | | Hylan G-F 20 injection | 1611 | 2.3643 | $123.30 | | $24.66 |
| J7330 | K | | Cultured chondrocytes implnt | 1059 | 114.2706 | $5,959.33 | | $1,191.87 |
| J7340 | E | | Metabolic active D/E tissue | | | | | |
| J7342 | N | NI | Metabolically active tissue | | | | | |
| J7350 | N | NI | Injectable human tissue | | | | | |
| J7500 | N | | Azathioprine oral 50mg | | | | | |
| J7501 | N | | Azathioprine parenteral | | | | | |
| J7502 | K | | Cyclosporine oral 100 mg | 0888 | 0.0484 | $2.52 | | $.50 |
| J7504 | K | | Lymphocyte immune globulin | 0890 | 3.3429 | $174.34 | | $34.87 |
| J7505 | K | | Monoclonal antibodies | 7038 | 6.9572 | $362.82 | | $72.56 |
| J7506 | N | | Prednisone oral | | | | | |
| J7507 | K | | Tacrolimus oral per 1 MG | 0891 | 0.0291 | $1.52 | | $.30 |
| J7508 | E | | Tacrolimus oral per 5 MG | | | | | |
| J7509 | N | | Methylprednisolone oral | | | | | |
| J7510 | N | | Prednisolone oral per 5 mg | | | | | |
| J7511 | K | | Antithymocyte globuln rabbit | 9104 | 2.6356 | $137.45 | | $27.49 |
| J7513 | K | | Daclizumab, parenteral | 1612 | 4.3991 | $229.42 | | $45.88 |
| J7515 | N | | Cyclosporine oral 25 mg | | | | | |
| J7516 | N | | Cyclosporin parenteral 250mg | | | | | |
| J7517 | K | | Mycophenolate mofetil oral | 9015 | 0.0291 | $1.52 | | $.30 |
| J7520 | K | | Sirolimus, oral | 9020 | 0.0581 | $3.03 | | $.61 |
| J7525 | N | | Tacrolimus injection | | | | | |
| J7599 | E | | Immunosuppressive drug noc | | | | | |
| J7608 | A | | Acetylcysteine inh sol u d | | | | | |
| J7618 | A | | Albuterol inh sol con | | | | | |
| J7619 | A | | Albuterol inh sol u d | | | | | |
| J7622 | A | | Beclomethasone inhalatn sol | | | | | |
| J7624 | A | | Betamethasone inhalation sol | | | | | |
| J7626 | A | | Budesonide inhalation sol | | | | | |
| J7628 | A | | Bitolterol mes inhal sol con | | | | | |
| J7629 | A | | Bitolterol mes inh sol u d | | | | | |
| J7631 | A | | Cromolyn sodium inh sol u d | | | | | |
| J7633 | N | NI | Budesonide concentrated sol | | | | | |
| J7635 | A | | Atropine inhal sol con | | | | | |
| J7636 | A | | Atropine inhal sol unit dose | | | | | |
| J7637 | A | | Dexamethasone inhal sol con | | | | | |
| J7638 | A | | Dexamethasone inhal sol u d | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| J7639 | A | | Dornase alpha inhal sol u d | | | | | |
| J7641 | A | | Flunisolide, inhalation sol | | | | | |
| J7642 | A | | Glycopyrrolate inhal sol con | | | | | |
| J7643 | A | | Glycopyrrolate inhal sol u d | | | | | |
| J7644 | A | | Ipratropium brom inh sol u d | | | | | |
| J7648 | A | | Isoetharine hcl inh sol con | | | | | |
| J7649 | A | | Isoetharine hcl inh sol u d | | | | | |
| J7658 | A | | Isoproterenolhcl inh sol con | | | | | |
| J7659 | A | | Isoproterenol hcl inh sol ud | | | | | |
| J7668 | A | | Metaproterenol inh sol con | | | | | |
| J7669 | A | | Metaproterenol inh sol u d | | | | | |
| J7680 | A | | Terbutaline so4 inh sol con | | | | | |
| J7681 | A | | Terbutaline so4 inh sol u d | | | | | |
| J7682 | A | | Tobramycin inhalation sol | | | | | |
| J7683 | A | | Triamcinolone inh sol con | | | | | |
| J7684 | A | | Triamcinolone inh sol u d | | | | | |
| J7699 | A | | Inhalation solution for DME | | | | | |
| J7799 | A | | Non-inhalation drug for DME | | | | | |
| J8499 | E | | Oral prescrip drug non chemo | | | | | |
| J8510 | N | | Oral busulfan | | | | | |
| J8520 | K | | Capecitabine, oral, 150 mg | 7042 | 0.0291 | $1.52 | | $.30 |
| J8521 | E | | Capecitabine, oral, 500 mg | | | | | |
| J8530 | N | | Cyclophosphamide oral 25 MG | | | | | |
| J8560 | K | | Etoposide oral 50 MG | 0802 | 0.5523 | $28.80 | | $5.76 |
| J8600 | N | | Melphalan oral 2 MG | | | | | |
| J8610 | N | | Methotrexate oral 2.5 MG | | | | | |
| J8700 | K | | Temozolmide | 1086 | 0.0581 | $3.03 | | $.61 |
| J8999 | E | | Oral prescription drug chemo | | | | | |
| J9000 | N | | Doxorubic hcl 10 MG vl chemo | | | | | |
| J9001 | K | | Doxorubicin hcl liposome inj | 7046 | 4.3894 | $228.91 | | $45.78 |
| J9010 | G | NI | Alemtuzumab injection | 9110 | | $511.22 | | $76.41 |
| J9015 | K | | Aldesleukin/single use vial | 0807 | 7.2867 | $380.01 | | $76.00 |
| J9017 | G | | Arsenic trioxide | 9012 | | $31.35 | | $4.69 |
| J9020 | N | | Asparaginase injection | | | | | |
| J9031 | N | | Bcg live intravesical vac | | | | | |
| J9040 | K | | Bleomycin sulfate injection | 0857 | 3.1879 | $166.25 | | $33.25 |
| J9045 | K | | Carboplatin injection | 0811 | 1.4922 | $77.82 | | $15.56 |
| J9050 | K | | Carmus bischl nitro inj | 0812 | 1.5310 | $79.84 | | $15.97 |
| J9060 | K | | Cisplatin 10 MG injection | 0813 | 0.4263 | $22.23 | | $4.45 |
| J9062 | E | | Cisplatin 50 MG injection | | | | | |
| J9065 | K | | Inj cladribine per 1 MG | 0858 | 0.7946 | $41.44 | | $8.29 |
| J9070 | N | | Cyclophosphamide 100 MG inj | | | | | |
| J9080 | E | | Cyclophosphamide 200 MG inj | | | | | |
| J9090 | E | | Cyclophosphamide 500 MG inj | | | | | |
| J9091 | E | | Cyclophosphamide 1.0 grm inj | | | | | |
| J9092 | E | | Cyclophosphamide 2.0 grm inj | | | | | |
| J9093 | N | | Cyclophosphamide lyophilized | | | | | |
| J9094 | E | | Cyclophosphamide lyophilized | | | | | |
| J9095 | E | | Cyclophosphamide lyophilized | | | | | |
| J9096 | E | | Cyclophosphamide lyophilized | | | | | |
| J9097 | E | | Cyclophosphamide lyophilized | | | | | |
| J9100 | N | | Cytarabine hcl 100 MG inj | | | | | |
| J9110 | E | | Cytarabine hcl 500 MG inj | | | | | |
| J9120 | N | | Dactinomycin actinomycin d | | | | | |
| J9130 | N | | Dacarbazine 10 MG inj | | | | | |
| J9140 | E | | Dacarbazine 200 MG inj | | | | | |
| J9150 | K | | Daunorubicin | 0820 | 1.9379 | $101.06 | | $20.21 |
| J9151 | K | | Daunorubicin citrate liposom | 0821 | 2.9069 | $151.60 | | $30.32 |
| J9160 | K | | Denileukin diftitox, 300 mcg | 1084 | 12.1315 | $632.67 | | $126.53 |
| J9165 | K | | Diethylstilbestrol injection | 0822 | 2.0251 | $105.61 | | $21.12 |
| J9170 | K | | Docetaxel | 0823 | 3.8953 | $203.14 | | $40.63 |
| J9180 | E | | Epirubicin HCl injection | | | | | |
| J9181 | N | | Etoposide 10 MG inj | | | | | |
| J9182 | E | | Etoposide 100 MG inj | | | | | |
| J9185 | K | | Fludarabine phosphate inj | 0842 | 3.2848 | $171.31 | | $34.26 |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| J9190 | N | | Fluorouracil injection | | | | | |
| J9200 | K | | Floxuridine injection | 0827 | 2.2189 | $115.72 | | $23.14 |
| J9201 | K | | Gemcitabine HCl | 0828 | 1.2984 | $67.71 | | $13.54 |
| J9202 | K | | Goserelin acetate implant | 0810 | 5.5619 | $290.06 | | $58.01 |
| J9206 | K | | Irinotecan injection | 0830 | 1.7538 | $91.46 | | $18.29 |
| J9208 | K | | Ifosfomide injection | 0831 | 1.9186 | $100.06 | | $20.01 |
| J9209 | K | | Mesna injection | 0732 | 0.5039 | $26.28 | | $5.26 |
| J9211 | K | | Idarubicin hcl injection | 0832 | 4.8642 | $253.67 | | $50.73 |
| J9212 | N | | Interferon alfacon-1 | | | | | |
| J9213 | N | | Interferon alfa-2a inj | | | | | |
| J9214 | N | | Interferon alfa-2b inj | | | | | |
| J9215 | N | | Interferon alfa-n3 inj | | | | | |
| J9216 | K | | Interferon gamma 1-b inj | 0838 | 3.0426 | $158.67 | | $31.73 |
| J9217 | K | | Leuprolide acetate suspnsion | 9217 | 6.5696 | $342.61 | | $68.52 |
| J9218 | K | | Leuprolide acetate injeciton | 0861 | 0.7752 | $40.43 | | $8.09 |
| J9219 | G | | Leuprolide acetate implant | 7051 | | $5,399.80 | | $807.13 |
| J9230 | N | | Mechlorethamine hcl inj | | | | | |
| J9245 | K | | Inj melphalan hydrochl 50 MG | 0840 | 4.5348 | $236.49 | | $47.30 |
| J9250 | N | | Methotrexate sodium inj | | | | | |
| J9260 | E | | Methotrexate sodium inj | | | | | |
| J9265 | K | | Paclitaxel injection | 0863 | 2.3158 | $120.77 | | $24.15 |
| J9266 | K | | Pegaspargase/singl dose vial | 0843 | 8.8079 | $459.34 | | $91.87 |
| J9268 | K | | Pentostatin injection | 0844 | 19.8833 | $1,036.93 | | $207.39 |
| J9270 | N | | Plicamycin (mithramycin) inj | | | | | |
| J9280 | K | | Mitomycin 5 MG inj | 0862 | 1.1337 | $59.12 | | $11.82 |
| J9290 | E | | Mitomycin 20 MG inj | | | | | |
| J9291 | E | | Mitomycin 40 MG inj | | | | | |
| J9293 | K | | Mitoxantrone hydrochl / 5 MG | 0864 | 2.9263 | $152.61 | | $30.52 |
| J9300 | F | | Gemtuzumab ozogamicin | | | | | |
| J9310 | K | | Rituximab cancer treatment | 0849 | 5.4941 | $286.52 | | $57.30 |
| J9320 | N | | Streptozocin injection | | | | | |
| J9340 | N | | Thiotepa injection | | | | | |
| J9350 | K | | Topotecan | 0852 | 7.7130 | $402.24 | | $80.45 |
| J9355 | K | | Trastuzumab | 1613 | 0.6298 | $32.84 | | $6.57 |
| J9357 | K | | Valrubicin, 200 mg | 1614 | 3.5658 | $185.96 | | $37.19 |
| J9360 | N | | Vinblastine sulfate inj | | | | | |
| J9370 | N | | Vincristine sulfate 1 MG inj | | | | | |
| J9375 | E | | Vincristine sulfate 2 MG inj | | | | | |
| J9380 | E | | Vincristine sulfate 5 MG inj | | | | | |
| J9390 | K | | Vinorelbine tartrate/10 mg | 0855 | 1.0756 | $56.09 | | $11.22 |
| J9600 | K | | Porfimer sodium | 0856 | 29.6117 | $1,544.28 | | $308.86 |
| J9999 | E | | Chemotherapy drug | | | | | |
| K0001 | A | | Standard wheelchair | | | | | |
| K0002 | A | | Stnd hemi (low seat) whlchr | | | | | |
| K0003 | A | | Lightweight wheelchair | | | | | |
| K0004 | A | | High strength ltwt whlchr | | | | | |
| K0005 | A | | Ultralightweight wheelchair | | | | | |
| K0006 | A | | Heavy duty wheelchair | | | | | |
| K0007 | A | | Extra heavy duty wheelchair | | | | | |
| K0009 | A | | Other manual wheelchair/base | | | | | |
| K0010 | A | | Stnd wt frame power whlchr | | | | | |
| K0011 | A | | Stnd wt pwr whlchr w control | | | | | |
| K0012 | A | | Ltwt portbl power whlchr | | | | | |
| K0014 | A | | Other power whlchr base | | | | | |
| K0015 | A | | Detach non-adjus hght armrst | | | | | |
| K0016 | A | | Detach adjust armrst cmplete | | | | | |
| K0017 | A | | Detach adjust armrest base | | | | | |
| K0018 | A | | Detach adjust armrst upper | | | | | |
| K0019 | A | | Arm pad each | | | | | |
| K0020 | A | | Fixed adjust armrest pair | | | | | |
| K0021 | A | DG | Anti-tipping device each | | | | | |
| K0022 | A | | Reinforced back upholstery | | | | | |
| K0023 | A | | Planr back insrt foam w/strp | | | | | |
| K0024 | A | | Plnr back insrt foam w/hrdwr | | | | | |
| K0025 | A | | Hook-on headrest extension | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| K0026 | A | | Back upholst lgtwt whlchr | | | | | |
| K0027 | A | | Back upholst other whlchr | | | | | |
| K0028 | A | | Manual fully reclining back | | | | | |
| K0029 | A | | Reinforced seat upholstery | | | | | |
| K0030 | A | | Solid plnr seat sngl dnsfoam | | | | | |
| K0031 | A | | Safety belt/pelvic strap | | | | | |
| K0032 | A | | Seat uphols lgtwt whlchr | | | | | |
| K0033 | A | | Seat upholstery other whlchr | | | | | |
| K0034 | A | DG | Heel loop each | | | | | |
| K0035 | A | | Heel loop with ankle strap | | | | | |
| K0036 | A | | Toe loop each | | | | | |
| K0037 | A | | High mount flip-up footrest | | | | | |
| K0038 | A | | Leg strap each | | | | | |
| K0039 | A | | Leg strap h style each | | | | | |
| K0040 | A | | Adjustable angle footplate | | | | | |
| K0041 | A | | Large size footplate each | | | | | |
| K0042 | A | | Standard size footplate each | | | | | |
| K0043 | A | | Ftrst lower extension tube | | | | | |
| K0044 | A | | Ftrst upper hanger bracket | | | | | |
| K0045 | A | | Footrest complete assembly | | | | | |
| K0046 | A | | Elevat legrst low extension | | | | | |
| K0047 | A | | Elevat legrst up hangr brack | | | | | |
| K0048 | A | | Elevate legrest complete | | | | | |
| K0049 | A | | Calf pad each | | | | | |
| K0050 | A | | Ratchet assembly | | | | | |
| K0051 | A | | Cam relese assem ftrst/lgrst | | | | | |
| K0052 | A | | Swingaway detach footrest | | | | | |
| K0053 | A | | Elevate footrest articulate | | | | | |
| K0054 | A | | Seat wdth 10-12/15/17/20 wc | | | | | |
| K0055 | A | | Seat dpth 15/17/18 ltwt wc | | | | | |
| K0056 | A | | Seat ht <17 or >=21 ltwt wc | | | | | |
| K0057 | A | | Seat wdth 19/20 hvy dty wc | | | | | |
| K0058 | A | | Seat dpth 17/18 power wc | | | | | |
| K0059 | A | | Plastic coated handrim each | | | | | |
| K0060 | A | | Steel handrim each | | | | | |
| K0061 | A | | Aluminum handrim each | | | | | |
| K0062 | A | | Handrim 8-10 vert/obliq proj | | | | | |
| K0063 | A | | Hndrm 12-16 vert/obliq proj | | | | | |
| K0064 | A | | Zero pressure tube flat free | | | | | |
| K0065 | A | | Spoke protectors | | | | | |
| K0066 | A | | Solid tire any size each | | | | | |
| K0067 | A | | Pneumatic tire any size each | | | | | |
| K0068 | A | | Pneumatic tire tube each | | | | | |
| K0069 | A | | Rear whl complete solid tire | | | | | |
| K0070 | A | | Rear whl compl pneum tire | | | | | |
| K0071 | A | | Front castr compl pneum tire | | | | | |
| K0072 | A | | Frnt cstr cmpl sem-pneum tir | | | | | |
| K0073 | A | | Caster pin lock each | | | | | |
| K0074 | A | | Pneumatic caster tire each | | | | | |
| K0075 | A | | Semi-pneumatic caster tire | | | | | |
| K0076 | A | | Solid caster tire each | | | | | |
| K0077 | A | | Front caster assem complete | | | | | |
| K0078 | A | | Pneumatic caster tire tube | | | | | |
| K0079 | A | | Wheel lock extension pair | | | | | |
| K0080 | A | | Anti-rollback device pair | | | | | |
| K0081 | A | | Wheel lock assembly complete | | | | | |
| K0082 | A | | 22 nf deep cycl acid battery | | | | | |
| K0083 | A | | 22 nf gel cell battery each | | | | | |
| K0084 | A | | Grp 24 deep cycl acid battry | | | | | |
| K0085 | A | | Group 24 gel cell battery | | | | | |
| K0086 | A | | U-1 lead acid battery each | | | | | |
| K0087 | A | | U-1 gel cell battery each | | | | | |
| K0088 | A | | Battry chrgr acid/gel cell | | | | | |
| K0089 | A | | Battery charger dual mode | | | | | |
| K0090 | A | | Rear tire power wheelchair | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| K0091 | A | | Rear tire tube power whlchr | | | | | |
| K0092 | A | | Rear assem cmplt powr whlchr | | | | | |
| K0093 | A | | Rear zero pressure tire tube | | | | | |
| K0094 | A | | Wheel tire for power base | | | | | |
| K0095 | A | | Wheel tire tube each base | | | | | |
| K0096 | A | | Wheel assem powr base complt | | | | | |
| K0097 | A | | Wheel zero presure tire tube | | | | | |
| K0098 | A | | Drive belt power wheelchair | | | | | |
| K0099 | A | | Pwr wheelchair front caster | | | | | |
| K0100 | A | | Amputee adapter pair | | | | | |
| K0101 | A | DG | One-arm drive attachment | | | | | |
| K0102 | A | | Crutch and cane holder | | | | | |
| K0103 | A | | Transfer board < 25≧ | | | | | |
| K0104 | A | | Cylinder tank carrier | | | | | |
| K0105 | A | | Iv hanger | | | | | |
| K0106 | A | | Arm trough each | | | | | |
| K0107 | A | | Wheelchair tray | | | | | |
| K0108 | A | | W/c component-accessory NOS | | | | | |
| K0112 | A | | Trunk vest supprt innr frame | | | | | |
| K0113 | A | | Trunk vest suprt w/o inr frm | | | | | |
| K0114 | A | | Whlchr back suprt inr frame | | | | | |
| K0115 | A | | Back module orthotic system | | | | | |
| K0116 | A | | Back & seat modul orthot sys | | | | | |
| K0183 | A | DG | Nasal application device | | | | | |
| K0184 | A | DG | Nasal pillow or face seal | | | | | |
| K0185 | A | DG | Pos airway pressure headgear | | | | | |
| K0186 | A | DG | Pos airway prssure chinstrap | | | | | |
| K0187 | A | DG | Pos airway pressure tubing | | | | | |
| K0188 | A | DG | Pos airway pressure filter | | | | | |
| K0189 | A | DG | Filter nondisposable w PAP | | | | | |
| K0195 | A | | Elevating whlchair leg rests | | | | | |
| K0268 | A | | Humidifier nonheated w PAP | | | | | |
| K0415 | E | | RX antiemetic drg, oral NOS | | | | | |
| K0416 | E | | Rx antiemetic drg,rectal NOS | | | | | |
| K0452 | A | | Wheelchair bearings | | | | | |
| K0455 | A | | Pump uninterrupted infusion | | | | | |
| K0460 | A | | WC power add-on joystick | | | | | |
| K0461 | A | | WC power add-on tiller cntrl | | | | | |
| K0462 | A | | Temporary replacement eqpmnt | | | | | |
| K0531 | A | | Heated humidifier used w pap | | | | | |
| K0532 | A | | Noninvasive assist wo backup | | | | | |
| K0533 | A | | Noninvasive assist w backup | | | | | |
| K0534 | A | | Invasive assist w backup | | | | | |
| K0538 | A | | Neg pressure wnd thrpy pump | | | | | |
| K0539 | A | | Neg pres wnd thrpy dsg set | | | | | |
| K0540 | A | | Neg pres wnd thrp canister | | | | | |
| K0541 | A | | SGD prerecorded msg <= 8 min | | | | | |
| K0542 | A | | SGD prerecorded msg > 8 min | | | | | |
| K0543 | A | | SGD msg formed by spelling | | | | | |
| K0544 | A | | SGD w multi methods msg/accs | | | | | |
| K0545 | A | | SGD sftwre prgrm for PC/PDA | | | | | |
| K0546 | A | | SGD accessory,mounting systm | | | | | |
| K0547 | A | | SGD accessory NOC | | | | | |
| K0548 | A | | Insulin lispro | | | | | |
| K0549 | A | | Hosp bed hvy dty xtra wide | | | | | |
| K0550 | A | | Hosp bed xtra hvy dty x wide | | | | | |
| K0551 | A | DG | Residual limb support system | | | | | |
| K0556 | A | NI | Socket insert w lock mech | | | | | |
| K0557 | A | NI | Socket insert w/o lock mech | | | | | |
| K0558 | A | NI | Intl custm cong/atyp insert | | | | | |
| K0559 | A | NI | Initial custom socket insert | | | | | |
| K0581 | A | NI | Ost pch clsd w barrier/filtr | | | | | |
| K0582 | A | NI | Ost pch w bar/bltinconv/fltr | | | | | |
| K0583 | A | NI | Ost pch clsd w/o bar w filtr | | | | | |
| K0584 | A | NI | Ost pch for bar w flange/flt | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| K0585 | A | NI | Ost pch clsd for bar w lk fl | | | | | |
| K0586 | A | NI | Ost pch for bar w lk fl/fltr | | | | | |
| K0587 | A | NI | Ost pch drain w bar & filter | | | | | |
| K0588 | A | NI | Ost pch drain for barrier fl | | | | | |
| K0589 | A | NI | Ost pch drain 2 piece system | | | | | |
| K0590 | A | NI | Ost pch drain/barr lk flng/f | | | | | |
| K0591 | A | NI | Urine ost pouch w faucet/tap | | | | | |
| K0592 | A | NI | Urine ost pouch w bltinconv | | | | | |
| K0593 | A | NI | Ost urine pch w b/bltin conv | | | | | |
| K0594 | A | NI | Ost pch urine w barrier/tapv | | | | | |
| K0595 | A | NI | Os pch urine w bar/fange/tap | | | | | |
| K0596 | A | NI | Urine ost pch bar w lock fln | | | | | |
| K0597 | A | NI | Ost pch urine w lock flng/ft | | | | | |
| L0100 | A | | Cranial orthosis/helmet mold | | | | | |
| L0110 | A | | Cranial orthosis/helmet nonm | | | | | |
| L0120 | A | | Cerv flexible non-adjustable | | | | | |
| L0130 | A | | Flex thermoplastic collar mo | | | | | |
| L0140 | A | | Cervical semi-rigid adjustab | | | | | |
| L0150 | A | | Cerv semi-rig adj molded chn | | | | | |
| L0160 | A | | Cerv semi-rig wire occ/mand | | | | | |
| L0170 | A | | Cervical collar molded to pt | | | | | |
| L0172 | A | | Cerv col thermplas foam 2 pi | | | | | |
| L0174 | A | | Cerv col foam 2 piece w thor | | | | | |
| L0180 | A | | Cer post col occ/man sup adj | | | | | |
| L0190 | A | | Cerv collar supp adj cerv ba | | | | | |
| L0200 | A | | Cerv col supp adj bar & thor | | | | | |
| L0210 | A | | Thoracic rib belt | | | | | |
| L0220 | A | | Thor rib belt custom fabrica | | | | | |
| L0300 | A | DG | TLSO flex surgical support | | | | | |
| L0310 | A | DG | Tlso flexible custom fabrica | | | | | |
| L0315 | A | DG | Tlso flex elas rigid post pa | | | | | |
| L0317 | A | DG | Tlso flex hypext elas post p | | | | | |
| L0320 | A | DG | Tlso a-p contrl w apron frnt | | | | | |
| L0321 | A | DG | Tlso anti-post-cntrl prefab | | | | | |
| L0330 | A | DG | Tlso ant-pos-lateral control | | | | | |
| L0331 | A | DG | Tlso ant-post-lat cntrl prfb | | | | | |
| L0340 | A | DG | Tlso a-p-l-rotary with apron | | | | | |
| L0350 | A | DG | Tlso flex compress jacket cu | | | | | |
| L0360 | A | DG | Tlso flex compress jacket mo | | | | | |
| L0370 | A | DG | Tlso a-p-l-rotary hyperexten | | | | | |
| L0380 | A | DG | Tlso a-p-l-rot w/ pos extens | | | | | |
| L0390 | A | DG | Tlso a-p-l control molded | | | | | |
| L0391 | A | DG | Tlso ant-post-lat-rot cntrl | | | | | |
| L0400 | A | DG | Tlso a-p-l w interface mater | | | | | |
| L0410 | A | DG | Tlso a-p-l two piece constr | | | | | |
| L0420 | A | DG | Tlso a-p-l 2 piece w interfa | | | | | |
| L0430 | A | DG | Tlso a-p-l w interface custm | | | | | |
| L0440 | A | DG | Tlso a-p-l overlap frnt cust | | | | | |
| L0450 | A | NI | TLSO flex prefab thoracic | | | | | |
| L0452 | A | NI | tlso flex custom fab thoraci | | | | | |
| L0454 | A | NI | TLSO flex prefab sacrococ-T9 | | | | | |
| L0456 | A | NI | TLSO flex prefab | | | | | |
| L0458 | A | NI | TLSO 2Mod symphis-xipho pre | | | | | |
| L0460 | A | NI | TLSO2Mod symphysis-stern pre | | | | | |
| L0462 | A | NI | TLSO 3Mod sacro-scap pre | | | | | |
| L0464 | A | NI | TLSO 4Mod sacro-scap pre | | | | | |
| L0466 | A | NI | TLSO rigid frame pre soft ap | | | | | |
| L0468 | A | NI | TLSO rigid frame prefab pelv | | | | | |
| L0470 | A | NI | TLSO rigid frame pre subclav | | | | | |
| L0472 | A | NI | TLSO rigid frame hyperex pre | | | | | |
| L0474 | A | NI | TLSO rigid frame pre pelvic | | | | | |
| L0476 | A | NI | TLSO flexion compres jac pre | | | | | |
| L0478 | A | NI | TLSO flexion compres jac cus | | | | | |
| L0480 | A | NI | TLSO rigid plastic custom fa | | | | | |
| L0482 | A | NI | TLSO rigid lined custom fab | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L0484 | A | NI | TLSO rigid plastic cust fab | | | | | |
| L0486 | A | NI | TLSO rigidlined cust fab two | | | | | |
| L0488 | A | NI | TLSO rigid lined pre one pie | | | | | |
| L0490 | A | NI | 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 | | | | | |
| L0900 | A | DG | Torso/ptosis support | | | | | |
| L0910 | A | DG | Torso & ptosis supp custm fa | | | | | |
| L0920 | A | DG | Torso/pendulous abd support | | | | | |
| L0930 | A | DG | Pendulous abdomen supp custm | | | | | |
| L0940 | A | DG | Torso/postsurgical support | | | | | |
| L0950 | A | DG | Post surg support custom fab | | | | | |
| 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 | | | | | |
| L0986 | A | DG | Spinal orth abdm pnl prefab | | | | | |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | NI | HO bi thighcuffs w sprdr bar | | | | | |
| L1660 | A | | HO abduction static plastic | | | | | |
| L1680 | A | | Pelvic & hip control thigh c | | | | | |
| L1685 | A | | Post-op hip abduct custom fa | | | | | |
| L1686 | A | | HO post-op hip abduction | | | | | |
| L1690 | A | | Combination bilateral HO | | | | | |
| L1700 | A | | Leg perthes orth toronto typ | | | | | |
| L1710 | A | | Legg perthes orth newington | | | | | |
| L1720 | A | | Legg perthes orthosis trilat | | | | | |
| L1730 | A | | Legg perthes orth scottish r | | | | | |
| L1750 | A | | Legg perthes sling | | | | | |
| L1755 | A | | Legg perthes patten bottom t | | | | | |
| L1800 | A | | Knee orthoses elas w stays | | | | | |
| L1810 | A | | Ko elastic with joints | | | | | |
| L1815 | A | | Elastic with condylar pads | | | | | |
| L1820 | A | | Ko elas w/ condyle pads & jo | | | | | |
| L1825 | A | | Ko elastic knee cap | | | | | |
| L1830 | A | | Ko immobilizer canvas longit | | | | | |
| L1832 | A | | KO adj jnt pos rigid support | | | | | |
| L1834 | A | | Ko w/0 joint rigid molded to | | | | | |
| L1836 | A | NI | 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 | | Knee upright w/resistance | | | | | |
| L1900 | A | | Afo sprng wir drsflx calf bd | | | | | |
| L1901 | A | NI | Prefab ankle orthosis | | | | | |
| L1902 | A | | Afo ankle gauntlet | | | | | |
| L1904 | A | | Afo molded ankle gauntlet | | | | | |
| L1906 | A | | Afo multiligamentus ankle su | | | | | |
| L1910 | A | | Afo sing bar clasp attach sh | | | | | |
| L1920 | A | | Afo sing upright w/ adjust s | | | | | |
| L1930 | A | | Afo plastic | | | | | |
| L1940 | A | | Afo molded to patient plasti | | | | | |
| L1945 | A | | Afo molded plas rig ant tib | | | | | |
| L1950 | A | | Afo spiral molded to pt plas | | | | | |
| L1960 | A | | Afo pos solid ank plastic mo | | | | | |
| L1970 | A | | Afo plastic molded w/ankle j | | | | | |
| L1980 | A | | Afo sing solid stirrup calf | | | | | |
| L1990 | A | | Afo doub solid stirrup calf | | | | | |
| L2000 | A | | Kafo sing fre stirr thi/calf | | | | | |
| L2010 | A | | Kafo sng solid stirrup w/o j | | | | | |
| L2020 | A | | Kafo dbl solid stirrup band/ | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L2030 | A | | Kafo dbl solid stirrup w/o j | | | | | |
| L2035 | A | | KAFO plastic pediatric size | | | | | |
| L2036 | A | | Kafo plas doub free knee mol | | | | | |
| L2037 | A | | Kafo plas sing free knee mol | | | | | |
| L2038 | A | | Kafo w/o joint multi-axis an | | | | | |
| L2039 | A | | KAFO,plstic,medlat rotat con | | | | | |
| L2040 | A | | Hkafo torsion bil rot straps | | | | | |
| L2050 | A | | Hkafo torsion cable hip pelv | | | | | |
| L2060 | A | | Hkafo torsion ball bearing j | | | | | |
| L2070 | A | | Hkafo torsion unilat rot str | | | | | |
| L2080 | A | | Hkafo unilat torsion cable | | | | | |
| L2090 | A | | Hkafo unilat torsion ball br | | | | | |
| L2102 | E | | Afo tibial fx cast plstr mol | | | | | |
| L2104 | E | | Afo tib fx cast synthetic mo | | | | | |
| L2106 | A | | Afo tib fx cast plaster mold | | | | | |
| L2108 | A | | Afo tib fx cast molded to pt | | | | | |
| L2112 | A | | Afo tibial fracture soft | | | | | |
| L2114 | A | | Afo tib fx semi-rigid | | | | | |
| L2116 | A | | Afo tibial fracture rigid | | | | | |
| L2122 | E | | Kafo fem fx cast plaster mol | | | | | |
| L2124 | E | | Kafo fem fx cast synthet mol | | | | | |
| L2126 | A | | Kafo fem fx cast thermoplas | | | | | |
| L2128 | A | | Kafo fem fx cast molded to p | | | | | |
| L2132 | A | | Kafo femoral fx cast soft | | | | | |
| L2134 | A | | Kafo fem fx cast semi-rigid | | | | | |
| L2136 | A | | Kafo femoral fx cast rigid | | | | | |
| L2180 | A | | Plas shoe insert w ank joint | | | | | |
| L2182 | A | | Drop lock knee | | | | | |
| L2184 | A | | Limited motion knee joint | | | | | |
| L2186 | A | | Adj motion knee jnt lerman t | | | | | |
| L2188 | A | | Quadrilateral brim | | | | | |
| L2190 | A | | Waist belt | | | | | |
| L2192 | A | | Pelvic band & belt thigh fla | | | | | |
| L2200 | A | | Limited ankle motion ea jnt | | | | | |
| L2210 | A | | Dorsiflexion assist each joi | | | | | |
| L2220 | A | | Dorsi & plantar flex ass/res | | | | | |
| L2230 | A | | Split flat caliper stirr & p | | | | | |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L2500 | A | | Thi/glut/ischia wgt bearing | | | | | |
| L2510 | A | | Th/wght bear quad-lat brim m | | | | | |
| L2520 | A | | Th/wght bear quad-lat brim c | | | | | |
| L2525 | A | | Th/wght bear nar m-l brim mo | | | | | |
| L2526 | A | | Th/wght bear nar m-l brim cu | | | | | |
| L2530 | A | | Thigh/wght bear lacer non-mo | | | | | |
| L2540 | A | | Thigh/wght bear lacer molded | | | | | |
| L2550 | A | | Thigh/wght bear high roll cu | | | | | |
| L2570 | A | | Hip clevis type 2 posit jnt | | | | | |
| L2580 | A | | Pelvic control pelvic sling | | | | | |
| L2600 | A | | Hip clevis/thrust bearing fr | | | | | |
| L2610 | A | | Hip clevis/thrust bearing lo | | | | | |
| L2620 | A | | Pelvic control hip heavy dut | | | | | |
| L2622 | A | | Hip joint adjustable flexion | | | | | |
| L2624 | A | | Hip adj flex ext abduct cont | | | | | |
| L2627 | A | | Plastic mold recipro hip & c | | | | | |
| L2628 | A | | Metal frame recipro hip & ca | | | | | |
| L2630 | A | | Pelvic control band & belt u | | | | | |
| L2640 | A | | Pelvic control band & belt b | | | | | |
| L2650 | A | | Pelv & thor control gluteal | | | | | |
| L2660 | A | | Thoracic control thoracic ba | | | | | |
| L2670 | A | | Thorac cont paraspinal uprig | | | | | |
| L2680 | A | | Thorac cont lat support upri | | | | | |
| L2750 | A | | Plating chrome/nickel pr bar | | | | | |
| L2755 | A | | Carbon graphite lamination | | | | | |
| L2760 | A | | Extension per extension per | | | | | |
| L2768 | A | | Ortho sidebar disconnect | | | | | |
| L2770 | A | | Low ext orthosis per bar/jnt | | | | | |
| L2780 | A | | Non-corrosive finish | | | | | |
| L2785 | A | | Drop lock retainer each | | | | | |
| L2795 | A | | Knee control full kneecap | | | | | |
| L2800 | A | | Knee cap medial or lateral p | | | | | |
| L2810 | A | | Knee control condylar pad | | | | | |
| L2820 | A | | Soft interface below knee se | | | | | |
| L2830 | A | | Soft interface above knee se | | | | | |
| L2840 | A | | Tibial length sock fx or equ | | | | | |
| L2850 | A | | Femoral lgth sock fx or equa | | | | | |
| L2860 | A | | Torsion mechanism knee/ankle | | | | | |
| L2999 | A | | Lower extremity orthosis NOS | | | | | |
| L3000 | E | | Ft insert ucb berkeley shell | | | | | |
| L3001 | E | | Foot insert remov molded spe | | | | | |
| L3002 | E | | Foot insert plastazote or eq | | | | | |
| L3003 | E | | Foot insert silicone gel eac | | | | | |
| L3010 | E | | Foot longitudinal arch suppo | | | | | |
| L3020 | E | | Foot longitud/metatarsal sup | | | | | |
| L3030 | E | | Foot arch support remov prem | | | | | |
| L3040 | E | | Ft arch suprt premold longit | | | | | |
| L3050 | E | | Foot arch supp premold metat | | | | | |
| L3060 | E | | Foot arch supp longitud/meta | | | | | |
| L3070 | E | | Arch suprt att to sho longit | | | | | |
| L3080 | E | | Arch supp att to shoe metata | | | | | |
| L3090 | E | | Arch supp att to shoe long/m | | | | | |
| L3100 | E | | Hallus-valgus nght dynamic s | | | | | |
| L3140 | E | | Abduction rotation bar shoe | | | | | |
| L3150 | E | | Abduct rotation bar w/o shoe | | | | | |
| L3160 | E | | Shoe styled positioning dev | | | | | |
| L3170 | E | | Foot plastic heel stabilizer | | | | | |
| L3201 | E | | Oxford w supinat/pronat inf | | | | | |
| L3202 | E | | Oxford w/ supinat/pronator c | | | | | |
| L3203 | E | | Oxford w/ supinator/pronator | | | | | |
| L3204 | E | | Hightop w/ supp/pronator inf | | | | | |
| L3206 | E | | Hightop w/ supp/pronator chi | | | | | |
| L3207 | E | | Hightop w/ supp/pronator jun | | | | | |
| L3208 | E | | Surgical boot each infant | | | | | |
| L3209 | E | | Surgical boot each child | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L3211 | E | | Surgical boot each junior | | | | | |
| L3212 | E | | Benesch boot pair infant | | | | | |
| L3213 | E | | Benesch boot pair child | | | | | |
| L3214 | E | | Benesch boot pair junior | | | | | |
| L3215 | E | | Orthopedic ftwear ladies oxf | | | | | |
| L3216 | E | | Orthoped ladies shoes dpth i | | | | | |
| L3217 | E | | Ladies shoes hightop depth i | | | | | |
| L3218 | E | DG | Ladies surgical boot each | | | | | |
| L3219 | E | | Orthopedic mens shoes oxford | | | | | |
| L3221 | E | | Orthopedic mens shoes dpth i | | | | | |
| L3222 | E | | Mens shoes hightop depth inl | | | | | |
| L3223 | E | DG | Mens surgical boot each | | | | | |
| L3224 | A | | Woman's shoe oxford brace | | | | | |
| L3225 | A | | Man's shoe oxford brace | | | | | |
| L3230 | | | Custom shoes depth inlay | | | | | |
| L3250 | E | | Custom mold shoe remov prost | | | | | |
| L3251 | E | | Shoe molded to pt silicone s | | | | | |
| L3252 | E | | Shoe molded plastazote cust | | | | | |
| L3253 | E | | Shoe molded plastazote cust | | | | | |
| L3254 | E | | Orth foot non-stndard size/w | | | | | |
| L3255 | E | | Orth foot non-standard size/ | | | | | |
| L3257 | E | | Orth foot add charge split s | | | | | |
| L3260 | E | | Ambulatory surgical boot eac | | | | | |
| L3265 | E | | Plastazote sandal each | | | | | |
| L3300 | E | | Sho lift taper to metatarsal | | | | | |
| L3310 | E | | Shoe lift elev heel/sole neo | | | | | |
| L3320 | E | | Shoe lift elev heel/sole cor | | | | | |
| L3330 | E | | Lifts elevation metal extens | | | | | |
| L3332 | E | | Shoe lifts tapered to one-ha | | | | | |
| L3334 | E | | Shoe lifts elevation heel /i | | | | | |
| L3340 | E | | Shoe wedge sach | | | | | |
| L3350 | E | | Shoe heel wedge | | | | | |
| L3360 | E | | Shoe sole wedge outside sole | | | | | |
| L3370 | E | | Shoe sole wedge between sole | | | | | |
| L3380 | E | | Shoe clubfoot wedge | | | | | |
| L3390 | E | | Shoe outflare wedge | | | | | |
| L3400 | E | | Shoe metatarsal bar wedge ro | | | | | |
| L3410 | E | | Shoe metatarsal bar between | | | | | |
| L3420 | E | | Full sole/heel wedge btween | | | | | |
| L3430 | E | | Sho heel count plast reinfor | | | | | |
| L3440 | E | | Heel leather reinforced | | | | | |
| L3450 | E | | Shoe heel sach cushion type | | | | | |
| L3455 | E | | Shoe heel new leather standa | | | | | |
| L3460 | E | | Shoe heel new rubber standar | | | | | |
| L3465 | E | | Shoe heel thomas with wedge | | | | | |
| L3470 | E | | Shoe heel thomas extend to b | | | | | |
| L3480 | E | | Shoe heel pad & depress for | | | | | |
| L3485 | E | | Shoe heel pad removable for | | | | | |
| L3500 | E | | Ortho shoe add leather insol | | | | | |
| L3510 | E | | Orthopedic shoe add rub insl | | | | | |
| L3520 | E | | O shoe add felt w leath insl | | | | | |
| L3530 | E | | Ortho shoe add half sole | | | | | |
| L3540 | E | | Ortho shoe add full sole | | | | | |
| L3550 | E | | O shoe add standard toe tap | | | | | |
| L3560 | E | | O shoe add horseshoe toe tap | | | | | |
| L3570 | E | | O shoe add instep extension | | | | | |
| L3580 | E | | O shoe add instep velcro clo | | | | | |
| L3590 | E | | O shoe convert to sof counte | | | | | |
| L3595 | E | | Ortho shoe add march bar | | | | | |
| L3600 | E | | Trans shoe calip plate exist | | | | | |
| L3610 | E | | Trans shoe caliper plate new | | | | | |
| L3620 | E | | Trans shoe solid stirrup exi | | | | | |
| L3630 | E | | Trans shoe solid stirrup new | | | | | |
| L3640 | E | | Shoe dennis browne splint bo | | | | | |
| L3649 | E | | Orthopedic shoe modifica NOS | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L3650 | A | | Shlder fig 8 abduct restrain | | | | | |
| L3651 | A | NI | Prefab shoulder orthosis | | | | | |
| L3652 | A | NI | Prefab dbl shoulder orthosis | | | | | |
| L3660 | A | | Abduct restrainer canvas&web | | | | | |
| L3670 | A | | Acromio/clavicular canvas&we | | | | | |
| L3675 | A | | Canvas vest SO | | | | | |
| L3677 | A | | SO hard plastic stabilizer | | | | | |
| L3700 | A | | Elbow orthoses elas w stays | | | | | |
| L3701 | A | NI | 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 | NI | Rigid EO wo joints | | | | | |
| L3800 | A | | Whfo short opponen no attach | | | | | |
| L3805 | A | | Whfo long opponens no attach | | | | | |
| L3807 | A | | WHFO,no joint, prefabricated | | | | | |
| L3810 | A | | Whfo thumb abduction bar | | | | | |
| L3815 | A | | Whfo second m.p. abduction a | | | | | |
| L3820 | A | | Whfo ip ext asst w/ mp ext s | | | | | |
| L3825 | A | | Whfo m.p. extension stop | | | | | |
| L3830 | A | | Whfo m.p. extension assist | | | | | |
| L3835 | A | | Whfo m.p. spring extension a | | | | | |
| L3840 | A | | Whfo spring swivel thumb | | | | | |
| L3845 | A | | Whfo thumb ip ext ass w/ mp | | | | | |
| L3850 | A | | Action wrist w/ dorsiflex as | | | | | |
| L3855 | A | | Whfo adj m.p. flexion contro | | | | | |
| L3860 | A | | Whfo adj m.p. flex ctrl & i. | | | | | |
| L3890 | E | | Torsion mechanism wrist/elbo | | | | | |
| L3900 | A | | Hinge extension/flex wrist/f | | | | | |
| L3901 | A | | Hinge ext/flex wrist finger | | | | | |
| L3902 | A | | Whfo ext power compress gas | | | | | |
| L3904 | A | | Whfo electric custom fitted | | | | | |
| L3906 | A | | Wrist gauntlet molded to pt | | | | | |
| L3907 | A | | Whfo wrst gauntlt thmb spica | | | | | |
| L3908 | A | | Wrist cock-up non-molded | | | | | |
| L3909 | A | NI | Prefab wrist orthosis | | | | | |
| L3910 | A | | Whfo swanson design | | | | | |
| L3911 | A | NI | 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 | | | | | |
| L3918 | A | | HFO knuckle bender | | | | | |
| L3920 | A | | Knuckle bender with outrigge | | | | | |
| L3922 | A | | Knuckle bend 2 seg to flex j | | | | | |
| L3923 | A | | HFO, no joint, prefabricated | | | | | |
| L3924 | A | | Oppenheimer | | | | | |
| L3926 | A | | Thomas suspension | | | | | |
| L3928 | A | | Finger extension w/ clock sp | | | | | |
| L3930 | A | | Finger extension with wrist | | | | | |
| L3932 | A | | Safety pin spring wire | | | | | |
| L3934 | A | | Safety pin modified | | | | | |
| L3936 | A | | Palmer | | | | | |
| L3938 | A | | Dorsal wrist | | | | | |
| L3940 | A | | Dorsal wrist w/ outrigger at | | | | | |
| L3942 | A | | Reverse knuckle bender | | | | | |
| L3944 | A | | Reverse knuckle bend w/ outr | | | | | |
| L3946 | A | | HFO composite elastic | | | | | |
| L3948 | A | | Finger knuckle bender | | | | | |
| L3950 | A | | Oppenheimer w/ knuckle bend | | | | | |
| L3952 | A | | Oppenheimer w/ rev knuckle 2 | | | | | |
| L3954 | A | | Spreading hand | | | | | |
| L3956 | A | | Add joint upper ext orthosis | | | | | |
| L3960 | A | | Sewho airplan desig abdu pos | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | NI | 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—Continued

[Calendar Year 2003]

| 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 | | | | | |
| L5660 | A | DG | Sock insrt syme silicone gel | | | | | |
| L5661 | A | | Multi-durometer symes | | | | | |
| L5662 | A | DG | Socket insert bk silicone ge | | | | | |
| L5663 | A | DG | Sock knee disartic silicone | | | | | |
| L5664 | A | DG | Socket insert ak silicone ge | | | | | |
| L5665 | A | | Multi-durometer below knee | | | | | |
| L5666 | A | | Below knee cuff suspension | | | | | |
| L5668 | A | | Socket insert w/o lock lower | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L5670 | A | | Bk molded supracondylar susp | | | | | |
| L5671 | A | | BK/AK locking mechanism | | | | | |
| L5672 | A | | Bk removable medial brim sus | | | | | |
| L5674 | A | | Bk suspension sleeve | | | | | |
| L5675 | A | | Bk heavy duty susp sleeve | | | | | |
| L5676 | A | | Bk knee joints single axis p | | | | | |
| L5677 | A | | Bk knee joints polycentric p | | | | | |
| L5678 | A | | Bk joint covers pair | | | | | |
| L5680 | A | | Bk thigh lacer non-molded | | | | | |
| L5682 | A | | Bk thigh lacer glut/ischia m | | | | | |
| L5684 | A | | Bk fork strap | | | | | |
| L5686 | A | | Bk back check | | | | | |
| L5688 | A | | Bk waist belt webbing | | | | | |
| L5690 | A | | Bk waist belt padded and lin | | | | | |
| L5692 | A | | Ak pelvic control belt light | | | | | |
| L5694 | A | | Ak pelvic control belt pad/l | | | | | |
| L5695 | A | | Ak sleeve susp neoprene/equa | | | | | |
| L5696 | A | | Ak/knee disartic pelvic join | | | | | |
| L5697 | A | | Ak/knee disartic pelvic band | | | | | |
| L5698 | A | | Ak/knee disartic silesian ba | | | | | |
| L5699 | A | | Shoulder harness | | | | | |
| L5700 | A | | Replace socket below knee | | | | | |
| L5701 | A | | Replace socket above knee | | | | | |
| L5702 | A | | Replace socket hip | | | | | |
| L5704 | A | | Custom shape cover BK | | | | | |
| L5705 | A | | Custom shape cover AK | | | | | |
| L5706 | A | | Custom shape cvr knee disart | | | | | |
| L5707 | A | | Custom shape cvr hip disart | | | | | |
| L5710 | A | | Kne-shin exo sng axi mnl loc | | | | | |
| L5711 | A | | Knee-shin exo mnl lock ultra | | | | | |
| L5712 | A | | Knee-shin exo frict swg & st | | | | | |
| L5714 | A | | Knee-shin exo variable frict | | | | | |
| L5716 | A | | Knee-shin exo mech stance ph | | | | | |
| L5718 | A | | Knee-shin exo frct swg & sta | | | | | |
| L5722 | A | | Knee-shin pneum swg frct exo | | | | | |
| L5724 | A | | Knee-shin exo fluid swing ph | | | | | |
| L5726 | A | | Knee-shin ext jnts fld swg e | | | | | |
| L5728 | A | | Knee-shin fluid swg & stance | | | | | |
| L5780 | A | | Knee-shin pneum/hydra pneum | | | | | |
| L5781 | A | NI | Lower limb pros vacuum pump | | | | | |
| L5782 | A | NI | 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 | NI | 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L5930 | A | | High activity knee frame | | | | | |
| L5940 | A | | Endo bk ultra-light material | | | | | |
| L5950 | A | | Endo ak ultra-light material | | | | | |
| L5960 | A | | Endo hip ultra-light materia | | | | | |
| L5962 | A | | Below knee flex cover system | | | | | |
| L5964 | A | | Above knee flex cover system | | | | | |
| L5966 | A | | Hip flexible cover system | | | | | |
| L5968 | A | | Multiaxial ankle w dorsiflex | | | | | |
| L5970 | A | | Foot external keel sach foot | | | | | |
| L5972 | A | | Flexible keel foot | | | | | |
| L5974 | A | | Foot single axis ankle/foot | | | | | |
| L5975 | A | | Combo ankle/foot prosthesis | | | | | |
| L5976 | A | | Energy storing foot | | | | | |
| L5978 | A | | Ft prosth multiaxial ankl/ft | | | | | |
| L5979 | A | | Multi-axial ankle/ft prosth | | | | | |
| L5980 | A | | Flex foot system | | | | | |
| L5981 | A | | Flex-walk sys low ext prosth | | | | | |
| L5982 | A | | Exoskeletal axial rotation u | | | | | |
| L5984 | A | | Endoskeletal axial rotation | | | | | |
| L5985 | A | | Lwr ext dynamic prosth pylon | | | | | |
| L5986 | A | | Multi-axial rotation unit | | | | | |
| L5987 | A | | Shank ft w vert load pylon | | | | | |
| L5988 | A | | Vertical shock reducing pylo | | | | | |
| L5989 | A | | Pylon w elctrnc force sensor | | | | | |
| L5990 | A | | User adjustable heel height | | | | | |
| L5995 | A | NI | 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 | NI | 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L6615 | A | | Disconnect locking wrist uni | | | | | |
| L6616 | A | | Disconnect insert locking wr | | | | | |
| L6620 | A | | Flexion-friction wrist unit | | | | | |
| L6623 | A | | Spring-ass rot wrst w/ latch | | | | | |
| L6625 | A | | Rotation wrst w/ cable lock | | | | | |
| L6628 | A | | Quick disconn hook adapter o | | | | | |
| L6629 | A | | Lamination collar w/ couplin | | | | | |
| L6630 | A | | Stainless steel any wrist | | | | | |
| L6632 | A | | Latex suspension sleeve each | | | | | |
| L6635 | A | | Lift assist for elbow | | | | | |
| L6637 | A | | Nudge control elbow lock | | | | | |
| L6638 | A | NI | 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 | NI | Multipo locking shoulder jnt | | | | | |
| L6647 | A | NI | Shoulder lock actuator | | | | | |
| L6648 | A | NI | Ext pwrd shlder lock/unlock | | | | | |
| L6650 | A | | Shoulder universal joint | | | | | |
| L6655 | A | | Standard control cable extra | | | | | |
| L6660 | A | | Heavy duty control cable | | | | | |
| L6665 | A | | Teflon or equal cable lining | | | | | |
| L6670 | A | | Hook to hand cable adapter | | | | | |
| L6672 | A | | Harness chest/shlder saddle | | | | | |
| L6675 | A | | Harness figure of 8 sing con | | | | | |
| L6676 | A | | Harness figure of 8 dual con | | | | | |
| L6680 | A | | Test sock wrist disart/bel e | | | | | |
| L6682 | A | | Test sock elbw disart/above | | | | | |
| L6684 | A | | Test socket shldr disart/tho | | | | | |
| L6686 | A | | Suction socket | | | | | |
| L6687 | A | | Frame typ socket bel elbow/w | | | | | |
| L6688 | A | | Frame typ sock above elb/dis | | | | | |
| L6689 | A | | Frame typ socket shoulder di | | | | | |
| L6690 | A | | Frame typ sock interscap-tho | | | | | |
| L6691 | A | | Removable insert each | | | | | |
| L6692 | A | | Silicone gel insert or equal | | | | | |
| L6693 | A | | Lockingelbow forearm cntrbal | | | | | |
| L6700 | A | | Terminal device model #3 | | | | | |
| L6705 | A | | Terminal device model #5 | | | | | |
| L6710 | A | | Terminal device model #5x | | | | | |
| L6715 | A | | Terminal device model #5xa | | | | | |
| L6720 | A | | Terminal device model #6 | | | | | |
| L6725 | A | | Terminal device model #7 | | | | | |
| L6730 | A | | Terminal device model #7lo | | | | | |
| L6735 | A | | Terminal device model #8 | | | | | |
| L6740 | A | | Terminal device model #8x | | | | | |
| L6745 | A | | Terminal device model #88x | | | | | |
| L6750 | A | | Terminal device model #10p | | | | | |
| L6755 | A | | Terminal device model #10x | | | | | |
| L6765 | A | | Terminal device model #12p | | | | | |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L6835 | A | | Hand sierra vo | | | | | |
| L6840 | A | | Hand becker imperial | | | | | |
| L6845 | A | | Hand becker lock grip | | | | | |
| L6850 | A | | Term dvc-hand becker plylite | | | | | |
| L6855 | A | | Hand robin-aids vo | | | | | |
| L6860 | A | | Hand robin-aids vo soft | | | | | |
| L6865 | A | | Hand passive hand | | | | | |
| L6867 | A | | Hand detroit infant hand | | | | | |
| L6868 | A | | Passive inf hand steeper/hos | | | | | |
| L6870 | A | | Hand child mitt | | | | | |
| L6872 | A | | Hand nyu child hand | | | | | |
| L6873 | A | | Hand mech inf steeper or equ | | | | | |
| L6875 | A | | Hand bock vc | | | | | |
| L6880 | A | | Hand bock vo | | | | | |
| L6881 | A | | Autograsp feature ul term dv | | | | | |
| L6882 | A | | Microprocessor control uplmb | | | | | |
| L6890 | A | | Production glove | | | | | |
| L6895 | A | | Custom glove | | | | | |
| L6900 | A | | Hand restorat thumb/1 finger | | | | | |
| L6905 | A | | Hand restoration multiple fi | | | | | |
| L6910 | A | | Hand restoration no fingers | | | | | |
| L6915 | A | | Hand restoration replacmnt g | | | | | |
| L6920 | A | | Wrist disarticul switch ctrl | | | | | |
| L6925 | A | | Wrist disart myoelectronic c | | | | | |
| L6930 | A | | Below elbow switch control | | | | | |
| L6935 | A | | Below elbow myoelectronic ct | | | | | |
| L6940 | A | | Elbow disarticulation switch | | | | | |
| L6945 | A | | Elbow disart myoelectronic c | | | | | |
| L6950 | A | | Above elbow switch control | | | | | |
| L6955 | A | | Above elbow myoelectronic ct | | | | | |
| L6960 | A | | Shldr disartic switch contro | | | | | |
| L6965 | A | | Shldr disartic myoelectronic | | | | | |
| L6970 | A | | Interscapular-thor switch ct | | | | | |
| L6975 | A | | Interscap-thor myoelectronic | | | | | |
| L7010 | A | | Hand otto back steeper/eq sw | | | | | |
| L7015 | A | | Hand sys teknik village swit | | | | | |
| L7020 | A | | Electronic greifer switch ct | | | | | |
| L7025 | A | | Electron hand myoelectronic | | | | | |
| L7030 | A | | Hand sys teknik vill myoelec | | | | | |
| L7035 | A | | Electron greifer myoelectro | | | | | |
| L7040 | A | | Prehensile actuator hosmer s | | | | | |
| L7045 | A | | Electron hook child michigan | | | | | |
| L7170 | A | | Electronic elbow hosmer swit | | | | | |
| L7180 | A | | Electronic elbow utah myoele | | | | | |
| L7185 | A | | Electron elbow adolescent sw | | | | | |
| L7186 | A | | Electron elbow child switch | | | | | |
| L7190 | A | | Elbow adolescent myoelectron | | | | | |
| L7191 | A | | Elbow child myoelectronic ct | | | | | |
| L7260 | A | | Electron wrist rotator otto | | | | | |
| L7261 | A | | Electron wrist rotator utah | | | | | |
| L7266 | A | | Servo control steeper or equ | | | | | |
| L7272 | A | | Analogue control unb or equa | | | | | |
| 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 | NI | Replacemnt lithium ionbatter | | | | | |
| L7368 | A | NI | Lithium ion battery charger | | | | | |
| L7499 | A | | Upper extremity prosthes NOS | | | | | |
| L7500 | A | | Prosthetic dvc repair hourly | | | | | |
| L7510 | A | | Prosthetic device repair rep | | | | | |
| L7520 | A | | Repair prosthesis per 15 min | | | | | |
| L7900 | A | | Vacuum erection system | | | | | |
| L8000 | A | | Mastectomy bra | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L8001 | A | | Breast prosthesis bra & form | | | | | |
| L8002 | A | | Brst prsth bra & bilat form | | | | | |
| L8010 | A | | Mastectomy sleeve | | | | | |
| L8015 | A | | Ext breastprosthesis garment | | | | | |
| L8020 | A | | Mastectomy form | | | | | |
| L8030 | A | | Breast prosthesis silicone/e | | | | | |
| L8035 | A | | Custom breast prosthesis | | | | | |
| L8039 | A | | Breast prosthesis NOS | | | | | |
| L8040 | A | | Nasal prosthesis | | | | | |
| L8041 | A | | Midfacial prosthesis | | | | | |
| L8042 | A | | Orbital prosthesis | | | | | |
| L8043 | A | | Upper facial prosthesis | | | | | |
| L8044 | A | | Hemi-facial prosthesis | | | | | |
| L8045 | A | | Auricular prosthesis | | | | | |
| L8046 | A | | Partial facial prosthesis | | | | | |
| L8047 | A | | Nasal septal prosthesis | | | | | |
| L8048 | A | | Unspec maxillofacial prosth | | | | | |
| L8049 | A | | Repair maxillofacial prosth | | | | | |
| L8100 | E | | Compression stocking BK18-30 | | | | | |
| L8110 | E | | Compression stocking BK30-40 | | | | | |
| L8120 | E | | Compression stocking BK40-50 | | | | | |
| L8130 | E | | Gc stocking thighlngth 18-30 | | | | | |
| L8140 | E | | Gc stocking thighlngth 30-40 | | | | | |
| L8150 | E | | Gc stocking thighlngth 40-50 | | | | | |
| L8160 | E | | Gc stocking full lngth 18-30 | | | | | |
| L8170 | E | | Gc stocking full lngth 30-40 | | | | | |
| L8180 | E | | Gc stocking full lngth 40-50 | | | | | |
| L8190 | E | | Gc stocking waistlngth 18-30 | | | | | |
| L8195 | E | | Gc stocking waistlngth 30-40 | | | | | |
| L8200 | E | | Gc stocking waistlngth 40-50 | | | | | |
| L8210 | E | | Gc stocking custom made | | | | | |
| L8220 | E | | Gc stocking lymphedema | | | | | |
| L8230 | E | | Gc stocking garter belt | | | | | |
| L8239 | E | | G compression stocking NOS | | | | | |
| L8300 | A | | Truss single w/ standard pad | | | | | |
| L8310 | A | | Truss double w/ standard pad | | | | | |
| L8320 | A | | Truss addition to std pad wa | | | | | |
| L8330 | A | | Truss add to std pad scrotal | | | | | |
| L8400 | A | | Sheath below knee | | | | | |
| L8410 | A | | Sheath above knee | | | | | |
| L8415 | A | | Sheath upper limb | | | | | |
| L8417 | A | | Pros sheath/sock w gel cushn | | | | | |
| L8420 | A | | Prosthetic sock multi ply BK | | | | | |
| L8430 | A | | Prosthetic sock multi ply AK | | | | | |
| L8435 | A | | Pros sock multi ply upper lm | | | | | |
| L8440 | A | | Shrinker below knee | | | | | |
| L8460 | A | | Shrinker above knee | | | | | |
| L8465 | A | | Shrinker upper limb | | | | | |
| L8470 | A | | Pros sock single ply BK | | | | | |
| L8480 | A | | Pros sock single ply AK | | | | | |
| L8485 | A | | Pros sock single ply upper l | | | | | |
| L8490 | A | | Air seal suction reten systm | | | | | |
| L8499 | A | | Unlisted misc prosthetic ser | | | | | |
| L8500 | A | | Artificial larynx | | | | | |
| L8501 | A | | Tracheostomy speaking valve | | | | | |
| L8505 | A | | Artificial larynx, accessory | | | | | |
| L8507 | A | | Trach-esoph voice pros pt in | | | | | |
| L8509 | A | | Trach-esoph voice pros md in | | | | | |
| L8510 | A | | Voice amplifier | | | | | |
| L8600 | N | | Implant breast silicone/eq | | | | | |
| L8603 | N | | Collagen imp urinary 2.5 ml | | | | | |
| L8606 | A | | Synthetic implnt urinary 1ml | | | | | |
| L8610 | N | | Ocular implant | | | | | |
| L8612 | N | | Aqueous shunt prosthesis | | | | | |
| L8613 | N | | Ossicular implant | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| L8614 | E | | Cochlear device/system | | | | | |
| L8619 | A | | Replace cochlear processor | | | | | |
| L8630 | N | | Metacarpophalangeal implant | | | | | |
| L8641 | N | | Metatarsal joint implant | | | | | |
| L8642 | N | | Hallux implant | | | | | |
| L8658 | N | | Interphalangeal joint implnt | | | | | |
| L8670 | N | | Vascular graft, synthetic | | | | | |
| L8699 | N | | Prosthetic implant NOS | | | | | |
| L9900 | A | | O&P supply/accessory/service | | | | | |
| M0064 | X | | Visit for drug monitoring | 0374 | 1.1434 | $59.63 | $9.97 | $11.93 |
| M0075 | E | | Cellular therapy | | | | | |
| M0076 | E | | Prolotherapy | | | | | |
| M0100 | E | | Intragastric hypothermia | | | | | |
| M0300 | E | | IV chelationtherapy | | | | | |
| M0301 | E | | Fabric wrapping of aneurysm | | | | | |
| P2028 | A | | Cephalin floculation test | | | | | |
| P2029 | A | | Congo red blood test | | | | | |
| P2031 | E | | Hair analysis | | | | | |
| P2033 | A | | Blood thymol turbidity | | | | | |
| P2038 | A | | Blood mucoprotein | | | | | |
| P3000 | A | | Screen pap by tech w md supv | | | | | |
| P3001 | E | | Screening pap smear by phys | | | | | |
| P7001 | E | | Culture bacterial urine | | | | | |
| P9010 | K | | Whole blood for transfusion | 0950 | 1.6860 | $87.93 | | $17.59 |
| P9011 | E | | Blood split unit | | | | | |
| P9012 | K | | Cryoprecipitate each unit | 0952 | 0.5620 | $29.31 | | $5.86 |
| P9016 | K | | RBC leukocytes reduced | 0954 | 2.2868 | $119.26 | | $23.85 |
| P9017 | K | | One donor fresh frozn plasma | 0955 | 1.8217 | $95.00 | | $19.00 |
| P9019 | K | | Platelets, each unit | 0957 | 0.7946 | $41.44 | | $8.29 |
| P9020 | K | | Plaelet rich plasma unit | 0958 | 1.0271 | $53.56 | | $10.71 |
| P9021 | K | | Red blood cells unit | 0959 | 1.6569 | $86.41 | | $17.28 |
| P9022 | K | | Washed red blood cells unit | 0960 | 3.0813 | $160.69 | | $32.14 |
| P9023 | K | | Frozen plasma, pooled, sd | 0949 | 2.3837 | $124.31 | | $24.86 |
| P9031 | K | | Platelets leukocytes reduced | 1013 | 0.9496 | $49.52 | | $9.90 |
| P9032 | K | | Platelets, irradiated | 9500 | 1.4341 | $74.79 | | $14.96 |
| P9033 | K | | Platelets leukoreduced irrad | 0954 | 2.2868 | $119.26 | | $23.85 |
| P9034 | K | | Platelets, pheresis | 9501 | 7.8390 | $408.81 | | $81.76 |
| P9035 | K | | Platelet pheres leukoreduced | 9501 | 7.8390 | $408.81 | | $81.76 |
| P9036 | K | | Platelet pheresis irradiated | 9502 | 8.5076 | $443.68 | | $88.74 |
| P9037 | K | | Plate pheres leukoredu irrad | 1019 | 7.7905 | $406.28 | | $81.26 |
| P9038 | K | | RBC irradiated | 9505 | 2.0833 | $108.65 | | $21.73 |
| P9039 | K | | RBC deglycerolized | 9504 | 3.5174 | $183.44 | | $36.69 |
| P9040 | K | | RBC leukoreduced irradiated | 9504 | 3.5174 | $183.44 | | $36.69 |
| P9041 | K | | Albumin (human),5%, 50ml | 0961 | 0.9980 | $52.05 | | $10.41 |
| P9043 | K | | Plasma protein fract,5%,50ml | 0956 | 1.7829 | $92.98 | | $18.60 |
| P9044 | K | | Cryoprecipitatereducedplasma | 1009 | 0.7170 | $37.39 | | $7.48 |
| P9045 | K | | Albumin (human), 5%, 250 ml | 0963 | 4.9708 | $259.23 | | $51.85 |
| P9046 | K | | Albumin (human), 25%, 20 ml | 0964 | 1.0756 | $56.09 | | $11.22 |
| P9047 | K | | Albumin (human), 25%, 50ml | 0965 | 2.6840 | $139.97 | | $27.99 |
| P9048 | K | | Plasmaprotein fract,5%,250ml | 0966 | 8.9145 | $464.90 | | $92.98 |
| P9050 | K | | Granulocytes, pheresis unit | 9506 | 23.9432 | $1,248.66 | | $249.73 |
| P9603 | A | | One-way allow prorated miles | | | | | |
| P9604 | A | | One-way allow prorated trip | | | | | |
| P9612 | N | | Catheterize for urine spec | | | | | |
| P9615 | N | | Urine specimen collect mult | | | | | |
| Q0035 | X | | Cardiokymography | 0100 | 1.6085 | $83.88 | $41.44 | $16.78 |
| Q0081 | T | | Infusion ther other than che | 0120 | 2.1802 | $113.70 | $30.75 | $22.74 |
| Q0083 | S | | Chemo by other than infusion | 0116 | 0.7752 | $40.43 | | $8.09 |
| Q0084 | S | | Chemotherapy by infusion | 0117 | 3.6046 | $187.98 | $48.28 | $37.60 |
| Q0085 | S | | Chemo by both infusion and o | 0118 | 5.4844 | $286.02 | $72.03 | $57.20 |
| Q0086 | A | | Physical therapy evaluation/ | | | | | |
| Q0091 | T | | Obtaining screen pap smear | 0191 | 0.2035 | $10.61 | $3.08 | $2.12 |
| Q0092 | N | | Set up port xray equipment | | | | | |
| Q0111 | A | | Wet mounts/ w preparations | | | | | |
| Q0112 | A | | Potassium hydroxide preps | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| Q0113 | A | | Pinworm examinations | | | | | |
| Q0114 | A | | Fern test | | | | | |
| Q0115 | A | | Post-coital mucous exam | | | | | |
| Q0136 | K | | Non esrd epoetin alpha inj | 0733 | 0.1744 | $9.10 | | $1.82 |
| Q0144 | E | | Azithromycin dihydrate, oral | | | | | |
| Q0163 | N | | Diphenhydramine HCl 50mg | | | | | |
| Q0164 | N | | Prochlorperazine maleate 5mg | | | | | |
| Q0165 | E | | Prochlorperazine maleate10mg | | | | | |
| Q0166 | N | | Granisetron HCl 1 mg oral | | | | | |
| Q0167 | N | | Dronabinol 2.5mg oral | | | | | |
| Q0168 | E | | Dronabinol 5mg oral | | | | | |
| Q0169 | N | | Promethazine HCl 12.5mg oral | | | | | |
| Q0170 | E | | Promethazine HCl 25 mg oral | | | | | |
| Q0171 | N | | Chlorpromazine HCl 10mg oral | | | | | |
| Q0172 | E | | Chlorpromazine HCl 25mg oral | | | | | |
| Q0173 | N | | Trimethobenzamide HCl 250mg | | | | | |
| Q0174 | N | | Thiethylperazine maleate10mg | | | | | |
| Q0175 | N | | Perphenazine 4mg oral | | | | | |
| Q0176 | E | | Perphenazine 8mg oral | | | | | |
| Q0177 | N | | Hydroxyzine pamoate 25mg | | | | | |
| Q0178 | E | | Hydroxyzine pamoate 50mg | | | | | |
| Q0179 | N | | Ondansetron HCl 8mg oral | | | | | |
| Q0180 | N | | Dolasetron mesylate oral | | | | | |
| Q0181 | E | | Unspecified oral anti-emetic | | | | | |
| Q0183 | N | | Nonmetabolic active tissue | | | | | |
| Q0184 | N | | Metabolically active tissue | | | | | |
| Q0187 | K | | Factor viia recombinant | 1409 | 20.7844 | $1,083.93 | | $216.79 |
| Q1001 | E | | Ntiol category 1 | | | | | |
| Q1002 | E | | Ntiol category 2 | | | | | |
| Q1003 | E | | Ntiol category 3 | | | | | |
| Q1004 | E | | Ntiol category 4 | | | | | |
| Q1005 | E | | Ntiol category 5 | | | | | |
| Q2001 | N | | Oral cabergoline 0.5 mg | | | | | |
| Q2002 | N | | Elliotts b solution per ml | | | | | |
| Q2003 | N | | Aprotinin, 10,000 kiu | | | | | |
| Q2004 | N | | Bladder calculi irrig sol | | | | | |
| Q2005 | K | | Corticorelin ovine triflutat | 7024 | 2.2965 | $119.76 | | $23.95 |
| Q2006 | K | | Digoxin immune fab (ovine) | 7025 | 4.9805 | $259.74 | | $51.95 |
| Q2007 | N | | Ethanolamine oleate 100 mg | | | | | |
| Q2008 | N | | Fomepizole, 15 mg | | | | | |
| Q2009 | N | | Fosphenytoin, 50 mg | | | | | |
| Q2010 | N | | Glatiramer acetate, per dose | | | | | |
| Q2011 | K | | Hemin, per 1 mg | 7030 | 0.0097 | $.51 | | $.10 |
| Q2012 | N | | Pegademase bovine, 25 iu | | | | | |
| Q2013 | N | | Pentastarch 10% solution | | | | | |
| Q2014 | N | | Sermorelin acetate, 0.5 mg | | | | | |
| Q2017 | K | | Teniposide, 50 mg | 7035 | 1.9573 | $102.08 | | $20.42 |
| Q2018 | N | | Urofollitropin, 75 iu | | | | | |
| Q2019 | K | | Basiliximab | 1615 | 13.3621 | $696.85 | | $139.37 |
| Q2020 | E | | Histrelin acetate | | | | | |
| Q2021 | N | | Lepirudin | | | | | |
| Q2022 | K | | VonWillebrandFactrCmplxperIU | 1618 | 0.0194 | $1.01 | | $.20 |
| Q3001 | N | | Brachytherapy Radioelements | | | | | |
| Q3002 | N | | Gallium ga 67 | | | | | |
| Q3003 | K | | Technetium tc99m bicisate | 1620 | 3.8759 | $202.13 | | $40.43 |
| Q3004 | N | | Xenon xe 133 | | | | | |
| Q3005 | N | | Technetium tc99m mertiatide | | | | | |
| Q3006 | N | | Technetium tc99m glucepatate | | | | | |
| Q3007 | N | | Sodium phosphate p32 | | | | | |
| Q3008 | K | | Indium 111-in pentetreotide | 1625 | 8.2169 | $428.52 | | $85.70 |
| Q3009 | N | | Technetium tc99m oxidronate | | | | | |
| Q3010 | N | | Technetium tc99mlabeledrbcs | | | | | |
| Q3011 | K | | Chromic phosphate p32 | 1628 | 1.5891 | $82.87 | | $16.57 |
| Q3012 | N | | Cyanocobalamin cobalt co57 | | | | | |
| Q3014 | A | | Telehealth facility fee | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| Q3017 | E | DG | ALS assessment | | | | | |
| Q3019 | A | | ALS emer trans no ALS serv | | | | | |
| Q3020 | A | | ALS nonemer trans no ALS se | | | | | |
| Q3021 | K | NI | Ped hepatitis b vaccine inj | 0355 | 0.2132 | $11.12 | | $2.22 |
| Q3022 | K | NI | Hepatitis b vaccine adult ds | 0356 | 0.7655 | $39.92 | | $7.98 |
| Q3023 | K | NI | Injection hepatitis Bvaccine | 0356 | 0.7655 | $39.92 | | $7.98 |
| Q3025 | K | NI | IM inj interferon beta 1-a | 9022 | 0.9302 | $48.51 | | $9.70 |
| Q3026 | N | NI | Subc inj interferon beta-1a | | | | | |
| Q4001 | A | | Cast sup body cast plaster | | | | | |
| Q4002 | A | | Cast sup body cast fiberglas | | | | | |
| Q4003 | A | | Cast sup shoulder cast plstr | | | | | |
| Q4004 | A | | Cast sup shoulder cast fbrgl | | | | | |
| Q4005 | A | | Cast sup long arm adult plst | | | | | |
| Q4006 | A | | Cast sup long arm adult fbrg | | | | | |
| Q4007 | A | | Cast sup long arm ped plster | | | | | |
| Q4008 | A | | Cast sup long arm ped fbrgls | | | | | |
| Q4009 | A | | Cast sup sht arm adult plstr | | | | | |
| Q4010 | A | | Cast sup sht arm adult fbrgl | | | | | |
| Q4011 | A | | Cast sup sht arm ped plaster | | | | | |
| Q4012 | A | | Cast sup sht arm ped fbrglas | | | | | |
| Q4013 | A | | Cast sup gauntlet plaster | | | | | |
| Q4014 | A | | Cast sup gauntlet fiberglass | | | | | |
| Q4015 | A | | Cast sup gauntlet ped plster | | | | | |
| Q4016 | A | | Cast sup gauntlet ped fbrgls | | | | | |
| Q4017 | A | | Cast sup lng arm splint plst | | | | | |
| Q4018 | A | | Cast sup lng arm splint fbrg | | | | | |
| Q4019 | A | | Cast sup lng arm splnt ped p | | | | | |
| Q4020 | A | | Cast sup lng arm splnt ped f | | | | | |
| Q4021 | A | | Cast sup sht arm splint plst | | | | | |
| Q4022 | A | | Cast sup sht arm splint fbrg | | | | | |
| Q4023 | A | | Cast sup sht arm splnt ped p | | | | | |
| Q4024 | A | | Cast sup sht arm splnt ped f | | | | | |
| Q4025 | A | | Cast sup hip spica plaster | | | | | |
| Q4026 | A | | Cast sup hip spica fiberglas | | | | | |
| Q4027 | A | | Cast sup hip spica ped plstr | | | | | |
| Q4028 | A | | Cast sup hip spica ped fbrgl | | | | | |
| Q4029 | A | | Cast sup long leg plaster | | | | | |
| Q4030 | A | | Cast sup long leg fiberglass | | | | | |
| Q4031 | A | | Cast sup lng leg ped plaster | | | | | |
| Q4032 | A | | Cast sup lng leg ped fbrgls | | | | | |
| Q4033 | A | | Cast sup lng leg cylinder pl | | | | | |
| Q4034 | A | | Cast sup lng leg cylinder fb | | | | | |
| Q4035 | A | | Cast sup lngleg cylndr ped p | | | | | |
| Q4036 | A | | Cast sup lngleg cylndr ped f | | | | | |
| Q4037 | A | | Cast sup shrt leg plaster | | | | | |
| Q4038 | A | | Cast sup shrt leg fiberglass | | | | | |
| Q4039 | A | | Cast sup shrt leg ped plster | | | | | |
| Q4040 | A | | Cast sup shrt leg ped fbrgls | | | | | |
| Q4041 | A | | Cast sup lng leg splnt plstr | | | | | |
| Q4042 | A | | Cast sup lng leg splnt fbrgl | | | | | |
| Q4043 | A | | Cast sup lng leg splnt ped p | | | | | |
| Q4044 | A | | Cast sup lng leg splnt ped f | | | | | |
| Q4045 | A | | Cast sup sht leg splnt plstr | | | | | |
| Q4046 | A | | Cast sup sht leg splnt fbrgl | | | | | |
| Q4047 | A | | Cast sup sht leg splnt ped p | | | | | |
| Q4048 | A | | Cast sup sht leg splnt ped f | | | | | |
| Q4049 | A | | Finger splint, static | | | | | |
| Q4050 | A | | Cast supplies unlisted | | | | | |
| Q4051 | A | | Splint supplies misc | | | | | |
| Q9920 | A | | Epoetin with hct <= 20 | | | | | |
| Q9921 | A | | Epoetin with hct = 21 | | | | | |
| Q9922 | A | | Epoetin with hct = 22 | | | | | |
| Q9923 | A | | Epoetin with hct = 23 | | | | | |
| Q9924 | A | | Epoetin with hct = 24 | | | | | |
| Q9925 | A | | Epoetin with hct = 25 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| Q9926 | A | | Epoetin with hct = 26 | | | | | |
| Q9927 | A | | Epoetin with hct = 27 | | | | | |
| Q9928 | A | | Epoetin with hct = 28 | | | | | |
| Q9929 | A | | Epoetin with hct = 29 | | | | | |
| Q9930 | A | | Epoetin with hct = 30 | | | | | |
| Q9931 | A | | Epoetin with hct = 31 | | | | | |
| Q9932 | A | | Epoetin with hct = 32 | | | | | |
| Q9933 | A | | Epoetin with hct = 33 | | | | | |
| Q9934 | A | | Epoetin with hct = 34 | | | | | |
| Q9935 | A | | Epoetin with hct = 35 | | | | | |
| Q9936 | A | | Epoetin with hct = 36 | | | | | |
| Q9937 | A | | Epoetin with hct = 37 | | | | | |
| Q9938 | A | | Epoetin with hct = 38 | | | | | |
| Q9939 | A | | Epoetin with hct = 39 | | | | | |
| Q9940 | A | | Epoetin with hct >= 40 | | | | | |
| R0070 | N | | Transport portable x-ray | | | | | |
| R0075 | N | | Transport port x-ray multipl | | | | | |
| R0076 | N | | Transport portable EKG | | | | | |
| T1015 | E | | Clinic service | | | | | |
| T1016 | E | NI | Case management | | | | | |
| T1017 | E | NI | Targeted case management | | | | | |
| T1018 | E | NI | School-based IEP ser bundled | | | | | |
| T1019 | E | NI | Personal care ser per 15 min | | | | | |
| T1020 | E | NI | Personal care ser per diem | | | | | |
| T1021 | E | NI | HH Aide or cn aide per visit | | | | | |
| T1022 | E | NI | Contracted services per day | | | | | |
| T1023 | E | NI | Program intake assessment | | | | | |
| T1024 | E | NI | Team evaluation & management | | | | | |
| T1025 | E | NI | Ped compr care pkg, per diem | | | | | |
| T1026 | E | NI | Ped compr care pkg, per hour | | | | | |
| T1027 | E | NI | Family training & counseling | | | | | |
| T1028 | E | NI | Home environment assessment | | | | | |
| T1029 | E | NI | Dwelling lead investigation | | | | | |
| T1030 | E | NI | RN home care per diem | | | | | |
| T1031 | E | NI | LPN home care per diem | | | | | |
| T1500 | E | NI | Reusable diaper/pant | | | | | |
| T1502 | E | NI | Medication admin visit | | | | | |
| T1999 | E | NI | NOC retail items andsupplies | | | | | |
| T2001 | E | NI | N-et; patient attend/escort | | | | | |
| T2002 | E | NI | N-et; per diem | | | | | |
| T2003 | E | NI | N-et; encounter/trip | | | | | |
| T2004 | E | NI | N-et; commerc carrier pass | | | | | |
| T2005 | E | NI | N-et; stretcher van | | | | | |
| T2006 | E | NI | Amb response & trt, no trans | | | | | |
| T2007 | E | NI | Non-emer transport wait time | | | | | |
| V2020 | A | | Vision svcs frames purchases | | | | | |
| V2025 | E | | Eyeglasses delux frames | | | | | |
| V2100 | A | | Lens spher single plano 4.00 | | | | | |
| V2101 | A | | Single visn sphere 4.12-7.00 | | | | | |
| V2102 | A | | Singl visn sphere 7.12-20.00 | | | | | |
| V2103 | A | | Spherocylindr 4.00d/12-2.00d | | | | | |
| V2104 | A | | Spherocylindr 4.00d/2.12-4d | | | | | |
| V2105 | A | | Spherocylinder 4.00d/4.25-6d | | | | | |
| V2106 | A | | Spherocylinder 4.00d/>6.00d | | | | | |
| V2107 | A | | Spherocylinder 4.25d/12-2d | | | | | |
| V2108 | A | | Spherocylinder 4.25d/2.12-4d | | | | | |
| V2109 | A | | Spherocylinder 4.25d/4.25-6d | | | | | |
| V2110 | A | | Spherocylinder 4.25d/over 6d | | | | | |
| V2111 | A | | Spherocylindr 7.25d/.25-2.25 | | | | | |
| V2112 | A | | Spherocylindr 7.25d/2.25-4d | | | | | |
| V2113 | A | | Spherocylindr 7.25d/4.25-6d | | | | | |
| V2114 | A | | Spherocylinder over 12.00d | | | | | |
| V2115 | A | | Lens lenticular bifocal | | | | | |
| V2116 | A | | Nonaspheric lens bifocal | | | | | |
| V2117 | A | | Aspheric lens bifocal | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| V2118 | A | | Lens aniseikonic single | | | | | |
| V2199 | A | | Lens single vision not oth c | | | | | |
| V2200 | A | | Lens spher bifoc plano 4.00d | | | | | |
| V2201 | A | | Lens sphere bifocal 4.12-7.0 | | | | | |
| V2202 | A | | Lens sphere bifocal 7.12-20. | | | | | |
| V2203 | A | | Lens sphcyl bifocal 4.00d/.1 | | | | | |
| V2204 | A | | Lens sphcy bifocal 4.00d/2.1 | | | | | |
| V2205 | A | | Lens sphcy bifocal 4.00d/4.2 | | | | | |
| V2206 | A | | Lens sphcy bifocal 4.00d/ove | | | | | |
| V2207 | A | | Lens sphcy bifocal 4.25-7d/. | | | | | |
| V2208 | A | | Lens sphcy bifocal 4.25-7/2. | | | | | |
| V2209 | A | | Lens sphcy bifocal 4.25-7/4. | | | | | |
| V2210 | A | | Lens sphcy bifocal 4.25-7/ov | | | | | |
| V2211 | A | | Lens sphcy bifo 7.25-12/.25- | | | | | |
| V2212 | A | | Lens sphcyl bifo 7.25-12/2.2 | | | | | |
| V2213 | A | | Lens sphcyl bifo 7.25-12/4.2 | | | | | |
| V2214 | A | | Lens sphcyl bifocal over 12. | | | | | |
| V2215 | A | | Lens lenticular bifocal | | | | | |
| V2216 | A | | Lens lenticular nonaspheric | | | | | |
| V2217 | A | | Lens lenticular aspheric bif | | | | | |
| V2218 | A | | Lens aniseikonic bifocal | | | | | |
| V2219 | A | | Lens bifocal seg width over | | | | | |
| V2220 | A | | Lens bifocal add over 3.25d | | | | | |
| V2299 | A | | Lens bifocal speciality | | | | | |
| V2300 | A | | Lens sphere trifocal 4.00d | | | | | |
| V2301 | A | | Lens sphere trifocal 4.12-7. | | | | | |
| V2302 | A | | Lens sphere trifocal 7.12-20 | | | | | |
| V2303 | A | | Lens sphcy trifocal 4.0/.12- | | | | | |
| V2304 | A | | Lens sphcy trifocal 4.0/2.25 | | | | | |
| V2305 | A | | Lens sphcy trifocal 4.0/4.25 | | | | | |
| V2306 | A | | Lens sphcyl trifocal 4.00/>6 | | | | | |
| V2307 | A | | Lens sphcy trifocal 4.25-7/. | | | | | |
| V2308 | A | | Lens sphc trifocal 4.25-7/2. | | | | | |
| V2309 | A | | Lens sphc trifocal 4.25-7/4. | | | | | |
| V2310 | A | | Lens sphc trifocal 4.25-7/>6 | | | | | |
| V2311 | A | | Lens sphc trifo 7.25-12/.25- | | | | | |
| V2312 | A | | Lens sphc trifo 7.25-12/2.25 | | | | | |
| V2313 | A | | Lens sphc trifo 7.25-12/4.25 | | | | | |
| V2314 | A | | Lens sphcyl trifocal over 12 | | | | | |
| V2315 | A | | Lens lenticular trifocal | | | | | |
| V2316 | A | | Lens lenticular nonaspheric | | | | | |
| V2317 | A | | Lens lenticular aspheric tri | | | | | |
| V2318 | A | | Lens aniseikonic trifocal | | | | | |
| V2319 | A | | Lens trifocal seg width > 28 | | | | | |
| V2320 | A | | Lens trifocal add over 3.25d | | | | | |
| V2399 | A | | Lens trifocal speciality | | | | | |
| V2410 | A | | Lens variab asphericity sing | | | | | |
| V2430 | A | | Lens variable asphericity bi | | | | | |
| V2499 | A | | Variable asphericity lens | | | | | |
| V2500 | A | | Contact lens pmma spherical | | | | | |
| V2501 | A | | Cntct lens pmma-toric/prism | | | | | |
| V2502 | A | | Contact lens pmma bifocal | | | | | |
| V2503 | A | | Cntct lens pmma color vision | | | | | |
| V2510 | A | | Cntct gas permeable sphericl | | | | | |
| V2511 | A | | Cntct toric prism ballast | | | | | |
| V2512 | A | | Cntct lens gas permbl bifocl | | | | | |
| V2513 | A | | Contact lens extended wear | | | | | |
| 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| V2610 | A | | Single lens spectacle mount | | | | | |
| V2615 | A | | Telescop/othr compound lens | | | | | |
| V2623 | A | | Plastic eye prosth custom | | | | | |
| V2624 | A | | Polishing artifical eye | | | | | |
| V2625 | A | | Enlargemnt of eye prosthesis | | | | | |
| V2626 | A | | Reduction of eye prosthesis | | | | | |
| V2627 | A | | Scleral cover shell | | | | | |
| V2628 | A | | Fabrication & fitting | | | | | |
| V2629 | A | | Prosthetic eye other type | | | | | |
| V2630 | N | | Anter chamber intraocul lens | | | | | |
| V2631 | N | | Iris support intraoclr lens | | | | | |
| V2632 | N | | Post chmbr intraocular lens | | | | | |
| V2700 | A | | Balance lens | | | | | |
| V2710 | A | | Glass/plastic slab off prism | | | | | |
| V2715 | A | | Prism lens/es | | | | | |
| V2718 | A | | Fresnell prism press-on lens | | | | | |
| V2730 | A | | Special base curve | | | | | |
| V2740 | A | | Rose tint plastic | | | | | |
| V2741 | A | | Non-rose tint plastic | | | | | |
| V2742 | A | | Rose tint glass | | | | | |
| V2743 | A | | Non-rose tint glass | | | | | |
| V2744 | A | | Tint photochromatic lens/es | | | | | |
| V2750 | A | | Anti-reflective coating | | | | | |
| V2755 | A | | UV lens/es | | | | | |
| V2760 | A | | Scratch resistant coating | | | | | |
| V2770 | A | | Occluder lens/es | | | | | |
| V2780 | A | | Oversize lens/es | | | | | |
| V2781 | E | | Progressive lens per lens | | | | | |
| V2785 | F | | Corneal tissue processing | | | | | |
| V2790 | N | | Amniotic membrane | | | | | |
| V2799 | A | | Miscellaneous vision service | | | | | |
| V5008 | E | | Hearing screening | | | | | |
| V5010 | E | | Assessment for hearing aid | | | | | |
| V5011 | E | | Hearing aid fitting/checking | | | | | |
| V5014 | E | | Hearing aid repair/modifying | | | | | |
| V5020 | E | | Conformity evaluation | | | | | |
| V5030 | E | | Body-worn hearing aid air | | | | | |
| V5040 | E | | Body-worn hearing aid bone | | | | | |
| V5050 | E | | Hearing aid monaural in ear | | | | | |
| V5060 | E | | Behind ear hearing aid | | | | | |
| V5070 | E | | Glasses air conduction | | | | | |
| V5080 | E | | Glasses bone conduction | | | | | |
| V5090 | E | | Hearing aid dispensing fee | | | | | |
| V5095 | E | NI | 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 | | | | | |

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

| CPT/ HCPCS | Status indicator | Condition | Description | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---|---|---|---|---|---|---|---|---|
| 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 | NI | Hearing aid noc | | | | | |
| V5299 | E | | Hearing service | | | | | |
| V5336 | E | | Repair communication device | | | | | |
| V5362 | A | | Speech screening | | | | | |
| V5363 | A | | Language screening | | | | | |
| V5364 | A | | Dysphagia screening | | | | | |

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

| Indicator | Service | Status |
|---|---|---|
| A | Ambulance | Ambulance Fee Schedule. |
| A | Clinical Diagnostic Laboratory Services | Laboratory Fee Schedule. |
| A | Durable Medical Equipment, Prosthetics and Orthotics (excluding implanted DME and prosthetics). | DMEPOS Fee Schedule. |
| A | EPO for ESRD Patients | National Rate. |
| A | Physical, Occupational and Speech Therapy | Physician Fee Schedule. |
| A | Physician Services for ESRD Patients | Physician Fee Schedule. |
| A | Screening Mammography | Physician Fee Schedule. |
| C | Inpatient Procedures | Not Payable under OPPS; Admit Patient; Bill as Inpatient. |
| D | Deleted Code | Deleted Effective Beginning of Calendar Year. |
| E | Non-Covered Items and Services, Codes not Reportable in Hospital Outpatient Settings. | Not Paid Under Medicare or When Performed in a Hospital Outpatient Setting. |
| F | Corneal tissue acquisition; orphan drugs | Paid at Reasonable Cost. |
| G | Drug/Biological Pass-Through | Paid Under OPPS; Separate APC Payment Includes Pass Through Amount. |
| H | Device Category Pass-Through | Paid Under OPPS; Separate Cost Based Pass Through Payment. |
| K | Non Pass-Through Drug/Biological, Radiopharmaceutical Agents, Certain Brachytherapy seeds. | Paid Under OPPS; Separate APC. |
| L | Influenza Vaccine; Pneumococcal Pneumonia Vaccine | Paid reasonable cost; not subject to deductible or coinsurance. |
| N | Items and Services Packaged into APC Rate | Paid under OPPS; Payment Is Packaged Into Payment for Other Services. |

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

| Indicator | Service | Status |
|---|---|---|
| P | Partial Hospitalization | Paid under OPPS; Per Diem APC. |
| S | Significant Procedure, Not Discounted When Multiple | Paid Under OPPS; Separate APC. |
| T | Significant Procedure, Multiple Procedure Reduction Applies | Paid Under OPPS; Separate APC. |
| V | Visit to Clinic or Emergency Department | Paid Under OPPS; Separate APC . |
| X | Ancillary Service | Paid Under OPPS; Separate APC. |

ADDENDUM D1.—CODE CONDITIONS

| Code condition | Descriptor |
|---|---|
| DG | Deleted code with a grace period; payment will be made under the deleted code in accord with the status indicator during the standard grace period. |
| DNG | Deleted code with no grace period; payment will not be made under the deleted code after January 1, 2003. |
| NF | New code final APC assignment; comments were accepted on a proposed APC assignment in the NPRM; 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 2003]

| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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 |
| 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 |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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,remove 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 |
| 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 |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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 |
| 22326 | C | Treat neck spine fracture |
| 22327 | C | Treat thorax spine fracture |
| 22328 | C | Treat each add spine fx |
| 22548 | C | Neck spine fusion |
| 22554 | C | Neck spine fusion |
| 22556 | C | Thorax spine fusion |
| 22558 | C | Lumbar spine fusion |
| 22585 | C | Additional spinal fusion |
| 22590 | C | Spine & skull spinal fusion |
| 22595 | C | Neck spinal fusion |
| 22600 | C | Neck spine fusion |
| 22610 | C | Thorax spine fusion |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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 |
| 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 |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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 |
| 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 |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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 |
| 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 |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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 |
| 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 |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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 |
| 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 |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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 |
| 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 |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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 |
| 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 |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 34001 | C | Removal of artery clot |
| 34051 | C | Removal of artery clot |
| 34151 | C | Removal of artery clot |
| 34401 | C | Removal of vein clot |
| 34451 | C | Removal of vein clot |
| 34502 | C | Reconstruct vena cava |
| 34800 | C | Endovasc abdo repair w/tube |
| 34802 | C | Endovasc abdo repr w/device |
| 34804 | C | Endovasc abdo repr w/device |
| 34808 | C | Endovasc abdo occlud device |
| 34812 | C | Xpose for endoprosth, aortic |
| 34813 | C | Xpose for endoprosth, femorl |
| 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 |
| 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 |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 35371 | C | Rechanneling of artery |
| 35372 | C | Rechanneling of artery |
| 35381 | C | Rechanneling of artery |
| 35390 | C | Reoperation, carotid add-on |
| 35400 | C | Angioscopy |
| 35450 | C | Repair arterial blockage |
| 35452 | C | Repair arterial blockage |
| 35454 | C | Repair arterial blockage |
| 35456 | C | Repair arterial blockage |
| 35480 | C | Atherectomy, open |
| 35481 | C | Atherectomy, open |
| 35482 | C | Atherectomy, open |
| 35483 | C | Atherectomy, open |
| 35501 | C | Artery bypass graft |
| 35506 | C | Artery bypass graft |
| 35507 | C | Artery bypass graft |
| 35508 | C | Artery bypass graft |
| 35509 | C | Artery bypass graft |
| 35511 | C | Artery bypass graft |
| 35515 | C | Artery bypass graft |
| 35516 | C | Artery bypass graft |
| 35518 | C | Artery bypass graft |
| 35521 | C | Artery bypass graft |
| 35526 | C | Artery bypass graft |
| 35531 | C | Artery bypass graft |
| 35533 | C | Artery bypass graft |
| 35536 | C | Artery bypass graft |
| 35541 | C | Artery bypass graft |
| 35546 | C | Artery bypass graft |
| 35548 | C | Artery bypass graft |
| 35549 | C | Artery bypass graft |
| 35551 | C | Artery bypass graft |
| 35556 | C | Artery bypass graft |
| 35558 | C | Artery bypass graft |
| 35560 | C | Artery bypass graft |
| 35563 | C | Artery bypass graft |
| 35565 | C | Artery bypass graft |
| 35566 | C | Artery bypass graft |
| 35571 | C | Artery bypass graft |
| 35582 | C | Vein bypass graft |
| 35583 | C | Vein bypass graft |
| 35585 | C | Vein bypass graft |
| 35587 | C | Vein bypass graft |
| 35600 | C | Harvest artery for cabg |
| 35601 | C | Artery bypass graft |
| 35606 | C | Artery bypass graft |
| 35612 | C | Artery bypass graft |
| 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 |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 35666 | C | Artery bypass graft |
| 35671 | C | Artery bypass graft |
| 35681 | C | Composite bypass graft |
| 35682 | C | Composite bypass graft |
| 35683 | C | Composite bypass graft |
| 35691 | C | Arterial transposition |
| 35693 | C | Arterial transposition |
| 35694 | C | Arterial transposition |
| 35695 | C | Arterial transposition |
| 35700 | C | Reoperation, bypass graft |
| 35701 | C | Exploration, carotid artery |
| 35721 | C | Exploration, femoral artery |
| 35741 | C | Exploration popliteal artery |
| 35800 | C | Explore neck vessels |
| 35820 | C | Explore chest vessels |
| 35840 | C | Explore abdominal vessels |
| 35870 | C | Repair vessel graft defect |
| 35901 | C | Excision, graft, neck |
| 35905 | C | Excision, graft, thorax |
| 35907 | C | Excision, graft, abdomen |
| 36510 | C | Insertion of catheter, vein |
| 36660 | C | Insertion catheter, artery |
| 36822 | C | Insertion of cannula(s) |
| 36823 | C | Insertion of cannula(s) |
| 37140 | C | Revision of circulation |
| 37145 | C | Revision of circulation |
| 37160 | C | Revision of circulation |
| 37180 | C | Revision of circulation |
| 37181 | C | Splice spleen/kidney veins |
| 37182 | C | Insert hepatic shunt (tips) |
| 37183 | C | Remove hepatic shunt (tips) |
| 37195 | C | Thrombolytic therapy, stroke |
| 37616 | C | Ligation of chest artery |
| 37617 | C | Ligation of abdomen artery |
| 37618 | C | Ligation of extremity artery |
| 37660 | C | Revision of major vein |
| 37788 | C | Revascularization, penis |
| 38100 | C | Removal of spleen, total |
| 38101 | C | Removal of spleen, partial |
| 38102 | C | Removal of spleen, total |
| 38115 | C | Repair of ruptured spleen |
| 38380 | C | Thoracic duct procedure |
| 38381 | C | Thoracic duct procedure |
| 38382 | C | Thoracic duct procedure |
| 38562 | C | Removal, pelvic lymph nodes |
| 38564 | C | Removal, abdomen lymph nodes |
| 38724 | C | Removal of lymph nodes, neck |
| 38746 | C | Remove thoracic lymph nodes |
| 38747 | C | Remove abdominal lymph nodes |
| 38765 | C | Remove groin lymph nodes |
| 38770 | C | Remove pelvis lymph nodes |
| 38780 | C | Remove abdomen lymph nodes |
| 39000 | C | Exploration of chest |
| 39010 | C | Exploration of chest |
| 39200 | C | Removal chest lesion |
| 39220 | C | Removal chest lesion |
| 39499 | C | Chest procedure |
| 39501 | C | Repair diaphragm laceration |
| 39502 | C | Repair paraesophageal hernia |
| 39503 | C | Repair of diaphragm hernia |
| 39520 | C | Repair of diaphragm hernia |
| 39530 | C | Repair of diaphragm hernia |
| 39531 | C | Repair of diaphragm hernia |
| 39540 | C | Repair of diaphragm hernia |
| 39541 | C | Repair of diaphragm hernia |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 39545 | C | Revision of diaphragm |
| 39560 | C | Resect diaphragm, simple |
| 39561 | C | Resect diaphragm, complex |
| 39599 | C | Diaphragm surgery procedure |
| 41130 | C | Partial removal of tongue |
| 41135 | C | Tongue and neck surgery |
| 41140 | C | Removal of tongue |
| 41145 | C | Tongue removal, neck surgery |
| 41150 | C | Tongue, mouth, jaw surgery |
| 41153 | C | Tongue, mouth, neck surgery |
| 41155 | C | Tongue, jaw, & neck surgery |
| 42426 | C | Excise parotid gland/lesion |
| 42845 | C | Extensive surgery of throat |
| 42894 | C | Revision of pharyngeal walls |
| 42953 | C | Repair throat, esophagus |
| 42961 | C | Control throat bleeding |
| 42971 | C | Control nose/throat bleeding |
| 43045 | C | Incision of esophagus |
| 43100 | C | Excision of esophagus lesion |
| 43101 | C | Excision of esophagus lesion |
| 43107 | C | Removal of esophagus |
| 43108 | C | Removal of esophagus |
| 43112 | C | Removal of esophagus |
| 43113 | C | Removal of esophagus |
| 43116 | C | Partial removal of esophagus |
| 43117 | C | Partial removal of esophagus |
| 43118 | C | Partial removal of esophagus |
| 43121 | C | Partial removal of esophagus |
| 43122 | C | Parital 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 congential |
| 43314 | C | Tracheo-esophagoplasty cong |
| 43320 | C | Fuse esophagus & stomach |
| 43324 | C | Revise esophagus & stomach |
| 43325 | C | Revise esophagus & stomach |
| 43326 | C | Revise esophagus & stomach |
| 43330 | C | Repair of esophagus |
| 43331 | C | Repair of esophagus |
| 43340 | C | Fuse esophagus & intestine |
| 43341 | C | Fuse esophagus & intestine |
| 43350 | C | Surgical opening, esophagus |
| 43351 | C | Surgical opening, esophagus |
| 43352 | C | Surgical opening, esophagus |
| 43360 | C | Gastrointestinal repair |
| 43361 | C | Gastrointestinal repair |
| 43400 | C | Ligate esophagus veins |
| 43401 | C | Esophagus surgery for veins |
| 43405 | C | Ligate/staple esophagus |
| 43410 | C | Repair esophagus wound |
| 43415 | C | Repair esophagus wound |
| 43420 | C | Repair esophagus opening |
| 43425 | C | Repair esophagus opening |
| 43460 | C | Pressure treatment esophagus |
| 43496 | C | Free jejunum flap, microvasc |
| 43500 | C | Surgical opening of stomach |
| 43501 | C | Surgical repair of stomach |
| 43502 | C | Surgical repair of stomach |
| 43510 | C | Surgical opening of stomach |
| 43520 | C | Incision of pyloric muscle |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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/taper, cong |
| 44127 | C | Enterectomy w/o 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 |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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 reservoir |
| 45540 | C | Correct rectal prolapse |
| 45541 | C | Correct rectal prolapse |
| 45550 | C | Repair rectum/remove sigmoid |
| 45562 | C | Exploration/repair of rectum |
| 45563 | C | Exploration/repair of rectum |
| 45800 | C | Repair rect/bladder fistula |
| 45805 | C | Repair fistula w/colostomy |
| 45820 | C | Repair rectourethral fistula |
| 45825 | C | Repair fistula w/colostomy |
| 46705 | C | Repair of anal stricture |
| 46715 | C | Repair of anovaginal fistula |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 46716 | C | Repair of anovaginal fistula |
| 46730 | C | Construction of absent anus |
| 46735 | C | Construction of absent anus |
| 46740 | C | Construction of absent anus |
| 46742 | C | Repair of imperforated anus |
| 46744 | C | Repair of cloacal anomaly |
| 46746 | C | Repair of cloacal anomaly |
| 46748 | C | Repair of cloacal anomaly |
| 46751 | C | Repair of anal sphincter |
| 47010 | C | Open drainage, liver lesion |
| 47015 | C | Inject/aspirate liver cyst |
| 47100 | C | Wedge biopsy of liver |
| 47120 | C | Partial removal of liver |
| 47122 | C | Extensive removal of liver |
| 47125 | C | Partial removal of liver |
| 47130 | C | Partial removal of liver |
| 47133 | C | Removal of donor liver |
| 47134 | C | Partial removal, donor liver |
| 47135 | C | Transplantation of liver |
| 47136 | C | Transplantation of liver |
| 47300 | C | Surgery for liver lesion |
| 47350 | C | Repair liver wound |
| 47360 | C | Repair liver wound |
| 47361 | C | Repair liver wound |
| 47362 | C | Repair liver wound |
| 47380 | C | Open ablate liver tumor rf |
| 47381 | C | Open ablate liver tumor cryo |
| 47400 | C | Incision of liver duct |
| 47420 | C | Incision of bile duct |
| 47425 | C | Incision of bile duct |
| 47460 | C | Incise bile duct sphincter |
| 47480 | C | Incision of gallbladder |
| 47550 | C | Bile duct endoscopy add-on |
| 47570 | C | Laparo cholecystoenterostomy |
| 47600 | C | Removal of gallbladder |
| 47605 | C | Removal of gallbladder |
| 47610 | C | Removal of gallbladder |
| 47612 | C | Removal of gallbladder |
| 47620 | C | Removal of gallbladder |
| 47700 | C | Exploration of bile ducts |
| 47701 | C | Bile duct revision |
| 47711 | C | Excision of bile duct tumor |
| 47712 | C | Excision of bile duct tumor |
| 47715 | C | Excision of bile duct cyst |
| 47716 | C | Fusion of bile duct cyst |
| 47720 | C | Fuse gallbladder & bowel |
| 47721 | C | Fuse upper gi structures |
| 47740 | C | Fuse gallbladder & bowel |
| 47741 | C | Fuse gallbladder & bowel |
| 47760 | C | Fuse bile ducts and bowel |
| 47765 | C | Fuse liver ducts & bowel |
| 47780 | C | Fuse bile ducts and bowel |
| 47785 | C | Fuse bile ducts and bowel |
| 47800 | C | Reconstruction of bile ducts |
| 47801 | C | Placement, bile duct support |
| 47802 | C | Fuse liver duct & intestine |
| 47900 | C | Suture bile duct injury |
| 48000 | C | Drainage of abdomen |
| 48001 | C | Placement of drain, pancreas |
| 48005 | C | Resect/debride pancreas |
| 48020 | C | Removal of pancreatic stone |
| 48100 | C | Biopsy of pancreas, open |
| 48120 | C | Removal of pancreas lesion |
| 48140 | C | Partial removal of pancreas |
| 48145 | C | Partial removal of pancreas |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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 | Removal of abdominal lesion |
| 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 |
| 50290 | C | Removal of kidney lesion |
| 50300 | C | Removal of donor kidney |
| 50320 | C | Removal of donor kidney |
| 50340 | C | Removal of kidney |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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 |
| 51565 | C | Revise bladder & ureter(s) |
| 51570 | C | Removal of bladder |
| 51575 | C | Removal of bladder & nodes |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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 | Remv/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 |
| 57305 | C | Repair rectum-vagina fistula |
| 57307 | C | Fistula repair & colostomy |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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 | Vaginal hysterectomy |
| 58263 | C | Vaginal hysterectomy |
| 58267 | C | Hysterectomy & vagina repair |
| 58270 | C | Hysterectomy & vagina 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 |
| 59850 | C | Abortion |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 59851 | C | Abortion |
| 59852 | C | Abortion |
| 59855 | C | Abortion |
| 59856 | C | Abortion |
| 59857 | C | Abortion |
| 60254 | C | Extensive thyroid surgery |
| 60270 | C | Removal of thyroid |
| 60271 | C | Removal of thyroid |
| 60502 | C | Re-explore parathyroids |
| 60505 | C | Explore parathyroid glands |
| 60520 | C | Removal of thymus gland |
| 60521 | C | Removal of thymus gland |
| 60522 | C | Removal of thymus gland |
| 60540 | C | Explore adrenal gland |
| 60545 | C | Explore adrenal gland |
| 60600 | C | Remove carotid body lesion |
| 60605 | C | Remove carotid body lesion |
| 60650 | C | Laparoscopy adrenalectomy |
| 61105 | C | Twist drill hole |
| 61107 | C | Drill skull for implantation |
| 61108 | C | Drill skull for drainage |
| 61120 | C | Burr hole for puncture |
| 61140 | C | Pierce skull for biopsy |
| 61150 | C | Pierce skull for drainage |
| 61151 | C | Pierce skull for drainage |
| 61154 | C | Pierce skull & remove clot |
| 61156 | C | Pierce skull for drainage |
| 61210 | C | Pierce skull, implant device |
| 61250 | C | Pierce skull & explore |
| 61253 | C | Pierce skull & explore |
| 61304 | C | Open skull for exploration |
| 61305 | C | Open skull for exploration |
| 61312 | C | Open skull for drainage |
| 61313 | C | Open skull for drainage |
| 61314 | C | Open skull for drainage |
| 61315 | C | Open skull for drainage |
| 61320 | C | Open skull for drainage |
| 61321 | C | Open skull for drainage |
| 61322 | C | Decompressive craniotomy |
| 61323 | C | Decompressive lobectomy |
| 61332 | C | Explore/biopsy eye socket |
| 61333 | C | Explore orbit/remove lesion |
| 61334 | C | Explore orbit/remove object |
| 61340 | C | Relieve cranial pressure |
| 61343 | C | Incise skull (press relief) |
| 61345 | C | Relieve cranial pressure |
| 61440 | C | Incise skull for surgery |
| 61450 | C | Incise skull for surgery |
| 61458 | C | Incise skull for brain wound |
| 61460 | C | Incise skull for surgery |
| 61470 | C | Incise skull for surgery |
| 61480 | C | Incise skull for surgery |
| 61490 | C | Incise skull for surgery |
| 61500 | C | Removal of skull lesion |
| 61501 | C | Remove infected skull bone |
| 61510 | C | Removal of brain lesion |
| 61512 | C | Remove brain lining lesion |
| 61514 | C | Removal of brain abscess |
| 61516 | C | Removal of brain lesion |
| 61518 | C | Removal of brain lesion |
| 61519 | C | Remove brain lining lesion |
| 61520 | C | Removal of brain lesion |
| 61521 | C | Removal of brain lesion |
| 61522 | C | Removal of brain abscess |
| 61524 | C | Removal of brain lesion |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 61526 | C | Removal of brain lesion |
| 61530 | C | Removal of brain lesion |
| 61531 | C | Implant brain electrodes |
| 61533 | C | Implant brain electrodes |
| 61534 | C | Removal of brain lesion |
| 61535 | C | Remove brain electrodes |
| 61536 | C | Removal of brain lesion |
| 61538 | C | Removal of brain tissue |
| 61539 | C | Removal of brain tissue |
| 61541 | C | Incision of brain tissue |
| 61542 | C | Removal of brain tissue |
| 61543 | C | Removal of brain tissue |
| 61544 | C | Remove & treat brain lesion |
| 61545 | C | Excision of brain tumor |
| 61546 | C | Removal of pituitary gland |
| 61548 | C | Removal of pituitary gland |
| 61550 | C | Release of skull seams |
| 61552 | C | Release of skull seams |
| 61556 | C | Incise skull/sutures |
| 61557 | C | Incise skull/sutures |
| 61558 | C | Excision of skull/sutures |
| 61559 | C | Excision of skull/sutures |
| 61563 | C | Excision of skull tumor |
| 61564 | C | Excision of skull tumor |
| 61570 | C | Remove foreign body, brain |
| 61571 | C | Incise skull for brain wound |
| 61575 | C | Skull base/brainstem surgery |
| 61576 | C | Skull base/brainstem surgery |
| 61580 | C | Craniofacial approach, skull |
| 61581 | C | Craniofacial approach, skull |
| 61582 | C | Craniofacial approach, skull |
| 61583 | C | Craniofacial approach, skull |
| 61584 | C | Orbitocranial approach/skull |
| 61585 | C | Orbitocranial approach/skull |
| 61586 | C | Resect nasopharynx, skull |
| 61590 | C | Infratemporal approach/skull |
| 61591 | C | Infratemporal approach/skull |
| 61592 | C | Orbitocranial approach/skull |
| 61595 | C | Transtemporal approach/skull |
| 61596 | C | Transcochlear approach/skull |
| 61597 | C | Transcondylar approach/skull |
| 61598 | C | Transpetrosal approach/skull |
| 61600 | C | Resect/excise cranial lesion |
| 61601 | C | Resect/excise cranial lesion |
| 61605 | C | Resect/excise cranial lesion |
| 61606 | C | Resect/excise cranial lesion |
| 61607 | C | Resect/excise cranial lesion |
| 61608 | C | Resect/excise cranial lesion |
| 61609 | C | Transect artery, sinus |
| 61610 | C | Transect artery, sinus |
| 61611 | C | Transect artery, sinus |
| 61612 | C | Transect artery, sinus |
| 61613 | C | Remove aneurysm, sinus |
| 61615 | C | Resect/excise lesion, skull |
| 61616 | C | Resect/excise lesion, skull |
| 61618 | C | Repair dura |
| 61619 | C | Repair dura |
| 61624 | C | Occlusion/embolization cath |
| 61680 | C | Intracranial vessel surgery |
| 61682 | C | Intracranial vessel surgery |
| 61684 | C | Intracranial vessel surgery |
| 61686 | C | Intracranial vessel surgery |
| 61690 | C | Intracranial vessel surgery |
| 61692 | C | Intracranial vessel surgery |
| 61697 | C | Brain aneurysm repr, complx |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 61698 | C | Brain aneurysm repr, complx |
| 61700 | C | Brain aneurysm repr , simple |
| 61702 | C | Inner skull vessel surgery |
| 61703 | C | Clamp neck artery |
| 61705 | C | Revise circulation to head |
| 61708 | C | Revise circulation to head |
| 61710 | C | Revise circulation to head |
| 61711 | C | Fusion of skull arteries |
| 61720 | C | Incise skull/brain surgery |
| 61735 | C | Incise skull/brain surgery |
| 61750 | C | Incise skull/brain biopsy |
| 61751 | C | Brain biopsy w/ ct/mr guide |
| 61760 | C | Implant brain electrodes |
| 61770 | C | Incise skull for treatment |
| 61850 | C | Implant neuroelectrodes |
| 61860 | C | Implant neuroelectrodes |
| 61862 | C | Implant neurostimul, subcort |
| 61870 | C | Implant neuroelectrodes |
| 61875 | C | Implant neuroelectrodes |
| 62000 | C | Treat skull fracture |
| 62005 | C | Treat skull fracture |
| 62010 | C | Treatment of head injury |
| 62100 | C | Repair brain fluid leakage |
| 62115 | C | Reduction of skull defect |
| 62116 | C | Reduction of skull defect |
| 62117 | C | Reduction of skull defect |
| 62120 | C | Repair skull cavity lesion |
| 62121 | C | Incise skull repair |
| 62140 | C | Repair of skull defect |
| 62141 | C | Repair of skull defect |
| 62142 | C | Remove skull plate/flap |
| 62143 | C | Replace skull plate/flap |
| 62145 | C | Repair of skull & brain |
| 62146 | C | Repair of skull with graft |
| 62147 | C | Repair of skull with graft |
| 62161 | C | Dissect brain w/scope |
| 62162 | C | Remove colloid cyst w/scope |
| 62163 | C | Neuroendoscopy w/fb removal |
| 62164 | C | Remove brain tumor w/scope |
| 62165 | C | Remove pituit tumor w/scope |
| 62180 | C | Establish brain cavity shunt |
| 62190 | C | Establish brain cavity shunt |
| 62192 | C | Establish brain cavity shunt |
| 62200 | C | Establish brain cavity shunt |
| 62201 | C | Establish brain cavity shunt |
| 62220 | C | Establish brain cavity shunt |
| 62223 | C | Establish brain cavity shunt |
| 62256 | C | Remove brain cavity shunt |
| 62258 | C | Replace brain cavity shunt |
| 63043 | C | Laminotomy, addl cervical |
| 63044 | C | Laminotomy, addl lumbar |
| 63075 | C | Neck spine disk surgery |
| 63076 | C | Neck spine disk surgery |
| 63077 | C | Spine disk surgery, thorax |
| 63078 | C | Spine disk surgery, thorax |
| 63081 | C | Removal of vertebral body |
| 63082 | C | Remove vertebral body add-on |
| 63085 | C | Removal of vertebral body |
| 63086 | C | Remove vertebral body add-on |
| 63087 | C | Removal of vertebral body |
| 63088 | C | Remove vertebral body add-on |
| 63090 | C | Removal of vertebral body |
| 63091 | C | Remove vertebral body add-on |
| 63170 | C | Incise spinal cord tract(s) |
| 63172 | C | Drainage of spinal cyst |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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 |
| 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 |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 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 |
| 94652 | C | Pressure breathing (IPPB) |
| 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 |
| 99297 | 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 |
| 0001T | C | Endovas repr abdo ao aneurys |
| 0002T | C | Endovas repr abdo ao aneurys |
| 0005T | C | Perc cath stent/brain cv art |
| 0006T | C | Perc cath stent/brain cv art |
| 0007T | C | Perc cath stent/brain cv art |
| 00174 | C | Anesth, pharyngeal surgery |
| 00176 | C | Anesth, pharyngeal surgery |
| 00192 | C | Anesth, facial bone surgery |
| 00214 | C | Anesth, skull drainage |
| 00215 | C | Anesth, skull repair/fract |
| 0021T | C | Fetal oximetry, trnsvag/cerv |
| 0024T | C | Transcath cardiac reduction |
| 0033T | C | Endovasc taa repr incl subcl |
| 0034T | C | Endovasc taa repr w/o subcl |
| 0035T | C | Insert endovasc prosth, taa |
| 0036T | C | Endovasc prosth, taa, add-on |
| 0037T | C | Artery transpose/endovas taa |
| 0038T | C | Rad endovasc taa rpr w/cover |
| 0039T | C | Rad s/i, endovasc taa repair |
| 00404 | C | Anesth, surgery of breast |
| 00406 | C | Anesth, surgery of breast |
| 0040T | C | Rad s/i, endovasc taa prosth |
| 00452 | C | Anesth, surgery of shoulder |
| 00474 | C | Anesth, surgery of rib(s) |
| 00524 | C | Anesth, chest drainage |
| 00540 | C | Anesth, chest surgery |
| 00542 | C | Anesth, release of lung |
| 00544 | C | Anesth, chest lining removal |
| 00546 | C | Anesth, lung,chest wall surg |
| 00560 | C | Anesth, open heart surgery |

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ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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| CPT/HCPCS | Status indicator | Description |
|---|---|---|
| 00562 | C | Anesth, open heart surgery |
| 00580 | C | Anesth heart/lung transplant |
| 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 |

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ADDENDUM H.—WAGE INDEX FOR URBAN AREAS

| Urban area (constituent counties) | Wage index |
|---|---|
| 0040 Abilene, TX [2] | 0.7827 |
| Taylor, TX | |
| 0060 Aguadilla, PR | 0.4587 |
| Aguada, PR | |
| Aguadilla, PR | |
| Moca, PR | |
| 0080 Akron, OH | 0.9600 |
| Portage, OH | |
| Summit, OH | |
| 0120 Albany, GA | 1.0594 |
| Dougherty, GA | |
| Lee, GA | |
| 0160 Albany-Schenectady-Troy, NY [2] | 0.8542 |
| Albany, NY | |
| Montgomery, NY | |
| Rensselaer, NY | |
| Saratoga, NY | |
| Schenectady, NY | |
| Schoharie, NY | |
| 0200 Albuquerque, NM | 0.9390 |
| Bernalillo, NM | |
| Sandoval, NM | |
| Valencia, NM | |
| 0220 Alexandria, LA | 0.7883 |
| Rapides, LA | |
| 0240 Allentown-Bethlehem-Easton, PA | 0.9735 |
| Carbon, PA | |
| Lehigh, PA | |
| Northampton, PA | |
| 0280 Altoona, PA | 0.9225 |
| Blair, PA | |
| 0320 Amarillo, TX | 0.9034 |
| Potter, TX | |
| Randall, TX | |
| 0380 Anchorage, AK | 1.2490 |
| Anchorage, AK | |
| 0440 Ann Arbor, MI | 1.1103 |
| Lenawee, MI | |
| Livingston, MI | |
| Washtenaw, MI | |
| 0450 Anniston, AL | 0.8044 |
| Calhoun, AL | |
| 0460 Appleton-Oshkosh-Neenah, WI [2] | 0.9162 |
| Calumet, WI | |
| Outagamie, WI | |
| Winnebago, WI | |
| 0470 Arecibo, PR [2] | 0.4356 |
| Arecibo, PR | |
| Camuy, PR | |
| Hatillo, PR | |
| 0480 Asheville, NC | 0.9876 |
| Buncombe, NC | |
| Madison, NC | |
| 0500 Athens, GA | 1.0211 |
| Clarke, GA | |
| Madison, GA | |
| Oconee, GA | |
| 0520 Atlanta, GA [1] | 0.9991 |
| 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 | 1.1017 |
| Atlantic, NJ | |
| Cape May, NJ | |
| 0580 Auburn-Opelika, AL | 0.8325 |
| Lee, AL | |
| 0600 Augusta-Aiken, GA-SC | 1.0264 |
| Columbia, GA | |
| McDuffie, GA | |
| Richmond, GA | |
| Aiken, SC | |
| Edgefield, SC | |
| 0640 Austin-San Marcos, TX [1] | 0.9637 |
| Bastrop, TX | |
| Caldwell, TX | |
| Hays, TX | |
| Travis, TX | |
| Williamson, TX | |
| 0680 Bakersfield, CA | 0.9899 |
| Kern, CA | |
| 0720 Baltimore, MD [1] | 0.9929 |
| Anne Arundel, MD | |
| Baltimore, MD | |
| Baltimore City, MD | |
| Carroll, MD | |
| Harford, MD | |
| Howard, MD | |
| Queen Anne's, MD | |
| 0733 Bangor, ME | 0.9664 |
| Penobscot, ME | |
| 0743 Barnstable-Yarmouth, MA | 1.3202 |
| Barnstable, MA | |
| 0760 Baton Rouge, LA | 0.8294 |
| Ascension, LA | |
| East Baton Rouge, LA | |
| Livingston, LA | |
| West Baton Rouge, LA | |
| 0840 Beaumont-Port Arthur, TX | 0.8324 |
| Hardin, TX | |
| Jefferson, TX | |
| Orange, TX | |
| 0860 Bellingham, WA | 1.2282 |
| Whatcom, WA | |
| 0870 Benton Harbor, MI | 0.9106 |
| Berrien, MI | |
| 0875 Bergen-Passaic, NJ [1] | 1.2207 |
| Bergen, NJ | |
| Passaic, NJ | |
| 0880 Billings, MT | 0.9022 |
| Yellowstone, MT | |
| 0920 Biloxi-Gulfport-Pascagoula, MS | 0.8757 |
| Hancock, MS | |
| Harrison, MS | |
| Jackson, MS | |
| 0960 Binghamton, NY [2] | 0.8542 |
| Broome, NY | |
| Tioga, NY | |
| 1000 Birmingham, AL | 0.9222 |
| Blount, AL | |
| Jefferson, AL | |
| St. Clair, AL | |

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| Shelby, AL | |
| 1010 Bismarck, ND | 0.7972 |
| Burleigh, ND | |
| Morton, ND | |
| 1020 Bloomington, IN | 0.8907 |
| Monroe, IN | |
| 1040 Bloomington-Normal, IL | 0.9109 |
| McLean, IL | |
| 1080 Boise City, ID | 0.9310 |
| Ada, ID | |
| Canyon, ID | |
| 1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (MA Hospitals) [1 2] | 1.1288 |
| Bristol, MA | |
| Essex, MA | |
| Middlesex, MA | |
| Norfolk, MA | |
| Plymouth, MA | |
| Suffolk, MA | |
| Worcester, MA | |
| Hillsborough, NH | |
| Merrimack, NH | |
| Rockingham, NH | |
| Strafford, NH | |
| 1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (NH Hospitals) [1] | 1.1235 |
| 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 | 0.9689 |
| Boulder, CO | |
| 1145 Brazoria, TX | 0.8535 |
| Brazoria, TX | |
| 1150 Bremerton, WA | 1.0944 |
| Kitsap, WA | |
| 1240 Brownsville-Harlingen-San Benito, TX | 0.8880 |
| Cameron, TX | |
| 1260 Bryan-College Station, TX | 0.8821 |
| Brazos, TX | |
| 1280 Buffalo-Niagara Falls, NY [1] | 0.9365 |
| Erie, NY | |
| Niagara, NY | |
| 1303 Burlington, VT | 1.0052 |
| Chittenden, VT | |
| Franklin, VT | |
| Grand Isle, VT | |
| 1310 Caguas, PR | 0.4408 |
| Caguas, PR | |
| Cayey, PR | |
| Cidra, PR | |
| Gurabo, PR | |
| San Lorenzo, PR | |
| 1320 Canton-Massillon, OH | 0.8932 |
| Carroll, OH | |
| Stark, OH | |
| 1350 Casper, WY | 0.9690 |
| Natrona, WY | |
| 1360 Cedar Rapids, IA | 0.9056 |
| Linn, IA | |

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| 1400 Champaign-Urbana, IL | 1.0635 |
| Champaign, IL | |
| 1440 Charleston-North Charleston, SC | 0.9235 |
| Berkeley, SC | |
| Charleston, SC | |
| Dorchester, SC | |
| 1480 Charleston, WV | 0.8898 |
| Kanawha, WV | |
| Putnam, WV | |
| 1520 Charlotte-Gastonia-Rock Hill, NC-SC [1] | 0.9850 |
| Cabarrus, NC | |
| Gaston, NC | |
| Lincoln, NC | |
| Mecklenburg, NC | |
| Rowan, NC | |
| Stanly, NC | |
| Union, NC | |
| York, SC | |
| 1540 Charlottesville, VA | 1.0438 |
| Albemarle, VA | |
| Charlottesville City, VA | |
| Fluvanna, VA | |
| Greene, VA | |
| 1560 Chattanooga, TN-GA | 0.8976 |
| Catoosa, GA | |
| Dade, GA | |
| Walker, GA | |
| Hamilton, TN | |
| Marion, TN | |
| 1580 Cheyenne, WY [2] | 0.9007 |
| Laramie, WY | |
| 1600 Chicago, IL [1] | 1.1044 |
| Cook, IL | |
| DeKalb, IL | |
| DuPage, IL | |
| Grundy, IL | |
| Kane, IL | |
| Kendall, IL | |
| Lake, IL | |
| McHenry, IL | |
| Will, IL | |
| 1620 Chico-Paradise, CA [2] | 0.9840 |
| Butte, CA | |
| 1640 Cincinnati, OH-KY-IN [1] | 0.9389 |
| 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 | 0.8419 |
| Christian, KY | |
| Montgomery, TN | |
| 1680 Cleveland-Lorain-Elyria, OH [1] | 0.9670 |
| Ashtabula, OH | |
| Cuyahoga, OH | |
| Geauga, OH | |
| Lake, OH | |
| Lorain, OH | |
| Medina, OH | |

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| 1720 Colorado Springs, CO | 0.9916 |
| El Paso, CO | |
| 1740 Columbia, MO | 0.8515 |
| Boone, MO | |
| 1760 Columbia, SC | 0.9307 |
| Lexington, SC | |
| Richland, SC | |
| 1800 Columbus, GA-AL | 0.8374 |
| Russell, AL | |
| Chattahoochee, GA | |
| Harris, GA | |
| Muscogee, GA | |
| 1840 Columbus, OH [1] | 0.9751 |
| Delaware, OH | |
| Fairfield, OH | |
| Franklin, OH | |
| Licking, OH | |
| Madison, OH | |
| Pickaway, OH | |
| 1880 Corpus Christi, TX | 0.8729 |
| Nueces, TX | |
| San Patricio, TX | |
| 1890 Corvallis, OR | 1.1453 |
| Benton, OR | |
| 1900 Cumberland, MD-WV (MD Hospitals) [2] | 0.8946 |
| Allegany, MD | |
| Mineral, WV | |
| 1900 Cumberland, MD-WV (WV Hospitals) [2] | 0.7975 |
| Allegany, MD | |
| Mineral, WV | |
| 1920 Dallas, TX [1] | 0.9998 |
| Collin, TX | |
| Dallas, TX | |
| Denton, TX | |
| Ellis, TX | |
| Henderson, TX | |
| Hunt, TX | |
| Kaufman, TX | |
| Rockwall, TX | |
| 1950 Danville, VA | 0.8859 |
| Danville City, VA | |
| Pittsylvania, VA | |
| 1960 Davenport-Moline-Rock Island, IA-IL | 0.8835 |
| Scott, IA | |
| Henry, IL | |
| Rock Island, IL | |
| 2000 Dayton-Springfield, OH | 0.9282 |
| Clark, OH | |
| Greene, OH | |
| Miami, OH | |
| Montgomery, OH | |
| 2020 Daytona Beach, FL | 0.9062 |
| Flagler, FL | |
| Volusia, FL | |
| 2030 Decatur, AL | 0.8973 |
| Lawrence, AL | |
| Morgan, AL | |
| 2040 Decatur, IL [2] | 0.8204 |
| Macon, IL | |
| 2080 Denver, CO [1] | 1.0601 |
| Adams, CO | |
| Arapahoe, CO | |
| Broomfield, CO | |
| Denver, CO | |
| Douglas, CO | |
| Jefferson, CO | |
| 2120 Des Moines, IA | 0.8827 |

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| Dallas, IA | |
| Polk, IA | |
| Warren, IA | |
| 2160 Detroit, MI [1] | 1.0448 |
| Lapeer, MI | |
| Macomb, MI | |
| Monroe, MI | |
| Oakland, MI | |
| St. Clair, MI | |
| Wayne, MI | |
| 2180 Dothan, AL | 0.8158 |
| Dale, AL | |
| Houston, AL | |
| 2190 Dover, DE | 0.9356 |
| Kent, DE | |
| 2200 Dubuque, IA | 0.8795 |
| Dubuque, IA | |
| 2240 Duluth-Superior, MN-WI | 1.0368 |
| St. Louis, MN | |
| Douglas, WI | |
| 2281 Dutchess County, NY | 1.0684 |
| Dutchess, NY | |
| 2290 Eau Claire, WI [2] | 0.9162 |
| Chippewa, WI | |
| Eau Claire, WI | |
| 2320 El Paso, TX | 0.9265 |
| El Paso, TX | |
| 2330 Elkhart-Goshen, IN | 0.9722 |
| Elkhart, IN | |
| 2335 Elmira, NY [2] | 0.8542 |
| Chemung, NY | |
| 2340 Enid, OK | 0.8376 |
| Garfield, OK | |
| 2360 Erie, PA | 0.8925 |
| Erie, PA | |
| 2400 Eugene-Springfield, OR | 1.0944 |
| Lane, OR | |
| 2440 Evansville-Henderson, IN-KY (IN Hospitals) [2] | 0.8755 |
| Posey, IN | |
| Vanderburgh, IN | |
| Warrick, IN | |
| Henderson, KY | |
| 2440 Evansville-Henderson, IN-KY (KY Hospitals) | 0.8177 |
| Posey, IN | |
| Vanderburgh, IN | |
| Warrick, IN | |
| Henderson, KY | |
| 2520 Fargo-Moorhead, ND-MN | 0.9684 |
| Clay, MN | |
| Cass, ND | |
| 2560 Fayetteville, NC | 0.8992 |
| Cumberland, NC | |
| 2580 Fayetteville-Springdale-Rogers, AR | 0.8100 |
| Benton, AR | |
| Washington, AR | |
| 2620 Flagstaff, AZ-UT | 1.0682 |
| Coconino, AZ | |
| Kane, UT | |
| 2640 Flint, MI | 1.1135 |
| Genesee, MI | |
| 2650 Florence, AL | 0.7819 |
| Colbert, AL | |
| Lauderdale, AL | |
| 2655 Florence, SC | 0.8780 |
| Florence, SC | |
| 2670 Fort Collins-Loveland, CO | 1.0066 |
| Larimer, CO | |

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| 2680 Ft. Lauderdale, FL [1] | 1.0704 |
| Broward, FL | |
| 2700 Fort Myers-Cape Coral, FL | 0.9680 |
| Lee, FL | |
| 2710 Fort Pierce-Port St. Lucie, FL | 0.9931 |
| Martin, FL | |
| St. Lucie, FL | |
| 2720 Fort Smith, AR-OK | 0.7895 |
| Crawford, AR | |
| Sebastian, AR | |
| Sequoyah, OK | |
| 2750 Fort Walton Beach, FL | 0.9693 |
| Okaloosa, FL | |
| 2760 Fort Wayne, IN | 0.9457 |
| Adams, IN | |
| Allen, IN | |
| De Kalb, IN | |
| Huntington, IN | |
| Wells, IN | |
| Whitley, IN | |
| 2800 Forth Worth-Arlington, TX [1] | 0.9446 |
| Hood, TX | |
| Johnson, TX | |
| Parker, TX | |
| Tarrant, TX | |
| 2840 Fresno, CA | 1.0216 |
| Fresno, CA | |
| Madera, CA | |
| 2880 Gadsden, AL | 0.8599 |
| Etowah, AL | |
| 2900 Gainesville, FL | 0.9871 |
| Alachua, FL | |
| 2920 Galveston-Texas City, TX | 0.9465 |
| Galveston, TX | |
| 2960 Gary, IN | 0.9584 |
| Lake, IN | |
| Porter, IN | |
| 2975 Glens Falls, NY [2] | 0.8542 |
| Warren, NY | |
| Washington, NY | |
| 2980 Goldsboro, NC Wayne, NC | 0.8892 |
| 2985 Grand Forks, ND-MN | 0.9243 |
| Polk, MN | |
| Grand Forks, ND | |
| 2995 Grand Junction, CO | 0.9679 |
| Mesa, CO | |
| 3000 Grand Rapids-Muskegon-Holland, MI [1] | 0.9548 |
| Allegan, MI | |
| Kent, MI | |
| Muskegon, MI | |
| Ottawa, MI | |
| 3040 Great Falls, MT | 0.8966 |
| Cascade, MT | |
| 3060 Greeley, CO | 0.9336 |
| Weld, CO | |
| 3080 Green Bay, WI | 0.9668 |
| Brown, WI | |
| 3120 Greensboro-Winston-Salem-High Point, NC [1] | 0.9282 |
| Alamance, NC | |
| Davidson, NC | |
| Davie, NC | |
| Forsyth, NC | |
| Guilford, NC | |
| Randolph, NC | |
| Stokes, NC | |
| Yadkin, NC | |
| 3150 Greenville, NC | 0.9174 |

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| Pitt, NC | |
| 3160 Greenville-Spartanburg-Anderson, SC | 0.9122 |
| Anderson, SC | |
| Cherokee, SC | |
| Greenville, SC | |
| Pickens, SC | |
| Spartanburg, SC | |
| 3180 Hagerstown, MD | 0.9268 |
| Washington, MD | |
| 3200 Hamilton-Middletown, OH | 0.9418 |
| Butler, OH | |
| 3240 Harrisburg-Lebanon-Carlisle, PA | 0.9223 |
| Cumberland, PA | |
| Dauphin, PA | |
| Lebanon, PA | |
| Perry, PA | |
| 3283 Hartford, CT [1 2] | 1.2394 |
| Hartford, CT | |
| Litchfield, CT | |
| Middlesex, CT | |
| Tolland, CT | |
| 3285 Hattiesburg, MS [2] | 0.7680 |
| Forrest, MS | |
| Lamar, MS | |
| 3290 Hickory-Morganton-Lenoir, NC | 0.9028 |
| Alexander, NC | |
| Burke, NC | |
| Caldwell, NC | |
| Catawba, NC | |
| 3320 Honolulu, HI | 1.1457 |
| Honolulu, HI | |
| 3350 Houma, LA | 0.8385 |
| Lafourche, LA | |
| Terrebonne, LA | |
| 3360 Houston, TX [1] | 0.9892 |
| Chambers, TX | |
| Fort Bend, TX | |
| Harris, TX | |
| Liberty, TX | |
| Montgomery, TX | |
| Waller, TX | |
| 3400 Huntington-Ashland, WV-KY-OH | 0.9636 |
| Boyd, KY | |
| Carter, KY | |
| Greenup, KY | |
| Lawrence, OH | |
| Cabell, WV | |
| Wayne, WV | |
| 3440 Huntsville, AL | 0.8903 |
| Limestone, AL | |
| Madison, AL | |
| 3480 Indianapolis, IN [1] | 0.9717 |
| Boone, IN | |
| Hamilton, IN | |
| Hancock, IN | |
| Hendricks, IN | |
| Johnson, IN | |
| Madison, IN | |
| Marion, IN | |
| Morgan, IN | |
| Shelby, IN | |
| 3500 Iowa City, IA | 0.9587 |
| Johnson, IA | |
| 3520 Jackson, MI | 0.9532 |
| Jackson, MI | |
| 3560 Jackson, MS | 0.8607 |

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| Hinds, MS | |
| Madison, MS | |
| Rankin, MS | |
| 3580 Jackson, TN | 0.9275 |
| Madison, TN | |
| Chester, TN | |
| 3600 Jacksonville, FL [1] | 0.9381 |
| Clay, FL | |
| Duval, FL | |
| Nassau, FL | |
| St. Johns, FL | |
| 3605 Jacksonville, NC [2] | 0.8666 |
| Onslow, NC | |
| 3610 Jamestown, NY [2] | 0.8542 |
| Chautauqua, NY | |
| 3620 Janesville-Beloit, WI | 0.9849 |
| Rock, WI | |
| 3640 Jersey City, NJ | 1.1190 |
| Hudson, NJ | |
| 3660 Johnson City-Kingsport-Bristol, TN-VA (TN Hospitals) | 0.8337 |
| Carter, TN | |
| Hawkins, TN | |
| Sullivan, TN | |
| Unicoi, TN | |
| Washington, TN | |
| Bristol City, VA | |
| Scott, VA | |
| Washington, VA | |
| 3660 Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals) [2] | 0.8504 |
| Carter, TN | |
| Hawkins, TN | |
| Sullivan, TN | |
| Unicoi, TN | |
| Washington, TN | |
| Bristol City, VA | |
| Scott, VA | |
| Washington, VA | |
| 3680 Johnstown, PA [2] | 0.8462 |
| Cambria, PA | |
| Somerset, PA | |
| 3700 Jonesboro, AR | 0.7843 |
| Craighead, AR | |
| 3710 Joplin, MO | 0.8613 |
| Jasper, MO | |
| Newton, MO | |
| 3720 Kalamazoo-Battlecreek, MI | 1.0595 |
| Calhoun, MI | |
| Kalamazoo, MI | |
| Van Buren, MI | |
| 3740 Kankakee, IL [2] | 0.8204 |
| Kankakee, IL | |
| 3760 Kansas City, KS-MO [1] | 0.9736 |
| 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 | 0.9686 |
| Kenosha, WI | |
| 3810 Killeen-Temple, TX | 0.9570 |
| Bell, TX | |
| Coryell, TX | |
| 3840 Knoxville, TN | 0.8970 |
| Anderson, TN | |
| Blount, TN | |
| Knox, TN | |
| Loudon, TN | |
| Sevier, TN | |
| Union, TN | |
| 3850 Kokomo, IN | 0.9038 |
| Howard, IN | |
| Tipton, IN | |
| 3870 La Crosse, WI-MN | 0.9400 |
| Houston, MN | |
| La Crosse, WI | |
| 3880 Lafayette, LA | 0.8475 |
| Acadia, LA | |
| Lafayette, LA | |
| St. Landry, LA | |
| St. Martin, LA | |
| 3920 Lafayette, IN | 0.9278 |
| Clinton, IN | |
| Tippecanoe, IN | |
| 3960 Lake Charles, LA | 0.7965 |
| Calcasieu, LA | |
| 3980 Lakeland-Winter Haven, FL | 0.9357 |
| Polk, FL | |
| 4000 Lancaster, PA | 0.9078 |
| Lancaster, PA | |
| 4040 Lansing-East Lansing, MI | 0.9726 |
| Clinton, MI | |
| Eaton, MI | |
| Ingham, MI | |
| 4080 Laredo, TX | 0.8472 |
| Webb, TX | |
| 4100 Las Cruces, NM [2] | 0.8872 |
| Dona Ana, NM | |
| 4120 Las Vegas, NV-AZ [1] | 1.1521 |
| Mohave, AZ | |
| Clark, NV | |
| Nye, NV | |
| 4150 Lawrence, KS | 0.7923 |
| Douglas, KS | |
| 4200 Lawton, OK | 0.8315 |
| Comanche, OK | |
| 4243 Lewiston-Auburn, ME | 0.9179 |
| Androscoggin, ME | |
| 4280 Lexington, KY | 0.8581 |
| Bourbon, KY | |
| Clark, KY | |
| Fayette, KY | |
| Jessamine, KY | |
| Madison, KY | |
| Scott, KY | |
| Woodford, KY | |
| 4320 Lima, OH | 0.9483 |
| Allen, OH | |
| Auglaize, OH | |
| 4360 Lincoln, NE | 0.9892 |
| Lancaster, NE | |
| 4400 Little Rock-North Little Rock, AR | 0.9097 |
| Faulkner, AR | |
| Lonoke, AR | |
| Pulaski, AR | |
| Saline, AR | |
| 4420 Longview-Marshall, TX | 0.8629 |
| Gregg, TX | |
| Harrison, TX | |
| Upshur, TX | |
| 4480 Los Angeles-Long Beach, CA [1] | 1.2011 |
| Los Angeles, CA | |
| 4520 Louisville, KY-IN [1] | 0.9276 |
| Clark, IN | |
| Floyd, IN | |
| Harrison, IN | |
| Scott, IN | |
| Bullitt, KY | |
| Jefferson, KY | |
| Oldham, KY | |
| 4600 Lubbock, TX | 0.9646 |
| Lubbock, TX | |
| 4640 Lynchburg, VA | 0.9219 |
| Amherst, VA | |
| Bedford, VA | |
| Bedford City, VA | |
| Campbell, VA | |
| Lynchburg City, VA | |
| 4680 Macon, GA | 0.9250 |
| Bibb, GA | |
| Houston, GA | |
| Jones, GA | |
| Peach, GA | |
| Twiggs, GA | |
| 4720 Madison, WI | 1.0467 |
| Dane, WI | |
| 4800 Mansfield, OH | 0.8900 |
| Crawford, OH | |
| Richland, OH | |
| 4840 Mayaguez, PR | 0.4914 |
| Anasco, PR | |
| Cabo Rojo, PR | |
| Hormigueros, PR | |
| Mayaguez, PR | |
| Sabana Grande, PR | |
| San German, PR | |
| 4880 McAllen-Edinburg-Mission, TX | 0.8428 |
| Hidalgo, TX | |
| 4890 Medford-Ashland, OR | 1.0498 |
| Jackson, OR | |
| 4900 Melbourne-Titusville-Palm Bay, FL | 1.0253 |
| Brevard, Fl | |
| 4920 Memphis, TN-AR-MS [1] | 0.8920 |
| Crittenden, AR | |
| DeSoto, MS | |
| Fayette, TN | |
| Shelby, TN | |
| Tipton, TN | |
| 4940 Merced, CA [2] | 0.9840 |
| Merced, CA | |
| 5000 Miami, FL [1] | 0.9815 |
| Dade, FL | |
| 5015 Middlesex-Somerset-Hunterdon, NJ [1] | 1.1213 |
| Hunterdon, NJ | |
| Middlesex, NJ | |
| Somerset, NJ | |
| 5080 Milwaukee-Waukesha, WI [1] | 0.9893 |
| Milwaukee, WI | |
| Ozaukee, WI | |
| Washington, WI | |
| Waukesha, WI | |
| 5120 Minneapolis-St. Paul, MN-WI [1] | 1.0903 |
| Anoka, MN | |
| Carver, MN | |
| Chisago, MN | |
| Dakota, MN | |
| Hennepin, MN | |

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| Isanti, MN | |
| Ramsey, MN | |
| Scott, MN | |
| Sherburne, MN | |
| Washington, MN | |
| Wright, MN | |
| Pierce, WI | |
| St. Croix, WI | |
| 5140 Missoula, MT | 0.9157 |
| Missoula, MT | |
| 5160 Mobile, AL | 0.8110 |
| Baldwin, AL | |
| Mobile, AL | |
| 5170 Modesto, CA | 1.0498 |
| Stanislaus, CA | |
| 5190 Monmouth-Ocean, NJ [1] | 1.0814 |
| Monmouth, NJ | |
| Ocean, NJ | |
| 5200 Monroe, LA | 0.8137 |
| Ouachita, LA | |
| 5240 Montgomery, AL | 0.7734 |
| Autauga, AL | |
| Elmore, AL | |
| Montgomery, AL | |
| 5280 Muncie, IN | 0.9284 |
| Delaware, IN | |
| 5330 Myrtle Beach, SC | 0.8976 |
| Horry, SC | |
| 5345 Naples, FL | 0.9754 |
| Collier, FL | |
| 5360 Nashville, TN [1] | 0.9578 |
| Cheatham, TN | |
| Davidson, TN | |
| Dickson, TN | |
| Robertson, TN | |
| Rutherford TN | |
| Sumner, TN | |
| Williamson, TN | |
| Wilson, TN | |
| 5380 Nassau-Suffolk, NY [1] | 1.3357 |
| Nassau, NY | |
| Suffolk, NY | |
| 5483 New Haven-Bridgeport-Stamford-Waterbury- Danbury, CT [1] | 1.2459 |
| Fairfield, CT | |
| New Haven, CT | |
| 5523 New London-Norwich, CT [2] | 1.2394 |
| New London, CT | |
| 5560 New Orleans, LA [1] | 0.9046 |
| Jefferson, LA | |
| Orleans, LA | |
| Plaquemines, LA | |
| St. Bernard, LA | |
| St. Charles, LA | |
| St. James, LA | |
| St. John The Baptist, LA | |
| St. Tammany, LA | |
| 5600 New York, NY [1] | 1.4414 |
| Bronx, NY | |
| Kings, NY | |
| New York, NY | |
| Putnam, NY | |
| Queens, NY | |
| Richmond, NY | |
| Rockland, NY | |
| Westchester, NY | |
| 5640 Newark, NJ [1] | 1.1406 |
| Essex, NJ | |
| Morris, NJ | |
| Sussex, NJ | |
| Union, NJ | |
| Warren, NJ | |
| 5660 Newburgh, NY-PA | 1.1387 |
| Orange, NY | |
| Pike, PA | |
| 5720 Norfolk-Virginia Beach-Newport News, VA-NC [1] | 0.8574 |
| 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 Oakland, CA [1] | 1.5185 |
| Alameda, CA | |
| Contra Costa, CA | |
| 5790 Ocala, FL | 0.9402 |
| Marion, FL | |
| 5800 Odessa-Midland, TX | 0.9397 |
| Ector, TX | |
| Midland, TX | |
| 5880 Oklahoma City, OK [1] | 0.8900 |
| Canadian, OK | |
| Cleveland, OK | |
| Logan, OK | |
| McClain, OK | |
| Oklahoma, OK | |
| Pottawatomie, OK | |
| 5910 Olympia, WA | 1.0960 |
| Thurston, WA | |
| 5920 Omaha, NE-IA | 0.9978 |
| Pottawattamie, IA | |
| Cass, NE | |
| Douglas, NE | |
| Sarpy, NE | |
| Washington, NE | |
| 5945 Orange County, CA [1] | 1.1594 |
| Orange, CA | |
| 5960 Orlando, FL [1] | 0.9640 |
| Lake, FL | |
| Orange, FL | |
| Osceola, FL | |
| Seminole, FL | |
| 5990 Owensboro, KY | 0.8344 |
| Daviess, KY | |
| 6015 Panama City, FL | 0.8865 |
| Bay, FL | |
| 6020 Parkersburg-Marietta, WV-OH (WV Hospitals) | 0.8127 |
| Washington, OH | |
| Wood, WV | |
| 6020 Parkersburg-Marietta, WV-OH (OH Hospitals) [2] | 0.8613 |
| Washington, OH | |
| Wood, WV | |
| 6080 Pensacola, FL [2] | 0.8814 |
| Escambia, FL | |
| Santa Rosa, FL | |
| 6120 Peoria-Pekin, IL | 0.8739 |
| Peoria, IL | |
| Tazewell, IL | |
| Woodford, IL | |
| 6160 Philadelphia, PA-NJ [1] | 1.0713 |
| Burlington, NJ | |
| Camden, NJ | |
| Gloucester, NJ | |
| Salem, NJ | |
| Bucks, PA | |
| Chester, PA | |
| Delaware, PA | |
| Montgomery, PA | |
| Philadelphia, PA | |
| 6200 Phoenix-Mesa, AZ [1] | 0.9820 |
| Maricopa, AZ | |
| Pinal, AZ | |
| 6240 Pine Bluff, AR | 0.7962 |
| Jefferson, AR | |
| 6280 Pittsburgh, PA [1] | 0.9365 |
| Allegheny, PA | |
| Beaver, PA | |
| Butler, PA | |
| Fayette, PA | |
| Washington, PA | |
| Westmoreland, PA | |
| 6323 Pittsfield, MA [2] | 1.1288 |
| Berkshire, MA | |
| 6340 Pocatello, ID | 0.9674 |
| Bannock, ID | |
| 6360 Ponce, PR | 0.5169 |
| Guayanilla, PR | |
| Juana Diaz, PR | |
| Penuelas, PR | |
| Ponce, PR | |
| Villalba, PR | |
| Yauco, PR | |
| 6403 Portland, ME | 0.9794 |
| Cumberland, ME | |
| Sagadahoc, ME | |
| York, ME | |
| 6440 Portland-Vancouver, OR-WA [1] | 1.0684 |
| Clackamas, OR | |
| Columbia, OR | |
| Multnomah, OR | |
| Washington, OR | |
| Yamhill, OR | |
| Clark, WA | |
| 6483 Providence-Warwick-Pawtucket, RI [1] | 1.0854 |
| Bristol, RI | |
| Kent, RI | |
| Newport, RI | |
| Providence, RI | |
| Washington, RI | |
| 6520 Provo-Orem, UT | 0.9984 |
| Utah, UT | |
| 6560 Pueblo, CO [2] | 0.9015 |
| Pueblo, CO | |
| 6580 Punta Gorda, FL | 0.9218 |
| Charlotte, FL | |
| 6600 Racine, WI | 0.9334 |
| Racine, WI | |
| 6640 Raleigh-Durham-Chapel Hill, NC [1] | 0.9990 |
| Chatham, NC | |
| Durham, NC | |
| Franklin, NC | |
| Johnston, NC | |
| Orange, NC | |
| Wake, NC | |

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| 6660 Rapid City, SD | 0.8846 |
| Pennington, SD | |
| 6680 Reading, PA | 0.9295 |
| Berks, PA | |
| 6690 Redding, CA | 1.1135 |
| Shasta, CA | |
| 6720 Reno, NV | 1.0648 |
| Washoe, NV | |
| 6740 Richland-Kennewick-Pasco, WA | 1.1491 |
| Benton, WA | |
| Franklin, WA | |
| 6760 Richmond-Petersburg, VA | 0.9477 |
| Charles City County, VA | |
| Chesterfield, VA | |
| Colonial Heights City, VA | |
| Dinwiddie, VA | |
| Goochland, VA | |
| Hanover, VA | |
| Henrico, VA | |
| Hopewell City, VA | |
| New Kent, VA | |
| Petersburg City, VA | |
| Powhatan, VA | |
| Prince George, VA | |
| Richmond City, VA | |
| 6780 Riverside-San Bernardino, CA [1] | 1.1365 |
| Riverside, CA | |
| San Bernardino, CA | |
| 6800 Roanoke, VA | 0.8614 |
| Botetourt, VA | |
| Roanoke, VA | |
| Roanoke City, VA | |
| Salem City, VA | |
| 6820 Rochester, MN | 1.2139 |
| Olmsted, MN | |
| 6840 Rochester, NY [1] | 0.9194 |
| Genesee, NY | |
| Livingston, NY | |
| Monroe, NY | |
| Ontario, NY | |
| Orleans, NY | |
| Wayne, NY | |
| 6880 Rockford, IL | 0.9625 |
| Boone, IL | |
| Ogle, IL | |
| Winnebago, IL | |
| 6895 Rocky Mount, NC | 0.9228 |
| Edgecombe, NC | |
| Nash, NC | |
| 6920 Sacramento, CA [1] | 1.1513 |
| El Dorado, CA | |
| Placer, CA | |
| Sacramento, CA | |
| 6960 Saginaw-Bay City-Midland, MI | 0.9650 |
| Bay, MI | |
| Midland, MI | |
| Saginaw, MI | |
| 6980 St. Cloud, MN | 0.9785 |
| Benton, MN | |
| Stearns, MN | |
| 7000 St. Joseph, MO [2] | 0.8026 |
| Andrew, MO | |
| Buchanan, MO | |
| 7040 St. Louis, MO-IL [1] | 0.8855 |
| 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 | 1.0367 |
| Marion, OR | |
| Polk, OR | |
| 7120 Salinas, CA | 1.4623 |
| Monterey, CA | |
| 7160 Salt Lake City-Ogden, UT [1] | 0.9945 |
| Davis, UT | |
| Salt Lake, UT | |
| Weber, UT | |
| 7200 San Angelo, TX | 0.8374 |
| Tom Green, TX | |
| 7240 San Antonio, TX [1] | 0.8753 |
| Bexar, TX | |
| Comal, TX | |
| Guadalupe, TX | |
| Wilson, TX | |
| 7320 San Diego, CA [1] | 1.1135 |
| San Diego, CA | |
| 7360 San Francisco, CA [1] | 1.4142 |
| Marin, CA | |
| San Francisco, CA | |
| San Mateo, CA | |
| 7400 San Jose, CA [1] | 1.4145 |
| Santa Clara, CA | |
| 7440 San Juan-Bayamon, PR [1] | 0.4741 |
| Aguas Buenas, PR | |
| Barceloneta, PR | |
| Bayamon, PR | |
| Canovanas, PR | |
| Carolina, PR | |
| Catano, PR | |
| Ceiba, PR | |
| Comerio, PR | |
| Corozal, PR | |
| Dorado, PR | |
| Fajardo, PR | |
| Florida, PR | |
| Guaynabo, PR | |
| Humacao, PR | |
| Juncos, PR | |
| Los Piedras, PR | |
| Loiza, PR | |
| Luguillo, PR | |
| Manati, PR | |
| Morovis, PR | |
| Naguabo, PR | |
| Naranjito, PR | |
| Rio Grande, PR | |
| San Juan, PR | |
| Toa Alta, PR | |
| Toa Baja, PR | |
| Trujillo Alto, PR | |
| Vega Alta, PR | |
| Vega Baja, PR | |
| Yabucoa, PR | |
| 7460 San Luis Obispo-Atascadero-Paso Robles, CA | 1.1271 |
| San Luis Obispo, CA | |
| 7480 Santa Barbara-Santa Maria-Lompoc, CA | 1.0481 |
| Santa Barbara, CA | |
| 7485 Santa Cruz-Watsonville, CA | 1.3646 |
| Santa Cruz, CA | |
| 7490 Santa Fe, NM | 1.0712 |
| Los Alamos, NM | |
| Santa Fe, NM | |
| 7500 Santa Rosa, CA | 1.3046 |
| Sonoma, CA | |
| 7510 Sarasota-Bradenton, FL | 0.9449 |
| Manatee, FL | |
| Sarasota, FL | |
| 7520 Savannah, GA | 0.9376 |
| Bryan, GA | |
| Chatham, GA | |
| Effingham, GA | |
| 7560 Scranton--Wilkes-Barre--Hazleton, PA | 0.8599 |
| Columbia, PA | |
| Lackawanna, PA | |
| Luzerne, PA | |
| Wyoming, PA | |
| 7600 Seattle-Bellevue-Everett, WA [1] | 1.1474 |
| Island, WA | |
| King, WA | |
| Snohomish, WA | |
| 7610 Sharon, PA [2] | 0.8462 |
| Mercer, PA | |
| 7620 Sheboygan, WI [2] | 0.9162 |
| Sheboygan, WI | |
| 7640 Sherman-Denison, TX | 0.9255 |
| Grayson, TX | |
| 7680 Shreveport-Bossier City, LA | 0.8987 |
| Bossier, LA | |
| Caddo, LA | |
| Webster, LA | |
| 7720 Sioux City, IA-NE | 0.9046 |
| Woodbury, IA | |
| Dakota, NE | |
| 7760 Sioux Falls, SD | 0.9257 |
| Lincoln, SD | |
| Minnehaha, SD | |
| 7800 South Bend, IN | 0.9802 |
| St. Joseph, IN | |
| 7840 Spokane, WA | 1.0852 |
| Spokane, WA | |
| 7880 Springfield, IL | 0.8659 |
| Menard, IL | |
| Sangamon, IL | |
| 7920 Springfield, MO | 0.8424 |
| Christian, MO | |
| Greene, MO | |
| Webster, MO | |
| 8003 Springfield, MA [2] | 1.1288 |
| Hampden, MA | |
| Hampshire, MA | |
| 8050 State College, PA | 0.8941 |
| Centre, PA | |
| 8080 Steubenville-Weirton, OH-WV | 0.8804 |
| Jefferson, OH | |
| Brooke, WV | |
| Hancock, WV | |
| 8120 Stockton-Lodi, CA | 1.0650 |
| San Joaquin, CA | |
| 8140 Sumter, SC [2] | 0.8607 |
| Sumter, SC | |
| 8160 Syracuse, NY | 0.9714 |
| Cayuga, NY | |
| Madison, NY | |
| Onondaga, NY | |

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties) | Wage index |
|---|---|
| Oswego, NY | |
| 8200 Tacoma, WA | 1.0940 |
| Pierce, WA | |
| 8240 Tallahassee, FL [2] | 0.8814 |
| Gadsden, FL | |
| Leon, FL | |
| 8280 Tampa-St. Petersburg-Clearwater, FL [1] | 0.9171 |
| Hernando, FL | |
| Hillsborough, FL | |
| Pasco, FL | |
| Pinellas, FL | |
| 8320 Terre Haute, IN [2] | 0.8755 |
| Clay, IN | |
| Vermillion, IN | |
| Vigo, IN | |
| 8360 Texarkana,AR-Texarkana, TX | 0.8126 |
| Miller, AR | |
| Bowie, TX | |
| 8400 Toledo, OH | 0.9810 |
| Fulton, OH | |
| Lucas, OH | |
| Wood, OH | |
| 8440 Topeka, KS | 0.9199 |
| Shawnee, KS | |
| 8480 Trenton, NJ | 1.0432 |
| Mercer, NJ | |
| 8520 Tucson, AZ | 0.8911 |
| Pima, AZ | |
| 8560 Tulsa, OK | 0.8332 |
| Creek, OK | |
| Osage, OK | |
| Rogers, OK | |
| Tulsa, OK | |
| Wagoner, OK | |
| 8600 Tuscaloosa, AL | 0.8203 |
| Tuscaloosa, AL | |
| 8640 Tyler, TX | 0.9521 |
| Smith, TX | |
| 8680 Utica-Rome, NY [2] | 0.8542 |
| Herkimer, NY | |
| Oneida, NY | |
| 8720 Vallejo-Fairfield-Napa, CA | 1.3421 |
| Napa, CA | |
| Solano, CA | |
| 8735 Ventura, CA | 1.1096 |
| Ventura, CA | |
| 8750 Victoria, TX | 0.8756 |
| Victoria, TX | |
| 8760 Vineland-Millville-Bridgeton, NJ | 1.0031 |
| Cumberland, NJ | |
| 8780 Visalia-Tulare-Porterville, CA [2] | 0.9840 |
| Tulare, CA | |
| 8800 Waco, TX | 0.8088 |
| McLennan, TX | |
| 8840 Washington, DC-MD-VA-WV [1] | 1.0851 |
| 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 Waterloo-Cedar Falls, IA | 0.8902 |
| Black Hawk, IA | |
| 8940 Wausau, WI | 0.9782 |
| Marathon, WI | |
| 8960 West Palm Beach-Boca Raton, FL [1] | 0.9939 |
| Palm Beach, FL | |
| 9000 Wheeling, WV-OH (WV Hospitals) [2] | 0.7975 |
| Belmont, OH | |
| Marshall, WV | |
| Ohio, WV | |
| 9000 Wheeling, WV-OH (OH Hospitals) [2] | 0.8613 |
| Belmont, OH | |
| Marshall, WV | |
| Ohio, WV | |
| 9040 Wichita, KS | 0.9520 |
| Butler, KS | |
| Harvey, KS | |
| Sedgwick, KS | |
| 9080 Wichita Falls, TX | 0.8498 |
| Archer, TX | |
| Wichita, TX | |
| 9140 Williamsport, PA | 0.8544 |
| Lycoming, PA | |
| 9160 Wilmington-Newark, DE-MD | 1.1173 |
| New Castle, DE | |
| Cecil, MD | |
| 9200 Wilmington, NC | 0.9640 |
| New Hanover, NC | |
| Brunswick, NC | |
| 9260 Yakima, WA | 1.0569 |
| Yakima, WA | |
| 9270 Yolo, CA [2] | 0.9840 |
| Yolo, CA | |
| 9280 York, PA | 0.9026 |
| York, PA | |
| 9320 Youngstown-Warren, OH | 0.9358 |
| Columbiana, OH | |
| Mahoning, OH | |
| Trumbull, OH | |
| 9340 Yuba City, CA | 1.0276 |
| Sutter, CA | |
| Yuba, CA | |
| 9360 Yuma, AZ | 0.8589 |
| Yuma, AZ | |

[1] Large Urban Area.

[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2003.

ADDENDUM I.—WAGE INDEX FOR RURAL AREAS

| Nonurban area | Wage index |
|---|---|
| Alabama | 0.7727 |
| Alaska | 1.2293 |
| Arizona | 0.8493 |
| Arkansas | 0.7666 |
| California | 0.9840 |
| Colorado | 0.9015 |
| Connecticut | 1.2394 |
| Delaware | 0.9128 |
| Florida | 0.8814 |
| Georgia | 0.8230 |
| Hawaii | 1.0255 |
| Idaho | 0.8747 |
| Illinois | 0.8204 |
| Indiana | 0.8755 |
| Iowa | 0.8315 |
| Kansas | 0.7923 |
| Kentucky | 0.8079 |
| Louisiana | 0.7647 |
| Maine | 0.8874 |
| Maryland | 0.8946 |
| Massachusetts | 1.1288 |
| Michigan | 0.9013 |
| Minnesota | 0.9151 |
| Mississippi | 0.7680 |
| Missouri | 0.8026 |
| Montana | 0.8481 |
| Nebraska | 0.8204 |
| Nevada | 0.9577 |
| New Hampshire | 0.9796 |
| New Jersey [1] | ..... |
| New Mexico | 0.8872 |
| New York | 0.8542 |
| North Carolina | 0.8666 |
| North Dakota | 0.7788 |
| Ohio | 0.8613 |
| Oklahoma | 0.7590 |
| Oregon | 1.0303 |
| Pennsylvania | 0.8462 |
| Puerto Rico | 0.4356 |
| Rhode Island [1] | ..... |
| South Carolina | 0.8607 |
| South Dakota | 0.7815 |
| Tennessee | 0.7877 |
| Texas | 0.7827 |
| Utah | 0.9312 |
| Vermont | 0.9345 |
| Virginia | 0.8504 |
| Washington | 1.0179 |
| West Virginia | 0.7975 |
| Wisconsin | 0.9162 |
| Wyoming | 0.9007 |

[1] All counties within the State are classified as urban.

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED

| Area | Wage index |
|---|---|
| Abilene, TX | 0.7827 |
| Akron, OH | 0.9600 |
| Albany, GA | 1.0427 |
| Albuquerque, NM | 0.9390 |
| Alexandria, LA | 0.7883 |
| Allentown-Bethlehem-Easton, PA | 0.9735 |
| Altoona, PA | 0.9225 |
| Amarillo, TX | 0.8884 |
| Anchorage, AK | 1.2490 |
| Ann Arbor, MI | 1.1103 |
| Anniston, AL | 0.7910 |
| Asheville, NC | 0.9575 |
| Athens, GA | 1.0066 |
| Atlanta, GA | 0.9889 |
| Augusta-Aiken, GA-SC | 0.9887 |
| Austin-San Marcos, TX | 0.9637 |
| Barnstable-Yarmouth, MA | 1.2943 |
| Baton Rouge, LA | 0.8190 |
| Bellingham, WA | 1.1642 |
| Benton Harbor, MI | 0.9106 |
| Bergen-Passaic, NJ | 1.2207 |
| Billings, MT | 0.9022 |
| Biloxi-Gulfport-Pascagoula, MS | 0.8368 |
| Binghamton, NY | 0.8462 |
| Birmingham, AL | 0.9222 |
| Bismarck, ND | 0.7972 |
| Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH | 1.1235 |
| Burlington, VT | 0.9572 |
| Caguas, PR | 0.4408 |
| Casper, WY | 0.9586 |
| Champaign-Urbana, IL | 0.9772 |
| Charleston-North Charleston, SC | 0.9235 |
| Charleston, WV | 0.8649 |
| Charlotte-Gastonia-Rock Hill, NC-SC | 0.9743 |
| Charlottesville, VA | 1.0120 |
| Chattanooga, TN-GA | 0.8843 |
| Chicago, IL | 1.0905 |
| Cincinnati, OH-KY-IN | 0.9389 |
| Clarksville-Hopkinsville, TN-KY | 0.8419 |
| Cleveland-Lorain-Elyria, OH | 0.9670 |
| Columbia, MO | 0.8515 |
| Columbia, SC | 0.9194 |
| Columbus, GA-AL (GA Hospitals) | 0.8230 |
| Columbus, GA-AL (AL Hospitals) | 0.7985 |
| Columbus, OH | 0.9549 |
| Corpus Christi, TX | 0.8729 |
| Dallas, TX | 0.9998 |
| Davenport-Moline-Rock Island, IA-IL | 0.8835 |
| Dayton-Springfield, OH | 0.9282 |
| Denver, CO | 1.0484 |
| Des Moines, IA | 0.8827 |
| Detroit, MI | 1.0448 |
| Dothan, AL | 0.8158 |
| Dover, DE | 0.9254 |
| Duluth-Superior, MN-WI | 1.0368 |
| Eau Claire, WI | 0.9162 |
| Elkhart-Goshen, IN | 0.9516 |
| Erie, PA | 0.8761 |
| Eugene-Springfield, OR | 1.0944 |
| Fargo-Moorhead, ND-MN | 0.9468 |
| Fayetteville, NC | 0.8992 |
| Flagstaff, AZ-UT | 1.0131 |
| Flint, MI | 1.0963 |
| Florence, AL | 0.7819 |
| Florence, SC | 0.8780 |
| Fort Collins-Loveland, CO | 1.0066 |
| Ft. Lauderdale, FL | 1.0704 |

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

| Area | Wage index |
|---|---|
| Fort Pierce-Port St. Lucie, FL | 0.9931 |
| Fort Smith, AR-OK | 0.7738 |
| Fort Walton Beach, FL | 0.9430 |
| Forth Worth-Arlington, TX | 0.9446 |
| Gadsden, AL | 0.8599 |
| Gainesville, FL | 0.9871 |
| Grand Forks, ND-MN | 0.9243 |
| Grand Junction, CO | 0.9679 |
| Grand Rapids-Muskegon-Holland, MI | 0.9548 |
| Great Falls, MT | 0.8966 |
| Greeley, CO | 0.9336 |
| Green Bay, WI | 0.9668 |
| Greensboro-Winston-Salem-High Point, NC | 0.9129 |
| Greenville, NC | 0.9174 |
| Harrisburg-Lebanon-Carlisle, PA | 0.9223 |
| Hartford, CT | 1.1549 |
| Hattiesburg, MS | 0.7680 |
| Hickory-Morganton-Lenoir, NC | 0.8926 |
| Houston, TX | 0.9792 |
| Huntington-Ashland, WV-KY-OH | 0.9167 |
| Huntsville, AL | 0.8771 |
| Indianapolis, IN | 0.9717 |
| Iowa City, IA | 0.9442 |
| Jackson, MS | 0.8607 |
| Jackson, TN | 0.9002 |
| Jacksonville, FL | 0.9237 |
| Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals) | 0.8504 |
| Johnson City-Kingsport-Bristol, TN-VA (KY Hospitals) | 0.8337 |
| Jonesboro, AR (AR Hospitals) | 0.7843 |
| Jonesboro, AR (MO Hospitals) | 0.8026 |
| Joplin, MO | 0.8613 |
| Kalamazoo-Battlecreek, MI | 1.0400 |
| Kansas City, KS-MO | 0.9736 |
| Knoxville, TN | 0.8970 |
| Kokomo, IN | 0.9038 |
| Lafayette, LA | 0.8316 |
| Lakeland-Winter Haven, FL | 0.9357 |
| Las Vegas, NV-AZ | 1.1521 |
| Lawton, OK | 0.8077 |
| Lexington, KY | 0.8581 |
| Lima, OH | 0.9483 |
| Lincoln, NE | 0.9711 |
| Little Rock-North Little Rock, AR | 0.8951 |
| Longview-Marshall, TX | 0.8629 |
| Los Angeles-Long Beach, CA | 1.2011 |
| Louisville, KY-IN | 0.9163 |
| Lubbock, TX | 0.9646 |
| Lynchburg, VA | 0.8909 |
| Macon, GA | 0.9250 |
| Madison, WI | 1.0467 |
| Medford-Ashland, OR | 1.0303 |
| Memphis, TN-AR-MS | 0.8712 |
| Miami, FL | 0.9815 |
| Milwaukee-Waukesha, WI | 0.9893 |
| Minneapolis-St. Paul, MN-WI | 1.0903 |
| Missoula, MT | 0.9047 |
| Mobile, AL | 0.8110 |
| Modesto, CA | 1.0498 |
| Monmouth-Ocean, NJ | 1.0814 |
| Monroe, LA | 0.8137 |
| Montgomery, AL | 0.7734 |
| Nashville, TN | 0.9375 |
| New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT | 1.2459 |
| New London-Norwich, CT | 1.1626 |

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

| Area | Wage index |
|---|---|
| New Orleans, LA | 0.9046 |
| New York, NY | 1.4220 |
| Newark, NJ | 1.1406 |
| Newburgh, NY-PA | 1.0747 |
| Norfolk-Virginia Beach-Newport News, VA-NC | 0.8666 |
| Oakland, CA | 1.5185 |
| Odessa-Midland, TX | 0.9180 |
| Oklahoma City, OK | 0.8900 |
| Omaha, NE-IA | 0.9978 |
| Orange County, CA | 1.1594 |
| Orlando, FL | 0.9640 |
| Peoria-Pekin, IL | 0.8739 |
| Philadelphia, PA-NJ | 1.0713 |
| Phoenix-Mesa, AZ | 0.9820 |
| Pine Bluff, AR | 0.7798 |
| Pittsburgh, PA | 0.9224 |
| Pittsfield, MA | 0.9863 |
| Pocatello, ID | 0.9674 |
| Portland, ME | 0.9620 |
| Portland-Vancouver, OR-WA | 1.0684 |
| Provo-Orem, UT | 0.9984 |
| Raleigh-Durham-Chapel Hill, NC | 0.9990 |
| Rapid City, SD | 0.8846 |
| Reading, PA | 0.9108 |
| Redding, CA | 1.1135 |
| Reno, NV | 1.0466 |
| Richland-Kennewick-Pasco, WA | 1.0800 |
| Richmond-Petersburg, VA | 0.9477 |
| Roanoke, VA | 0.8614 |
| Rochester, MN | 1.2139 |
| Rockford, IL | 0.9399 |
| Sacramento, CA | 1.1513 |
| Saginaw-Bay City-Midland, MI | 0.9543 |
| St. Cloud, MN | 0.9785 |
| St. Joseph, MO | 0.8240 |
| St. Louis, MO-IL | 0.8855 |
| Salinas, CA | 1.4623 |
| Salt Lake City-Ogden, UT | 0.9945 |
| San Antonio, TX | 0.8753 |
| San Diego, CA | 1.1135 |
| Santa Fe, NM | 0.9891 |
| Santa Rosa, CA | 1.2761 |
| Sarasota-Bradenton, FL | 0.9449 |
| Savannah, GA | 0.9376 |
| Seattle-Bellevue-Everett, WA | 1.1474 |
| Sherman-Denison, TX | 0.9008 |
| Shreveport-Bossier City, LA | 0.8987 |
| Sioux City, IA-NE | 0.8647 |
| Sioux Falls, SD | 0.9059 |
| South Bend, IN | 0.9802 |
| Spokane, WA | 1.0663 |
| Springfield, IL | 0.8659 |
| Springfield, MO | 0.8153 |
| Stockton-Lodi, CA | 1.0650 |
| Syracuse, NY | 0.9612 |
| Tampa-St. Petersburg-Clearwater, FL | 0.9171 |
| Texarkana,AR-Texarkana, TX | 0.8126 |
| Toledo, OH | 0.9810 |
| Topeka, KS | 0.9031 |
| Tucson, AZ | 0.8911 |
| Tulsa, OK | 0.8332 |
| Tuscaloosa, AL | 0.8203 |
| Tyler, TX | 0.9195 |
| Vallejo-Fairfield-Napa, CA | 1.3421 |
| Victoria, TX | 0.8756 |
| Waco, TX | 0.8088 |
| Washington, DC-MD-VA-WV | 1.0851 |

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

| Area | Wage index |
|---|---|
| Waterloo-Cedar Falls, IA | 0.8902 |
| Wausau, WI | 0.9782 |
| West Palm Beach-Boca Raton, FL | 0.9939 |
| Wichita, KS | 0.9179 |
| Wichita Falls, TX | 0.8498 |
| Wilmington-Newark, DE-MD | 1.0862 |
| Wilmington, NC | 0.9425 |
| York, PA | 0.9026 |
| Youngstown-Warren, OH | 0.9358 |

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

| Area | Wage index |
|---|---|
| Rural Alabama | 0.7727 |
| Rural Florida | 0.8814 |
| Rural Illinois (IA Hospitals) | 0.8315 |
| Rural Illinois (MO Hospitals) | 0.8204 |
| Rural Kentucky | 0.8079 |
| Rural Louisiana | 0.7647 |
| Rural Michigan | 0.9013 |
| Rural Minnesota | 0.9151 |
| Rural Missouri | 0.8026 |

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

| Area | Wage index |
|---|---|
| Rural Montana | 0.8481 |
| Rural Nebraska | 0.8204 |
| Rural Nevada | 0.9117 |
| Rural Texas | 0.7827 |
| Rural Washington | 1.0179 |
| Rural Wyoming | 0.9007 |

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