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42 CFR Part 419

Medicare Program; Hospital Outpatient Prospective Payment System; Payment Reform for Calendar Year 2004; Interim Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 419

[CMS–1371–IFC]

RIN 0938–AM96

Medicare Program; Hospital Outpatient Prospective Payment System; Payment Reform for Calendar Year 2004

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

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period implements provisions of the Medicare Prescription Drug, Improvement, and Modernization Act (DIMA) of 2003 that affect the Medicare outpatient prospective payment system (OPPS) that become effective January 1, 2004. Sections 303 and 621 of the DIMA include provisions that alter the methods for drug payment in hospital outpatient departments, some of which become effective January 1, 2004. These provisions affect the methodology for paying for pass-through and non-pass-through drugs under the OPPS. Further, the new law includes a requirement that all brachytherapy sources be paid separately. Section 411 of the DIMA reinstates the hold-harmless protection for small rural hospitals with fewer than 100 beds and extends that protection to sole community hospitals in rural areas.

DATES: *Effective date:* January 1, 2004.

Comment date: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on March 8, 2004.

ADDRESSES: In commenting, please refer to file code CMS–1371–IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission or e-mail.

Mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1371–IFC, P.O. Box 8018, Baltimore, MD 21244–8018.

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

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

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

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

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

FOR FURTHER INFORMATION CONTACT: Dana Burley, (410) 786–0378.

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

Availability of Copies and Electronic Access

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I. Background

A. Authority for the Outpatient Prospective Payment System

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

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (DIMA) (Pub. L. 108–173), enacted on December 8, 2003, made additional changes to the Act relating to the OPPS and calendar year 2004 payment rates to be implemented January 1, 2004.

We would ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued. We find good cause to waive notice and comment procedures for this correction notice as set forth in section IV, ''Waiver of Proposed Rulemaking and Waiver of 30-Day Delay in the Effective Date,'' below.

B. Summary of Relevant Provisions of the DIMA

The DIMA, enacted December 8, 2003, made the following changes to the Act that relate to the OPPS:

1. Transitional Corridor Payments Extended

Section 411 of the DIMA amends section 1833(t)(7)(D)(i) of the Act and extends the hold-harmless provision for small rural hospitals. The hold harmless

transitional corridor payments will continue through December 31, 2005 for small rural hospitals having 100 or fewer beds. Section 411 of the DIMA further amends section 1833(t)(7) of the Act to provide that hold-harmless transitional corridor payments shall apply to sole community hospitals as defined in section 1886(d)(5)(D)(iii) of the Act and will continue through December 31, 2005.

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

Section 621(a)(1) of the DIMA amends the Act by adding section 1833(t)(14) that requires classification of separately paid radiopharmaceutical agents and drugs or biologicals that had transitional pass-through status on or before December 31, 2002, into 3 categories: innovator multiple source drugs; noninnovator multiple source drugs; and sole source drugs. Payment levels based on the reference average wholesale price are specified for each category.

3. Payment for Drug or Biological Before HCPCS Code Assigned

Section 621(a)(1) of the DIMA amends the Act by adding section 1833(t)(15), which requires that payment be made at 95 percent of the average wholesale price (AWP) for new drugs and biologicals until a HCPCS code is assigned.

4. Payment for Pass-Through Drugs

Section 303(b) of the DIMA amends section 1842(o) of the Act. As a result, certain pass-through drugs are to be paid at 95 percent, and others at 85 percent, of the AWP. Drugs and biologicals furnished during 2004 for which pass-through payment was first made on or after January 1, 2003 (which removes them from application of section 621 of the DIMA) and were approved by the FDA for marketing as of April 1, 2003, will be paid 85 percent of AWP pursuant to section 1842(o)(1)(B) and 1842(o)(4)(A), unless sections 1842(o)(4)(B), (C) or (D) apply. Blood clotting factors furnished during 2004, drugs or biologicals furnished during 2004 that were not available for payment as of April 1, 2003, vaccines furnished on or after January 1, 2004, and drugs or biologicals furnished during 2004 in connection with the renal dialysis services if billed by renal dialysis facilities, are paid at 95 percent of the reference AWP. Drugs or biologicals that were paid on a pass-through basis under the OPPS on or after January 1, 2003 and that were available for payment as of April 1, 2003 are paid at 85 percent of the reference AWP rather than 95 percent as was previously the policy under section 1842(o) of the Act.

5. Exclude Separately Payable Drugs and Biologicals From Outlier Payments

Section 621(a)(3) amends section 1833(t)(5) of the Act to require that separately paid drugs and biologicals be excluded from outlier payments.

6. Brachytherapy Sources Are To Be Paid Separately

Section 621(b) amends the Act by adding section 1833(t)(16)(C) which requires that all devices of brachytherapy consisting of a seed or seeds (or radioactive source) be paid based on the hospital's charge for each device adjusted to cost. Also included in the new provision is a requirement that all such brachytherapy sources be excluded from outlier payments.

Payment Methodology That Applied Prior To Enactment

In the hospital outpatient prospective payment update final rule published in the **Federal Register** on November 7, 2003, CMS announced payments for 2004 under the Medicare hospital outpatient prospective payment system (68 FR 63398). The provisions of that final rule with regard to payment for brachytherapy sources, for separately payable drugs, biologicals and radiopharmaceutical agents and for pass-through drugs and biologicals is superceded in part with enactment of the DIMA, effective for services furnished on or after January 1, 2004. This interim final rule with comment presents the payment amounts that apply in 2004 that result from the changes made by DIMA.

The following is a summarization of the payment policies that we published for the 2004 OPPS before enactment of the new law.

Drugs and biologicals that were within the 2–3 year pass-through payment period were paid amounts as specified in section 1842(o) of the Act. Under the November 7 final rule, that payment was 95 percent of AWP.

Under the provisions of the November 7 OPPS final rule, payment for non-pass-through drugs, biologicals and radiopharmaceutical agents with per day median costs greater than $50 was based on data compiled from hospital claims submitted on or after April 1, 2002 through December 31, 2002. Those data were used to set median costs which were converted to relative weights, scaled for budget neutrality, and multiplied by the 2004 conversion factor, the same methodology used to set relative weights for procedural ambulatory payment classifications (APCs) under the OPPS. A detailed discussion of the rate setting methodology for the 2004 OPPS update is provided in the November 7, 2003 final rule (68 FR 63416).

Payment for drugs, biologicals and radiopharmaceutical agents that had per day median costs less than $50 and drugs, biologicals and radiopharmaceutical agents for which there was no HCPCS code, was included in the rate for the service in which the item was used. There were no separate payments for these drugs, biologicals and radiopharmaceutical agents.

Changes Required Under the DIMA

a. Changes in Payment for ''specified covered outpatient drugs'': radiopharmaceutical agents and drugs or biologicals that were paid as pass-throughs under the OPPS on or before December 31, 2002. The DIMA amends the Act by adding section 1833(t)(14) which states that payment for specified covered outpatient drugs is to be based on its ''reference average wholesale price,'' that is, the average wholesale price for the drug as determined under section 1842(o) of the Act as of May 1, 2003 (1833(t)(14)(G)).

Under new section 1833(t)(14)(B)(i) a ''specified covered outpatient drug'' is a covered outpatient drug as defined in 1927(k)(2) of the Act, for which a separate ambulatory payment classification group (APC) exists and that is a radiopharmaceutical agent or a drug or biological for which payment was made on a pass-through basis on or before December 31, 2002.

Under section 1833(t)(14)(B)(ii) of the Act, certain drugs and biologicals are designated as exceptions, which are not included in the definition of ''specified covered outpatient drugs.'' These exceptions are the following:

- A drug or biological for which payment is first made on or after January 1, 2003 under the transitional pass-through payment provision in section 1833(t)(6) of the Act.
- A drug or biological for which a temporary HCPCS code has not been assigned.
- During 2004 and 2005, an orphan drug (as designated by the Secretary).

Section 1833(t)(14)(A)(i) specifies payment limits for 3 categories of ''specified covered outpatient drugs'' in 2004. Section 1833(t)(14)(F) defines the 3 categories of ''specified covered outpatient drugs'' based on sections 1861(t)(1) and 1927(k)(7)(A)(ii), (iii) and (iv) of the Act. The categories of drugs are ''sole source drugs'', ''innovator multiple source drugs'' and ''noninnovator multiple source drugs.''

b. Definitions and payment rates for DIMA-specified categories for drugs, biologicals, and radiopharmaceutical agents. Section 1927(k) of the Act pertains to the Medicaid drug rebate program. In order to administer the Medicaid drug rebate program, CMS gathers information from manufacturers and classifies drugs into categories that are defined in sections 1927(k)(7)(A)(ii), (iii) and (iv) of the Act. We are using these category designations to guide our classification of covered OPPS drugs in order to implement the changes in payment under the OPPS that are required by DIMA in section 1833(t)(14) of the Act. The classifications are listed in the Medicaid average manufacturer price (AMP) database, which can be found at *http://www.cms.gov/medicaid/drugs/drug6.asp.* In cases when the AMP database does not provide a classification for an affected drug or biological, we relied on our clinical and pharmaceutical experts to determine the appropriate classification. Further, when there are conflicting or incomplete designations in the AMP, we assigned drugs to the noninnovator multiple-source category for payment effective January 1, 2004, until we can resolve the conflicts and make a definitive classification. Classification changes will be implemented April 1, 2004 effective for services furnished on or after January 1, 2004. We invite comments regarding the appropriate classification of the drugs listed in Table 2.

The Medicaid AMP database is updated on a quarterly basis. However, we believe that midyear changes in the classification of drugs could be confusing and burdensome for providers to administer. Therefore, the final category designations used to determine 2004 OPPS drug payments for the ''specified covered outpatient drugs'' to which section 1833(t)(14)(A)(i) of the Act applies, will remain in effect through December 31, 2004. We will update the category designations through rulemaking as part of the annual OPPS update for 2005.

The sole source category is defined in section 1833(t)(14)(F)(i) of the Act as a biological product (as defined under section 1861(t)(1) of the Act) or a single source drug (as defined in section 1927(k)(7)(A)(iv)) of the Act). Section 1927(k)(7)(A)(iv) of the Act defines the term ''single source drug'' to mean a covered outpatient drug which is produced or distributed under an original new drug application (NDA) approved by the Food and Drug Administration (FDA), including a drug product marketed by any cross-licensed producers or distributors operating under the NDA. Based on this definition, in effect, single source drugs are brand name drugs for which there is no FDA generic approval, and the term is used interchangeably with ''sole source drug'' in this preamble.

Section 621(a) of the DIMA, amends the Act by adding section 1833(t)(14)(A)(i)(I), which provides that a sole source drug shall, in 2004, be paid no less than 88 percent and no more than 95 percent of the reference AWP.

Innovator multiple source drugs are defined in section 1833(t)(14)(F)(ii) of the Act according to the definition provided in section 1927(k)(7)(A)(ii) of the Act. Section 1927(k)(7)(A)(ii) of the Act defines an innovator multiple source drug as a multiple source drug that was originally marketed under an original NDA approved by the FDA. Under this definition, these drugs were originally sole source drugs for which FDA subsequently approved a generic alternative(s). An innovator multiple source drug first must be a sole source drug.

Section 621(a) of the DIMA, amends the Act by adding section 1833(t)(14)(A)(i)(II), which provides that an innovator multiple source drug shall, in 2004, be paid no more than 68 percent of the reference AWP.

Section 1833(t)(14)(F)(III) defines a noninnovator multiple source drug according to the definition of the term in 1927(k)(7)(A)(iii). Section 1927(k)(7)(A)(iii) defines noninnovator multiple source drug as a multiple source drug that is not an innovator multiple source drug. Under this definition, noninnovator multiple source drugs are, in effect, generic drugs approved by the FDA.

Section 621(a) of the DIMA, amends the Act by adding section 1833(t)(14)(A)(i)(III), which provides that a noninnovator multiple source drug shall, in 2004, be paid no more than 46 percent of the reference AWP.

There are several drugs that are classified in the AMP database as qualifying for all three categories. A drug that meets the criteria for all 3 categories has FDA approval as an innovator drug. A generic version of the drug, the noninnovator, also has received FDA approval. In addition, there is an FDA approval for a different indication for use under a different NDA for which the drug is the sole source. When a single drug, biological or radiopharmaceutical agent that meets the definition of a single HCPCS code qualifies for all of the 3 categories in the AMP file, we are recognizing the product only as an innovator multiple source and noninnovator multiple source drug. That is, once a drug qualifies as a multiple source drug, we will not recognize it as a sole source drug for payment under the OPPS. We believe that it would be impossible to operationalize a system in which the same drug would be paid differently according to the clinical indication for its use. Medicare makes payment for a drug or biological that is reasonable and necessary to treat an illness or disease. Medicare does not base payment for drugs and biologicals according to their indicated uses, except when required by a national coverage decision. Further, to do so would circumvent the payment limitation that the law requires for drugs, biologicals and radiopharmaceutical agents that have generic competition by allowing payment for a drug that has generic competition at the sole source rate (88 to 95 percent of AWP) rather than at the limit for innovator multiple source (68 percent of AWP) or noninnovator multiple source (46 percent of AWP) drugs.

c. Definition of ''reference AWP'' and determination of payment amounts. Section 1833(t)(14)(G) of the Act defines reference AWP as the AWP determined under section 1842(o) as of May 1, 2003. We interpret this to mean the AWP set under the CMS single drug pricer (SDP) based on prices published in the Red Book on May 1, 2003.

We determined the payment amount for specified covered outpatient drugs under the provisions of the DIMA by comparing the payment amount calculated under the median cost methodology in effect prior to enactment of the DIMA to the percentages specified in new section 1833(t)(14)(A) of the Act.

Specifically, for sole source drugs, we compared the payments established in the November 7, 2003 final rule for the HCPCS code for the drug to its reference AWP. When the payment fell below 88 percent of the reference AWP, we increased the payment to 88 percent of the reference AWP. When the payment exceeded 95 percent of the reference AWP, we reduced the payment to 95 percent of the reference AWP. When the payment was no lower than 88 percent and no higher than 95 percent of reference AWP, we made no change. To receive payment for sole source drugs on or after January 1, 2004, hospitals should continue to bill the appropriate HCPCS code for the drug. Table 1 lists the payment amounts for sole source drugs, biologicals and radiopharmaceutical agents effective January 1, 2004 through December 31, 2004.

There are a few drugs for which we cannot find an AWP rate. We are working to resolve this on a case-by-case basis for each of the drugs. The drugs are: Technetium TC 99M Sodium Glucoheptonate (C1200), Cobalt Co 57 cobaltous chloride (C9013), I–131 tositumomab, diagnostic (C1080) and I–131 tositumomab, therapeutic (C1081).

With regard to C1080 and C1081, there is no AWP available because this drug did not receive FDA approval until June, 2003 and so could not be in the May 1, 2003 Red Book (AWP) that we have identified as the source of the reference AWP. We presented an in-depth discussion of our policy for payment of this drug, Bexxar, in our November 7 final rule. In that rule we explain our rationale for making payment for Bexxar parallel to that for another radiopharmaceutical called Zevalin. In order to set the payment rate for Bexxar in accordance with DIMA, we also have adhered to the policy regarding the pricing of Bexxar established in the November 7 final rule.

For the remaining drugs for which we could not identify a May 1, 2003 AWP amount, we will continue our research to find an AWP. If we are able to identify the AWP established on dates other than May 1, 2003, we will use whichever is closest to May 2003. In the interim, we will implement the payment rates published in the November 7 final rule to make payments for these drugs for January 1, 2004 through March 31, 2004. We will address our findings regarding development of payment rates for these drugs in our April update.

APC 9024 is made up of 3 sole source drugs: Amphotericin B lipid complex (J0287); Amphotericin B cholesteryl sulfate (J0288); and Amphotericin B liposome injection (J0289). To comply with the statute, these 3 drugs must all be paid separately under the OPPS and that will require that we create an APC for each of the drugs. Due to the limited time available to implement the changes required for January 1, 2004, we will not be able to implement the new APCs until April 1, 2004. We will continue to pay for these drugs in APC 9024 at the rate published in the November 7 final rule. The new APCs will be implemented April 1, 2004 and will be effective for services furnished on or after January 1, 2004.

TABLE 1.—SOLE SOURCE DRUGS

HCPCS	Status indicator	*Description*	APC	OPPS CY 2004 November 7, 2003 rate	DIMA final rate
A4642	K	Satumomab pendetide per dose	0704	$124.46	$1,474.00
A9500	K	Technetium TC 99m sestamibi	1600	64.28	112.73
A9502	K	Technetium TC99M tetrofosmin	0705	58.06	665.28
A9507	K	Indium/111 capromab pendetid	1604	687.71	2,030.60
A9511	K	Technetium TC 99m depreotide	1095	37.87	704.00
A9521	K	Technetiumtc-99m exametazine	1096	210.65	825.00
A9524	K	Iodinated I–131 serumalbumin, per 5uci	9100	0.36	48.58
A9600	K	Strontium-89 chloride	0701	402.85	892.43
C1079	K	CO 57/58 per 0.5 uCi	1079	68.51	235.14
C1080	K	I–131 tositumomab, dx	1080	2,260.00	2,565.55
C1081	K	I–131 tositumomab, tx	1081	19,565.00	22,210.19
C1082	K	In-111 ibritumomab tiuxetan	9118	2,260.00	2,565.55
C1083	K	Yttrium 90 ibritumomab tiuxetan	9117	19,565.00	22,210.19
C1092	K	IN 111 pentetate per 0.5 mCi	1092	217.45	237.60
C1122	K	Tc 99M ARCITUMOMAB PER VIAL	1122	534.77	1,144.00
C1166	K	CYTARABINE LIPOSOMAL, 10 mg	1166	278.99	344.08
C1167	K	EPIRUBICIN HCL, 2 mg	1167	20.43	25.60
C1178	K	BUSULFAN IV, 6 Mg	1178	299.70	27.87
C1200	K	TC 99M Sodium Glucoheptonat	1200	30.28	30.28
C1201	K	TC 99M SUCCIMER, PER Vial	1201	80.24	125.66
C1305	K	Apligraf	1305	822.19	1,199.00
C9003	K	Palivizumab, per 50 mg	9003	344.15	611.24
C9008	K	Baclofen Refill Kit-500mcg	9008	6.90	73.92
C9009	K	Baclofen Refill Kit-2000mcg	9009	40.92	40.92
C9010	K	Baclofen Refill Kit—4000mcg	9010	42.22	79.82
C9109	K	Tirofiban hcl, 6.25 mg	9109	118.60	218.33
C9202	K	Octafluoropropane	9202	118.60	137.28
J0130	K	Abciximab injection	1605	289.44	475.22
J0207	K	Amifostine	7000	289.40	419.59
J0287	K	Amphotericin b lipid complex	9024	20.86	20.86
J0288	K	Ampho b cholesteryl sulfate	9024	20.86	20.86
J0289	K	Amphotericin b liposome inj	9024	20.86	20.86
J0350	K	Injection anistreplase 30 u	1606	1,516.46	2,495.31
J0585	K	Botulinum toxin a per unit	0902	3.21	4.58
J0587	K	Botulinum toxin type B	9018	6.98	8.14
J0637	K	Caspofungin acetate	9019	29.64	30.52
J0850	K	Cytomegalovirus imm IV /vial	0903	291.18	659.60
J1327	K	Eptifibatide injection	1607	7.99	11.88
J1438	K	Etanercept injection	1608	102.37	143.73
J1440	K	Filgrastim 300 mcg injection	0728	123.48	172.20
J1441	K	Filgrastim 480 mcg injection	7049	175.96	290.93
J1565	K	RSV-ivig	0906	48.61	16.55
J1626	K	Granisetron HCl injection	0764	5.70	17.18
J1830	K	Interferon beta-1b / .25 MG	0910	100.51	67.22
J1950	K	Leuprolide acetate /3.75 MG	0800	182.92	479.20

TABLE 1.—SOLE SOURCE DRUGS—Continued

HCPCS	Status indicator	*Description*	APC	OPPS CY 2004 November 7, 2003 rate	DIMA final rate
J2020	K	Linezolid injection	9001	15.12	34.09
J2353	K	Octreotide injection, depot	1207	65.74	73.62
J2354	K	Octreotide inj, non-depot	7031	1.44	3.94
J2788	K	Rho d immune globulin 50 mcg	9023	1.69	32.21
J2790	K	Rho d immune globulin inj	0884	10.16	92.93
J2792	K	Rho(D) immune globulin h, sd	1609	9.76	19.03
J2820	K	Sargramostim injection	0731	16.32	26.92
J2941	K	Somatropin injection	7034	41.18	297.79
J2993	K	Reteplase injection	9005	568.33	1,263.90
J3100	K	Tenecteplase injection	9002	1,296.75	2,492.60
J3245	K	Tirofiban hydrochloride	7041	227.85	436.66
J3305	K	Inj trimetrexate glucoronate	7045	61.36	132.00
J3395	K	Verteporfin injection	1203	897.20	1,350.80
J7191	K	Factor VIII (porcine)	0926	1.52	1.89
J7195	K	Factor IX recombinant	0932	1.01	1.04
J7320	K	Hylan G–F 20 injection	1611	123.46	215.97
J7504	K	Lymphocyte immune globulin	0890	127.89	258.17
J7505	K	Monoclonal antibodies	7038	320.84	792.33
J7507	K	Tacrolimus oral per 1 MG	0891	1.34	3.24
J7511	K	Antithymocyte globuln rabbit	9104	163.56	331.23
J7520	K	Sirolimus, oral	9020	2.89	6.60
J7525	K	Tacrolimus injection	9006	5.72	110.04
J8510	K	Oral busulfan	7015	1.57	1.93
J8520	K	Capecitabine, oral, 150 mg	7042	1.65	3.14
J8700	K	Temozolmide	1086	3.76	6.81
J9001	K	Doxorubicin hcl liposome inj	7046	256.34	364.49
J9010	K	Alemtuzumab injection	9110	424.88	541.46
J9017	K	Arsenic trioxide	9012	26.91	34.32
J9020	K	Asparaginase injection	0814	16.13	58.00
J9045	K	Carboplatin injection	0811	86.47	137.79
J9098	K	Cytarabine liposome	1166	278.99	344.08
J9151	K	Daunorubicin citrate liposom	0821	163.55	64.60
J9170	K	Docetaxel	0823	220.97	331.53
J9178	K	Inj, epirubicin hcl, 2 mg	1167	20.43	25.60
J9185	K	Fludarabine phosphate inj	0842	205.74	329.83
J9201	K	Gemcitabine HCl	0828	80.43	112.09
J9202	K	Goserelin acetate implant	0810	285.16	413.59
J9206	K	Irinotecan injection	0830	100.55	135.00
J9213	K	Interferon alfa-2a inj	0834	20.61	32.31
J9214	K	Interferon alfa-2b inj	0836	10.93	13.78
J9215	K	Interferon alfa-n3 inj	0865	79.65	8.17
J9216	K	Interferon gamma 1-b inj	0838	180.15	290.70
J9217	K	Leuprolide acetate suspnsion	9217	312.37	576.47
J9219	K	Leuprolide acetate implant	7051	3,666.71	5,001.92
J9245	K	Inj melphalan hydrochl 50 MG	0840	254.90	389.14
J9268	K	Pentostatin injection	0844	965.98	1,784.64
J9270	K	Plicamycin (mithramycin) inj	0860	15.42	86.89
J9293	K	Mitoxantrone hydrochl / 5 MG	0864	173.68	332.87
J9310	K	Rituximab cancer treatment	0849	306.40	464.20
J9320	K	Streptozocin injection	0850	65.19	131.05
J9350	K	Topotecan	0852	433.41	739.80
J9355	K	Trastuzumab	1613	40.56	53.85
J9357	K	Valrubicin, 200 mg	1614	461.78	487.87
J9390	K	Vinorelbine tartrate/10 mg	0855	64.79	100.97
J9600	K	Porfimer sodium	0856	1,594.30	2,411.82
Q0136	K	Non esrd epoetin alpha inj	0733	9.83	11.76
Q0137	K	Darbepoetin alfa, non esrd	0734	3.24	3.88
Q0166	K	Granisetron HCl 1 mg oral	0765	34.49	171.78
Q0180	K	Dolasetron mesylate oral	0763	41.00	152.38
Q0187	K	Factor viia recombinant	1409	1,083.93	1,495.30
Q2003	K	Aprotinin, 10,000 kiu	7019	1.17	13.26
Q2005	K	Corticorelin ovine triflutat	7024	224.91	375.00
Q2006	K	Digoxin immune fab (ovine)	7025	271.14	1.79
Q2007	K	Ethanolamine oleate 100 mg	7026	27.82	67.10
Q2008	K	Fomepizole, 15 mg	7027	7.23	10.65
Q2009	K	Fosphenytoin, 50 mg	7028	4.88	5.63
Q2011	K	Hemin, per 1 mg	7030	0.64	6.86
Q2013	K	Pentastarch 10% solution	7040	26.40	139.94
Q2017	K	Teniposide, 50 mg	7035	137.41	238.49

TABLE 1.—SOLE SOURCE DRUGS—Continued

HCPCS	Status indicator	*Description*	APC	OPPS CY 2004 November 7, 2003 rate	DIMA final rate
Q2018	K	Urofollitropin, 75 iu	7037	63.48	63.48
Q3000	K	Rubidium-Rb-82	9025	143.89	162.63
Q3003	K	Technetium tc99m bicisate	1620	183.69	392.93
Q3005	K	Technetium tc99m mertiatide	1622	20.63	1,650.00
Q3008	K	Indium 111-in pentetreotide	1625	449.84	1,144.00
Q4052	K	Octreotide injection, depot	1207	65.74	73.62

TABLE 2.—MULTISOURCE DRUGS

HCPCS	Status indicator	Description	APC	OPPS CY 2004 November 7, 2003 rate	DIMA final rate
A9505	K	Thallous chloride TL 201/mci	1603	$19.89	$18.29
A9508	K	Iobenguane sulfate I–131, per 0.5 mCi	1045	165.82	165.82
A9517	K	Th I131 so iodide cap millic	1064	5.48	5.48
A9528	K	Dx I131 so iodide cap millic	1064	5.48	5.48
A9529	K	Dx I131 so iodide sol millic	1065	6.49	6.49
A9530	K	Th I131 so iodide sol millic	1065	6.49	6.49
A9605	K	Samarium sm153 lexidronamm	0702	874.44	493.89
C1091	K	IN111 oxyquinoline, per0.5mCi	1091	224.52	224.52
C1775	K	FDG, per dose (4–40 mCi/ml)	1775	324.48	324.48
C9013	K	Co 57 cobaltous chloride	9013	56.67	56.67
C9105	K	Hep B imm glob, per 1 ml	9105	71.33	65.58
J1190	K	Dexrazoxane HCl injection	0726	112.48	112.48
J1563	K	Immune globulin, 1 g	0905	43.96	37.95
J1564	K	Immune globulin 10 mg	9021	0.44	0.41
J1745	K	Infliximab injection	7043	38.86	31.81
J1825	K	Interferon beta-1a	0909	184.79	123.77
J2430	K	Pamidronate disodium /30 MG	0730	174.32	128.74
J7190	K	Factor viii	0925	0.51	0.42
J7192	K	Factor viii recombinant	0927	1.01	0.61
J7193	K	Factor IX non-recombinant	0931	0.51	0.51
J7194	K	Factor ix complex	0928	0.51	0.18
J7198	K	Anti-inhibitor	0929	1.01	0.69
J7310	K	Ganciclovir long act implant	0913	86.54	86.54
J7317	K	Sodium hyaluronate injection	7316	138.78	67.16
J7502	K	Cyclosporine oral 100 mg	0888	2.56	2.41
J7517	K	Mycophenolate mofetil oral	9015	2.04	1.36
J8560	K	Etoposide oral 50 MG	0802	27.37	21.91
J9000	K	Doxorubic hcl 10 MG vl chemo	0847	6.61	4.69
J9031	K	Bcg live intravesical vac	0809	103.75	77.54
J9040	K	Bleomycin sulfate injection	0857	160.56	88.32
J9060	K	Cisplatin 10 MG injection	0813	21.74	7.73
J9065	K	Inj cladribine per 1 MG	0858	37.82	24.84
J9070	K	Cyclophosphamide 100 MG inj	0815	4.74	2.77
J9093	K	Cyclophosphamide lyophilized	0816	4.50	2.36
J9100	K	Cytarabine hcl 100 MG inj	0817	5.07	1.55
J9130	K	Dacarbazine 100 mg inj	0819	5.31	5.31
J9150	K	Daunorubicin	0820	73.97	35.94
J9181	K	Etoposide 10 MG inj	0824	4.56	0.83
J9200	K	Floxuridine injection	0827	114.19	66.24
J9208	K	Ifosfomide injection	0831	106.04	72.81
J9209	K	Mesna injection	0732	28.43	17.66
J9211	K	Idarubicin hcl injection	0832	178.21	178.21
J9218	K	Leuprolide acetate injection	0861	43.60	14.48
J9265	K	Paclitaxel injection	0863	112.14	79.04
J9280	K	Mitomycin 5 MG inj	0862	53.03	30.91
J9340	K	Thiotepa injection	0851	59.93	45.31
Q2022	K	VonWillebrandFactr CmplxperIU	1618	1.01	0.46
Q3002	K	Gallium ga 67	1619	11.22	11.22
Q3007	K	Sodium phosphate p32	1624	70.61	66.44
Q3011	K	Chromic phosphate p32	1628	98.52	81.27
Q3012	K	Cyanocobalamin cobalt co57	1089	57.07	47.38
Q3025	K	IM inj interferon beta 1-a	9022	61.60	13.36

Coding for Specified Outpatient Drugs

In order to implement these provisions timely on January 1, 2004, we are instructing hospitals to use the existing HCPCS code that describes the drug for services furnished on or after January 1, 2004. For sole source drugs, the existing HCPCS code is priced in accordance with the provisions of section 1833(t)(14)(A)(i) of the Act as indicated in Table 1. However, existing HCPCS codes do not allow us to differentiate payment amounts for innovator multiple source and noninnovator multiple source forms of the drug.

Therefore, for implementation January 1, 2004, we set payment rates for all multiple source innovator and noninnovator drugs, biologicals and radiopharmaceutical agents at the lower of the payment rate in the November 7, 2003 final rule or 46 percent of the reference AWP. These rates are shown in Table 2.

Initially, we will implement sections 1833(t)(14)(A)(i)(II) and (III) of the Act in this manner because we are unable to compile a definitive list of the innovator multiple source drugs in time for January 1, 2004 implementation. On April 1, 2004, CMS will implement new HCPCS codes that providers may use to bill for innovator multiple source drugs in order to receive appropriate payment in accordance with section 1833(t)(14)(A)(i)(II) of the Act, that is, the payment amount established in the November 7, 2003 final rule or 68 percent of the reference AWP, whichever is lower. The new codes will be effective January 1, 2004 so that providers may submit adjustment bills after April 1, 2004 to receive appropriate payment for multiple source innovator drugs furnished on or after January 1, 2004 through March 31, 2004.

Beginning April 1, 2004, innovator multiple source drugs will be paid at the statutory rate as long as the new codes are used. The multiple source noninnovator rate will be the default payment rate for the existing HCPCS code assigned to the drug, and providers will continue to use the current HCPCS codes to bill for noninnovator multiple source drugs after March 31, 2004. The new HCPCS codes will be very similar to the current codes with only the distinction that the drug being billed is an innovator multiple source drug eligible for payment of as much as 68 percent of the AWP.

We recognize that creation and use of a new code to designate a drug to be an innovator multiple source drug creates burden for hospitals. However, the law provides different payment rules based on the category into which the drug falls and therefore, to ensure correct payment, hospitals must report a code for the drug that identifies the category into which it falls. We request comments on ways that we can reduce the reporting burden on hospitals that results from the law's imposing different payment limitations on brand name and generic versions of the same drug.

Table 2 lists the drugs for which the new HCPCS codes will be implemented April 1, 2004 to distinguish innovator multiple source from noninnovator multiple source drugs.

Other changes in payment methodology effective January 1, 2004 as a result of enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003

Payment for Pass-Through Drugs, Biologicals, and Radiopharmaceuticals

Drugs and biologicals that are within the 2–3 year pass-through payment period in 2004 continue to be paid pursuant to section 1842(o) of the Act. However, section 1842(o) of the Act has been revised by section 303(b) of the DIMA and those revisions change the way that these drugs are paid.

Drugs and biologicals furnished during 2004 that are approved for pass-through payment under the OPPS and that were not approved by the FDA for marketing as of April 1, 2003 will be paid 95 percent of AWP pursuant to section 1842(o)(1)(A)(iii). *See* Table 3b for a list of these pass-through drugs.

Drugs and biologicals furnished during 2004 for which pass-through payment was first made on or after January 1, 2003 (which removes them from application of section 621 of the DIMA) and were approved by the FDA for marketing as of April 1, 2003, will be paid 85 percent of AWP pursuant to section 1842(o)(1)(B) and 1842(o)(4)(A), unless sections 1842(o)(4)(B), (C) or (D) apply. See Table 3a for a list of these pass-through drugs.

Table 3c lists 10 drugs and biologicals with pass-through status in 2004 that also meet the criteria for ''specified covered outpatient drugs'' under section 1833(t)(14). That is, the drugs in Table 3c are pass-through drugs in 2004 that were available for payment before April 1, 2003 and would therefore be paid 85 percent of AWP (determined as of April 1, 2003) under the cross reference in section 1833(t)(6)(D)(i) to section 1842(o). Separate APCs have been established for these drugs and they were paid as pass-through drugs on or before December 31, 2002. Therefore, these pass-through drugs qualify under section 1833(t)(14)(B) as ''specified covered outpatient drugs.'' As specified covered outpatient drugs, the ten drugs would be categorized as ''sole source'' drugs.

Sole source drugs, under section 1833(t)(14)(A)(i)(I) are paid no less than 88 percent nor more than 95 percent of the reference AWP. To the extent that the ten drugs listed in Table 3c qualify as both pass-through drugs and sole source drugs under the DIMA, it appears that they are subject to two different payment provisions. We have reconciled the two apparently conflicting payment provisions in a way that we believe results in the fewest anomalies. The drugs will retain their pass-through status, and therefore, the rules and policies that otherwise apply to pass-through drugs continue to apply to them. They will also be considered sole source drugs for purposes of section 1833(t)(14). We will pay for the drugs as follows.

First, because the drugs are pass-through drugs, we will give them pass-through payments. The pass-through payments will equal 85 percent of AWP (determined as of April 1, 2003) under section 1833(t)(6)(D)(i). However, because the drugs are also sole source drugs, we will also apply the payment methodology set forth in section 1833(t)(14)(A)(i)(I), and raise the payment to 88 percent of the reference AWP (the AWP determined as of May 1, 2003).

Under the payment methodology that we are applying to sole source drugs, we look at the payment that would otherwise be made and if it is less than 88 percent or greater than 95 percent of reference AWP, we adjust it as minimally as necessary to ensure that it is within the required range. In the case of these drugs, absent the provisions of 1833(t)(14)(i)(I), we would pay 85 percent of AWP (determined as of April 1, 2003). Therefore adjusting the payment that would otherwise be made results in payment at 88 percent of reference AWP.

In light of the total revamping of the methodology for payment for drugs and biologicals under OPPS, we revisited the adjustment that we made under our authority in section 1833(t)(2)(E) of the Act to ensure equitable payments in 2003 and in the November 7 final rule for the 2004 update of the OPPS. After considering the nature of the DIMA payment changes, we have concluded that it is still appropriate to apply this adjustment to the methodology discussed in the previous two paragraphs for the reasons we stated in the OPPS rulemaking during the past two years. Therefore, for darbepoetin alpha (Q0137 and C1774), we are

making an adjustment in accordance with section 1833(t)(2)(E) of the Act (which was unaffected by DIMA) to the combined pass-through amount and 3 percent additional payment provided under section 1833(t)(14)(A)(i)(I) of DIMA, resulting in a payment rate of $3.88 per unit. This payment rate is budget neutral.

TABLE 3A.—PASS-THROUGH DRUGS REIMBURSED AT 85% OF AWP

HCPCS	APC	Long description	2004 Payment amount	2004 Co-payment amount
J9395	9120	Injection, Fulvestrant, per 25 mg	$78.36	$13.09
C9121	9121	Injection, Argotroban, per 5 mg	14.63	2.44
C9123	9123	TransCyte, per 247 sq cm	689.78	115.23
C9205	9205	Injection, Oxaliplatin, per 5 mg	8.45	1.41
C9203	9203	Injection, Perflexane lipid microspheres, per single use vial	127.50	21.30
J3315	9122	Injection, Triptorelin pamoate, per 3.75 mg	356.66	59.58
J3486	9204	Injection, Ziprasidone mesylate, per 10 mg	18.60	3.11
C9211	9211	Injection, IV, Alefacept, per 7.5 mg	595.00	99.40
C9212	9212	Injection, IM, Alefacept, per 7.5 mg	422.88	70.65

TABLE 3B.—PASS-THROUGH DRUGS PAID AT 95% OF AWP

HCPCS	APC	Long description	Amount	Amount
C9207	9207	Injection, IV, Bortezomib, per 3.5 mg	1,039.68	155.40
C9208	9208	Injection, IV, Agalsidase beta, per 1 mg	123.78	18.50
C9209	9209	Injection, IV, Laronidase, per 2.9 mg	644.10	96.28
C9210	9210	Injection, IV, Palonosetron HCl, per 0.25 mg (250 micrograms)	307.80	46.01

TABLE 3C.—PASS-THROUGH DRUGS PAID AS SOLE SOURCE DRUGS AT 88% OF AWP

HCPCS	APC	Long description	OPPS CY2004 November 7 rate	DIMA final rate
J0583	9111	Injection, Bivalirudin, per 1 mg	$1.43	$1.61
C9112	9112	Injection, Perflutren lipid microsphere, per 2 ml	132.60	137.28
C9113	9113	Injection, Pantoprazole sodium, per vial	22.44	23.23
J1335	9116	Injection, Ertapenem sodium, per 500 mg	21.24	21.99
J2505	9119	Injection, Pegfilgrastim, per 6 mg single dose vial	2,507.50	2,596.00
C9200	9200	Orcel, per 36 sqare centimeters	1,015.75	1,051.60
C9201	9201	Dermagraft, per 37.5 square centimeters	516.80	535.04
J2324	9114	Injection, Nesiritide, per 0.5 mg	135.66	140.45
J3487	9115	Injection, Zoledronic acid, per 1 mg	194.52	211.07

Payment for New Drugs and Biologicals Before a HCPCS Code Is Assigned

Under new section 1833(t)(15) of the Act, as added by section 621(a)(1) of the DIMA a drug or biological that is furnished as part of covered outpatient department services for which a HCPCS codes has not been established, is to be paid at 95 percent of the AWP for the drug or biological.

We are in the process of determining how hospitals would bill Medicare for a drug prior to assignment of a HCPCS code. We will issue instructions once we have determined how to make this requirement operational.

Payment for Orphan Drugs as Designated by the Secretary

Section 1833(t)(14)(C) as added by section 621(a)(1) of the DIMA, provides that the amount of payment for orphan drugs designated by the Secretary shall, for 2004 and 2005, equal the amount the Secretary shall specify. We have determined that single indication orphan drugs as designated by the Secretary will be paid at the rates published in the November 7, 2003 **Federal Register** (68 FR 63398). Neither the definition nor the 2004 payment amounts for single indication orphan drugs under the OPPS have changed from what was published in the November 7 final rule.

Brachytherapy

Section 621(b)(1) of the DIMA of 2003 amends the Act by adding section 1833(t)(16)(C) and section 1833(t)(2)(H) which establish separate payment for devices of brachytherapy consisting of a seed or seeds (or radioactive source) based on a hospital's charges for the service, adjusted to cost. Further, charges for the brachytherapy devices shall not be used in determining any outlier payments and consistent with our practice under OPPS to exclude items paid at cost from budget neutrality consideration, these items will be excluded from budget neutrality as well. The period of payment under this provision is for brachytherapy sources furnished from January 1, 2004 through December 31, 2006.

We will pay for the brachytherapy sources listed in Table 4 on a cost basis, as required by the statute. The status indicator for brachytherapy sources is changed to ''H.'' The definition of status indicator ''H'' is currently for pass-through payment for devices, but the brachytherapy sources affected by new sections 1833(t)(16)(C) and 1833(t)(2)(H) are not pass-through device categories. Therefore, we are also changing, for 2004, the definition of payment status indicator ''H'' to include non-pass-through brachytherapy sources paid for on a cost basis. This use of status indicator ''H'' is a pragmatic decision that allows us to pay for brachytherapy sources in accordance with new section 1833(t)(16)(C) effective January 1, 2004

without having to modify our claims processing systems. We will revisit the use and definition of status indicator ''H'' for this purpose for the OPPS update for 2005. Table 4 provides a complete listing of the HCPCS codes, descriptors, APC assignments and status indicators for brachytherapy sources.

TABLE 4.—BRACHYTHERAPY SOURCES TO BE PAID SEPARATELY, USING CHARGES REDUCED TO COST

HCPCS	Descriptor	APC	APC title	New status indicator
C1716	Brachytx source, Gold 198	1716	Brachytx source, Gold 198	H
C1717	Brachytx source, HDR Ir-192	1717	Brachytx source, HDR Ir-192	H
C1718	Brachytx source, Iodine 125	1718	Brachytx source, Iodine 125	H
C1719	Brachytx sour, Non-HDR Ir-192	1719	Brachytx source, Non-HDR Ir-192	H
C1720	Brachytx source, Paladium 103	1720	Brachytx source, Paladium 103	H
C2616	Brachytx source, Yttrium-90	2616	Brachytx source, Yttrium-90	H
C2632	Brachytx solution, I–125, per mCi	2632	Brachytx sol, I–125, per mCi	H
C2633	Brachytx source, Cesium-131	2633	Brachytx source, Cesium-131	H
C2632	Brachytx sol, I–125, per mCi	2632	Brachytx sol, I–125, per mCi	H

As indicated in Table 4, brachytherapy source in HCPCS code C1717 will be paid based on the hospital's charge reduced to cost beginning January 1, 2004. Prior to enactment of DIMA, these sources were paid as packaged services in APC 0313. As a result of the requirement to pay for C1717 separately, we are adjusting the payment rate for APC 0313 to reflect the unpackaging of the brachytherapy source. The new rate is listed in Addendum A.

Section 1833(t)(2)(H) is added by section 621(b)(2)(C) of DIMA, mandating the creation of separate groups of covered OPD services that classify brachytherapy devices separately from other services or groups of services. The additional groups shall be created in a manner reflecting the number, isotope and radioactive intensity of the devices of brachytherapy furnished, including separate groups for palladium-103 and iodine-125.

We invite the public to submit recommendations for new codes to describe brachytherapy sources in a manner reflecting the number, radioisotope, and radioactive intensity of the sources. We request that commenting parties provide a detailed rationale to support recommended new codes. We will propose appropriate changes in codes for brachytherapy sources in the 2005 OPPS update.

Continuation of Transitional Corridor Payments for CY 2004

Since the inception of the OPPS, providers have been eligible to receive additional transitional payments if the payments they received under the OPPS were less than the payments they would have received for the same services under the payment system in effect before the OPPS. Under 1833(t)(7) of the Act, most hospitals that realize lower payments under the OPPS received transitional corridor payments based on a percent of the decrease in payments. However, rural hospitals having 100 or fewer beds, as well as cancer hospitals and children's hospitals described in section 1886(d)(1)(B)(iii) and (v) of the Act, were held harmless under this provision and paid the full amount of the decrease in payments under the OPPS.

Transitional corridor payments were intended to be temporary payments to ease providers' transition from the prior cost-based payment system to the prospective payment system. In accordance with section 1833(t)(7) of the Act, transitional corridor payments were to be eliminated January 1, 2004, for all providers other than cancer hospitals and children's hospitals. Cancer hospitals and children's hospitals are held harmless permanently under the transitional corridor provisions of the statute.

Section 411 of the DIMA amends section 1833(t)(7) of the Act to provide that hold harmless transitional corridor payments will continue through December 31, 2005 for rural hospitals having 100 or fewer beds.

Section 411 of the DIMA further amends section 1833(t)(7) of the Act to provide that hold harmless transitional corridor payments shall apply to sole community hospitals, as defined in section 1886(d)(5)(D)(iii) of the Act, which are located in rural areas, with respect to services furnished during cost reporting periods beginning on or after January 1, 2004, and continuing through December 31, 2005. For purposes of this provision, a sole community hospital's location in a rural area will be determined as it is under the inpatient PPS, in 42 CFR 412.63(b).

II. Provisions of the Interim Final Rule With Comment Period

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (DIMA), enacted December 8, 2003 makes changes to the Social Security Act (the Act) relating to calendar year 2004 payments under the Hospital Outpatient Prospective Payment System. This interim final rule with comment period implements changes resulting from enactment of the DIMA that are effective January 1, 2004, as follows:

Transitional Corridor Payments Extended

Hold harmless transitional corridor payments are continued through December 31, 2005 for small rural hospitals having 100 or fewer beds. In addition, hold-harmless transitional corridor provisions shall apply to sole community hospitals as defined in section 1886(d)(5)(D)(iii) of the Act with respect to cost reporting periods beginning on or after January 1, 2004 and will continue through December 31, 2005.

Payment for ''Specified Covered Outpatient Drugs''

Separately paid radiopharmaceutical agents and drugs or biologicals that had transitional pass-through status on or before December 31, 2002, are classified into 3 categories: innovator multiple source drugs; noninnovator multiple source drugs; and sole source drugs. Payment levels based on the reference average wholesale price as of May 1, 2003 are specified for each category.

Payment for Pass-Through Drugs

Drugs and biologicals furnished during 2004 for which pass-through payment was first made on or after January 1, 2003 (which removes them from application of section 621 of the

DIMA) and were approved by the FDA for marketing as of April 1, 2003, will be paid 85 percent of AWP pursuant to section 1842(o)(1)(B) and 1842(o)(4)(A), unless sections 1842(o)(4)(B), (C) or (D) apply.

Certain drugs, biologicals and radiopharmaceutical agents that are pass-through drugs in 2004 and that also meet the definition of ''specified covered outpatient drugs'', except as otherwise specified, are paid 88 percent of the reference AWP. Those drugs, biologicals, and radiopharmaceutical agents remain pass-through drugs and all policies that apply to them as pass-through drugs continue to apply.

Exclude Separately Payable Drugs and Biologicals From Outlier Payments

Separately paid drugs and biologicals are excluded from outlier payments.

Brachytherapy Sources Are To Be Paid Separately

All devices of brachytherapy consisting of a seed or seeds (or radioactive source) are paid based on the hospital's charge for the device adjusted to cost. All such brachytherapy sources are excluded from outlier payments.

III. Collection of Information Requirements

This document 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.

IV. Waiver of Notice of Proposed Rulemaking and the 30-Day Delay in the Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule in accordance with 5 U.S.C. section 553(b) of the Administrative Procedure Act (APA). The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

In this case, we believe that it is in the public interest to comply with the statutory requirement to implement these changes effective January 1, 2004. Failure to meet this deadline would cause a delay in payment increases for many drugs and biologicals and brachytherapy sources.

Section 1871 of the Act also provides for publication of a notice of proposed rulemaking and opportunity for public comment before CMS issues a final rule. However, section 1871(b)(2)(B) provides an exception when a law establishes a specific deadline for implementation of a provision and the deadline is less than 150 days after the law's date of enactment. The DIMA was enacted by the Congress on November 25, 2003 and signed into law by the President on December 8, 2003. The provisions of this rule that amend the Medicare hospital outpatient prospective payment system are required to be implemented January 1, 2004. Therefore, these provisions are subject to waiver of proposed rulemaking in accordance with section 1871(b)(2)(B) of the Act.

In addition, we ordinarily provide a 30-day delay in the effective date of the provisions of an interim final rule. Section 553(d) of the APA (5 U.S.C. section 553(d)) ordinarily requires a 30-day delay in the effective date of final rules after the date of their publication in the **Federal Register**. This 30-day delay in effective date can be waived, however, if an agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the finding and its reasons in the rule issued.

In this case, we believe that it is in the public interest to comply with the statutory requirement to implement these changes effective January 1, 2004 without the 30-day delay in effective date. Failure to meet this deadline would cause a delay in payment increases for many drugs and biologicals and brachytherapy sources.

In addition to the APA requirements, section 1871(e)(1), as amended by section 903(b)(1) of DIMA also requires that a substantive change in a regulation shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published the substantive change. Section 903(b)(1) provides an exception to the requirement of a 30-day delay in the effective date if the Secretary finds that the waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest.

For purposes of DIMA, we believe that it is in the public interest to comply with the statutory requirement to implement these changes effective January 1, 2004 without the 30-day delay in effective date for the same reasons stated above—failure to meet this deadline would cause a delay in payment increases for many drugs and biologicals and brachytherapy sources. In addition, we find it is necessary to waive the 30-day delay period in order to timely comply with the statutory requirement that new payment rates be effective on January 1, 2004. We are providing a 60-day public comment period.

V. Regulatory Impact Analysis

A. Overall Impact

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. Our Office of the Actuary estimates that the total change in expenditures under the OPPS for CY 2004 as a result of the changes made by DIMA to be approximately $150 million. Therefore, this final rule with comment is an economically significant rule under Executive Order 12866, and a major rule under 5 U.S.C. 804(2). Therefore the discussion below, in combination with the rest of this final rule constitutes a regulatory impact analysis. The RFA requires agencies to analyze options for regulatory relief of small businesses. However a regulatory flexibility analysis is not required for an interim final rule because no proposed rule is being issued.

Therefore the discussion below constitutes a regulatory impact analysis but no regulatory flexibility analysis is provided.

Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This interim final rule will not mandate any requirements for State, local or tribal governments. This interim final rule will not impose unfunded mandates on the private sector of more than $110 million dollars.

Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined this interim 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.

B. Anticipated Effects of Changes in This Interim Final Rule and Alternatives Considered for Each Change

All of the changes made in this interim final rule with comment are required by DIMA. We are required under section 621 of the DIMA to revise payments for certain drugs and biologicals and for radiopharmaceuticals. We are also required under section 621 of the DIMA to pay for brachytherapy sources on the basis of application of a cost to charge ratio to the charges for the sources. In addition, we are required under section 621 of the DIMA to continue transitional outpatient payment for certain hospitals.

Impact on Drugs and Biologicals That Will Be Paid Under Pass-Through Provisions in 2004

Four of the drugs and biologicals that will be paid under pass-through provisions in 2004 will be paid at 95 percent of AWP. Nine of the drugs and biologicals that will be paid under pass-through provisions in 2004 will be paid at 85 percent of AWP in 2004. This is a reduction of 10 percent of AWP compared to the payment that would have been made for these drugs and biologicals before passage of the DIMA.

As discussed previously in this rule, some pass-through drugs and biologicals also meet the criteria for ''specified covered outpatient drugs'' under 1833(t)(14) and, except as specified in this rule, will be paid 88 percent of the reference AWP. Notwithstanding the payment amount, however, they remain pass-through drugs.

Hospitals that provide drugs paid at 85 percent of AWP will be paid less than they would have been paid absent passage of the new law.

It is unclear whether the reduction in payments for these drugs will have any effect on beneficiary access to them. Hospitals consider many factors when they determine whether they choose to provide the drugs and it is unclear whether the reduction in payment for Medicare will result in impaired access. However, reduction in the payment amounts for some drugs means that beneficiaries will have lower copayments for those drugs and that they, and complementary insurers who pay beneficiary cost sharing, will have reduced expenses. Hospitals, however, will clearly be paid reduced amounts by Medicare for these drugs compared to the amounts that would be paid had the statute not imposed these changes. Manufacturers and distributors of the pass-through drugs that will be paid at 85 percent of AWP will be under increased pressure to reduce the price of the drugs since the hospitals to which they sell the items will be paid lower amounts by Medicare for them when used in hospital outpatient departments.

We considered setting payment at 85 percent for pass-through drugs that also meet the definition of ''specified covered outpatient drugs'' as allowed in the cross reference from 1833(t)(6) to 1842(o). However, given that the drugs are eligible for payment under both sets of criteria, we chose to increase their payment to 88 percent of reference AWP, except as otherwise specified. We believe that this choice will result in the least possible disruption to beneficiary access to these drugs.

We considered no alternatives with regard to payment for pass-through drugs that did not meet the definition of ''specified covered outpatient drugs'' because the law provides only one payment methodology for these drugs.

Impact of Changes for ''Specified Covered Outpatient Drugs''

Radiopharmaceutical agents and drugs or biologicals for which payment was made on a pass-through basis on or before December 31, 2002, are now to be paid under section 1833(t)(14) of the Act as added by DIMA. Under these provisions, radiopharmaceuticals and drugs and biologicals that meet the criteria, are paid amounts that must be limited as specified in the law. Specifically, items that meet the definition of sole source drugs must be paid no less than 88 percent of reference AWP nor more than 95 percent of reference AWP. Items that meet the definition of innovator multiple source drugs must be paid no more than 68 percent of AWP and items that meet the definition of noninnovator multiple source drugs must be paid no more than 46 percent of AWP.

As described previously, these categories are defined in section 1927(k)(7) of the Act. That section classifies drugs, biologicals and radiopharmaceuticals for purposes of the Medicaid drug rebate program. CMS has a database in which these items are categorized to which we looked to seek the classification of each drug, biological and radiopharmaceutical paid under pass-through provisions before December 31, 2002. Table 1 shows those items that we believe meet the definition of sole source drug. Table 2 shows those items for which it is not clear to us whether the item should be classified as a sole source drug or as both an innovator multiple source and a noninnovator multiple source drug and which we will pay as noninnovator multiple source drugs until we receive comments and determine the classification into which the drug falls. Paying for those drugs with questionable classification as noninnovator multiple source drugs allows payment to be made to hospitals for these drugs when they are furnished and also protects hospitals from incurring overpayments. Once we review the public comments and establish the correct classification and codes for the billing of innovator multiple source drugs, hospitals may subject adjustment bills to be paid the additional amounts due.

We will pay the 121 drugs in Table 1 at the amounts shown, as previously discussed. Six of these drugs will have no payment change from the payment announced in the November 7, 2003 final rule. Six of these drugs will receive decreases in payment compared to the final rule because the payment established in the November 7, 2003 final rule exceeded 95 percent of the reference AWP. The payment amounts for these drugs are now set at 95 percent of the reference AWP in accordance with the law. One hundred nine of these drugs will receive increases in payment compared to the final rule because the payment established in the November 7, 2003 final rule was less than 88 percent of reference AWP. The payment amounts for these drugs, biologicals and radiopharmaceuticals is now set at 88 percent of the reference AWP.

We will temporarily pay the 52 drugs in Table 2 at the amounts shown, as previously discussed. Thirteen of these items will be paid the amount that was published in the November 7, 2003 final rule. Thirty-eight of these items will receive payment decreases. One of these items did not have a reference AWP under the SDP and will require further research to determine the correct payment amount. Until we determine a reference AWP for this item it will be paid at the amount that was published in the November 7, 2003 final rule.

It is unclear what the final overall impact of these changes will be because we are, as yet, unable to determine into which categories 52 items in dispute will fall. Moreover, once they are categorized, we do not anticipate that we will know the frequency with which hospitals will use the innovator multiple source drug versus the noninnovator multiple source drug in the outpatient department. Moreover, it is not clear to what extent hospitals may change their behavior with regard to which type of a drug they choose to purchase and whether their purchasing decisions will be affected by whether they furnish the item to hospital outpatient departments or inpatient departments.

We considered whether to classify the 52 items with questionable category assignment as both innovator multiple source and noninnovator multiple source drugs and to create HCPCS codes to be used when innovator multiple source drugs are administered. However, we believe that public comment is necessary to determine the correct classification of these items. Similarly, we believe that, given the burden the law imposes on hospitals for reporting drugs by the category into which they fall, it was important to receive public comment regarding whether new codes should be created and regarding ways we can reduce the reporting burden on hospitals. Hence, until we receive and review the comments, we will not be able to assess the impact of these requirements of the law.

We do acknowledge, however, that for the 52 drugs that are not sole source drugs, the temporary payments to hospitals at the noninnovator multiple source drug rate will be less than the payment that would have been made under the November 7, 2003 final rule. For those drugs that are sole source drugs, the payment will increase in most cases.

Hospitals that provide sole source drugs will be paid more for these drugs under these provisions than they would have been paid before enactment of the DIMA. Hospitals that provide innovator multiple source drugs and noninnovator multiple source drugs will be paid less for these items than they would have been before enactment of the DIMA. This may encourage use of sole source drugs and discourage use of multiple source drugs. As a result, beneficiaries may have greater access to sole source drugs but will also incur greater copayments because those payment rates are higher than they would have been before enactment of DIMA. In turn, there may be increased payment by complementary insurers for these items. Manufacturers of sole source drugs may realize increased sales and manufacturers of generic drugs may see reduced sales.

We considered whether to permit a drug that is classified by AMP as a sole source drug, an innovator multiple source drug and a noninnovator multiple source drug to be paid under all three classifications. We decided not to pay a drug as a sole source drug if it is also a multiple source drug for reasons described previously in this interim final rule. We considered no alternatives because the law is quite specific with regard to the classification of drugs and the payment rules that apply to each class of drug.

Impact of Cost-Based Payment for Sources of Brachytherapy

The law provides that sources of brachytherapy will be paid an amount equal to the hospital's charge for the source adjusted by the applicable cost to charge ratio. It is unclear whether this will result in an increase or decrease in payment for brachytherapy sources. However, removing the brachytherapy source from packaged payment for the services with which it is furnished removes incentives for using the least number of sources needed for the therapeutic purpose. There is no evidence that packaged payment for brachytherapy sources resulted in inappropriately low utilization of brachytherapy, nor that separate payment will result in any change in availability of the service. We are unable to estimate the impact of this change on utilization and program payment.

We considered no alternatives to this policy because the statute was specific with regard to how payment for brachytherapy sources must be made.

Impact of Continuation of Transitional Outpatient Payments for Certain Hospitals

The law provides that transitional outpatient payments must continue for rural hospitals with 100 or fewer beds and be provided for sole community hospitals in rural areas through December 31, 2005. There are approximately 600 sole community hospitals and approximately 1150 rural hospitals with 100 beds or fewer that may be affected by this provision. These hospitals will continue to receive transitional corridor payments in addition to the payments they will receive under OPPS. These payments should continue to strengthen the ability of these hospitals to furnish services to beneficiaries who reside in the areas served by these hospitals. Beneficiaries should be better assured of access to services in these hospitals. These hospitals will be assured of payment for the reasonable costs of providing outpatient services.

We considered no alternatives because the statute is quite directive with regard to the extension of hold harmless protection to these hospitals.

C. Conclusion

We have prepared the analysis above because we have determined that this interim final rule will have a significant economic impact. In accordance with the provisions of Executive Order 12866, this interim final rule was reviewed by the Office of Management and Budget.

Publication of Addenda

The addenda included in this interim final rule, Addenda A and D1 replace the addenda in the November 7, 2003 **Federal Register** (68 FR 63478). The revised addenda reflect changes required by the DIMA as well as corrections to minor errors contained in the addenda published November 7, 2003.

In addition to the addenda included here, we will post the updated Addenda B and C on our Web site at *http://www.cms.hhs.gov/regulations/hopps/*.

List of Subjects in 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 set forth below:

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).

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

■ 2. Section 419.32 is amended by revising paragraph (d) to read as follows:

§ 419.32 Calculation of prospective payment rates for hospital outpatient services.

* * * * *

(d) *Budget neutrality.* (1) CMS adjusts the conversion factor as needed to ensure that updates and adjustments under § 419.50(a) are budget neutral.

(2) In determining adjustments for 2004 and 2005, CMS will not take into account any additional expenditures per section 1833(t)(14) of the Act that would not have been made but for enactment of section 621 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Subpart D—Payments to Hospitals

■ 3. Section § 419.43 is amended as follows:

■ A. Paragraph (d)(1) introductory text is revised.

■ B. Paragraph (e) is revised.

■ C. New paragraph (f) is added.

The revisions and additions read as follows:

§ 419.43 Adjustments to national program payments and beneficiary copayment amounts.

* * * * *

(d) *Outlier adjustment*—(1) *General rule.* Subject to paragraph (d)(4) of this section, CMS provides for an additional payment for a hospital outpatient service (or group of services) not excluded under paragraph (f) of this section for which a hospital's charges, adjusted to cost, exceed the following:

* * * * *

(e) *Budget neutrality.* CMS establishes payment under paragraph (d) of this section in a budget-neutral manner excluding services and groups specified in paragraph (f) of this section.

(f) *Excluded services and groups.* Drugs and biologicals that are paid under a separate APC and devices of brachytherapy, consisting of a seed or seeds (including a radioactive source) are excluded from qualification for outlier payments.

Subpart G—Transitional Pass-Through Payments

■ 4. Section 419.64 is amended by revising paragraph (d).

§ 419.64 Transitional pass-through payments: Drugs and biologicals.

* * * * *

(d) *Amount of pass-through payment.* (1) Subject to any reduction determined under § 419.62(b), the pass-through payment for a drug or biological as specified in section 1842(o)(1)(A) and (o)(1)(D)(i) of the Act is 95 percent of the average wholesale price of the drug or biological minus the portion of the APC payment CMS determines is associated with the drug or biological.

(2) Subject to any reduction determined under § 419.62(b), the pass-through payment for a drug or biological as specified in section 1842(o)(1)(B) and (o)(1)(E)(i) of the Act is 85 percent of the average wholesale price, determined as of April 1, 2003, of the drug or biological minus the portion of the APC payment CMS determines is associated with the drug or biological.

Subpart H—Transitional Corridors

■ 5. Section 419.70 is amended as follows:

■ A. Paragraph (d)(1) is amended by removing ''2004'' and adding ''2006'' in its place.

■ B. A new paragraph (d)(3) is added to read as follows:

§ 419.70 Transitional adjustment to limit decline and payment.

* * * * *

(d) * * *

(3) *Temporary treatment for sole community hospitals located in rural areas.* For covered hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2004, and continuing through December 31, 2005, for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this part is increased by the amount of that difference if the hospital—

(i) Is a sole community hospital, under § 412.92 of this chapter; and

(ii) Is located in a rural area as defined in § 412.63(b) of this chapter or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act.

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

Dated: December 23, 2003.

Dennis G. Smith,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: December 23, 2003.

Tommy G. Thompson,

Secretary.

Note: The following addenda will not appear in the Code of Federal Regulations.

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0001	Level I Photochemotherapy	S	0.4237	$23.12	$7.09	$4.62
0002	Level I Fine Needle Biopsy/Aspiration	T	0.8083	$44.10	.....	$8.82
0003	Bone Marrow Biopsy/Aspiration	T	2.3229	$126.74	.....	$25.35
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	1.5882	$86.65	$22.36	$17.33
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	3.2698	$178.40	$71.59	$35.68
0006	Level I Incision & Drainage	T	1.6527	$90.17	$23.26	$18.03
0007	Level II Incision & Drainage	T	11.8633	$647.27	.....	$129.45
0008	Level III Incision and Drainage	T	19.4831	$1,063.02	.....	$212.60
0009	Nail Procedures	T	0.6652	$36.29	$8.34	$7.26
0010	Level I Destruction of Lesion	T	0.6480	$35.36	$10.08	$7.07
0011	Level II Destruction of Lesion	T	2.2217	$121.22	$27.88	$24.24
0012	Level I Debridement & Destruction	T	0.7612	$41.53	$11.18	$8.31
0013	Level II Debridement & Destruction	T	1.1302	$61.66	$14.20	$12.33
0015	Level III Debridement & Destruction	T	1.5968	$87.12	$20.35	$17.42
0016	Level IV Debridement & Destruction	T	2.5724	$140.35	$57.31	$28.07
0017	Level VI Debridement & Destruction	T	16.3697	$893.15	$227.84	$178.63
0018	Biopsy of Skin/Puncture of Lesion	T	0.9178	$50.08	$16.04	$10.02

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0019	Level I Excision/ Biopsy	T	3.9493	$215.48	$71.87	$43.10
0020	Level II Excision/ Biopsy	T	7.0842	$386.52	$113.25	$77.30
0021	Level III Excision/ Biopsy	T	14.3594	$783.46	$219.48	$156.69
0022	Level IV Excision/ Biopsy	T	18.7932	$1,025.38	$354.45	$205.08
0023	Exploration Penetrating Wound	T	2.8141	$153.54	$40.37	$30.71
0024	Level I Skin Repair	T	1.6850	$91.94	$33.10	$18.39
0025	Level II Skin Repair	T	5.1912	$283.24	$107.00	$56.65
0027	Level IV Skin Repair	T	15.8990	$867.47	$329.72	$173.49
0028	Level I Breast Surgery	T	17.6584	$963.46	$303.74	$192.69
0029	Level II Breast Surgery	T	30.1167	$1,643.20	$632.64	$328.64
0030	Level III Breast Surgery	T	37.3083	$2,035.58	$763.55	$407.12
0032	Insertion of Central Venous/Arterial Catheter	T	11.4907	$626.94	.....	$125.39
0033	Partial Hospitalization	P	5.2569	$286.82	.....	$57.36
0035	Placement of Arterial or Central Venous Catheter	T	0.1691	$9.23	$2.79	$1.85
0036	Level II Fine Needle Biopsy/Aspiration	T	1.5170	$82.77	.....	$16.55
0037	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.8921	$539.72	$237.45	$107.94
0039	Implantation of Neurostimulator	S	235.1866	$12,832.02	.....	$2,566.40
0040	Level II Implantation of Neurostimulator Electrodes	S	52.1002	$2,842.64	.....	$568.53
0041	Level I Arthroscopy	T	27.3819	$1,493.98	.....	$298.80
0042	Level II Arthroscopy	T	43.0808	$2,350.53	$804.74	$470.11
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.9074	$104.07	.....	$20.81
0045	Bone/Joint Manipulation Under Anesthesia	T	13.5889	$741.42	$268.47	$148.28
0046	Open/Percutaneous Treatment Fracture or Dislocation	T	32.5581	$1,776.40	$535.76	$355.28
0047	Arthroplasty without Prosthesis	T	29.9582	$1,634.55	$537.03	$326.91
0048	Arthroplasty with Prosthesis	T	51.4609	$2,807.76	$695.60	$561.55
0049	Level I Musculoskeletal Procedures Except Hand and Foot.	T	19.6046	$1,069.65	.....	$213.93
0050	Level II Musculoskeletal Procedures Except Hand and Foot.	T	24.8651	$1,356.66	.....	$271.33
0051	Level III Musculoskeletal Procedures Except Hand and Foot.	T	34.5144	$1,883.14	.....	$376.63
0052	Level IV Musculoskeletal Procedures Except Hand and Foot.	T	42.7126	$2,330.44	.....	$466.09
0053	Level I Hand Musculoskeletal Procedures	T	14.8831	$812.04	$253.49	$162.41
0054	Level II Hand Musculoskeletal Procedures	T	24.2456	$1,322.86	.....	$264.57
0055	Level I Foot Musculoskeletal Procedures	T	18.7205	$1,021.41	$355.34	$204.28
0056	Level II Foot Musculoskeletal Procedures	T	25.3930	$1,385.47	$405.81	$277.09
0057	Bunion Procedures	T	25.5035	$1,391.50	$475.91	$278.30
0058	Level I Strapping and Cast Application	S	1.0931	$59.64	.....	$11.93
0060	Manipulation Therapy	S	0.2788	$15.21	.....	$3.04
0068	CPAP Initiation	S	1.0807	$58.96	$29.48	$11.79
0069	Thoracoscopy	T	28.9392	$1,578.95	$591.64	$315.79
0070	Thoracentesis/Lavage Procedures	T	3.0717	$167.60	.....	$33.52
0071	Level I Endoscopy Upper Airway	T	0.8799	$48.01	$12.89	$9.60
0072	Level II Endoscopy Upper Airway	T	1.7613	$96.10	$26.68	$19.22
0073	Level III Endoscopy Upper Airway	T	3.4541	$188.46	$73.38	$37.69
0074	Level IV Endoscopy Upper Airway	T	13.9480	$761.02	$295.70	$152.20
0075	Level V Endoscopy Upper Airway	T	20.3815	$1,112.04	$445.92	$222.41
0076	Level I Endoscopy Lower Airway	T	9.2346	$503.85	$189.82	$100.77
0077	Level I Pulmonary Treatment	S	0.2837	$15.48	$7.74	$3.10
0078	Level II Pulmonary Treatment	S	0.7917	$43.20	$14.55	$8.64
0079	Ventilation Initiation and Management	S	2.1494	$117.27	.....	$23.45
0080	Diagnostic Cardiac Catheterization	T	36.0160	$1,965.07	$838.92	$393.01
0081	Non-Coronary Angioplasty or Atherectomy	T	35.0285	$1,911.19	.....	$382.24
0082	Coronary Atherectomy	T	110.2196	$6,013.69	$1,293.59	$1,202.74
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T	59.2047	$3,230.27	.....	$646.05
0084	Level I Electrophysiologic Evaluation	S	10.5226	$574.12	.....	$114.82
0085	Level II Electrophysiologic Evaluation	T	35.4126	$1,932.15	$426.25	$386.43
0086	Ablate Heart Dysrhythm Focus	T	44.9389	$2,451.91	$833.33	$490.38
0087	Cardiac Electrophysiologic Recording/Mapping	T	39.8161	$2,172.41	.....	$434.48
0088	Thrombectomy	T	34.6942	$1,892.95	$655.22	$378.59
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	T	117.1896	$6,393.98	$1,722.59	$1,278.80
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	96.8284	$5,283.05	$1,651.45	$1,056.61
0091	Level II Vascular Ligation	T	28.8326	$1,573.14	$348.23	$314.63
0092	Level I Vascular Ligation	T	25.0959	$1,369.26	$505.37	$273.85
0093	Vascular Reconstruction/Fistula Repair without Device	T	21.3104	$1,162.72	$277.34	$232.54
0094	Level I Resuscitation and Cardioversion	S	2.6345	$143.74	$48.58	$28.75
0095	Cardiac Rehabilitation	S	0.5994	$32.70	$16.35	$6.54

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0096	Non-Invasive Vascular Studies	S	1.7176	$93.71	$46.85	$18.74
0097	Cardiac and Ambulatory Blood Pressure Monitoring	X	1.0635	$58.03	$23.80	$11.61
0098	Injection of Sclerosing Solution	T	1.0729	$58.54	$14.06	$11.71
0099	Electrocardiograms	S	0.3703	$20.20	.....	$4.04
0100	Cardiac Stress Tests	X	1.5862	$86.54	$41.44	$17.31
0101	Tilt Table Evaluation	S	4.4040	$240.29	$105.27	$48.06
0103	Miscellaneous Vascular Procedures	T	11.6202	$634.01	$223.63	$126.80
0104	Transcatheter Placement of Intracoronary Stents	T	82.6713	$4,510.63	.....	$902.13
0105	Revision/Removal of Pacemakers, AICD, or Vascular	T	19.1898	$1,047.01	$370.40	$209.40
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes.	T	58.9719	$3,217.57	.....	$643.51
0107	Insertion of Cardioverter-Defibrillator	T	337.1304	$18,394.17	$3,699.14	$3,678.83
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	T	452.6995	$24,699.74	.....	$4,939.95
0109	Removal of Implanted Devices	T	7.4705	$407.60	$131.49	$81.52
0110	Transfusion	S	3.6718	$200.34	.....	$40.07
0111	Blood Product Exchange	S	13.1719	$718.67	$200.18	$143.73
0112	Apheresis, Photopheresis, and Plasmapheresis	S	37.5832	$2,050.58	$612.47	$410.12
0113	Excision Lymphatic System	T	19.9322	$1,087.52	.....	$217.50
0114	Thyroid/Lymphadenectomy Procedures	T	37.5963	$2,051.29	$485.91	$410.26
0115	Cannula/Access Device Procedures	T	25.6437	$1,399.15	$459.35	$279.83
0116	Chemotherapy Administration by Other Technique Except Infusion.	S	0.7996	$43.63	.....	$8.73
0117	Chemotherapy Administration by Infusion Only	S	3.0360	$165.65	$42.54	$33.13
0119	Implantation of Infusion Pump	T	134.7194	$7,350.43	.....	$1,470.09
0120	Infusion Therapy Except Chemotherapy	T	1.9114	$104.29	$28.21	$20.86
0121	Level I Tube changes and Repositioning	T	2.1114	$115.20	$43.80	$23.04
0122	Level II Tube changes and Repositioning	T	8.8621	$483.53	$99.16	$96.71
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant.	S	6.1499	$335.54	.....	$67.11
0124	Revision of Implanted Infusion Pump	T	23.8050	$1,298.82	.....	$259.76
0125	Refilling of Infusion Pump	T	2.1606	$117.88	.....	$23.58
0130	Level I Laparoscopy	T	32.7724	$1,788.09	$659.53	$357.62
0131	Level II Laparoscopy	T	40.8064	$2,226.44	$1,001.89	$445.29
0132	Level III Laparoscopy	T	57.2045	$3,121.13	$1,239.22	$624.23
0140	Esophageal Dilation without Endoscopy	T	6.4525	$352.05	$107.24	$70.41
0141	Upper GI Procedures	T	7.8206	$426.70	$143.38	$85.34
0142	Small Intestine Endoscopy	T	8.7959	$479.91	$152.78	$95.98
0143	Lower GI Endoscopy	T	8.2957	$452.62	$186.06	$90.52
0146	Level I Sigmoidoscopy	T	3.9826	$217.29	$64.40	$43.46
0147	Level II Sigmoidoscopy	T	7.6808	$419.07	.....	$83.81
0148	Level I Anal/Rectal Procedure	T	3.8320	$209.08	$63.38	$41.82
0149	Level III Anal/Rectal Procedure	T	17.1425	$935.31	$293.06	$187.06
0150	Level IV Anal/Rectal Procedure	T	22.1919	$1,210.81	$437.12	$242.16
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP).	T	17.9462	$979.16	$245.46	$195.83
0152	Percutaneous Abdominal and Biliary Procedures	T	9.1474	$499.09	$125.28	$99.82
0153	Peritoneal and Abdominal Procedures	T	20.8723	$1,138.81	$410.87	$227.76
0154	Hernia/Hydrocele Procedures	T	26.9636	$1,471.16	$464.85	$294.23
0155	Level II Anal/Rectal Procedure	T	10.0809	$550.02	$188.89	$110.00
0156	Level II Urinary and Anal Procedures	T	2.4747	$135.02	$40.52	$27.00
0157	Colorectal Cancer Screening: Barium Enema	S	2.5693	$140.18	.....	$28.04
0158	Colorectal Cancer Screening: Colonoscopy	T	7.4244	$405.08	.....	$101.27
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	2.7823	$151.81	.....	$37.95
0160	Level I Cystourethroscopy and other Genitourinary Procedures.	T	6.8801	$375.39	$105.06	$75.08
0161	Level II Cystourethroscopy and other Genitourinary Procedures.	T	16.8407	$918.85	$249.36	$183.77
0162	Level III Cystourethroscopy and other Genitourinary Procedures.	T	21.9098	$1,195.42	.....	$239.08
0163	Level IV Cystourethroscopy and other Genitourinary Procedures.	T	33.8805	$1,848.55	.....	$369.71
0164	Level I Urinary and Anal Procedures	T	1.2021	$65.59	$17.59	$13.12
0165	Level III Urinary and Anal Procedures	T	14.6838	$801.16	.....	$160.23
0166	Level I Urethral Procedures	T	16.7918	$916.18	$218.73	$183.24
0167	Level III Urethral Procedures	T	30.0186	$1,637.84	$555.84	$327.57
0168	Level II Urethral Procedures	T	30.0147	$1,637.63	$405.60	$327.53
0169	Lithotripsy	T	45.1150	$2,461.52	$1,115.69	$492.30
0170	Dialysis	S	5.9678	$325.61	.....	$65.12

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0180	Circumcision	T	18.6176	$1,015.79	$304.87	$203.16
0181	Penile Procedures	T	29.4217	$1,605.28	$621.82	$321.06
0183	Testes/Epididymis Procedures	T	21.6724	$1,182.47	.....	$236.49
0184	Prostate Biopsy	T	3.8995	$212.76	$96.27	$42.55
0187	Miscellaneous Placement/Repositioning	X	4.4288	$241.64	$90.71	$48.33
0188	Level II Female Reproductive Proc	T	1.1365	$62.01	.....	$12.40
0189	Level III Female Reproductive Proc	T	1.4232	$77.65	$18.09	$15.53
0190	Level I Hysteroscopy	T	19.6922	$1,074.43	$424.28	$214.89
0191	Level I Female Reproductive Proc	T	0.1853	$10.11	$2.93	$2.02
0192	Level IV Female Reproductive Proc	T	2.7121	$147.97	$39.11	$29.59
0193	Level V Female Reproductive Proc	T	15.0453	$820.89	$171.13	$164.18
0194	Level VIII Female Reproductive Proc	T	18.4286	$1,005.48	$397.84	$201.10
0195	Level IX Female Reproductive Proc	T	25.6950	$1,401.94	$483.80	$280.39
0196	Dilation and Curettage	T	16.1219	$879.63	$338.23	$175.93
0197	Infertility Procedures	T	4.8280	$263.42	.....	$52.68
0198	Pregnancy and Neonatal Care Procedures	T	1.3578	$74.08	$32.19	$14.82
0199	Obstetrical Care Service	T	17.2831	$942.98	.....	$188.60
0200	Level VII Female Reproductive Proc	T	17.9920	$981.66	$307.83	$196.33
0201	Level VI Female Reproductive Proc	T	16.8660	$920.23	$329.65	$184.05
0202	Level X Female Reproductive Proc	T	38.9821	$2,126.90	$1,042.18	$425.38
0203	Level IV Nerve Injections	T	11.5969	$632.74	$276.76	$126.55
0204	Level I Nerve Injections	T	2.1711	$118.46	$40.13	$23.69
0206	Level II Nerve Injections	T	5.2875	$288.49	$75.55	$57.70
0207	Level III Nerve Injections	T	6.4554	$352.21	$123.69	$70.44
0208	Laminotomies and Laminectomies	T	40.2830	$2,197.88	.....	$439.58
0209	Extended EEG Studies and Sleep Studies, Level II	S	11.5435	$629.82	$280.58	$125.96
0212	Nervous System Injections	T	2.9739	$162.26	$74.67	$32.45
0213	Extended EEG Studies and Sleep Studies, Level I	S	2.9055	$158.53	$65.74	$31.71
0214	Electroencephalogram	S	2.2176	$120.99	$58.12	$24.20
0215	Level I Nerve and Muscle Tests	S	0.6457	$35.23	$15.76	$7.05
0216	Level III Nerve and Muscle Tests	S	2.8535	$155.69	$67.98	$31.14
0218	Level II Nerve and Muscle Tests	S	1.1404	$62.22	.....	$12.44
0220	Level I Nerve Procedures	T	16.5554	$903.28	.....	$180.66
0221	Level II Nerve Procedures	T	24.8875	$1,357.89	$463.62	$271.58
0222	Implantation of Neurological Device	T	232.2024	$12,669.20	.....	$2,533.84
0223	Implantation or Revision of Pain Management Catheter	T	26.7610	$1,460.11	.....	$292.02
0224	Implantation of Reservoir/Pump/Shunt	T	34.1770	$1,864.73	$453.41	$372.95
0225	Level I Implementation of Neurostimulator Electrodes	S	206.0034	$11,239.75	.....	$2,247.95
0226	Implantation of Drug Infusion Reservoir	T	136.2989	$7,436.60	.....	$1,487.32
0227	Implantation of Drug Infusion Device	T	160.8363	$8,775.39	.....	$1,755.08
0228	Creation of Lumbar Subarachnoid Shunt	T	52.2880	$2,852.89	$639.03	$570.58
0229	Transcatherter Placement of Intravascular Shunt	T	61.9895	$3,382.21	$771.23	$676.44
0230	Level I Eye Tests & Treatments	S	0.7619	$41.57	$14.97	$8.31
0231	Level III Eye Tests & Treatments	S	2.1883	$119.40	$50.94	$23.88
0232	Level I Anterior Segment Eye Procedures	T	4.9206	$268.47	$103.17	$53.69
0233	Level II Anterior Segment Eye Procedures	T	14.4205	$786.80	$266.33	$157.36
0234	Level III Anterior Segment Eye Procedures	T	21.4631	$1,171.05	$511.31	$234.21
0235	Level I Posterior Segment Eye Procedures	T	5.0749	$276.89	$72.04	$55.38
0236	Level II Posterior Segment Eye Procedures	T	18.6701	$1,018.66	.....	$203.73
0237	Level III Posterior Segment Eye Procedures	T	34.1784	$1,864.81	$818.54	$372.96
0238	Level I Repair and Plastic Eye Procedures	T	3.1954	$174.34	$58.96	$34.87
0239	Level II Repair and Plastic Eye Procedures	T	6.1331	$334.63	.....	$66.93
0240	Level III Repair and Plastic Eye Procedures	T	17.4535	$952.28	$315.31	$190.46
0241	Level IV Repair and Plastic Eye Procedures	T	22.1969	$1,211.09	$384.47	$242.22
0242	Level V Repair and Plastic Eye Procedures	T	29.4294	$1,605.70	$597.36	$321.14
0243	Strabismus/Muscle Procedures	T	21.7323	$1,185.74	$431.39	$237.15
0244	Corneal Transplant	T	37.6284	$2,053.04	$803.26	$410.61
0245	Level I Cataract Procedures without IOL Insert	T	12.2973	$670.95	$222.22	$134.19
0246	Cataract Procedures with IOL Insert	T	22.9755	$1,253.57	$495.96	$250.71
0247	Laser Eye Procedures Except Retinal	T	4.9482	$269.98	$104.31	$54.00
0248	Laser Retinal Procedures	T	4.8223	$263.11	$95.08	$52.62
0249	Level II Cataract Procedures without IOL Insert	T	27.7406	$1,513.55	$524.67	$302.71
0250	Nasal Cauterization/Packing	T	1.4697	$80.19	$28.07	$16.04
0251	Level I ENT Procedures	T	1.7880	$97.56	.....	$19.51
0252	Level II ENT Procedures	T	6.4469	$351.75	$113.41	$70.35
0253	Level III ENT Procedures	T	15.2249	$830.69	$282.29	$166.14
0254	Level IV ENT Procedures	T	21.8901	$1,194.35	$321.35	$238.87
0256	Level V ENT Procedures	T	35.1548	$1,918.08	.....	$383.62
0258	Tonsil and Adenoid Procedures	T	20.6265	$1,125.40	$437.25	$225.08

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0259	Level VI ENT Procedures	T	392.8622	$21,434.95	$9,394.83	$4,286.99
0260	Level I Plain Film Except Teeth	X	0.7802	$42.57	$21.28	$8.51
0261	Level II Plain Film Except Teeth Including Bone Density Measurement.	X	1.3176	$71.89	.....	$14.38
0262	Plain Film of Teeth	X	0.7540	$41.14	$9.82	$8.23
0263	Level I Miscellaneous Radiology Procedures	X	2.1883	$119.40	$43.58	$23.88
0264	Level II Miscellaneous Radiology Procedures	X	3.0287	$165.25	$79.41	$33.05
0265	Level I Diagnostic Ultrasound Except Vascular	S	1.0289	$56.14	$28.07	$11.23
0266	Level II Diagnostic Ultrasound Except Vascular	S	1.6117	$87.94	$43.97	$17.59
0267	Level III Diagnostic Ultrasound Except Vascular	S	2.4586	$134.14	$65.52	$26.83
0268	Ultrasound Guidance Procedures	S	1.3081	$71.37	.....	$14.27
0269	Level III Echocardiogram Except Transesophageal	S	3.2309	$176.28	$87.24	$35.26
0270	Transesophageal Echocardiogram	S	5.8546	$319.43	$146.79	$63.89
0271	Mammography	S	0.6499	$35.46	$16.80	$7.09
0272	Level I Fluoroscopy	X	1.4184	$77.39	$38.36	$15.48
0274	Myelography	S	3.5931	$196.04	$93.63	$39.21
0275	Arthrography	S	3.2775	$178.82	$69.09	$35.76
0276	Level I Digestive Radiology	S	1.5906	$86.78	$41.72	$17.36
0277	Level II Digestive Radiology	S	2.4444	$133.37	$60.47	$26.67
0278	Diagnostic Urography	S	2.7012	$147.38	$66.07	$29.48
0279	Level II Angiography and Venography except Extremity	S	10.7073	$584.20	$174.57	$116.84
0280	Level III Angiography and Venography except Extremity	S	19.1015	$1,042.20	$353.85	$208.44
0281	Venography of Extremity	S	6.6031	$360.27	$115.16	$72.05
0282	Miscellaneous Computerized Axial Tomography	S	1.6834	$91.85	$44.51	$18.37
0283	Computerized Axial Tomography with Contrast Material	S	4.6543	$253.94	$126.27	$50.79
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contras.	S	7.1165	$388.28	$194.13	$77.66
0285	Myocardial Positron Emission Tomography (PET)	S	14.1508	$772.08	$334.45	$154.42
0287	Complex Venography	S	6.4923	$354.23	$111.33	$70.85
0288	Bone Density:Axial Skeleton	S	1.2726	$69.43	.....	$13.89
0289	Needle Localization for Breast Biopsy	X	3.4900	$190.42	$44.80	$38.08
0296	Level I Therapeutic Radiologic Procedures	S	2.8635	$156.24	$69.20	$31.25
0297	Level II Therapeutic Radiologic Procedures	S	7.7145	$420.91	$172.51	$84.18
0299	Miscellaneous Radiation Treatment	S	5.7618	$314.37	.....	$62.87
0300	Level I Radiation Therapy	S	1.4912	$81.36	.....	$16.27
0301	Level II Radiation Therapy	S	2.1340	$116.43	$23.29	
0302	Level III Radiation Therapy	S	6.3268	$345.20	$130.77	$69.04
0303	Treatment Device Construction	X	2.8835	$157.33	$66.95	$31.47
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.6742	$91.35	$41.52	$18.27
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.6767	$200.60	$91.38	$40.12
0310	Level III Therapeutic Radiation Treatment Preparation	X	13.7165	$748.39	$325.27	$149.68
0312	Radioelement Applications	S	3.6637	$199.90	.....	$39.98
0313	Brachytherapy	S	13.8073	$753.34	.....	$150.67
0314	Hyperthermic Therapies	S	4.6041	$251.20	$101.77	$50.24
0320	Electroconvulsive Therapy	S	5.3785	$293.46	$80.06	$58.69
0321	Biofeedback and Other Training	S	1.4817	$80.84	$21.78	$16.17
0322	Brief Individual Psychotherapy	S	1.2802	$69.85	.....	$13.97
0323	Extended Individual Psychotherapy	S	1.8689	$101.97	$21.26	$20.39
0324	Family Psychotherapy	S	2.4473	$133.53	.....	$26.71
0325	Group Psychotherapy	S	1.4865	$81.10	$18.27	$16.22
0330	Dental Procedures	S	0.5745	$31.35	.....	$6.27
0332	Computerized Axial Tomography and Computerized Angiography without Contras.	S	3.3936	$185.16	$91.27	$37.03
0333	Computerized Axial Tomography and Computerized Angio w/o Contrast Material.	S	5.4241	$295.94	$146.98	$59.19
0335	Magnetic Resonance Imaging, Miscellaneous	S	6.3499	$346.46	$151.46	$69.29
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Cont.	S	6.3897	$348.63	$174.31	$69.73
0337	MRI and Magnetic Resonance Angiography without Contrast Material followed.	S	9.2075	$502.37	$240.77	$100.47
0339	Observation	S	6.6961	$365.35	.....	$73.07
0340	Minor Ancillary Procedures	X	0.6314	$34.45	.....	$6.89
0341	Skin Tests	X	0.1365	$7.45	$3.03	$1.49
0342	Level I Pathology	X	0.2162	$11.80	$5.88	$2.36
0343	Level II Pathology	X	0.4617	$25.19	$12.55	$5.04
0344	Level III Pathology	X	0.6291	$34.32	$17.16	$6.86
0345	Level I Transfusion Laboratory Procedures	X	0.2550	$13.91	$3.10	$2.78
0346	Level II Transfusion Laboratory Procedures	X	0.3866	$21.09	$5.32	$4.22
0347	Level III Transfusion Laboratory Procedures	X	0.9610	$52.43	$13.20	$10.49

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0348	Fertility Laboratory Procedures	X	0.8194	$44.71	.....	$8.94
0352	Level I Injections	X	0.1230	$6.71	.....	$1.34
0353	Level II Allergy Injections	X	0.3982	$21.73	.....	$4.35
0355	Level III Immunizations	K	0.2749	$15.00	.....	$3.00
0356	Level IV Immunizations	K	0.7698	$42.00	.....	$8.40
0359	Level II Injections	X	0.8000	$43.65	.....	$8.73
0360	Level I Alimentary Tests	X	1.7313	$94.46	$42.45	$18.89
0361	Level II Alimentary Tests	X	3.5510	$193.75	$83.23	$38.75
0362	Level III Otorhinolaryngologic Function Tests	X	2.6984	$147.23	.....	$29.45
0363	Level I Otorhinolaryngologic Function Tests	X	0.8641	$47.15	$17.44	$9.43
0364	Level I Audiometry	X	0.4459	$24.33	$9.06	$4.87
0365	Level II Audiometry	X	1.2132	$66.19	$18.95	$13.24
0367	Level I Pulmonary Test	X	0.5887	$32.12	$15.16	$6.42
0368	Level II Pulmonary Tests	X	0.9319	$50.85	$25.42	$10.17
0369	Level III Pulmonary Tests	X	2.4984	$136.32	$44.18	$27.26
0370	Allergy Tests	X	0.9185	$50.11	$11.58	$10.02
0371	Level I Allergy Injections	X	0.4105	$22.40	.....	$4.48
0372	Therapeutic Phlebotomy	X	0.5607	$30.59	$10.09	$6.12
0373	Neuropsychological Testing	X	2.3288	$127.06	.....	$25.41
0374	Monitoring Psychiatric Drugs	X	1.1252	$61.39	.....	$12.28
0375	Ancillary Outpatient Services When Patient Expires	T	.....	$1,150.00	.....	$230.00
0376	Level II Cardiac Imaging	S	4.4510	$242.85	$121.42	$48.57
0377	Level III Cardiac Imaging	S	6.8830	$375.54	$187.76	$75.11
0378	Level II Pulmonary Imaging	S	5.4852	$299.28	$149.63	$59.86
0379	Injection adenosine 6 Mg	K	0.2078	$11.34	.....	$2.27
0380	Dipyridamole injection	K	0.2525	$13.78	.....	$2.76
0384	GI Procedures with Stents	T	36.5400	$1,993.66	$433.01	$398.73
0385	Level I Prosthetic Urological Procedures	S	67.1530	$3,663.93	.....	$732.79
0386	Level II Prosthetic Urological Procedures	S	116.2382	$6,342.07	.....	$1,268.41
0387	Level II Hysteroscopy	T	28.1480	$1,535.78	$655.55	$307.16
0388	Discography	S	11.6347	$634.80	$303.19	$126.96
0389	Non-imaging Nuclear Medicine	S	1.6328	$89.09	$44.54	$17.82
0390	Level I Endocrine Imaging	S	2.7907	$152.26	$76.13	$30.45
0391	Level II Endocrine Imaging	S	3.1956	$174.36	$87.18	$34.87
0393	Red Cell/Plasma Studies	S	4.4354	$242.00	$121.00	$48.40
0394	Hepatobiliary Imaging	S	4.3714	$238.51	$119.25	$47.70
0395	GI Tract Imaging	S	3.9536	$215.71	$107.85	$43.14
0396	Bone Imaging	S	4.1883	$228.52	$114.26	$45.70
0397	Vascular Imaging	S	2.2183	$121.03	$60.51	$24.21
0398	Level I Cardiac Imaging	S	4.5091	$246.02	$123.01	$49.20
0399	Nuclear Medicine Add-on Imaging	S	1.5273	$83.33	$41.66	$16.67
0400	Hematopoietic Imaging	S	3.8242	$208.65	$104.32	$41.73
0401	Level I Pulmonary Imaging	S	3.3736	$184.07	$92.03	$36.81
0402	Brain Imaging	S	5.4063	$294.97	$147.48	$58.99
0403	CSF Imaging	S	3.8402	$209.53	$104.76	$41.91
0404	Renal and Genitourinary Studies Level I	S	3.7303	$203.53	$101.76	$40.71
0405	Renal and Genitourinary Studies Level II	S	4.3432	$236.97	$118.48	$47.39
0406	Tumor/Infection Imaging	S	4.3955	$239.82	$119.91	$47.96
0407	Radionuclide Therapy	S	3.5841	$195.55	$97.77	$39.11
0409	Red Blood Cell Tests	X	0.1390	$7.58	$2.32	$1.52
0410	Mammogram Add On	S	0.1523	$8.31	.....	$1.66
0411	Respiratory Procedures	S	0.4367	$23.83	.....	$4.77
0412	IMRT Treatment Delivery	S	5.3904	$294.11	.....	$58.82
0415	Level II Endoscopy Lower Airway	T	20.7348	$1,131.31	$459.92	$226.26
0600	Low Level Clinic Visits	V	0.9278	$50.62	.....	$10.12
0601	Mid Level Clinic Visits	V	0.9816	$53.56	.....	$10.71
0602	High Level Clinic Visits	V	1.5041	$82.07	.....	$16.41
0610	Low Level Emergency Visits	V	1.3691	$74.70	$19.57	$14.94
0611	Mid Level Emergency Visits	V	2.3967	$130.77	$36.16	$26.15
0612	High Level Emergency Visits	V	4.1476	$226.30	$54.12	$45.26
0620	Critical Care	S	8.9992	$491.01	$142.30	$98.20
0648	Breast Reconstruction with Prosthesis	T	54.0165	$2,947.19	.....	$589.44
0651	Complex Interstitial Radiation Source Application	S	10.2314	$558.24	.....	$111.65
0652	Insertion of Intraperitoneal Catheters	T	27.0364	$1,475.13	.....	$295.03
0653	Vascular Reconstruction/Fistula Repair with Device	T	30.0334	$1,638.65	.....	$327.73
0654	Insertion/Replacement of a permanent dual chamber pacemaker.	T	112.6957	$6,148.79	.....	$1,229.76
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	T	142.7039	$7,786.07	.....	$1,557.21

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents.	T	103.4907	$5,646.56	.....	$1,129.31
0657	Placement of Tissue Clips	S	1.5102	$82.40	.....	$16.48
0658	Percutaneous Breast Biopsies	T	5.5779	$304.34	.....	$60.87
0659	Hyperbaric Oxygen	S	3.0228	$164.93	.....	$32.99
660	Level II Otorhinolaryngologic Function Tests	X	1.7353	$94.68	$30.66	$18.94
0661	Level IV Pathology	X	3.2576	$177.74	$88.87	$35.55
0662	CT Angiography	S	5.8775	$320.68	$156.47	$64.14
0664	Proton Beam Radiation Therapy	S	9.7295	$530.85	.....	$106.17
0665	Bone Density: Appendicular Skeleton	S	0.7257	$39.59	.....	$7.92
0668	Level I Angiography and Venography except Extremity	S	10.2660	$560.12	$237.76	$112.02
0669	Digital Mammography	S	0.9009	$49.15	.....	$9.83
0670	Intravenous and Intracardiac Ultrasound	S	27.4483	$1,497.61	$542.37	$299.52
0671	Level II Echocardiogram Except Transesophageal	S	1.6384	$89.39	$44.69	$17.88
0672	Level IV Posterior Segment Procedures	T	38.9476	$2,125.02	$988.43	$425.00
0673	Level IV Anterior Segment Eye Procedures	T	26.8390	$1,464.36	$649.56	$292.87
0674	Prostate Cryoablation	T	119.9733	$6,545.86	.....	$1,309.17
0675	Prostatic Thermotherapy	T	49.3452	$2,692.32	.....	$538.46
0676	Level II Transcatheter Thrombolysis	T	2.7315	$149.03	$40.30	$29.81
0677	Level I Transcatheter Thrombolysis	T	2.1805	$118.97	.....	$23.79
0678	External Counterpulsation	T	2.0659	$112.72	.....	$22.54
0679	Level II Resuscitation and Cardioversion	S	5.4887	$299.47	$95.30	$59.89
0680	Insertion of Patient Activated Event Recorders	S	62.8252	$3,427.81	.....	$685.56
0681	Knee Arthroplasty	T	98.1613	$5,355.78	$2,131.36	$1,071.16
0682	Level V Debridement & Destruction	T	8.0790	$440.80	$174.57	$88.16
0683	Level II Photochemotherapy	S	1.5489	$84.51	$30.42	$16.90
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	4.8100	$262.44	$115.47	$52.49
0686	Level III Skin Repair	T	7.9247	$432.38	$198.89	$86.48
0687	Revision/Removal of Neurostimulator Electrodes	T	20.4416	$1,115.31	$513.05	$223.06
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver.	T	46.7347	$2,549.89	$1,249.45	$509.98
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.5533	$30.19	.....	$6.04
0690	Electronic Analysis of Pacemakers and other Cardiac Devices.	S	0.4074	$22.23	$10.63	$4.45
0691	Electronic Analysis of Programmable Shunts/Pumps	S	2.8066	$153.13	$76.56	$30.63
0692	Electronic Analysis of Neurostimulator Pulse Generators	S	1.1057	$60.33	$30.16	$12.07
0693	Level II Breast Reconstruction	T	39.0111	$2,128.48	$798.17	$425.70
0694	Mohs Surgery	T	2.9752	$162.33	$64.93	$32.47
0695	Level VII Debridement & Destruction	T	19.1849	$1,046.75	$266.59	$209.35
0697	Level I Echocardiogram Except Transesophageal	S	1.4415	$78.65	$39.32	$15.73
0698	Level II Eye Tests & Treatments	S	0.9599	$52.37	$18.72	$10.47
0699	Level IV Eye Tests & Treatments	T	2.2303	$121.69	$47.46	$24.34
0700	Antepartum Manipulation	T	2.4306	$132.62	$37.13	$26.52
0701	SR 89 chloride, per mCi	K	.....	$892.43	.....	$178.49
0702	SM 153 lexidronam, 50 mCi	K	.....	$493.89	.....	$98.78
0704	IN 111 Satumomab pendetide per dose	K	.....	$1,474.00	.....	$294.80
0705	Technetium TC99M tetrofosmin	K	1.0642	$665.28	.....	$133.06
0726	Dexrazoxane hcl injection, 250 mg	K	2.0616	$112.48	.....	$22.50
0728	Filgrastim 300 mcg injection	K	.....	$172.20	.....	$34.44
0730	Pamidronate disodium , 30 mg	K	.....	$128.74	.....	$25.75
0731	Sargramostim injection	K	.....	$26.92	.....	$5.38
0732	Mesna injection 200 mg	K	.....	$17.66	.....	$3.53
0733	Non esrd epoetin alpha inj, 1000 u	K	.....	$11.76	.....	$2.35
0734	Injection, darbepoetin alfa (for non-ESRD), per 1 mcg	K	.....	$3.88	.....	$0.78
0763	Dolasetron mesylate oral	K	.....	$152.38	.....	$30.48
0764	Granisetron HCl injection	K	.....	$17.18	.....	$3.44
0765	Granisetron HCl 1 mg oral	K	.....	$171.78	.....	$34.36
0800	Leuprolide acetate, 3.75 mg	K	.....	$479.20	.....	$95.84
0802	Etoposide oral 50 mg	K	.....	$21.91	.....	$4.38
0807	Aldesleukin/single use vial	K	.....	$680.35	.....	$136.07
0809	Bcg live intravesical vac	K	.....	$77.54	.....	$15.51
0810	Goserelin acetate implant 3.6 mg	K	.....	$413.59	.....	$82.72
0811	Carboplatin injection 50 mg	K	.....	$137.79	.....	$27.56
0813	Cisplatin 10 mg injection	K	.....	$7.73	.....	$1.55
0814	Asparaginase injection	K	.....	$58.00	.....	$11.60
0815	Cyclophosphamide 100 MG inj	K	.....	$2.77	.....	$0.55
0816	Cyclophosphamide lyophilized	K	.....	$2.36	.....	$0.47
0817	Cytarabine hcl 100 MG inj	K	.....	$1.55	.....	$0.31
0819	Dacarbazine 100 mg inj	K	0.0974	$5.31	.....	$1.06

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0820	Daunorubicin 10 mg	K		$35.94		$7.19
0821	Daunorubicin citrate liposom 10 mg	K		$64.60		$12.92
0823	Docetaxel, 20 mg	K		$331.53		$66.31
0824	Etoposide 10 MG inj	K		$0.83		$0.17
0827	Floxuridine injection 500 mg	K		$66.24		$13.25
0828	Gemcitabine HCL 200 mg	K		$112.09		$22.42
0830	Irinotecan injection 20 mg	K		$135.00		$27.00
0831	Ifosfomide injection 1 gm	K		$72.81		$14.56
0832	Idarubicin hcl injection 5 mg	K	3.2663	$178.21		$35.64
0834	Interferon alfa-2a inj	K		$32.31		$6.46
0836	Interferon alfa-2b inj recombinant, 1 million	K		$13.78		$2.76
0838	Interferon gamma 1-b inj, 3 million u	K		$290.70		$58.14
0840	Melphalan hydrochl 50 mg	K		$389.14		$77.83
0842	Fludarabine phosphate inj 50 mg	K		$329.83		$65.97
0844	Pentostatin injection, 10 mg	K		$1,784.64		$356.93
0847	Doxorubic hcl 10 MG vl chemo	K		$4.69		$0.94
0849	Rituximab, 100 mg	K		$464.20		$92.84
0850	Streptozocin injection, 1 gm	K		$131.05		$26.21
0851	Thiotepa injection	K		$45.31		$9.06
0852	Topotecan, 4 mg	K		$739.80		$147.96
0855	Vinorelbine tartrate, 10 mg	K		$100.97		$20.19
0856	Porfimer sodium, 75 mg	K		$2,411.82		$482.36
0857	Bleomycin sulfate injection 15 u	K		$88.32		$17.66
0858	Cladribine, 1mg	K		$24.84		$4.97
0860	Plicamycin (mithramycin) inj	K		$86.89		$17.38
0861	Leuprolide acetate injection 1 mg	K		$14.48		$2.90
0862	Mitomycin 5 mg inj	K		$30.91		$6.18
0863	Paclitaxel injection, 30 mg	K		$79.04		$15.81
0864	Mitoxantrone hcl, 5 mg	K		$332.87		$66.57
0865	Interferon alfa-n3 inj, human leukocyte derived, 2	K		$8.17		$1.63
0884	Rho d immune globulin inj, 1 dose pkg	K		$92.93		$18.59
0888	Cyclosporine oral 100 mg	K		$2.41		$0.48
0890	Lymphocyte immune globulin 250 mg	K		$258.17		$51.63
0891	Tacrolimus oral per 1 mg	K		$3.24		$0.65
0900	Alglucerase injection, per 10 u	K		$37.13		$7.43
0901	Alpha 1 proteinase inhibitor, 10 mg	K		$3.43		$0.69
0902	Botulinum toxin a, per unit	K		$4.58		$0.92
0903	Cytomegalovirus imm IV/vial	K		$659.60		$131.92
0905	Immune globulin, 1g	K		$37.95		$7.59
0906	RSV-ivig, 50 mg	K		$16.55		$3.31
0907	Ganciclovir sodium injection	K	0.5918	$32.29		$6.46
0909	Interferon beta-1a, 33 mcg	K		$123.77		$24.75
0910	Interferon beta-1b /0.25 mg	K		$67.22		$13.44
0911	Streptokinase per 250,000 iu	K	1.5733	$85.84		$17.17
0913	Ganciclovir long act implant	K	1.5861	$86.54		$17.31
0916	Imiglucerase injection/unit	K		$3.71		$0.74
0917	Adenosine injection	K	1.0393	$56.71		$11.34
0925	Factor viii per iu	K		$0.42		$0.08
0926	Factor VIII (porcine) per iu	K		$1.89		$0.38
0927	Factor viii recombinant per iu	K		$0.61		$0.12
0928	Factor ix complex per iu	K		$0.18		$0.04
0929	Anti-inhibitor per iu	K		$0.69		$0.14
0931	Factor IX non-recombinant, per iu	K		$0.51		$0.10
0932	Factor IX recombinant, per iu	K		$1.04		$0.21
0949	Plasma, Pooled Multiple Donor, Solvent/Detergent	K		$124.31		$24.86
0950	Blood (Whole) For Transfusion	K		$87.93		$17.59
0952	Cryoprecipitate	K		$29.31		$5.86
0954	RBC leukocytes reduced	K		$119.26		$23.85
0955	Plasma, Fresh Frozen	K		$95.00		$19.00
0956	Plasma Protein Fraction	K		$92.98		$18.60
0957	Platelet Concentrate	K		$41.44		$8.29
0958	Platelet Rich Plasma	K		$53.56		$10.71
0959	Red Blood Cells	K		$86.41		$17.28
0960	Washed Red Blood Cells	K		$160.69		$32.14
0961	Infusion, Albumin (Human) 5%, 50 ml	K	0.2802	$15.29		$3.06
0963	Albumin (human), 5%, 250 ml	K	1.0901	$59.48		$11.90
0964	Albumin (human), 25%, 20 ml	K	0.3741	$20.41		$4.08
0965	Albumin (human), 25%, 50ml	K	0.8869	$48.39		$9.68
0966	Plasmaprotein fract,5%,250ml	K		$464.90		$92.98

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1009	Cryoprecip reduced plasma	K		$37.39		$7.48
1010	Blood, L/R, CMV-neg	K		$121.78		$24.36
1011	Platelets, HLA-m, L/R, unit	K		$499.77		$99.95
1013	Platelet concentrate, L/R, unit	K		$49.52		$9.90
1016	Blood, L/R, froz/deglycerol/washed	K		$301.68		$60.34
1017	Platelets, aph/pher, L/R, CMV-neg, unit	K		$393.15		$78.63
1018	Blood, L/R, irradiated	K		$132.40		$26.48
1019	Platelets, aph/pher, L/R, irradiated, unit	K		$406.28		$81.26
1020	Pit, pher,L/R,CMV,irrad	K		$495.22		$99.04
1021	RBC, frz/deg/wsh, L/R, irrad	K		$336.04		$67.21
1022	RBC, L/R, CMV neg, irrad	K		$201.12		$40.22
1045	Iobenguane sulfate I-131per 0.5 mCi	K	3.0392	$165.82		$33.16
1064	I-131 sodium iodide capsule	K	0.1004	$5.48		$1.10
1065	I-131 sodium iodide solution	K	0.1189	$6.49		$1.30
1079	CO 57/58 per 0.5 uCi	K		$235.14		$47.03
1080	I-131 tositumomab, dx	K		$2,565.55		$513.11
1081	I-131 tositumomab, tx	K		$22,210.19		$4,442.04
1084	Denileukin diftitox, 300 MCG	K		$1,232.88		$246.58
1086	Temozolomide,oral 5 mg	K		$6.81		$1.36
1089	Cyanocobalamin cobalt co57	K		$47.38		$9.48
1091	IN 111 Oxyquinoline, per .5 mCi	K	4.1151	$224.52		$44.90
1092	IN 111 Pentetate, per 0.5 mCi	K		$237.60		$47.52
1095	Technetium TC 99M Depreotide	K		$704.00		$140.80
1096	TC 99M Exametazime, per dose	K		$825.00		$165.00
1122	TC 99M arcitumomab, per vial	K		$1,144.00		$228.80
1166	Cytarabine liposome	K		$344.08		$68.82
1167	Epirubicin hcl, 2 mg	K		$25.60		$5.12
1178	Busulfan IV, 6 mg	K		$27.87		$5.57
1200	TC 99M Sodium Glucoheptonat	K		$30.28		$6.06
1201	TC 99M SUCCIMER, PER Vial	K		$125.66		$25.13
1203	Verteporfin for injection	K		$1,350.80		$270.16
1207	Octreotide injection, depd	K		$73.62		$14.72
1305	Apligraf	K		$1,199.00		$239.80
1409	Factor viia recombinant, per 1.2 mg	K		$1,495.30		$299.06
1501	New Technology - Level I ($0–$50)	S		$25.00		$5.00
1502	New Technology - Level II ($50–$100)	S		$75.00		$15.00
1503	New Technology - Level III ($100–$200)	S		$150.00		$30.00
1504	New Technology - Level IV ($200–$300)	S		$250.00		$50.00
1505	New Technology - Level V ($300–$400)	S		$350.00		$70.00
1506	New Technology - Level VI ($400–$500)	S		$450.00		$90.00
1507	New Technology - Level VII ($500–$600)	S		$550.00		$110.00
1508	New Technology - Level VIII ($600–$700)	S		$650.00		$130.00
1509	New Technology - Level IX ($700–$800)	S		$750.00		$150.00
1510	New Technology - Level X ($800–$900)	S		$850.00		$170.00
1511	New Technology - Level XI ($900–$1000)	S		$950.00		$190.00
1512	New Technology - Level XII ($1000–$1100)	S		$1,050.00		$210.00
1513	New Technology - Level XIII ($1100–$1200)	S		$1,150.00		$230.00
1514	New Technology - Level XIV ($1200–$1300)	S		$1,250.00		$250.00
1515	New Technology - Level XV ($1300–$1400)	S		$1,350.00		$270.00
1516	New Technology - Level XVI ($1400–$1500)	S		$1,450.00		$290.00
1517	New Technology - Level XVII ($1500–$1600)	S		$1,550.00		$310.00
1518	New Technology - Level XVIII ($1600–$1700)	S		$1,650.00		$330.00
1519	New Technology - Level IXX ($1700–$1800)	S		$1,750.00		$350.00
1520	New Technology - Level XX ($1800–$1900)	S		$1,850.00		$370.00
1521	New Technology - Level XXI ($1900–$2000)	S		$1,950.00		$390.00
1522	New Technology - Level XXII ($2000–$2500)	S		$2,250.00		$450.00
1523	New Technology - Level XXIII ($2500–$3000)	S		$2,750.00		$550.00
1524	New Technology - Level XIV ($3000–$3500)	S		$3,250.00		$650.00
1525	New Technology - Level XXV ($3500–$4000)	S		$3,750.00		$750.00
1526	New Technology - Level XXVI ($4000–$4500)	S		$4,250.00		$850.00
1527	New Technology - Level XXVII ($4500–$5000)	S		$4,750.00		$950.00
1528	New Technology - Level XXVIII ($5000–$5500)	S		$5,250.00		$1,050.00
1529	New Technology - Level XXIX ($5500–$6000)	S		$5,750.00		$1,150.00
1530	New Technology - Level XXX ($6000–$6500)	S		$6,250.00		$1,250.00
1531	New Technology - Level XXXI ($6500–$7000)	S		$6,750.00		$1,350.00
1532	New Technology - Level XXXII ($7000–$7500)	S		$7,250.00		$1,450.00
1533	New Technology - Level XXXIII ($7500–$8000)	S		$7,750.00		$1,550.00
1534	New Technology - Level XXXIV ($8000–$8500)	S		$8,250.00		$1,650.00
1535	New Technology - Level XXXV ($8500–$9000)	S		$8,750.00		$1,750.00

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1536	New Technology - Level XXXVI ($9000–$9500)	S		$9,250.00		$1,850.00
1537	New Technology - Level XXXVII ($9500–$10000)	S		$9,750.00		$1,950.00
1538	New Technology - Level I ($0–$50)	T		$25.00		$5.00
1539	New Technology - Level II ($50–$100)	T		$75.00		$15.00
1540	New Technology - Level III ($100–$200)	T		$150.00		$30.00
1541	New Technology - Level IV ($200–$300)	T		$250.00		$50.00
1542	New Technology - Level V ($300–$400)	T		$350.00		$70.00
1543	New Technology - Level VI ($400–$500)	T		$450.00		$90.00
1544	New Technology - Level VII ($500–$600)	T		$550.00		$110.00
1545	New Technology - Level VIII ($600–$700)	T		$650.00		$130.00
1546	New Technology - Level IX ($700–$800)	T		$750.00		$150.00
1547	New Technology - Level X ($800–$900)	T		$850.00		$170.00
1548	New Technology - Level XI ($900–$1000)	T		$950.00		$190.00
1549	New Technology - Level XII ($1000–$1100)	T		$1,050.00		$210.00
1550	New Technology - Level XIII ($1100–$1200)	T		$1,150.00		$230.00
1551	New Technology - Level XIV ($1200–$1300)	T		$1,250.00		$250.00
1552	New Technology - Level XV ($1300–$1400)	T		$1,350.00		$270.00
1553	New Technology - Level XVI ($1400–$1500)	T		$1,450.00		$290.00
1554	New Technology - Level XVII ($1500–$1600)	T		$1,550.00		$310.00
1555	New Technology - Level XVIII ($1600–$1700)	T		$1,650.00		$330.00
1556	New Technology - Level XIX ($1700–$1800)	T		$1,750.00		$350.00
1557	New Technology - Level XX ($1800–$1900)	T		$1,850.00		$370.00
1558	New Technology - Level XXI ($1900–$2000)	T		$1,950.00		$390.00
1559	New Technology - Level XXII ($2000–$2500)	T		$2,250.00		$450.00
1560	New Technology - Level XXIII ($2500–$3000)	T		$2,750.00		$550.00
1561	New Technology - Level XXIV ($3000–$3500)	T		$3,250.00		$650.00
1562	New Technology - Level XXV ($3500–$4000)	T		$3,750.00		$750.00
1563	New Technology - Level XXVI ($4000–$4500)	T		$4,250.00		$850.00
1564	New Technology - Level XXVII ($4500–$5000)	T		$4,750.00		$950.00
1565	New Technology - Level XXVIII ($5000–$5500)	T		$5,250.00		$1,050.00
1566	New Technology - Level XXIX ($5500–$6000)	T		$5,750.00		$1,150.00
1567	New Technology - Level XXX ($6000–$6500)	T		$6,250.00		$1,250.00
1568	New Technology - Level XXXI ($6500–$7000)	T		$6,750.00		$1,350.00
1569	New Technology - Level XXXII ($7000–$7500)	T		$7,250.00		$1,450.00
1570	New Technology - Level XXXIII ($7500–$8000)	T		$7,750.00		$1,550.00
1571	New Technology - Level XXXIV ($8000–$8500)	T		$8,250.00		$1,650.00
1572	New Technology - Level XXXV ($8500–$9000)	T		$8,750.00		$1,750.00
1573	New Technology - Level XXXVI ($9000–$9500)	T		$9,250.00		$1,850.00
1574	New Technology - Level XXXVII ($9500–$10000)	T		$9,750.00		$1,950.00
1600	Technetium TC 99m sestamibi	K		$112.73		$22.55
1603	Thallous chloride TL 201/mci	K		$18.29		$3.66
1604	IN 111 capromab pendetide, per dose	K		$2,030.60		$406.12
1605	Abciximab injection, 10 mg	K		$475.22		$95.04
1606	Anistreplase, 30 u	K		$2,495.31		$499.06
1607	Eptifibatide injection, 5mg	K		$11.88		$2.38
1608	Etanercept injection	K		$143.73		$28.75
1609	Rho(D) immune globulin h, sd, 100 iu	K		$19.03		$3.81
1611	Hylan G-F 20 injection, 16 mg	K		$215.97		$43.19
1612	Daclizumab, parenteral, 25 mg	K		$393.78		$78.76
1613	Trastuzumab, 10 mg	K		$53.85		$10.77
1614	Valrubicin, 200 mg	K		$487.87		$97.57
1615	Basiliximab, 20 mg	K		$1,425.06		$285.01
1618	Vonwillebrandfactrcmplx, per iu	K		$0.46		$0.09
1619	Gallium ga 67	K	0.2056	$11.22		$2.24
1620	Technetium tc99m bicisate	K		$392.93		$78.59
1622	Technetium tc99m mertiatide	K		$1,650.00		$330.00
1624	Sodium phosphate p32	K		$66.44		$13.29
1625	Indium 111-in pentetreotide	K		$1,144.00		$228.80
1628	Chromic phosphate p32	K		$81.27		$16.25
1716	Brachytx source, Gold 198	H				
1717	Brachytx source, HDR Ir-192	H				
1718	Brachytx source, Iodine 125	H				
1719	Brachytx source,Non-HDR Ir-192	H				
1720	Brachytx source, Palladium 103	H				
1775	FDG, per dose (4-40 mCi/ml)	K	5.9471	$324.48		$64.90
1783	Ocular implant, aqueous drain device	H				$-
1814	Retinal Tamp, silicone oil	H				$-
1818	Integrated keratoprosthesis	H				$-
1819	Tissue localization-excision dev	H				$-

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1884	Embolization Protect syst	H				$-
1888	Catheter, ablation, non-cardiac, endovascular (implantable).	H				$-
1900	Lead coronary venous	H				$-
2614	Probe, percutaneous lumbar disc	H				$-
2616	Brachytx source, Yttrium-90	H				
2632	Brachytx sol, I-125, per mCi	H				$-
2633	Brachytx source, Cesium-131	H				
7000	Amifostine, 500 mg	K		$419.59		$83.92
7007	Inj milrinone lactate, per 5 mg	K	0.2129	$11.62		$2.32
7011	Oprelvekin injection, 5 mg	K		$248.16		$49.63
7015	Busulfan, oral, 2 mg	K		$1.93		$0.39
7019	Aprotinin, 10,000 kiu	K		$13.26		$2.65
7024	Corticorelin ovine triflutat	K		$375.00		$75.00
7025	Digoxin immune FAB (ovine)	K		$1.79		$0.36
7026	Ethanolamine oleate 100 mg	K		$67.10		$13.42
7027	Fomepizole, 15mg	K		$10.65		$2.13
7028	Fosphenytoin, 50 mg	K		$5.63		$1.13
7030	Hemin, per 1 mg	K		$6.86		$1.37
7031	Octreotide acetate injection	K		$3.94		$0.79
7034	Somatropin injection	K		$297.79		$59.56
7035	Teniposide, 50 mg	K		$238.49		$47.70
7036	Urokinase 250,000 iu inj	K	3.7855	$206.54		$41.31
7037	Urofollitropin, 75 iu	K	1.1634	$63.48		$12.70
7038	Muromonab-CD3, 5 mg	K		$792.33		$158.47
7040	Pentastarch 10% solution	K		$139.94		$27.99
7041	Tirofiban hydrochloride 12.5 mg	K		$436.66		$87.33
7042	Capecitabine, oral, 150 mg	K		$3.14		$0.63
7043	Infliximab injection 10 mg	K		$31.81		$6.36
7045	Trimetrexate glucoronate	K		$132.00		$26.40
7046	Doxorubicin hcl liposome inj 10 mg	K		$364.49		$72.90
7048	Alteplase recombinant	K	0.2856	$15.58		$3.12
7049	Filgrastim 480 mcg injection	K		$290.93		$58.19
7051	Leuprolide acetate implant, 65 mg	K		$5,001.92		$1,000.38
7316	Sodium hyaluronate injection	K		$67.16		$13.43
9001	Linezolid injection	K		$34.09		$6.82
9002	Tenecteplase, 50mg/vial	K		$2,492.60		$498.52
9003	Palivizumab, per 50mg	K		$611.24		$122.25
9004	Gemtuzumab ozogamicin inj,5mg	K		$2,022.90		$404.58
9005	Reteplase injection	K		$1,263.90		$252.78
9006	Tacrolimus injection	K		$110.04		$22.01
9008	Baclofen Refill Kit-500mcg	K		$73.92		$14.78
9009	Baclofen refill kit - per 2000 mcg	K	0.7499	$40.92		$8.18
9010	Baclofen refill kit - per 4000 mcg	K		$79.82		$15.96
9012	Arsenic Trioxide	K		$34.32		$6.86
9013	Co 57 cobaltous chloride	K		$56.67		$11.33
9015	Mycophenolate mofetil oral 250 mg	K		$1.36		$0.27
9018	Botulinum toxin B, per 100 u	K		$8.14		$1.63
9019	Caspofungin acetate, 5 mg	K		$30.52		$6.10
9020	Sirolimus tablet, 1 mg	K		$6.60		$1.32
9021	Immune globulin 10 mg	K		$0.41		$0.08
9022	IM inj interferon beta 1-a	K		$13.36		$2.67
9023	Rho d immune globulin 50 mcg	K		$32.21		$6.44
9024	Amphotericin B, lipid formulation	K		$20.86		$4.17
9025	Radiopharms Used to Image Perfusion of Heart	K		$162.63		$32.53
9100	Iodinated I-131albumin, per 5 uci	K		$48.58		$9.72
9104	Anti-thymocycte globulin rabbit	K		$331.23		$66.25
9105	Hep B imm glob, per 1 ml	K		$65.58		$13.12
9108	Thyrotropin alfa, per 1.1 mg	K		$572.00		$114.40
9109	Tirofliban hcl, per 6.25 mg	K		$218.33		$43.67
9110	Alemtuzumab, per 10 mg	K		$541.46		$108.29
9111	Inj, bivalirudin, per 250 mg vial	G		$1.61		$0.32
9112	Perflutren lipid micro, per 2ml	G		$137.28		$27.46
9113	Inj, pantoprazole sodium, vial	G		$23.23		$4.65
9114	Nesiritide, per 0.5 mg vial	G		$140.45		$28.09
9115	Inj, zoledronic acid, per 1 mg	G		$211.07		$42.21
9116	Inj, Ertapenem sodium, per 500 mg	G		$21.99		$4.40
9117	Yttrium 90 ibritumomab tiuxetan	K		$22,210.19		$4,442.04
9118	In-111 ibritumomab tiuxetan	K		$2,565.55		$513.11

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2004—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
9119	Pegfilgrastim, per 1 mg	G		$2,596.00		$519.20
9120	Inj, Fulvestrant, per 50 mg	G		$78.36		$13.09
9121	Inj, Argatroban, per 5 mg	G		$14.63		$2.44
9122	Inj, Triptorelin pamoate, per 3.75 mg	G		$356.66		$59.58
9123	Transcyte, per 247 sq cm	G		$689.78		$115.23
9200	Orcel, per 36 cm2	G		$1,051.60		$210.32
9201	Dermagraft, per 37.5 sq cm	G		$535.04		$107.01
9202	Octafluoropropane	K		$137.28		$27.46
9203	Perflexane lipid micro	G		$127.50		$21.30
9204	Ziprasidone mesylate	G		$18.60		$3.11
9205	Oxaliplatin	G		$8.45		$14.12
9207	Injection, bortezomib	G		$1,039.68		$155.40
9208	Injection, agalsidase beta	G		$123.78		$18.50
9209	Injection, laronidase	G		$644.10		$96.28
9210	Injection, palonosetron HCL	G		$307.80		$46.01
9211	Inj, alefacept, IV	G		$595.00		$99.40
9212	Inj, alefacept, IM	G		$422.88		$70.65
9217	Leuprolide acetate suspnsion, 7.5 mg	K		$576.47		$115.29
9500	Platelets, irradiated	K		$74.79		$14.96
9501	Platelets, pheresis	K		$408.81		$81.76
9502	Platelet pheresis irradiated	K		$443.68		$88.74
9503	Fresh frozen plasma, ea unit	K		$69.74		$13.95
9504	RBC deglycerolized	K		$183.44		$36.69
9505	RBC irradiated	K		$108.65		$21.73
9506	Granulocytes, pheresis	K		$1,248.66		$249.73

ADDENDUM D1.—PAYMENT STATUS INDICATORS FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Indicator	Item/Code/Service	Explanation
A	Services furnished to a Hospital Outpatient that are paid under a Fee Schedule/Payment System other than OPPS, e.g.: • Ambulance Services • Clinical Diagnostic Laboratory Services • Non-Implantable Prosthetic and Orthotic Devices • EPO for ESRD Patients • Physical, Occupational and Speech Therapy • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital. • Screening Mammography	Not paid under OPPS. Paid by Intermediaries under a Fee Schedule/Payment System other than OPPS.
B	Codes that are not recognized by OPPS when submitted on an Outpatient Hospital Part B bill type (12x, 13x, and 14x).	Not paid under OPPS. • May be paid by Intermediaries when submitted on a different bill type, e.g., 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an Outpatient Hospital Part B bill type (12x, 13x, and 14x) may be available.
C	Inpatient Procedures	Not paid under OPPS. Admit patient; Bill as Inpatient.
D	Deleted Codes	Not paid under OPPS. Not paid under Medicare.
E	Items, Codes, and Services: • That are not covered by Medicare based on Statutory Exclusion. • That are not covered by Medicare for reasons other than Statutory Exclusion. • That are not recognized by Medicare but for which an alternate code for the same item or service may be available. • For which separate payment is not provided by Medicare Not paid under OPPS.	
F	Corneal Tissue Acquisition; Certain CRNA Services	Not paid under OPPS. Paid at reasonable cost.
G	Drug/Biological Pass-Through	Paid under OPPS; Separate APC payment includes Pass-Through amount.
H	Device Category Pass-Through and Brachytherapy Source	Paid under OPPS; Separate cost-based
K	Non Pass-Through Drugs and Biologicals; Radiopharmaceutical Agents.	Paid under OPPS; Separate APC payment.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; Not subject to deductible or coinsurance.
N	Items and Services packaged into APC Rates	Paid under OPPS. However, payment is packaged into payment for other services, including Outliers. Therefore, there is no separate APC payment.

ADDENDUM D1.—PAYMENT STATUS INDICATORS FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

Indicator	Item/Code/Service	Explanation
P	Partial Hospitalization	Paid under OPPS; Per diem APC payment.
S	Significant Procedure, Not Discounted when Multiple	Paid under OPPS; Separate APC payment.
T	Significant Procedure, Multiple Procedure Reduction Applies	Paid under OPPS; Separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; Separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than Home Health Agencies bill to DMERC.
X	Ancillary Service	Paid under OPPS; Separate APC payment.

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