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Department of Health and Human Services

Centers for Medicare and Medicaid Services

42 CFR Parts 405, 410, 411, et al.

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410, 411, 414, 418, 424, 484, and 486

[CMS–1429–P]

RIN 0938–AM90

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would refine the resource-based practice expense relative value units (RVUs) and make other changes to Medicare Part B payment policy. The proposed policy changes concern: supplemental survey data for practice expense, updated geographic practice cost indices for physician work and practice expense, updated malpractice RVUs, revised requirements for supervision of therapy assistants, revised payment rules for low osmolar contrast media, changes to payment policies for physicians and practitioners managing dialysis patients, clarification of care plan oversight requirements, revised requirements for supervision of diagnostic psychological testing services, clarifications to the policies affecting therapy services, revised requirements for assignment of Medicare claims, addition to the list of telehealth services, and several coding issues.

We are proposing these changes to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. We solicit comments on these proposed policy changes.

This proposed rule also addresses the following provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA): coverage of an initial preventive physical examination; coverage of cardiovascular screening blood tests; coverage of diabetes screening tests; incentive payment improvements for physicians in shortage areas; payment for covered outpatient drugs and biologicals; payment for renal dialysis services; coverage of routine costs associated with certain clinical trials of category A devices as defined by the Food and Drug Administration; hospice consultation service; indexing the Part B deductible to inflation; extension of coverage of intravenous immune globulin (IVIG) for the treatment in the home of primary immune deficiency diseases; revisions to reassignment provisions; clinical conditions for payment of covered items of durable medical equipment; and payment for diagnostic mammograms.

In addition, we discuss physicians' services associated with drug administration services and payment for set-up of portable x-ray equipment.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 24, 2004.

ADDRESSES: In commenting, please refer to file code CMS–1429–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/regulations/ecomments*. (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By mail.* You may 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–1429–P, P.O. Box 8012, Baltimore, MD 21244–8012.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7197 in advance to schedule your arrival with one of our staff members.

Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 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 received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the ''Collection of Information Requirements'' section in this document.

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

FOR FURTHER INFORMATION CONTACT:

Pam West (410) 786–2302 (for issues related to Practice Expense, Respiratory Therapy Coding, and Therapy Supervision).

Rick Ensor (410) 786–5617 (for issues related to Geographic Practice Cost Index (GPCI) and malpractice RVUs).

Craig Dobyski (410) 786–4584 (for issues related to list of telehealth services or payments for physicians and practitioners managing dialysis patients).

Bill Larson or Tiffany Sanders (410) 786–7176 (for issues related to coverage of an initial preventive physical examination).

Cathleen Scally (410) 786–5714 (for issues related to payment of an initial preventive physical examination).

Joyce Eng (410) 786–7176 (for issues related to coverage of cardiovascular screening tests).

Betty Shaw (410) 786–7176 (for issues related to coverage of diabetes screening tests).

Anita Greenberg (410) 786–0548 (for issues related to payment of cardiovascular and diabetes screening tests).

David Worgo (410) 786–5919, (for issues related to incentive payment improvements for physicians practicing in shortage areas).

Angela Mason or Jennifer Fan (410) 786–0548 (for issues related to payment for covered outpatient drugs and biologicals).

David Walczak (410) 786–4475 (for issues related to reassignment provisions).

Henry Richter (410) 786–4562 (for issues related to payments for ESRD facilities).

Steve Berkowitz (410) 786–7176 (for issues related to coverage of routine costs associated with certain clinical trials of category A devices).

Terri Deutsch (410) 786–9462 (for issues related to hospice consultation services).

Karen Daily (410) 786–7176 (for issues related to clinical conditions for payment of covered items of durable medical equipment).

Dorothy Shannon (410) 786–3396 (for issues related to outpatient therapy services performed ''incident to'' physicians' services).
Roberta Epps (410) 786–5919 (for issues related to low osmolar contrast media or supervision of diagnostic psychological testing services).
Gail Addis (410) 786–4522 (for issues related to care plan oversight).
Diane Milstead (410) 786–3355 or Gaysha Brooks (410) 786–9649 (for all other issues).

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–1429-P and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: Comments received timely will be available for public inspection as they are processed, 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, phone (410) 786–7197.

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This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access*, a service of the U.S. Government Printing Office. The web site address is: *http://www.access.gpo.gov/nara/index.html*.

Information on the physician fee schedule can be found on the CMS homepage. You can access this data by using the following directions:

1. Go to the CMS homepage (*http://www.cms.hhs.gov*).
2. Place your cursor over the word ''Professionals'' in the blue area near the top of the page. Select ''physicians'' from the drop-down menu.
3. Under ''Policies/Regulations'' select ''Physician Fee Schedule.''

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

Table of Contents

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

ACC American College of Cardiology
ACR American College of Radiology
AMA American Medical Association
APA American Psychological Association
ASP Average Sales Price
ATA American Telemedicine Association
BBA Balanced Budget Act of 1997
BBRA Balanced Budget Refinement Act of 1999
BIPA Benefits Improvement and Protection Act of 2000
BLS Bureau of Labor Statistics
CAH Critical Access Hospital
CF Conversion factor
CFR Code of Federal Regulations
CMS Centers for Medicare & Medicaid Services
CNS Clinical Nurse Specialist
CPT [Physicians'] Current Procedural Terminology [4th Edition, 2002, copyrighted by the American Medical Association]
CPEP Clinical Practice Expert Panel
CY Calendar Year
E/M Evaluation and management
ESRD End-Stage Renal Disease
FMR Fair market rental
FY Fiscal Year
GAF Geographic adjustment factor
GPCI Geographic practice cost index
HCPCS Healthcare Common Procedure Coding System
HHA Home health agency
HHS [Department of] Health and Human Services

HOCM High osmolar contrast media
HPSA Health Professional Shortage Area
HRSA Health Resources and Services Administration
IDTFs Independent Diagnostic Testing Facilities
IPPS Inpatient prospective payment system
IOM Internet Only Manual
ISO Insurance Services Office
LOCM Low osmolar contrast media
MCM Medicare Carrier Manual
MCP Monthly Capitation Payment
MedPAC Medicare Payment Advisory Commission
MEI Medicare Economic Index
MGMA Medical Group Management Association
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MPFS Medicare Physician Fee Schedule
MSA Metropolitan Statistical Area
NAMCS National Ambulatory Medical Care Survey
NP Nurse Practitioner
OBRA Omnibus Budget Reconciliation Act
OMB Office of Management and Budget
OPPS Outpatient prospective payment system
PA Physician Assistant
PC Professional component
PCF Patient compensation fund
PEAC Practice Expense Advisory Committee
PET Positron Emission Tomography
PHSA Public Health Services Act
PPS Prospective payment system
PSA Physician Scarcity Area
RN Registered Nurse
RUC [AMA's Specialty Society] Relative [Value] Update Committee
RUCA Rural-Urban Commuting Area
RVU Relative value unit
SCHIP State Child Health Insurance Program
SGR Sustainable growth rate
SLP Speech language pathology
SMS [AMA's] Socioeconomic Monitoring System
TC Technical component
USPSTF U.S. Preventive Services Task Force

I. Background

A. Legislative History

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), ''Payment for Physicians' Services.'' The Act requires that payments under the fee schedule be based on national uniform relative value units (RVUs) based on the resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense, and malpractice expense. Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs may not cause total physician fee schedule payments to differ by more than $20 million from what they would have been had the adjustments not been made. If adjustments to RVUs cause expenditures to change by more than $20 million, we must make adjustments to ensure that they do not increase or decrease by more than $20 million.

B. Published Changes to the Fee Schedule

The July 2000 and August 2003 proposed rules ((65 FR 44177) and (68 FR 49030), respectively), include a summary of the final physician fee schedule rules published through February 2003.

In the November 7, 2003 final rule, we refined the resource-based practice expense RVUs and made other changes to Medicare Part B payment policy. The specific policy changes concerned: The Medicare Economic Index; practice expense for professional component services; definition of diabetes for diabetes self-management training; supplemental survey data for practice expense; geographic practice cost indices; and several coding issues. In addition, this rule updated the codes subject to the physician self-referral prohibition. We also made revisions to the sustainable growth rate, the anesthesia conversion factor and finalized the CY 2003 interim RVUs and issued interim RVUs for new and revised procedure codes for CY 2004.

As required by the statute, we announced that the physician fee schedule update for CY 2004 would be −4.5 percent; the initial estimate of the sustainable growth rate for CY 2004 was 7.4 percent; and the conversion factor for CY 2004 was $35.1339.

Subsequent to the November 7, 2003 final rule, the Congress enacted the MMA (Pub. L. 108–17). On January 7, 2004, an interim final rule was published to implement provisions of the MMA applicable in 2004 to Medicare payment for covered drugs and physician fee schedule services. These provisions included—

- Revising the current payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis;
- Making changes to Medicare payment for furnishing or administering drugs and biologicals;
- Revising the geographic practice cost indices;
- Changing the physician fee schedule conversion factor. The 2004 physician fee schedule conversion factor is $37.3374; and
- Extending the ''opt-out'' provisions of section 1802(b)(5)(3) of the Act to dentists, podiatrists, and optometrists.

The information contained in the January 7, 2004 interim final rule concerning payment under the physician fee schedule superceded information contained in the November 7, 2003 final rule to the extent that the two are inconsistent.

II. Provisions of the Proposed Rule

This proposed rule would affect the regulations set forth at Part 405, Federal Health Insurance for the Aged and Disabled; Part 410, Supplementary Medical Insurance (SMI) Benefits; Part 411, Exclusions from Medicare and Limitations on Medicare Payment; Part 414, Payment for Part B Medical and Other Health Services; Part 418, Hospice Care; Part 424, Conditions for Medicare Payment; Part 484, Home Health Services; and Part 486, Conditions for Coverage of Specialized Services Furnished by Suppliers.

A. Resource-Based Practice Expense Relative Value Units

[If you choose to comment on issues in this section, please include the caption ''Practice Expense'' at the beginning of your comments.]

1. Resource-Based Practice Expense Legislation

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, amended section 1848(c)(2)(C)(ii) of the Social Security Act and required us to develop a methodology for a resource-based system for determining practice expense RVUs for each physician's service beginning in 1998. Until that time, physicians' practice expenses were established based on historical allowed charges.

In developing the methodology, we were to consider the staff, equipment, and supplies used in providing medical and surgical services in various settings. The legislation specifically required that, in implementing the new system of practice expense RVUs, we apply the same budget-neutrality provisions that we apply to other adjustments under the physician fee schedule.

Section 4505(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), enacted on August 5, 1997, amended section 1848(c)(2)(C)(ii) of the Act and delayed the effective date of the resource-based practice expense RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period from charge-based practice expense RVUs to resource-based RVUs.

Further legislation affecting resource-based practice expense RVUs was included in the Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113)

enacted on November 29, 1999. Section 212 of the BBRA amended section 1848(c)(2)(C)(ii) of the Act by directing us to establish a process under which we accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations. These data would supplement the data we normally collect in determining the practice expense component of the physician fee schedule for payments in CY 2001 and CY 2002. (The 1999 and 2003 final rules (64 FR 59380 and 68 FR 63196, respectively, extended the period during which we would accept supplemental data.)

2. Current Methodology for Computing the Practice Expense Relative Value Unit System

In the November 2, 1998 final rule (63 FR 58910), effective with services furnished on or after January 1, 1999, we established at 42 CFR 414.22(b)(5) a new methodology for computing resource-based practice expense RVUs that used the two significant sources of actual practice expense data we have available—the Clinical Practice Expert Panel (CPEP) data and the American Medical Association's (AMA) Socioeconomic Monitoring System (SMS) data. The CPEP data were collected from panels of physicians, practice administrators, and nonphysicians (for example registered nurses) nominated by physician specialty societies and other groups. The CPEP panels identified the direct inputs required for each physician service in both the office setting and out-of-office setting. The AMA's SMS data provided aggregate specialty-specific information on hours worked and practice expenses. The methodology was based on an assumption that current aggregate specialty practice costs are a reasonable way to establish initial estimates of relative resource costs for physicians' services across specialties. The methodology allocated these aggregate specialty practice costs to specific procedures and, thus, can be seen as a ''top-down'' approach.

Also in the November 2, 1998 final rule, in response to comments, we discussed the establishment of the Practice Expense Advisory Committee (PEAC) of the AMA's Specialty Society Relative Value Update Committee (RUC), which would review code-specific CPEP data during the refinement period. This committee would include representatives from all major specialty societies and would make recommendations to us on suggested changes to the CPEP data.

As directed by the BBRA, we also established a process (*see* 65 FR 65380) under which we would accept and use, to the maximum extent practicable and consistent with sound data practices, data collected by entities and organizations to supplement the data we normally collect in determining the practice expense component of the physician fee schedule.

a. Major Steps

A brief discussion of the major steps involved in the determination of the practice expense RVUs follows. (Please see the November 1, 2001 final rule (66 FR 55249) for a more detailed explanation of the top-down methodology.)

- *Step 1*—Determine the specialty specific practice expense per hour of physician direct patient care. We used the AMA's SMS survey of actual aggregate cost data by specialty to determine the practice expenses per hour for each specialty. We calculated the practice expenses per hour for the specialty by dividing the aggregate practice expenses for the specialty by the total number of hours spent in patient care activities.
- *Step 2*—Create a specialty-specific practice expense pool of practice expense costs for treating Medicare patients. To calculate the total number of hours spent treating Medicare patients for each specialty, we used the physician time assigned to each procedure code and the Medicare utilization data. The primary sources for the physician time data were surveys submitted to the AMA's RUC and surveys done by Harvard for the establishment of the work RVUs. We then multiplied the physician time assigned per procedure code by the number of times that code was billed by each specialty, and summed the products for each code, by specialty, to get the total physician hours spent treating Medicare patients for that specialty. We then calculated the specialty specific practice expense pools by multiplying the specialty practice expenses per hour (from step 1) by the total Medicare physician hours for the specialty.
- *Step 3*—Allocate the specialty specific practice expense pool to the specific services (procedure codes) performed by each specialty. For each specialty, we divided the practice expense pool into two groups based on whether direct or indirect costs were involved and used a different allocation basis for each group.

(i) Direct costs—For direct costs (which include clinical labor, medical supplies, and medical equipment), we used the procedure-specific CPEP data on the staff time, supplies, and equipment as the allocation basis. For the separate practice expense pool for services without physician work RVUs, we have used, on an interim basis, 1998 practice expense RVUs to allocate the direct cost pools.

(ii) Indirect costs—To allocate the cost pools for indirect costs, including administrative labor, office expenses, and all other expenses, we used the total direct costs, or the 1998 practice expense RVUs, in combination with the physician fee schedule work RVUs. We converted the work RVUs to dollars using the Medicare CF (expressed in 1995 dollars for consistency with the SMS survey years).

- *Step 4*—The direct and indirect costs are then added together to attain the practice expense for each procedure, by specialty. For procedures performed by more than one specialty, the final practice expense allocation was a weighted average of practice expense allocations for the specialties that perform the procedure, based on the frequency with which each specialty performs the procedure on Medicare patients.

b. Other Methodological Issues

i. Nonphysician Work Pool

As an interim measure, until we could further analyze the effect of the top-down methodology on the Medicare payment for services with physician work RVUs equal to zero (including the technical components of radiology services and other diagnostic tests), we created a separate practice expense pool. We first used the average clinical staff time from the CPEP data and the ''all physicians'' practice expense per hour to create the pool. In the December 2002 final rule, we changed this policy and now use the total clinical staff time and the weighted average specialty–specific practice expense per hour for specialties with services in this pool. In the next step, we used the adjusted 1998 practice expense RVUs to allocate this pool to each service. Also, for all radiology services that are assigned physician work RVUs, we used the adjusted 1998 practice expense RVUs for radiology services as an interim measure to allocate the direct practice expense cost pool for radiology.

A specialty society may request that its services be removed from the nonphysician workpool. We have removed services from the nonphysician work pool if the requesting specialty predominates utilization of the service.

ii. Crosswalks for Specialties Without Practice Expense Survey Data

Since many specialties identified in our claims data did not correspond exactly to the specialties included in the SMS survey data, it was necessary to crosswalk these specialties to the most appropriate SMS specialty.

iii. Physical Therapy Services

Because we believe that most physical therapy services furnished in physicians' offices are performed by physical therapists, we crosswalked all utilization for therapy services in the CPT 97000 series to the physical and occupational therapy practice expense pool.

3. Practice Expense Proposals for Calendar Year 2005

a. Supplemental Practice Expense Surveys

i. Survey Criteria and Submission Dates

As required by the BBRA, we established criteria to evaluate survey data collected by organizations to supplement the SMS survey data normally used in the calculation of the practice expense component of the physician fee schedule. By regulation (see 68 FR 63200), we provided that, beginning this year, supplemental survey data must be submitted by March 1 to be considered for use in computing practice expense RVUs for the following year. This allows us to publish our decisions regarding survey data in the proposed rule and provides the opportunity for public comment on these results before implementation.

To continue to ensure the maximum opportunity for specialties to submit supplemental practice expense data, we extended until 2005 the period that we would accept survey data that meet the criteria set forth in the November 2000 final rule. We will no longer accept supplemental practice expense data after that point. The deadline for submission of supplemental data to be considered in CY 2006 is March 1, 2005.

ii. Survey by the College of American Pathologists (CAP)

In the June 28, 2002 **Federal Register** (67 FR 43849), we proposed a technical change to the practice expense methodology that calculated the technical component as the difference between the global and professional component RVUs for services not included in the nonphysician work pool. In the December 31, 2002 final rule (67 FR 79979), we established a 1-year moratorium on the technical change for pathology services to allow CAP to do a survey of independent laboratories. Consistent with last year's rules, CAP submitted its supplemental survey by August 1, 2003 for use in determining the 2004 practice expense RVUs. Our contractor, The Lewin Group, evaluated the data and recommended that we accept the survey to supplement the data on PE. However, because we changed the survey deadline to March 1, CAP requested that we delay incorporation of the survey data until this year's proposed rule. CAP also requested that we extend the moratorium on calculating the technical component as the difference between the global and professional component RVUs for pathology services for one additional year to allow us to evaluate in a proposed rule the combined effects of the use of the new survey data along with other proposed technical changes. In the November 7, 2003 final rule, in response to the CAP comment, we agreed to extend the moratorium by an additional year. In this proposed rule, we propose to incorporate the CAP survey data into the practice expense methodology and to end the moratorium on calculating the technical component as the difference between the global and professional component RVUs for pathology services. We propose to use the following practice expense per hour figures for specialty 69—Independent Laboratory.

TABLE 1.—PRACTICE EXPENSE PER HOUR FIGURES FOR SPECIALTY 69—INDEPENDENT LABORATORY

Specialty	Clinical staff	Admin. staff	Office expense	Medical supplies	Medical equipment	Other	Total
Independent Laboratory	$39.7	$37.5	$40.1	$19.3	$11.1	$16.1	$163.8

iii. Submission of Supplemental Surveys

We received surveys from the American College of Cardiology (ACC), the American College of Radiology (ACR), and the American Society for Therapeutic Radiation Oncology (ASTRO). Our contractor, The Lewin Group, evaluated the data and made recommendations to us regarding use of the data in a report on May 26, 2004. We have made The Lewin Group report available on the CMS Web site at *http://www.cms.hhs.gov/physicians/pfs/*. The Lewin Group is recommending that we accept the data from ACC and ACR but indicated that the survey from ASTRO does not meet the precision criteria we have established for supplemental surveys. As a result, The Lewin Group is not recommending that we use the ASTRO survey results at this time. We agree with this recommendation and are proposing not using the ASTRO survey data at this time.

Many of the procedures that are performed by radiology, cardiology, and radiation oncology are affected by the nonphysician work pool calculations. We created the nonphysician work pool as an interim measure because of a concern that the top-down methodology was having a large adverse impact on payment for services that do not have physician work RVUs. As we stated in the December 31, 2002 final rule (67 FR 79979), we believe a relatively low practice expense per hour explains the adverse impact on diagnostic and other services that would occur from eliminating the nonphysician work pool. The ACR, ACC, and ASTRO began undertaking surveys in 2003 following our analysis of options for eliminating the nonphysician work pool in the December 31, 2002 final rule. CMS' interest is in using the supplemental survey data to eliminate the nonphysician work pool and use a single methodology to establish payments for all physician fee schedule services.

We appreciate the efforts of these three specialties to undertake surveys and assist CMS in finding a permanent resolution of issues related to the nonphysician work pool. While the radiology survey data do meet the criteria we have established for use of supplemental surveys, the ACR has written to us asking that we not use the data until we have a stable and global solution that is workable for all specialties that are currently paid using the nonphysician work pool. The ACC also requested that we use the supplemental survey for services that are in the cardiology pool. However, ACC also indicated if CMS determines that it would only be appropriate to use the survey data if cardiology services are removed from the nonphysician work pool or if the nonphysician work pool

is eliminated, we should delay using the data until the issues involved can be discussed further.

At this time, we are not proposing to eliminate the nonphysician work pool or to remove selected radiology and cardiology codes from it. Since our interest is in using supplemental data in conjunction with pricing all services under the top-down methodology, we agree with the request from ACR to delay use of its supplemental survey until issues related to the nonphysician work pool can be addressed. Furthermore, we believe the high practice expense per hour for cardiology from the supplemental survey results from the inclusion of practices that do very high cost office-based cardiology services. Because the RVUs for these office-based cardiology services are currently determined using the nonphysician work pool methodology, we believe the ACC supplemental survey data should only be used in conjunction with removing cardiology services from the nonphysician work pool. For this reason, we are also delaying use of the ACC survey data as we continue to analyze elimination of the nonphysician work pool in conjunction with using supplemental survey data. As we complete our analysis, we look forward to working with the medical community to find a permanent resolution of this issue.

b. Practice Expense Advisory Committee (PEAC) Recommendations on CPEP Inputs for 2005

Since 1999, the PEAC, an advisory committee of the RUC, has been providing us with recommendations for refining the direct practice expense inputs (clinical staff, supplies, and equipment) for existing CPT codes. As we did last year, we are including our proposals regarding the PEAC recommendations in the proposed rule, to enable specialty groups to assess the impact of the proposed changes on their services and to make comments on them before the final rule.

These PEAC recommendations are the result of meetings held in March and August 2003 and January and March 2004, and account for over 2,200 codes from many specialties. (A list of these codes can be found in Addendum C.)

The PEAC held its last meeting in March 2004, and these are the last recommendations we will be receiving from the committee. The AMA established the PEAC to assist the RUC in refining the direct input data used in calculating the practice expense RVUs for established codes. Since its inception, the PEAC has provided recommendations on over 7,600 codes, which leaves only a few hundred physician fee schedule codes that we believe are still unrefined. The PEAC has also recommended standard times for many clinical staff activities and has established several supply and equipment packages that can be applied across wide ranges of codes. This has helped us ensure that the CPEP inputs have been assigned equitably across procedures performed by different specialties. The work of the PEAC has, therefore, contributed greatly to the refinement of the practice expense inputs, and we appreciate the 5 years of hard work by the specialty societies and the AMA that helped make the PEAC so successful. Future practice expense issues, including the refinement of the remaining codes not addressed by the PEAC, will be handled by the RUC. We anticipate the RUC will formulate the specific process at a future meeting, possibly as soon as October 2004. If possible, additional information on this process will be included in the final fee schedule rule.

We have reviewed the PEAC-submitted recommendations and propose to adopt nearly all of them. We have worked with the PEAC staff to correct any typographical errors and to make certain that the recommendations are in line with previously accepted standards. In addition, in order to prevent rank order anomalies, we reviewed those codes that are currently unrefined or that were refined early in the PEAC process to apply some of the major PEAC-agreed standards. For the unrefined 10-day global services, we are proposing to substitute for the original CPEP times the PEAC-agreed standard post-service office visit clinical staff times used for all 90-day and refined 10-day global services. We also are proposing to eliminate the discharge management clinical staff time from all but the 10 and 90-day global codes, substituting one post-service phone call if not already in the earlier data. Lastly, we are proposing to delete any extra clinical staff time for post-visit phone calls because that time is already included in the time allotted for the visits.

The complete PEAC recommendations and the revised practice expense database can be found on our web site. (See the ''Supplementary Information'' section of this proposed rule for directions on accessing our website.)

We disagree with the PEAC recommendation for clinical labor time for CPT 99183, Hyperbaric oxygen (HBO) therapy. During last year's rulemaking, we assigned, on an interim basis, 135 minutes of total clinical labor. The PEAC however, recommended 42 minutes of total clinical labor time, which allows for 20 minutes for the HBO chamber treatment (intra) time. We believe that 90 minutes is a more appropriate estimation of the clinical staff time actually needed for the intra time because, according to our data, a typical HBO treatment session billed under the outpatient prospective payment system is 90 minutes and the clinical staff is in constant attendance. Therefore, we are proposing a total clinical labor time of 112 minutes for this service.

The PEAC recommendations for CPT codes 91011 and 91052 included a supply input for methacholine chloride as the injected stimulant for these two services. In discussions with representatives from the gastroenterology specialty subsequent to receipt of the PEAC recommendations, we learned this is incorrect, since an injected form of methacholine chloride is not currently available. For CPT 91011, esophageal motility study, we are proposing to include edrophonium, 1 ml, as the drug typically used in this procedure. For CPT 91052, gastric analysis study, we were unable to identify the single drug that is most typically used with this procedure. We have added the edrophonium to the list of supplies where we need information from the specialty in order to price appropriately (see Table 3). We are also requesting that commenters, particularly the specialty organizations, provide us with information on the drug that is most typically used for CPT 91052, including drug dosage and price, so that it can be included in the practice expense database.

In last year's final rule, we indicated that we would not go forward with the 2003 PEAC recommendations on eight E/M codes for nursing home services, CPT codes 99301 through 99316 and on two E/M codes for home visits, CPT codes 99348 and 99350, to allow the PEAC to reconsider the clinical staff time for these codes based on the specific input from the representatives of the nursing home and home visit specialties. This year's PEAC recommendations for the E/M nursing home services included the views of the long-term care physicians and represent an overall decrease in clinical labor inputs for these codes. However, the home care physicians subsequently withdrew these codes from further PEAC consideration, which leaves the 2003 PEAC recommendation for these services unchanged. Therefore, we are proposing to adopt the direct practice expense input recommendations from

the March 2003 PEAC meeting for CPT codes 99348 and 99350.

c. Repricing of Clinical Practice Expense Inputs—Equipment

We use the practice expense inputs (the clinical staff, supplies, and equipment assigned to each procedure) to allocate the specialty-specific practice expense cost pools to the procedures performed by each specialty. The costs of the original equipment inputs assigned by the CPEP panels were determined in 1997 by our contractor, Abt Associates, based primarily on list prices from equipment suppliers. Subsequent to the CPEP panels, equipment has also been added to the CPEP data, with the costs of the inputs provided by the relevant specialty society. We only include equipment with costs equal to or exceeding $500 in our practice expense database because the cost per use for equipment costing less than $500 would be negligible. We also considered the useful life of the equipment in establishing an equipment cost per minute of use. This was discussed in our proposed rule published June 18, 1997 (62 FR 33164). The primary source of this information was the ''Estimated Useful Lives of Depreciable Hospital Assets'' (1993 edition) from the American Hospital Association (AHA).

We proposed updates and revisions to the clinical staff salary data and supply inputs and finalized these in the rules published November 1, 2001 (66 FR 55255) and November 7, 2003 (68 FR 63196), respectively. We also indicated that, in future rulemaking, we would be proposing updates to the equipment inputs that are used in the CPEP database.

We contracted with a consultant to assist us in obtaining the current price for each equipment item in our CPEP database. The consultant has been able to determine the current prices for most of the equipment inputs and, to ensure that accurate information was obtained, has submitted documentation from vendor catalogs or websites for nearly 600 equipment items.

Our contractor also clarified the specific composition of each of the various packaged and standardized rooms or ophthalmology ''lanes'' currently identified in the equipment practice expense database (for example, ''mammography room'' or ''exam lane''). We are proposing to delete the current ''room'' designation for the radiopharmaceutical receiving area and, in its place, list separately the equipment necessary for each procedure as individual line items because there does not appear to be a standard configuration for such a room across the nuclear medicine codes.

Although individual equipment items valued under $500 are not included in the equipment database, we do include instrument packs or surgical trays that are maintained, stored, and used as a unit, where the aggregate cost of individual items equals or exceeds $500. We have adopted the PEAC recommendation based on consensus among specialties to establish two generic instrument packages rather than list a myriad of different packages for each specialty. The basic instrument pack, assigned a value of $500, includes instrument aggregate costs ranging from $500 to $1,499. The medium pack was assigned $1,500, for instrument packages priced at or above $1,500. We are proposing to replace all surgical packs and trays in the practice expense database with the appropriate standardized packs described above.

Our consultant worked closely with the specialty societies to obtain accurate information to identify equipment and applicable prices. The useful life for each equipment item has also been reviewed and updated as necessary. This update is primarily based on the AHA's ''Estimated Useful Lives of Depreciable Hospital Assets'' (1998 edition) by direct association with a listed item in the publication or by crosswalking from a reasonably similar item. We understand that AHA will publish updated guidelines this summer, and we plan to reflect any updates in our final rule.

Addendum D lists the proposed new prices for equipment items, instrument packs, and rooms/lanes, as well as new descriptions when needed. A more detailed spreadsheet can be found on our website, *http://www.cms.hhs.gov/physicians/pfs.* This spreadsheet contains additional information regarding the sources used to price each equipment item.

Additionally, there are specific equipment items for which a source has not yet been identified or for which pricing information has not yet been found and documented. These are included in Table 2 below. In this table, we have identified the equipment code (if assigned), the existing description for the equipment item and current price, the procedures or specialties associated with the item, as well as the proposed new description and standardized life for the equipment's use, where this could be identified. We have also identified equipment for deletion from the database, such as equipment items less than $500 and items that have become obsolete. We are requesting that commenters, particularly the relevant specialty groups, provide us with the needed pricing information, including appropriate documentation. Whenever possible, commenters should provide multiple sources of documentation so that a typical price can be determined. If we are not able to obtain any verified pricing information for an item, we may eliminate it from the database.

TABLE 2.—EQUIPMENT ITEMS NEEDING SPECIALTY INPUT FOR PRICING AND PROPOSED DELETIONS

Code	2005 description	Price	Primary specialties associated with item	*CPT code(s) associated with item	Status of item
	Ambulatory blood pressure monitor.	3,000.00	Cardiology	93784, 93786, 93788	See Note A.
	Biofeedback equipment		Psychology	90875	See Note A.
	CAD processor unit (mammography).	210,000.00	Radiology	76082, 76083, 76085	See Note A (Need system components).
E53005	Camera system, cardiac, nuclear.	675,000.00	Anesthesia, IM, cardiology	78414	See Note A.
E53026	Collimator, cardiofocal set	29,990.00	Radiology	78206, 78607, 78647, 78803, 78807.	See Note A.
E71013	Computer and VDT and software.	9,000.00	Ophthalmology, optometry	92060, 92065	See Notes A and C.
	Computer software, MR/PET/CT fusion.	60,000.00	Radiation oncology	77301	See Note A.
E51022	Computer system, record and verify.	60,000.00	Radiation oncology	77418	See Note A.

TABLE 2.—EQUIPMENT ITEMS NEEDING SPECIALTY INPUT FOR PRICING AND PROPOSED DELETIONS—Continued

Code	2005 description	Price	Primary specialties associated with item	*CPT code(s) associated with item	Status of item
E51050	Computer workstation, 3D teletherapy treatment planning.	221,500.00	Radiation oncology	77300, 77305, 77310, 77315, 77321, 77331.	See Note A.
	Computer workstation, MRA post processing.		Radiology	71555, 72159, 72198, 73225, 73725, 74185.	See Note A.
	Computer, server		Radiation oncology	77301	See Note A. (Need system components).
	Cortical bipolar-biphasic stimulating equipment.		Neurosurgery, neurology	95961, 95962	See Note A.
	CPAP/BiPAP remote clinical unit.		Pulmonary disease, neurology.	95811	See Note A.
	Cryo-thermal unit		Anesthesia	64620	See Notes A and C.
E53034	Densitometry unit, whole body, DPA.	65,000.00	Radiology	78351	See Notes A and C.
E53032	Densitometry unit, whole body, SPA.	22,500.00	Radiology	78350	See Notes A and C.
E53036	Detector (Probe)	14,000.00	Radiology, cardiology	78455	See Notes A and C.
	Dialysis access flow monitor.	10,000.00	Nephrology	90940	See Note A.
	Diathermy, microwave		Anesthesia, GP, podiatry	97020	See Notes A and C.
	DNA image analyzer (ACIS).	200,000.00	Lab, pathology	88358, 88361	See Note A.
	Drill, ophthalmology		Ophthalmology	65125	See Note A.
E55035	ECG signal averaging system.	8,250.00	Cardiology, IM	93278	See Note A.
	EEG monitor, digital, portable.		95953	Neurology	See Note A.
E54008	EEG recorder, ambulatory	6,940.00	Neurology	95950	See Note A.
E54009	EEG review station, ambulatory.	44,950.00	Neurology	95950	See Note A.
	Electroconvulsive therapy machine.		Psychiatry	90870	See Note A.
	Electromagnetic therapy machine.	25,000.00	Physical therapy	G0329	See Note A.
E54012	EMG botox	1,500.00	Critical care, pulmonary, ophthalmology.	92265	See Note A.
E52002	Fetal monitor *software*	35,000.00	Ob-gyn, radiology	76818, 76819	See Note A.
	Film alternator (motorized film viewbox).	27,500.00	Radiology	329 codes	See Note B.
	Generator, constant current.	950.00	Neurology, NP	95923	See Note A.
E51072	HDR Afterload System, Nucletron—Oldelft.	375,000.00	Radiation oncology	77781–84	See Note A.
	Hyperbaric chamber	125,000.00	FP, IM, EM	99183	See Note A.
	Hyperthermia system, ultrasound, external.	360,000.00	Radiation oncology	77600	See Note A.
	Hyperthermia system, ultrasound, intracavitary.	250,000.00	Radiation oncology	77620	See Note A.
	Hysteroscopy ablation system.	19,500.00	Ob-gyn	58563	See Note A.
E13652	image analyzer (CAS system).	92,000.00	Pathology, neurology	88355, 88356	See Note A.
	IMRT physics tools	55,485.00	Radiation oncology	77301, 77418	See Note A.
E91008	IVAC Injection Automatic Pump.	2,500.00	Radiology	78206, 78607, 78647, 78803, 78807.	See Note A.
	Mammography reporting software.		Radiology	76090, 76091, 76092	See Note A.
E12002	Neurobehavioral status instrument-average.	717.00	Psychology, IM	96115, 96117	See Note A.
	Orthovoltage radiotherapy system.	140,000.00	Radiation oncology	77401	See Note A.
	OSHA ventilated hood	5,000.00	Radiation oncology	77334	See Note B.
E91011	Plasma pheresis machine w/UV light source.	37,900.00	Radiology, dermatology	36481, 36510, 36522	See Note A.
E55013	Programmer, pacemaker	10,000.00	Cardiology, cardiothoracic surgery, general surgery.	33200–01, 33206–08, 33212–18, 33220, 33222, 33240, 33245–46, 33249, 33282.	See Note A.

TABLE 2.—EQUIPMENT ITEMS NEEDING SPECIALTY INPUT FOR PRICING AND PROPOSED DELETIONS—Continued

Code	2005 description	Price	Primary specialties associated with item	*CPT code(s) associated with item	Status of item
	Pulse oxymetry recording *software* (prolonged monitoring).	3,660.00	Pulmonary disease, IM	94762	See Note A.
	Radiation treatment vault	550,670.00	Radiation oncology	774XX	See Note B.
	Radiation virtual simulation system.		Radiation oncology	77280, 77285, 77290, 77402–16.	See Note A.
	Remote monitoring service (neurodiagnostics).	9,500.00	Neurology	95955	See Note A.
E54010	Review master	23,500.00	Pulmonary disease, neurology.	95805, 95807–11, 95816, 95822, 95955–56.	See Note A.
E51004	Room, basic radiology	150,000.00	Radiology	103 codes	See Note A.
E51016	Room, mammography	130,000.00	Radiology	19030, 19290–91, 19295, 76086–92, 76096.	See Note A.
E51005	Room, radiographic-fluoroscopic.	475,000.00		123 codes	See Note A.
	Source, 10 Ci Ir 192	22,000.00	Radiation oncology	77781–84	See Note A.
	Strontium-90 applicator	8,599.00	Radiation oncology	77789	See Note A.
	Table, cystoscopy		urology	52204–24, 52265-75 52310–17, 52327–32.	See Note A.
E52001	Ultrasound color doppler, transducers and vaginal probe.	155,000.00	Ob-gyn	59070, 59074, 76818–19.	See Note A.
E52007	Ultrasound, echocardiography digital acquisition (Novo Microsonics, TomTec).	29,900.00	Ob-gyn, cardiology, pediatrics.	76825–28, 93303-12, 93314, 93320, 93325, 93350.	See Note A.
	Vacuum cart		Anesthesia	64620	See Notes A and C.
E13635	Video camera	1,000.00	Radiation oncology	77418	See Note A.
	Water chiller (radiation treatment).	28,000.00	Radiation oncology	77402–16	See Note B.
E51076	Well counter		Radiology	78160–72, 78282	See Note A.

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Notes:

A. Additional information required. Need detailed description (including system components as specified), source, and current pricing information.

B. Proposed deletion as indirect expense.

C. Item may no longer be available.

In addition to reviewing and updating the cost information for equipment items in the database, our contractor also recommended the following revisions to provide uniformity and consistency in the CPEP equipment database. All of the following recommendations are noted in Addendum D:

Assignment of equipment categories. In the original CPEP data, a number was assigned to each item of equipment. The contractor has recommended that each equipment item also be assigned a ''category'' to allow for easier identification and sorting of items. We agree and are proposing that equipment be assigned to one of the following six categories: documentation, laboratory, scopes, radiology, furniture, rooms-lanes, and other equipment.

These categories could also be used to establish a new numbering system for equipment that would more clearly identify them for practice expense purposes. We would assign a letter to each category and use this in conjunction with a number (000 through 999) to identify each item of equipment. This would enable specialty groups to identify more easily whether an item of equipment has already been included in the practice expense database and would help avoid duplication of references to the same item of equipment under different descriptions. If we proceed in the final rule with this proposed method for categorizing equipment, we will assign new identifying numbers to each equipment input item and these will be available on our website.

Consolidation/standardization of item descriptions.

When items appear to be duplicative, we are proposing to combine the items. For example, for two cervical endoscopy procedures, our contractor identified that the price of the LEEP system includes a smoke evacuation system but that system is also listed separately. We propose to merge these two line items and reflect both prices in the price of the LEEP system. All proposed changes are specifically referenced in Addendum D.

We welcome any comments on the proposed pricing and all other proposed revisions. To help us evaluate the information provided, comments should include documentation from more than one source, where available, such as information from a vendor catalog or website or from a current invoice.

d. Miscellaneous Practice Expense Issues

i. Pricing for Seldinger Needle

We received comments from a specialty organization on our November 7, 2003 rule stating that the $72.90 price assigned to the Seldinger needle, which is used in certain radiological procedures, is too high. The organization estimated that the cost is actually closer to $7.00; however, documentation was not provided to

support this price estimate. Our contractor was able to confirm pricing information from two sources, including a price of $3.50 from a hospital supplier and a price of $6.85 from a cardiology supplier. Based on this pricing variability, we are proposing to average the two prices of this supply item to reflect a cost of $5.175. If a commenter disagrees with this proposed change in price, the comment should provide documentation to support the recommended price, as well as the specific type of needle that is most commonly used.

ii. Hysteroscopic Endometrial Ablation

We received requests from a manufacturer and physicians to price CPT code 56853, Hysteroscopy with endometrial ablation, in the office setting so that physicians providing this service in the nonfacility setting could receive an appropriate payment. (This service is currently valued only in the facility setting.) We have worked with the specialty society, the American College of Obstetricians and Gynecologists, to identify the required resources based on the typical practice. We propose to assign on an interim basis, the following direct practice expense inputs in the nonfacility setting for this service.

- *Clinical Staff:* RN/LPN/MTA—72 minutes (18 pre-service and 54 service)
- *Supplies:* PEAC multispecialty visit supply package, Post-op incision care kit, pelvic exam package, irrigation tubing, sterile impervious gown, surgical cap, shoe cover, surgical mask with face shield, 3x3 sterile gauze (20), cotton tip applicator, cotton balls (4), irrigation 0.9 percent sodium chloride 500–1000ml(3), maxi-pad, mini-pad, 3-pack betadine swab (4), Monsel's solution (10ml), lidocaine jelly (1000ml), disposable speculum, spinal needle, 18–24g needle, 20 ml syringe, bupivicaine 0.25 percent (10ml), 1 percent xylocaine (20ml), cidex (10ml), Polaroid film–type 667 (2), endosheath, and hysteroscopic ablation device kit.
- *Equipment:* power table, fiberoptic exam light, endoscopic-rigid hysteroscope, endoscopy video system, and hysteroscopic ablation system.

We will request that the RUC review these inputs along with inputs of other codes still in need of refinement. iii. Photopheresis

We received a request from a supplier to review the direct practice expense inputs currently in our database for the photopheresis service, CPT code 36522. These inputs are based on the original CPEP panel recommendations and the supplier does not believe they are reflective of the resources now being used. This service was not reviewed by the PEAC during the refinement process, and we agree that the direct inputs need to be revised for this service. We propose to assign, on an interim basis, the following nonfacility practice expense inputs, and we will request that the RUC review them as part of the practice expense refinement process.

- *Clinical Staff:* RN—223 minutes (treatment is for approximately 4 hours)
- *Supplies:* multispecialty visit supply package, photopheresis procedural kit, blood filter (filter iv set), IV blood administration set, 0.9 percent irrigation sodium chloride 500–1000 ml (2), heparin 1,000 units-ml (10), povidone solution-betadine, methoxsalen (UVADEX) sterile solution-10 ml vial, 1 percent-2 percent lidocaine-xylocaine, paper surgical tape (12), 2x3 underpad (chux), nonsterile drapesheet 40 inches x 60 inches, nonsterile Kling bandage, bandage strip, 3x3 sterile gauze, 4x4 sterile gauze, alcohol swab pad (3), impervious staff gown, 19–25 g butterfly needle, 14–24g angiocatheter, 18–27 g needle, 20 ml syringe, 10–12 ml syringe, 1 ml syringe, 22–26 g syringe needle-3 ml.
- *Equipment:* plasma pheresis machine with ultraviolet light source, medical recliner.

iv. Pricing of New Supply Items

As part of last year's rulemaking process, we reviewed and updated the prices for supply items in our practice expense database. During subsequent meetings of both the PEAC and the RUC, supply items were added that were not included in the supply pricing update. The following table, Proposed Practice Expense Supply Item Additions for 2005, lists these additional supply items and the proposed associated prices that we will use in the practice expense calculation.

TABLE 3.—PROPOSED PRACTICE EXPENSE SUPPLY ITEM ADDITIONS FOR 2004

Supply description	Unit price *	Unit	* CPT code(s) associated with item	Supply category
Acrylic tray-base material	1.775	oz	21421, 21452	Lab.
Adapter, luer lock	1.249	Item	36515	Hypodermic, IV.
Adapter, spike (for syringe)	4.558	Item	36515	Hypodermic, IV.
Adhesive, conductive (silver, liquid)	3.000	gm	88349	Lab.
Adhesive, cyanoacrylate (2ml uou).doc.	28.988	Item	65286	Pharmacy, Rx.
Airway adapter	12.500	Item	94770	Accessory, Procedure.
Albuterol inhal soln (3ml vial)	0.436	Item	95070	Pharmacy, Rx.
Alcohol ethyl 100%	0.028	ml	88348	Lab.
Applicator, cotton-tipped, sterile, 6in	0.056	Item	127 codes	Wound Care, Dressings.
Applicator, wood, 6.5in	0.008	Item	99348–49	Lab.
Bag system, 1000ml (for angiography waste fluids).	8.925	Item	93501, 93505–10	Accessory, Procedure.
Balanced salt soln (BSS) (15ml uou)	1.600	Item	59 codes	Pharmacy, Rx.
Battery, AA	0.450	Item	95250	Office Supply, Grocery.
Blade, surgical, super-sharp	4.167	Item	14 codes	Cutters, Closures, Cautery.
Blade, urethrotome	85.030	Item	52270	Cutters, Closures, Cautery.
Blood collection tube holder	0.163	Item	78110–11, 78120–22, 78130, 78191, 78725.	Hypodermic, IV.
Blood collection tube needle	0.142	Item	36514–16, 78110–11, 78120–22, 78130, 78191, 78725.	Hypodermic, IV.
Blood pressure recording form, average.	0.310	Item	93784, 93786, 93788	Office Supply, Grocery.
Brush, protected airway specimen	13.000	Item	31623, 31717	Accessory, Procedure.
Bur, surgical, sterile (drill)	4.792	Item	28289	Accessory, Procedure.
Canned air (Dust-Off)	1.021	oz	88348	Office Supply, Grocery.
Cannula, anterior chamber, 18–27g	2.688	Item	65815, 66020, 66030, 66250	Accessory, Procedure.

TABLE 3.—PROPOSED PRACTICE EXPENSE SUPPLY ITEM ADDITIONS FOR 2004—Continued

Supply description	Unit price *	Unit	* CPT code(s) associated with item	Supply category
Catheter percutaneous fastener (Percu-Stay).	12.745	Item	32201, 44901, 47525, 47530, 48511, 49021, 49041, 49061, 49423, 49424, 50021, 58823.	Accessory, Procedure.
Catheter, (Glide)	62.000	Item	36218, 36248	Accessory, Procedure.
Catheter, (SIM2F1)	17.000	Item	36011–15, 36215–17, 36245–47	Accessory, Procedure.
Catheter, angiographic	16.200	Item	93508, 93510, 93526	Hypodermic, IV.
Catheter, balloon inflation device	24.900	Item	35470–76	Accessory, Procedure.
Catheter, balloon ureteral (Dowd)	65.000	Item	52330	Accessory, Procedure.
Catheter, balloon, low profile PTA	431.500	Item	35470, 35471, 35474	Accessory, Procedure.
Catheter, balloon, PTA	243.500	Item	35472–73, 35475–76	Accessory, Procedure.
Catheter, curved	17.775	Item	36218	Accessory, Produce.
Catheter, hyperthermia, closed-end		Item	77600–20	Hypodermic, IV.
Catheter, hyperthermia, open-end		Item	77600	Hypodermic, IV.
Catheter, microcatheter (selective 3rd order).	337.880	Item	36217, 36247	Accessory, Procedure.
Catheter, Swan Ganz	65.000	Item	93501, 93526	Accessory, Procedure.
Catheter, ureteral, acorn tip	9.550	Item	52007, 52010, 52327, 52330	Accessory, Procedure.
Clamp, circumcision	7.500	Item	54150	Cutters, Closures, Cautery.
Collagen, dermal implant (2.5ml uou) (Contigen).	317.000	Item	52327, 52330	Pharmacy, Rx.
Conformer, sterile, acrylic	20.000	Item	68340	Accessory, Procedure.
Contact lens (hard) care kit	7.950	Item	92325–26	Pharmacy, NonRx.
Contact lens (hard) extra strength cleaning solution.	0.158	ml	92325–26	Pharmacy, NonRx.
Contact lends (RGP) polishing soln (Silo2 Care).	0.077	ml	92325	Pharmacy, NonRx.
Container, 2000ml, transfer pack	7.120	Item	36515	Accessory, Procedure.
Container, 600ml, transfer pack	3.360	Item	36515	Accessory Procedure.
Cotton balls, sterile	0.022	Item	115 codes	Wound Care, Dressings.
Cup, sterile, 12–16 oz	0.760	Item	32201, 44901, 48511, 49021, 49041, 49061, 50021, 58823, 93501, 93505, 93508, 93510, 93526.	Lab.
Cup, sterile, 8 oz	0.542	Item	32201, 44901, 48511, 49021, 49041, 49061, 50021, 58823.	Lab.
Cuvette, whole blood oximeter	115.000	Item	93501, 93526	Hypodermic, IV.
Diamond knife cleaning rod	1.000	Item	99348	Lab.
Drainage catheter, all purpose	88.430	Item	44901, 47525, 47530, 48511, 49021, 49041, 49061, 49423, 50021, 50398, 58823.	Accessory, Procedure.
Drainage catheter, chest	88.890	Item	32201	Accessory, Procedure.
Drainage pouch, nephrostomy-biliary	13.250	Item	32201, 44901, 47525, 47530, 48511, 49021, 49041, 49061, 49423, 50021, 50398, 58823.	Accessory, Procedure.
Drape, sterile, incise, ophthalmic	4,900		67025, 67028, 67110, 67120	Gown, Drape.
Drape, sterile, split-sheet	10,243	Item	212 codes	Gown, Drape.
Drape, sterile, table 44 in x 76 in	5.250	Item	93501–10, 93526	Gown, Drape.
Electrode, Bugbee	115.000	Item	52204, 52214, 52224, 52265, 52275, 55200, 55250.	Accessory, Procedure.
Electrode, EEG (single)	1.638	Item	95961, 95816	Accessory, Procedure.
Electrode, EGG (single)	2.917	Item	91132, 95925–27, 95930	Accessory, Procedure.
Endoscopic deflecting brush	73.500	Item	52007	Accessory, Procedure.
Film, x-ray, laser print	1.437	Item	146 codes	Office Supply, Grocery.
Floxin 0.3% otic soln	2.354	ml	69145, 69620	Pharmacy, Rx.
Forceps, endomyocardial biopsy	250.000	Item	93505	Accessory, Procedure.
Forceps, Kelly	2.335	Item	93501–10, 93526	Accessory, Procedure.
Gas, nitrogen	2.708	cu ft	88348–49	Lab.
Glass knife boat	0.200	Item	88348	Lab.
Grid storage box (holds 50 grids)	3.750	Item	88348	Lab.
Guidewire bowl w-lid, sterile	3.000	Item	93501–10, 93526	Accessory, Procedure.
Guidewire, cerebral (Bentson)	14.500	Item	36011–15, 36215–17, 36245–47	Accessory, Procedure.
Guidewire, low profile (SpartaCore)	101.250	Item	35470–71, 35474	Accessory, Procedure.
Guidewire, steerable (Hi-Torque)	90.000	Item	35470–76, 37203	Accessory, Procedure.
Guidewire, steerable (Transcend)	180.000	Item	36217, 32647	Accessory, Procedure.
Guidewire, torque	41.000	Item	35470–76	Accessory, Procedure.
Heparin 5,000 units-mi inj	0.509	ml	36514–15	Pharmacy, Rx.
Hyaluronic acid viscoelastic inj (Amvisc, 0.5ml uou.	61.000	Item	65286, 65815, 66250	Pharmacy, Rx.
Hysteroscope ablation device	1,146.000	Item	58563	Accessory, Procedure.
Jessner's soln	0.240	ml	15788–89, 15792–93	Pharmacy, Rx.
Kenalog 40 inj	1.830	ml	31830	Pharmacy, Rx.

TABLE 3.—PROPOSED PRACTICE EXPENSE SUPPLY ITEM ADDITIONS FOR 2004—Continued

Supply description	Unit price *	Unit	* CPT code(s) associated with item	Supply category
Kit, AccuStick II Introducer system with RO Marker.	82.620	Kit	26 codes	Kit, Pack, Tray.
Kit, apheresis treatment	140.000	Kit	36515	Kit, Pack, Tray.
Kit, barium enema	9.466	Kit	75270, 74283	Kit, Pack, Tray.
Kit, BCR/ABL DNA probe	42.650	Kit	88365	Kit, Pack, Tray.
Kit, slit catheter (for compartment pressure monitor).	73.750	Kit	20950	Kit, Pack, Tray.
Kit, vasotomy		Kit	55200, 55250	Kit, Pack, Tray.
Lacrimal duct stent-tube set	74.000	Item	68815	Accessory, Procedure.
Lead citrate	0.510	gm	88348	Lab.
Manifold (for angiography)	6.682	Item	93501, 93508, 93510, 93526	Accessory, procedure.
Marker, gold, for radiosurgery-radiotherapy.	29.667	Item	77761–63	Accessory, Procedure.
Mask, CPR (RespAide)	16.950	Item	92950	Accessory, Procedure.
Methoxsalen, sterile solution (UVADEX), 10ml vial.	49.500	ml	36522	Pharmacy, Rx.
Microsponge, cellulose (10 pack uou).	3.620	Item	22 codes	Wound Care, Dressings.
Mount, carbon spectro-pure (for SEM).	0.500	Item	88349	Lab.
Nasal tip, olive	0.340	Item	92512	Accessory, Procedure.
Nebulizer medication cup	0.140	Item	95070	Accessory, Procedure.
Needle, arterial, percutaneous	3.150	Item	93501, 93505, 93508, 93510, 93526	Hypodermic, IV.
Needle, bone biopsy	65.000	Item	20225	Hypodermic, IV.
Needle, flexi, hyperthermia	12.000	Item	77600–20	Hypodermic, IV.
Needle, micropigmentation (tattoo)	12.000	Item	11920–21	Hypodermic, IV.
Needle, OSHA compliant (SafetyGlide).	0.454	Item	37 codes	Hypodermic, IV.
Needle, retrobulbar (Atkinson)	1.825	Item	67120, 67141	Hypodermic, IV.
Omnipaque 350mg (125ml uou)	29.530	Item	93508, 93510, 93526	Pharmacy, Rx.
Omnipaque 350mg (50ml uou)	12.498	Item	42550, 70370	Pharmacy, Rx.
Osmometer sample tip and cleaner	0.534	Item	88348	Lab.
Osmometer std, 50 mOsm-kg, 2ml amp.	17.000	ml	88348	Lab.
Osmometer std, 850 mOsm-kg, 2ml amp.	17.000	ml	88348	Lab.
Pack, drapes, ortho, large	40.646	Pack	102 codes	Kit, Pack, Tray.
Pack, drapes, ortho, small	1.128	Pack	37 codes	Kit, Pack, Tray.
Pack, ophthalmology visit (w-dilation)	1.997	Pack	65272–73, 65280–85, 65290, 65810–015, 65855–60, 66130, 66625–35, 67031, 68130.	Kit, Pack, Tray.
Pack, protective, ortho, large	9.182	Pack	99 codes	Kit, Pack, Tray.
Pack, protective, ortho, small	4.441	Pack	38 codes	Kit, Pack, Tray.
Paper, weighing (glassine)	0.021	Item	88348	Lab.
Phenol, liquified, USP	0.135	ml	15788–93	Pharmacy, Rx.
Photo-Flo soln	0.021	ml	88348	Office Supply, Grocery.
Pipette bulb	0.271	Item	88348–49	Lab.
Pipette 9inch	0.054	Item	88348–89	Lab.
Plasma antibody adsorption column (Prosorba).	1,150.000	Item	36515	Accessory, Procedure.
Plasma LDL adsorption column (Liposorber).	1,300.000	Item	36516	Accessory, Procedure.
Plasma leukocyte filter	49.719	Item	36515	Accessory, Procedure.
Plasma separator (Liposorber)	100.000	Item	36516	Accessory, Procedure.
Plate, surgical, mini-compression, 4 hole.	226.000	Item	21208	Accessory, Procedure.
Plate, surgical, mini-i, 16mm	147.000	Item	21210	Accessory, Procedure.
Plate, surgical, reconstruction, left, 5 x 16 hole.	719.000	Item	21125–27, 21215	Accessory, Procedure.
Plate, surgical, reconstruction, template, 5 x 16 hole.	50.000	Item	21125–27, 21215	Accessory, Procedure.
Plate, surgical, rigid comminuted fracture.	389,000	item	21461, 21462	Accessory, Procedure.
Plate, surgical, rigid comminuted fracture, template.	29.000	Item	21461, 21462	Accessory, Procedure.
Pressure bag		Item	93501, 93508–10, 93526	Hypodermic, IV.
Prosthesis, voice button (Blom-Singer).	48.000	Item	31611	Accessory, Procedure.
Scalpel, safety, surgical, with blade (#10–20).	2.143	Item	54150, 54160, 54162	Cutters, Closures, Cautery.
Screw, surgical, auto-drive, 2.0mm x 4mm.	37.000	Item	2120	Accessory, Procedure.

TABLE 3.—PROPOSED PRACTICE EXPENSE SUPPLY ITEM ADDITIONS FOR 2004—Continued

Supply description	Unit price *	Unit	* CPT code(s) associated with item	Supply category
Screw, surgical, Carroll-Girard, 9cm x 3.75in.	92.000	Item	21401	Accessory, Procedure.
Screw, surgical, lag, 2.4mm x 26mm	66.000	Item	21461–62	Accessory, Procedure.
Screw, surgical, locking, 2.4mm x 16mm.	74.000	Item	21127, 21208, 21215	Accessory, Procedure.
Screw, surgical, self-tapping, 1.5–2.0 mm.	27.000	Item	21100, 21452	Accessory, Procedure.
Screw, surgical, standard, 2.4mm x 14mm.	42.000	Item	21125	Accessory, Procedure.
Screw, surgical, standard, 2.7mm x 12mm.	47.000	Item	21125–27, 21208, 21215, 21461–62	Accessory, Procedure.
Sea salt	0.004	gm	15810–11	Office Supply, Grocery.
Sensor, manometry	25.000	Item	91010–12, 91122	Accessory, Procedure.
Sheath, peel away	68.990	Item	47530	Accessory, Procedure.
Skin refrigerant-anesthetic spray (Frigiderm).	5.000	oz	15780–86, 15788–93	Pharmacy, Rx.
Sodium acetate	0.064	gm	88348	Lab.
Sodium barbital	0.315	gm	88348	Lab.
Specimen block storage box	0.625	Item	88348	Lab.
Splint, finger (metal-foam)	1.655	Item	26700–05, 26720–25, 26740–42, 26750–55, 26770–75.	Wound Care, Dressings.
Sucrose, reagent	0.037	gm	88348	Lab.
Suture device for vessel closure (Perclose A–T).	225.000	Item	35470–75	Accessory, Procedure.
Suture, monocryl, 3–0 to 6–0, p, ps	9.887	Item	15050, 15200, 15220, 15240, 15260	Cutters, Closures, Cautery.
Suture, nylon, 8–0 to 9–0	15.320	Item	65270–72, 65275, 65420–26, 66130, 66250, 68115–30, 68320, 68330, 68340, 68360.	Cutters, Closures, Cautery.
Suture, plain, gut, 2–0 to 6–0	4.262	Item	41872	Cutters, Closures, Cautery.
Suture, polyester, 0 to 3–0 (Mersilene).	3.895	Item	40840–45	Cutters, Closures, Cautery.
Suture, vicryl, 7–0	21.773	Item	67120	Cutters, Closures, Cautery.
Syringe 12ml, coronary control	7.000	Item	93508–10, 93526	Hypodermic, IV.
Syringe filter	2.040	Item	88348	Hypodermic, IV.
Tape, foam, elastic, 2in (Microfoam)	0.003	Inch	21120–23, 21315, 21355–56, 31820–25.	Wound Care, Dressings.
Toluidine Blue O (for microscopy)	0.580	gm	88348	Lab.
Towel clamp, plastic	0.556	Item	93501–10, 93526	Accessory, Procedure.
Tracheostomy collar-neckband	3.235	Item	31580–84, 31588, 31610	Wound Care, Dressings.
Tracheostomy dressing	3.240	Item	31580–84, 31588, 31610	Wound Care, Dressings.
Tracheostomy tube	20.934	Item	31370–82, 31580–84, 31588, 31610, 31613–14, 31750, 41140, 41145.	Accessory, Procedure.
Transducer, pressure monitoring (for angiography).	9.520	Item	93501, 93508, 93510, 93526	Accessory, Procedure.
Tray, bronchogram		Tray	31708	Kit, Pack, Tray.
Tray, central line dressing change	2.430	Tray	36514–16	Kit, Pack, Tray.
Tray, circumcision	25.173	Tray	54150, 54160–62	Kit, Pack, Tray.
Tray, surgical skin prep, sterile	6.765	Tray	134 codes	Kit, Pack, Tray.
Trichloroacetic acid 90% (sat soln)	0.855	ml	46900	Pharmacy, Rx.
Tubing set (Liposorber)	50.000	Item	36516	Hypodermic, IV.
Tubing set, blood warmer	7.396	Item	36514–16	Hypodermic, IV.
Tubing set, plasma exchange	173.333	Item	36514	Hypodermic, IV.
Tubing set, plasma transfer	1.680	Item	36515	Hypodermic, IV.
Tubing set, Y-type blood recipient	5.750	Item	36515	Hypodermic, IV.
Tubing, pressure injection line (angiography).	3.170	Item	93508, 93510, 93526	Accessory, Procedure.
Tubing, sterile, connecting (fluid administration).	1.950	Item	93510, 93526	Accessory, Procedure.
Tubing, sterile, non-vented (fluid administration).		Item	93501, 93508, 93510, 93526	Accessory, Procedure.
Tubing, suction, non-latex (2ft) with Frazier tip (1).	7.557	Item	99 codes	Accessory, Procedure.
Underpad 2ft x 2ft (lab bench)	0.377	Item	88348–49	Lab.
Vial, specimen-sample, 4ml	0.550	Item	88348–49	Lab.
Wax sheet	0.285	Item	88348	Lab.

* CPT codes and descriptions only are copyright.

We have identified certain supply items for which we were unable to verify the pricing information (see Table 4, Supply Items Needing Specialty Input for Pricing). Therefore, we are requesting commenters, particularly specialty organizations, to provide pricing information on items in this table along with documentation to support the recommended price. In addition, we are seeking information on the specific contents of the listed kits, so that we do not duplicate any supply items.

TABLE 4.—SUPPLY ITEMS NEEDING SPECIALTY INPUT FOR PRICING

Code	2005 Description	Unit	Unit price	Primary specialties associated with item	*CPT code(s) associated with item	Status of item
SL008	Antibodies—detection	Slide	30.90	Lab, pathology	88365	See Note A.
	Blood pressure recording form, average.	Item	0.31	Cardiology	93784, 93786, 93788	See Note A.
	Catheter, hyperthermia, closed-end.	Item		Radiation oncology	77600–20	See Note A.
	Catheter, hyperthermia, open-end.	Item		Radiation oncology	77600	See Note A.
	Edrophonium	ml	4.67	Gastroenterology	91011	See Note A
	Hysteroscope, ablation device.	Item	1,146.00	Ob-gyn	58563	See Note A
	Kit, BCR/ABL DNA probe	Kit	42.65	Pathology	88365	See Note A.
SA013	Kit, detection	Slide	8.50	Pathology, neurology	88355, 88356	See Note A.
SA024	Kit, photopheresis procedure.	Kit	809.00	Dermatology, ob-gyn	36522	See Note A.
	Kit, vasotomy	Kit		Urology	55200, 55250	See Note A.
	Methoxsalen, sterile solution (UVADEX) 10 ml vial.	ml	49.50	Dermatology, radiation oncology.	36522	See Note A.
	Pressure bag	Item		Cardiology	93501, 93508, 93510, 93526.	See Note A.
SL114	Primary antibodies	Slide	3.52	Pathology, neurology	88355, 88356, 88358	See Note A.
	Tray, bronchogram	Tray		Pulmonary disease	31708	See Note A.
	Tubing, sterile, non-vented (fluid administration).	Item		Cardiology	93501, 93508, 93510, 93526.	See Note A.

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Note A. Additional information required. Need detailed description (including kit contents), source, and current pricing information.

v. Addition of Supply Item to CPT 88365, Tissue In Situ Hybridization

We received a request from a pathology society to add a DNA probe to the CPEP database for CPT 88365, tissue in situ hybridization. The society specified that 1.5 DNA probes are typically used in this service and the cost of one probe is $42.65. Documentation supporting this price was also provided. We are proposing to add, on an interim basis, this supply to the practice expense database with the understanding that the inclusion of the item will be subject to forthcoming RUC review.

vi. Ophthalmology Equipment

In the CPEP equipment data for many of the ophthalmology procedures, there is a duplication of time assigned to the screening lane and exam lane. In a majority of these identified procedures, the same timeframe was assigned to both the screening and exam lanes. While some of the procedures had not been refined by the PEAC, others were refined early on in the PEAC process before the PEAC agreed to assign only one equipment lane to each procedure because a patient can be in only one room at a time. In cases where both the screening and exam lanes are included, we are proposing to adjust the lane assignment by defaulting to the exam lane and, thus, we will delete the screening lane from these procedures. For all of the above services where a lane change was made, time values were assigned to the exam lane in accordance with our established standard procedure. We are asking commenters, in particular, organizations representing ophthalmology, to review these proposed changes and submit specific comments on the appropriateness of the exam lane default.

vii. Other Practice Expense Issues

Parathyroid Imaging, CPT 78070

We received comments from the RUC and the specialty society representing nuclear medicine that the practice expenses for CPT 78070, parathyroid imaging, which is valued in the nonphysician work pool, are too low. Because this procedure involves multiple imaging sessions, the organizations have requested that a different crosswalk of charge-based RVUs be used to more appropriately value the practice expenses involved with CPT 78070. We agree and are proposing to crosswalk the charge-based RVUs from CPT 78306, whole body imaging, to this procedure.

B. Geographic Practice Cost Indices (GPCIs)

[If you choose to comment on issues in this section, please include the caption ''GPCI'' at the beginning of your comments.]

1. Background

The Social Security Act (the Act) requires that payments vary among physician fee schedule areas according to the extent that resource costs vary as measured by the Geographic Practice Cost Indices (GPCIs). In general, the fee schedule areas that existed under the prior reasonable charge system were retained under the physician fee schedule from calendar years 1992 to 1996. We implemented a comprehensive revision in the physician fee schedule payment areas (localities) in 1997, reducing the number of localities from 210 to 89. A detailed discussion of physician fee schedule areas can be found in the July 2, 1996 proposed rule (61 FR 34615) and the November 22, 1996 final rule (61 FR 59494).

We are required by section 1848(e)(1)(A) of the Act to develop separate GPCIs to measure resource cost differences among localities compared to the national average for each of the three fee schedule components. While requiring that the practice expense and malpractice GPCIs reflect the full relative cost differences, section 1848(e)(1)(A)(iii) of the Act requires that the physician work GPCIs reflect only one-quarter of the relative cost differences compared to the national average.

Section 1848(e)(1)(C) of the Act requires us to review and, if necessary, to adjust the GPCIs at least every 3 years. This section of the Act also requires us to phase-in the adjustment over 2 years and implement only one-half of any adjustment if more than 1 year has elapsed since the last GPCI revision. The GPCIs were first implemented in 1992. The first review and revision was implemented in 1995, the second review was implemented in 1998, and the third review was implemented in 2001. This constitutes the fourth review of the work and practice expense GPCIs.

The malpractice GPCIs were reviewed and revised as part of the November 7, 2003 (68 FR 63196) physician fee schedule final rule. At the time of the publication of the November 2003 final rule, the U.S. Census data upon which the work and practice expense GPCIs are based were not yet available.

Section 412 of MMA amends section 1848(e)(1) of the Act and establishes a floor of 1.0 for the work GPCI for any locality where the GPCI would otherwise fall below 1.0. This 1.0 work GPCI floor will be used for purposes of payment for services furnished on or after January 1, 2004 and before January 1, 2007. In addition, section 602 of MMA further amended section 1848(e)(1) of the Act for purposes of payment for services furnished in Alaska under the physician fee schedule on or after January 1, 2004 and before January 1, 2006, and sets the work, practice expense, and malpractice expense GPCIs at 1.67 if any GPCI would otherwise be less than 1.67.

Based on these MMA provisions, we revised the addenda published in the November 7, 2003 final rule (68 FR 63196) that reflected both the transitional 2004 and 2005 malpractice GPCIs, as well as the work and practice expense GPCIs that were not updated (Addendum D and Addendum E, respectively) in an interim final rule with comment period entitled, ''Changes to Medicare Payment for Drugs and Physician Fee Schedule Payments for Calendar Year 2004,'' published January 7, 2004 (69 FR 1084). Due to the MMA provisions, no locality in these revised addenda has a work GPCI of less than 1.00. Additionally, the work, practice expense, and malpractice GPCIs for Alaska are set at 1.67.

We are proposing to revise the work and practice expense GPCIs beginning in 2005 based on updated U.S. Census data and Department of Housing and Urban Development fair market rent data.

2. Development of the Geographic Practice Cost Indices

The GPCIs were developed by a joint effort of the Urban Institute and the Center for Health Economics Research under contract to us. Indices were developed that measured the relative physician resource cost differences among areas compared to the national average in a ''market basket'' of goods. The market basket consists of the resources involved with operating a private medical practice. The resource inputs are—

- Physician work or net income (used to construct the physician work GPCI);
- Employee wages, office rents, medical equipment, supplies, and other miscellaneous expenses used to comprise the practice expense GPCI; and
- Professional liability insurance premiums (used to construct the malpractice GPCI).

The resource inputs and their respective weights for the resource costs associated with the work, practice expense, and malpractice expense associated with providing a physician service, were obtained from the 2003 AMA Physician Socioeconomic Characteristics publication (2003 Patient Care Physician Survey data) which measures physicians' earnings and overall practice expenses for 2000.

The weights for the 2004 GPCIs, as well as the proposed 2005 through 2007 GPCI revisions, are from the 2003 AMA survey and were used in the Medicare Economic Index (MEI) revision discussed in the November 2003 physician fee schedule final rule (68 FR 63245). Table 5 below shows the weights of the resource inputs, as defined by the MEI, those used for the original GPCIs, as well as the weights for the first, second, and third GPCI revisions. The MEI weights associated with the first and second GPCI updates (1995–2000 GPCIs) were not revised. In addition, the MEI weights for the proposed fourth GPCI revision are also shown.

TABLE 5.—HISTORICAL VIEW OF MEI WEIGHTS

Input component	Percentage of practice cost indices			
	1992–1994 GPCIs	1995–2000 GPCIs	2001–2003 GPCIs	2004–2006 GPCI
Physician Work	54.2	54.2	54.5	52.5
Practice Expense	40.2	41.0	42.3	43.7
Employee Wages	15.7	16.3	16.8	18.7
Rent	11.1	10.3	11.6	12.2
Miscellaneous	13.4	14.4	13.9	12.8
Malpractice	5.6	4.8	3.2	3.9
Total	100.0	100.0	100.0	100.0

a. Work Geographic Practice Cost Indices

As in previous GPCI updates, the median hourly earnings component is based on a 20 percent sample of U.S. Census data from workers in seven professional occupations. The actual reported earnings of physicians were not used to establish the GPCIs because Medicare payments (which are based on the GPCIs) are in part determinants of the earnings. Including physician wages in the physician work GPCI could, in effect, make the index dependent upon Medicare payments. Based upon analysis performed by Health Economics Research, we believe that in the majority of instances, the earnings of physicians will vary among areas to the same degree that the earnings of other professionals vary.

Data from the 2000 decennial U.S. Census by county of seven professional occupations (architecture and engineering; computer, mathematical, and natural sciences; social scientist, social workers, lawyers; education, library, training; registered nurses; pharmacists; writers, artists, editors) were utilized in the development of the proposed work GPCIs.

TABLE 6.—SPECIFIC OCCUPATION CATEGORIES USED IN DEVELOPMENT OF PHYSICIAN WORK GPCI

Categories	Census 2000 occupation code
Architecture and Engineering	130–156
Computer, Mathematical, and Natural Sciences	100–124 160–176
Social Scientists, Social Workers, Lawyers	180–215
Education, Training, and Library	220–255
Registered Nurses	313
Pharmacists	305
Writers, Artists, and Editors	260–296

The Census Bureau has very specific criteria that tabulations must meet in order to be released to the public. To maximize the accuracy and availability of the data collection, the nonphysician professional wage data were aggregated into three geographic area categories:

1. By Individual Counties—The tabulations were requested for each county in a Consolidated Metropolitan Statistical Area (CMSA).

2. By Metropolitan Statistical Area (MSA)—The tabulations were requested by MSA for all counties that fall within an MSA.

3. By Rest of State—The tabulations were requested by rest of State for counties that are not in a CMSA or MSA.

The nonphysician professional wage data were subsequently assigned to each respective county within the MSA or Rest of State aggregations (or, in the case of CMSAs, the data were already at the county level), and a median wage by county was calculated for each occupational category. These median wages were then weighted by the total RVUs associated with a given county to ultimately arrive at locality-specific work GPCIs. This geographic aggregation of Census data is the same methodology that was utilized in previous updates to the GPCIs.

The work GPCIs reflect one-fourth of the relative cost differences, as required by statute, with the exception of those areas where MMA requires that the GPCI be set at no lower than 1.00 and that the Alaska GPCIs be set at 1.67.

b. Practice Expense GPCIs

As in the past, we are proposing that the practice expense GPCI would be comprised of several factors that represent the major expenses incurred in operating a physician practice. The factors and the data sources we propose to use are detailed below. The impact of each individual factor on the calculation of the practice expense GPCI is based on the relative weight for that factor consistent with the calculation of the MEI.

Employee Wage Indices—The employee wage index is based on special tabulations of 2000 census data, which are generated from the Long Form Questionnaire. These special tabulations provided by the Census Bureau are designed to capture the median wage by county of the professional labor force. The Employee Wage Index uses the median wages of four labor categories that are most commonly present in a physician's private practice (administrative support, registered nurses, licensed practical nurses, and health technicians). Median wages for these occupations were provided by the U.S. Census Bureau using the same set of geographic aggregation rules discussed previously in the physician work GPCI section.

TABLE 7.—SPECIFIC OCCUPATIONS USED IN CREATING EMPLOYEE WAGE INDEX UPDATE

Categories	Census 2000 occupation code
Administrative Support	500–593
Registered Nurses	313
Licensed Practical Nurses	350
Health Technicians	330, 332, 341, 351–354, 365

Office Rent Indices— Since no national data are readily available for physician office rents, some proxy must be used for this portion of the practice expense index. To construct the practice expense GPCIs, we need data that are widely and consistently available across all fee schedule areas. Although we searched for alternative commercial rental data that were both widely and consistently available across all fee schedule areas, we were unable to identify any reliable sources of commercial rental data.

As with the current practice expense GPCIs, the Department of Housing and Urban Development (HUD) Fair Market Rental (FMR) data for the residential rents were again used as the proxy for physician office rents. The proposed 2005 through 2007 practice expense GPCIs reflect the final fiscal year 2004 HUD FMR data. See Addendum E for a more detailed illustration of the actual office rent indices.

We believe that the FMR data remain the best available source for constructing the office rent index. The FMR data are available for all areas, are updated annually, and retain consistency from area-to-area and from year-to-year. Additionally, physicians frequently locate their offices in areas that are residential, rather than commercial, in nature. Residential rates may, in fact, be a better measure of the differences among areas in the physician office market than a general commercial rental index. In developing FMRs for metropolitan areas, HUD assumes that all counties within an MSA have the same rent. However, we believe that the rents in the New York City MSA vary too widely and propose that the FMR for this metropolitan area should be adjusted to account for this variation. For the New York City MSA, we used median gross rent from the 2000 Census to adjust the individual rents within counties in this MSA.

A reduction in an area's rent index does not necessarily mean that rents have gone down in that area since the last GPCI update. Since the GPCIs measure area costs compared to the national average, a decrease in an area's rent index means that that area's rental costs are lower relative to the national average rental costs. Addendum E illustrates the changes in the rental index based upon the new FMR data.

Medical Equipment, Supplies, and other Miscellaneous Expenses—The GPCIs assume that items such as medical equipment and supplies have a national market and that input prices do not vary among geographic areas. We were again unable to find any data sources that demonstrated price differences by geographic areas. As mentioned in previous updates, some price differences might exist, but these differences are more likely to be based on volume discounts rather than on geographic areas. The medical equipment, supplies, and miscellaneous expense portion of the practice expense geographic index will continue to be 1.000 for all areas in the proposed GPCIs, except for Alaska which will have an overall practice expense GPCI set at 1.67 for 2004 and 2005.

c. Malpractice Expense GPCIs

The malpractice GPCIs were reviewed and revised as part of the November 7, 2003 (68 FR 63196) physician fee schedule final rule. Please refer to that

final rule for a detailed discussion of the update to the malpractice GPCIs.

4. Calculation and Effect of the Proposed 2005 Through 2007 Work and Practice Expense GPCIs

All three of the indices for a specific fee schedule locality are based on the indices for the individual counties within the respective fee schedule localities. As has been done in the past, fee schedule RVUs would again be used to weight the county indices (to reflect volumes of services within counties) when mapping to fee schedule areas and in constructing the national average indices. However, we propose to use more recent data, 2002 versus 1998 RVUs, in the county, locality, and national mapping in the proposed GPCIs. The payment effect associated with the use of these revised RVUs would generally be negligible, in most cases resulting in changes at the third decimal point, if at all.

Fee schedule payments are the product of the RVUs, the GPCIs, and the conversion factor. Updating the GPCIs changes the relative position of fee schedule areas compared to the national average. Since the changes represented by the proposed GPCIs could result in total payments either greater than or less than what would have been paid if the GPCIs were not updated, it would be necessary to apply scaling factors to the proposed GPCIs to ensure budget neutrality (prior to applying the provisions of MMA that change the work GPCIs to a minimum of 1.0 and increase the Alaska GPCIs to 1.67 because these provisions are exempted from budget neutrality). We determined that the proposed work and practice expense GPCIs would have resulted in slightly higher total national payments. Since the law requires that each individual component of the fee schedule—work, practice expense, and malpractice expense—is separately adjusted by its respective GPCI, we propose to scale each of the GPCIs separately. To ensure budget neutrality prior to applying the MMA provisions, it would be necessary to—

- Decrease the proposed work GPCI by 0.9965;
- Decrease the proposed practice expense GPCI by 0.9930; and
- Increase the malpractice GPCIs that were published in the November 7, 2003 final rule by 1.0021.

As all geographic payment areas would receive the same percentage adjustments, the adjustments do not change the new relative positions among areas indicated by the proposed GPCIs. After the appropriate scaling factors are applied, the MMA provision setting a 1.0 floor would be applied to all work GPCIs falling below 1.0. Additionally, the GPCIs for Alaska would all be set to 1.67 in accordance with MMA.

The locality specific effect of these proposed revisions to the work and practice expense GPCIs, as well as the revisions to the malpractice GPCIs published in the November 7, 2003 final rule, and the MMA provisions enacted December 8, 2003, are shown in Addendum F through Addendum H. Addendum F reflects the current GPCIs that were effective on January 1, 2004. Addendum F can be utilized as a baseline for purposes of comparison to the proposed GPCIs. Addendum H illustrates the proposed fully implemented 2006 GPCIs. Addendum G illustrates the proposed transitional 2005 GPCIs, which are one-half of the effect of the proposed fully implemented GPCI revisions as required by section 1848(e)(1)(C) of the Act.

Because the three GPCIs have different weights, the overall effect of the proposed changes cannot be achieved by summing the individual effects of the revisions on the work, practice expense, and malpractice expense GPCIs. The overall effect of all three revised GPCI components on an area can be estimated by a comparison of the area's geographic adjustment factors (GAFs). The GAF for a specific payment area is the weighted composite of the three separate components. The GAF illustrates an estimate of the general effect on total payments across a specific fee schedule locality. The effects on individual physicians would vary depending on each physician's mix and volume of services.

To illustrate a comparison of the overall effect of the current and proposed GPCIs, Addendum J contains a comparison of the current 2004 GAFs to the proposed fully-implemented 2006 GAFs. Addendum I contains a comparison of the proposed transitional GAFs (2005) to the current 2004 GAFs. Both Addenda I and J are sorted in descending order of change. As Addendum J shows, no fee schedule area would experience a total decrease in its respective GAF by more than 3.5 percent, or increase by more than 7 percent, if the proposed GPCI revisions are fully implemented in 2006. The majority of payment areas would change by considerably less than these amounts. Nearly 75 percent of payment areas would change by less than 2 percent with the majority of these payment areas changing by less than 1 percent. Consequently, as illustrated by Addendum I, no fee schedule area would experience a total decrease in its respective GAF of more than 1.6 percent, or an increase of more than 3.5 percent, in the transition year (2005).

The GPCIs measure relative cost differences among payment areas compared to the national average. The national average cost is represented by a value of about 1.000. A proposed GPCI revision showing a decrease from the current value does not necessarily mean that absolute costs in a payment area have decreased, only that the average costs of a payment area have decreased as compared to the national average costs.

5. Payment Localities

In the August 15, 2003 proposed rule, we requested comments on the composition of the current 89 Medicare physician payment localities to which the GPCIs are applied. In the November 7, 2003 final rule, we indicated that we received comments from various parties requesting that specific counties be removed from their current locality. We further indicated that we are continuing to examine alternatives for reconfiguring the current locality structure.

While we have considered alternatives, we have not yet been able to come up with a policy and criteria that would satisfactorily apply to all situations. Any policy that we would propose would have to apply to all States and payment localities. For example, if we were to establish a policy that if adjacent county geographic indices exceeded a threshold amount, the lower county could be moved to the higher county or a separate locality could be created, that approach would cause redistributions within a State.

Locality changes are budget-neutral with respect to the aggregate amount of Medicare money in a State. That is, reconfigurations of localities within a State do not result in any more Medicare money for the State in the aggregate, but only redistributions of money within a State. Since there will be both winners and losers in any locality reconfiguration, the State medical associations should be the impetus behind these changes. Since 1996, we have moved to Statewide areas in several States after receiving resolutions from State medical societies including support from physicians in losing areas, and after going through Notice and Comment rulemaking. The support of State medical associations has been the basis for previous changes to Statewide areas, and continues to be equally important in our consideration of other future locality changes.

C. Malpractice Relative Value Units (RVUs)

[If you choose to comment on issues in this section, please include the caption ''Malpractice RVUs'' at the beginning of your comments.]

1. History of Relative Value Unit System

Section 1848(c)(2)(C) of the Act requires that each service paid under the physician fee schedule be comprised of three components: work, practice expense, and malpractice.

From 1992 to 1999, malpractice RVUs were charge-based, using weighted specialty-specific malpractice expense percentages and 1991 average allowed charges. Malpractice RVUs for new codes after 1991 were extrapolated from similar existing codes or as a percentage of the corresponding work RVU. Section 4505(f) of the BBA required us to implement resource-based malpractice RVUs for services furnished beginning in 2000. With the implementation of resource-based malpractice RVUs in 2000 and the full implementation of resource-based practice expense RVUs in 2002, all physician fee schedule RVUs were resource-based, eliminating the last vestiges of charged-based payment.

2. Proposed Methodology for the Revision of Resource-based Malpractice RVUs

The methodology used in calculating the proposed resource-based malpractice RVUs is the same methodology that was used in the initial development of resource-based RVUs, the only difference being the use of more current data. The proposed resource-based malpractice expense RVUs are based upon:

- Actual 2001 and 2002 malpractice premium data;
- Projected 2003 premium data; and
- 2002 Medicare payment data on allowed services and charges.

As was done in the initial development of resource-based malpractice expense RVUs in the November 2, 1999 final rule, we are proposing to revise resource-based malpractice expense RVUs using specialty-specific malpractice premium data because they represent the actual malpractice expense to the physician. In addition, malpractice premium data are widely available. We propose to use actual 2001 and 2002 malpractice premium data and projected 2003 malpractice premium data for three reasons:

- These are the most current data available.
- These data capture the highly publicized and most recent trends in the specialty-specific costs of professional liability insurance.
- These are the same malpractice premium data that were utilized in the development of revised malpractice GPCIs in the November 7, 2003 final rule.

We were unable to obtain a nationally representative sample of 2003 malpractice premium data for two reasons: (1) The premium data that we collected from the private insurance companies had to ''match'' the market share data that were provided by the respective State Departments of Insurance. Because none of the State Departments of Insurance had 2003 market share information at the time of this data collection, 2003 premium data were not usable; and (2) the majority of private insurers were not amicable to releasing premium data to us. In the majority of instances, the private insurance companies would release their premium data only to the State Departments of Insurance.

Discussions with the industry lead us to conclude that the primary determinants of malpractice liability costs remain physician specialty, level of surgical involvement, and the physician's malpractice history. Malpractice premium data were collected for the top 20 Medicare physician specialties measured by total payments. Premiums were for a $1 million/$3 million mature claims-made policy (a policy covering claims made, rather than services provided during the policy term). We attempted to collect premium data from all 50 States, Washington, DC, and Puerto Rico. Data were collected from commercial and physician-owned insurers and from joint underwriting associations (JUAs). A JUA is a State government-administered risk pooling insurance arrangement in areas where commercial insurers have left the market. Adjustments were made to reflect mandatory patient compensation funds (PCFs) (funds to pay for any claim beyond the statutory amount, thereby limiting an individual physician's liability in cases of a large suit) surcharges in States where PCF participation is mandatory. The premium data collected represent at least 50 percent of physician malpractice premiums paid in each State.

For 2001, we were able to collect premium data from 48 States (for purposes of this discussion, State counts include Washington, DC and Puerto Rico). We were unable to obtain premium data from Kentucky, New Hampshire, New Mexico, and Washington DC. To calculate a proxy for the malpractice premium data for these four areas in 2001, we began with the most current malpractice premium data collected for these areas, 1996 through 1998 (the last premium data collection that was undertaken). An average premium price was calculated (using 1996 through 1998 data) for all States except Kentucky, New Hampshire, New Mexico, and Washington, DC. Similarly, an average premium price was calculated for the 1999 through 2001 period for all States except Kentucky, New Hampshire, New Mexico, and Washington, DC. The percentage change in these premium prices was calculated as the percent difference between the 1999 to 2001 calculated average premium price and the 1996 to 1998 calculated average premium price. This percentage change was then applied to the weighted average 1996 to 1998 malpractice premium price for these four areas to arrive at a comparable 1999 to 2001 average premium price.

For 2002, we were able to obtain malpractice premium data from 33 States. Many State Departments of Insurance had not yet obtained premium data from the primary insurers within their State at the time of this data collection. For those States for which we were unable to obtain malpractice premium data, we calculated a national average rate of growth for 2002 and applied this national rate of growth to the weighted average premium for 2001 to obtain an average premium for 2002 for each county for which we were unable to obtain malpractice premium data for 2002.

We projected premium values for 2003 based on the average of historical year-to-year changes for each locality (when locality level data were available) or by State (when only Statewide premium data projections were available). First, we calculated the percentage changes in the premiums from the 1999 through 2000, 2000 through 2001, and 2001 through 2002 periods for each payment locality. Next, we calculated the geometric mean of these three percentages and applied the mean to the 2002 premium to obtain the forecasted 2003 malpractice premium. We used the geometric mean to calculate the forecasted 2003 premium data because the geometric mean is commonly used to derive the mean of a series of values that represent rates of change. Because the geometric mean is based on the logarithmic scale, it is less impacted by outlying data.

Malpractice insurers generally use five-digit codes developed by the Insurance Services Office (ISO), an advisory body serving property and casualty insurers, to classify physician

specialties into different risk classes for premium rating purposes. ISO codes classify physicians not only by specialty, but in many cases also by whether or not the specialty performs surgical procedures. A given specialty could thus have two ISO codes, one for use in rating a member of that specialty who performs surgical procedures and another for rating a member who does not perform surgery. Medicare uses its own system of specialty classification for payment and data purposes. It was therefore necessary to map Medicare specialties to ISO codes and insurer risk classes. Different insurers, while using ISO codes, have their own risk class categories. To ensure consistency, we used the risk classes of St. Paul Companies, one of the oldest and largest malpractice insurers. Table 8 crosswalks Medicare specialties to ISO codes and to the St. Paul risk classes used.

TABLE 8.—CROSSWALK OF MEDICARE SPECIALTIES TO IOS CODES AND TO THE ST. PAUL RISK CLASSES USED

Medicare code	Medicare description	ISO code		Risk class		St. Paul's description
		Surgery	Other	Surgery	Other	
1	General practice	80117	80420	4	1	Family/Gen. Practitioners—No Obstetrical.
2	General surgery	80143	80143	5	5	Surgery, General.
3	Allergy/Immunology	80254	80254	1A	1A	Allergy.
4	Otolaryngology	80159	80265	3	1	Otarhinolaryngology.
5	Anesthesiology	80151	80151	5A	5A	Anesthesiology.
6	Cardiology	80281	80255	2	1	Cardiovascular Disease.
7	Dermatology	80472	80256	5	1A	Dermatology.
8	Family practice	80117	80420	4	1	Family/Gen. Practitioners—No Obstetrical.
10	Gastroenterology	80104	80241	3	1	Gastroenterology.
11	Internal medicine	80284	80257	2	1	Internal medicine.
13	Neurology	80288	80261	2	2	Neurology.
14	Neurosurgery	80152	80152	8	8	Surgery, Neurology.
16	Obstetrics/Gynecology	80167	80244	4	1	Gynecology.
18	Ophthalmology	80114	80263	2	1	Ophthalmology.
20	Orthopedic surgery	80501	80501	5	5	Surgery, Orthopedic—excluding Spinal Surgery.
20	Orthopedic surgery	80154	80154	6	6	Surgery, Orthopedic—including Spinal Surgery.
22	Pathology	80292	80266	2	1A	Pathology.
24	Plastic and reconstructive surgery	80156	80156	5	5	Surgery, Plastic.
25	Physical medicine and rehab	80235	80235	1	1	Physical medicine and rehab.
26	Psychiatry*	80492, 80431	80249	2	1A	Psychiatry.
28	Colorectal surgery	80115	80115	3	3	Surgery, Colon and Rectal.
29	Pulmonary Disease	80269	80269	1	1	Pulmonary Disease.
30	Diagnostic radiology **	80280	80253	2	2	Radiology.
33	Thoracic surgery	80144	80144	6	6	Surgery, Thoracic.
34	Urology	80145	80145	2	2	Surgery, Urological.
36	Nuclear medicine	80262	80262	1	1	Nuclear medicine.
37	Pediatric medicine	80293	80267	2	1	Pediatrics.
38	Geriatric medicine***	80276	80243	2	1	Geriatrics.
39	Nephrology***	80287	80260	2	1	Nephrology.
40	Hand surgery	80169	80169	5	5	Surgery, Hand.
44	Infectious disease	80279	80246	2	1	Infectious disease.
46	Endocrinology***	80272	80238	2	1	Endocrinology.
65	Physical therapist (independent)	80235	80235	1	1	Physical medicine and rehab.
66	Rheumatology	80252	80252	1	1	Rheumatology.
67	Occupational therapist (independent)	80235	80235	1	1	Occupational Medicine.
77	Vascular surgery	80146	80146	6	6	Surgery, Vascular.
78	Cardiac surgery	80141	80141	6	6	Surgery, Cardiac.
82	Hematology	80278	80245	2	1	Hematology.
83	Hematology/oncology	80473	80473	1	1	Oncology.
84	Preventive medicine	80231	80231	1	1	General Preventive Medicine.
92	Radiation Oncology****	80425	80425	2	2	Radiation Therapy.
93	Emergency medicine	80157	80102	5	4	Emergency Medicine.
98	Gynecologist/oncologist	80167	80244	4	1	Gynecology.

Note: For specialties with multiple risk classifications depending on the level of surgical involvement, the highest level of surgery for each specialty was selected for the ''surgery'' ISO and risk class; and the lowest level of surgery was selected for the ''nonsurgery'' ISO and risk class.

Note: If a specialty has only one risk classification, the same classification was used for both surgery and nonsurgery.

* The ISO codes for surgery for Psychiatry represents Psychiatry—shock therapy.

** St. Paul's is the only one of the five companies that has a ''major invasive'' procedures ISO Code for Radiology; therefore, the ''minor invasive procedures'' ISO Code is being used as the highest level of surgery.

*** St. Paul's is the only one of the five companies that has a ''major surgery'' ISO Code for Geriatrics, Nephrology, and Endocrinology; therefore, the minor surgery'' ISO Code is being used as the highest level of surgery.

**** Medical Protective's Description was used, as St. Paul's does not provide specific medical malpractice insurance for Radiation Therapy.

Some physician specialties, nonphysician practitioners, and other entities (for example, independent diagnostic testing facilities) paid under the physician fee schedule could not be assigned an ISO code. We crosswalked these specialties to similar physician specialties assigned an ISO code and a risk class. The unassigned specialties and the specialty to which they were assigned are shown in Table 9.

TABLE 9.—CROSSWALK OF SPECIALTIES TO SIMILAR PHYSICIAN SPECIALTIES ASSIGNED AN ISO CODE AND A RISK CLASS

Medicare code	Unassigned Medicare specialty	Crosswalk specialty
12	Osteopathic Manipulative Therapy	Family Practice.
32	Anesthesiologist Assistant	Anesthesiology.
35	Chiropractic	Physical medicine and rehab.
41	Optometry	Ophthalmology.
43	Certified Registered Nurse Assistant	All Physicians.
47	Physiological Laboratory (independent)	All Physicians.
48	Podiatry	All Physicians.
50	Nurse Practitioner	All Physicians.
62	Psychologist	Psychiatry.
68	Clinical Psychologist	Psychiatry.
69	Clinical Laboratory	All Physicians.
70	Multi-Specialty Clinic or Group Practice	All Physicians.
74	Radiation Therapy Center	Radiation Oncology.
76	Peripheral Vascular Disease	Vascular Surgery.
79	Addiction Medicine	Psychiatry.
80	Licensed Clinical Social Worker	Psychiatry.
81	Critical Care (Intensivists)	All Physicians.
85	Maxillofacial Surgery	Plastic Surgery.
86	Neuropsychiatry	Psychiatry.
89	Certified Clinical Nurse Specialist	All Physicians.
90	Medical Oncology	Internal Medicine.
91	Surgical Oncology	General Surgery.
94	Interventional Radiology	Radiology.
96	Optician	Ophthalmology.
97	Physician Assistant	All Physicians.

In the development of the proposed resource-based malpractice RVU methodology, we considered two malpractice premium-based alternatives for resource-based malpractice RVUs, the dominant specialty approach and the specialty-weighted approach.

Dominant Specialty Approach

The dominant specialty approach bases the malpractice RVUs upon the risk factor of only the dominant specialty performing a given service as long as the dominant specialty accounted for at least 51 percent of the total utilization for a given service. When 51 percent of the total utilization does not comprise the dominant specialty, this approach uses a modified specialty-weighted approach. In this modified specialty-weighted approach, two or more specialties are collectively defined as the dominant specialty. Starting with the specialty with the largest percentage of allowed services, the modified specialty-weighted approach successively adds the next highest specialty in terms of percentage of allowed services until a 50 percent threshold is achieved. The next step is to sum the risk factors of those specialties (weighted by utilization) in order to achieve at least 50 percent of the total utilization of a given service and then use the factors in the calculation of the final malpractice RVU.

The dominant specialty approach produces modest increases for some specialties and modest decreases for other specialties. The largest increase for any given specialty, over the specialty-weighted approach, is less than 1.5 percent of total RVUs, while the largest decrease for any given specialty is less than 0.5 percent of total RVUs.

Specialty-Weighted Approach

The approach that we adopted in the November 1999 final rule and are proposing to use in this proposed rule, bases the final malpractice RVUs upon a weighted average of the risk factors of all specialties performing a given service. The specialty-weighted approach ensures that all specialties performing a given service are accounted for in the calculation of the final malpractice RVU. Our proposed methodology is as follows:

(1) *Compute a national average premium for each specialty.* Insurance rating area malpractice premiums for each specialty were mapped to the county level. The specialty premium for each county is then multiplied by the total county RVUs (as defined by Medicare claims data), which had been divided by the malpractice GPCI applicable to each county to standardize the relative values for geographic variations. If the malpractice RVUs were not normalized for geographic variation, the locality cost differences (as reflected by the GPCIs) would be counted twice. The product of the malpractice premiums and standardized RVUs is then summed across specialties for each county. This calculation is then divided by the total RVUs for all counties, for each specialty, to yield a national average premium for each specialty.

Table 10 shows the national average premiums for the years 1999 through 2003 for the 20 specialties for which we collected premium data. As stated previously, we used an average of the 3 most current years, 2001 to projected 2003 malpractice premiums, in our calculation of the proposed malpractice RVUs.

TABLE 10.—NATIONAL AVERAGE PREMIUMS FOR THE YEARS 1999 THROUGH 2003 FOR THE 20 SPECIALTIES FOR WHICH WE COLLECTED PREMIUM DATA

ISO	Specialty	2001 average	2002 average	2003 average	1996–1998 average	2001–2003 average [1]	Annual trend [2] (percent)	Specialty MGPCI [3]	Normalized 2001–2003 premium [4]	Risk factor [5]
80269	Pulmonary disease	12,574	13,456	14,541	9,508	13,524	7.30	1.027	13,168	2.14
80280	Diagnostic radiology	15,807	16,783	17,997	12,372	16,862	6.39	0.997	16,913	2.75
80284	Internal medicine	14,395	15,714	16,985	11,836	15,698	5.81	1.028	15,270	2.48
80274	Gastroenterology	14,347	15,398	16,643	11,745	15,463	5.65	1.017	15,204	2.47
80143	General surgery	33,163	36,004	39,059	27,825	36,075	5.33	0.957	37,696	6.13
80423	General practice	13,325	14,479	15,731	11,234	14,512	5.25	0.943	15,389	2.50
80288	Neurology	16,206	17,330	18,629	13,726	17,388	4.84	1.032	16,849	2.74
80114	Ophthalmology	13,064	14,103	15,317	11,209	14,161	4.79	0.997	14,204	2.31
80152	Neurosurgery	64,724	70,125	76,060	57,701	70,303	4.03	0.952	73,848	12.00
80281	Cardiology	14,798	15,836	17,085	13,204	15,906	3.79	1.021	15,579	2.53
80145	Urology	18,701	20,253	21,931	16,958	20,295	3.66	0.999	20,315	3.30
80159	Otolaryngology	21,720	23,127	24,794	19,990	23,214	3.04	0.997	23,284	3.78
80154	Orthopedic w/spinal	40,384	43,758	47,321	38,584	43,821	2.58	0.955	45,886	7.46
80144	Thoracic surgery	39,538	43,200	47,249	38,812	43,329	2.23	1.020	42,479	6.91
80282	Dermatology	11,046	11,549	12,375	10,650	11,657	1.82	1.020	11,428	1.86
80260	Nephrology [6]	8,408	9,290	10,142	n/a	9,280	n/a	0.999	9,289	1.51
80146	Vascular surgery	39,391	42,660	46,211	n/a	42,754	n/a	1.014	42,164	6.85
80141	Cardiac surgery	37,802	40,498	43,722	n/a	40,674	n/a	0.921	44,163	7.18
80425	Radiation oncology	13,800	14,755	15,976	n/a	14,844	n/a	0.995	14,918	2.43
80102	Emergency medicine	20,671	22,672	24,733	n/a	22,692	n/a	0.974	23,298	3.79

[1] A simple average of figures for 2001, 2002, and 2003.
[2] Percent annualized average growth rate between 1996–1998 and 2001–2003.
[3] An average of locality malpractice GPCIs using specialty-specific malpractice RVUs as weights.
[4] 2001–2003 premium divided by specialty MGPCI.
[5] (Normalized 2001–2003 Premium, .9289) × 1.51.
[6] Nephrology is set to 1.51 to be consistent with the risk factor taken from the rating manuals. n/a signifies that the premium data were not available.

(2) *Calculate a risk factor for each specialty.* Differences among specialties in malpractice premiums are a direct reflection of the malpractice risk associated with the services performed by a given specialty. The relative differences in national average premiums between various specialties can be expressed as a specialty risk factor. These risk factors are an index calculated by dividing the national average premium for each specialty by the national average premium for the specialty with the lowest average premium, nephrology. Table 11 shows the risk factors, surgical and nonsurgical, by specialty.

TABLE 11.—RISK FACTORS, SURGICAL AND NONSURGICAL, BY SPECIALTY

Medicare code	Medicare description	Nonsurgical risk factor	Surgical risk factor
01	General practice	1.79	4.26
02	General surgery	6.13	6.13
03	Allergy/Immunology	1.00	1.00
04	Otolaryngology	1.45	3.78
05	Anesthesiology	2.84	2.84
06	Cardiology	1.45	2.53
07	Dermatology	1.00	3.90
08	Family practice	1.79	4.26
10	Gastroenterology	2.05	3.49
11	Internal medicine	2.05	2.48
12	Osteopathic Manipulative Therapy	1.79	4.26
13	Neurology	2.52	2.74
14	Neurosurgery	12.00	12.00
16	Obstetrics/Gynecology	2.15	5.63
18	Ophthalmology	1.24	2.31
20	Orthopedic surgery w/o Spinal	8.06	8.06
20	Orthopedic surgery with Spinal	7.46	7.46
22	Pathology	1.72	2.09
24	Plastic Surgery	6.92	6.92
25	Physical Med & Rehab	1.26	1.26
26	Psychiatry	1.11	3.08
28	Colorectal surgery	4.08	4.08
29	Pulmonary disease	2.14	2.14
30	Diagnostic radiology	2.07	2.75
32	Anesthesiologist Assistant	2.84	2.84
33	Thoracic surgery	6.91	6.91
34	Urology	3.30	3.30
35	Chiropractic	1.26	1.26
36	Nuclear medicine	1.66	1.66
37	Pediatric medicine	1.76	2.42
38	Geriatric medicine	1.35	2.17
39	Nephrology	1.51	1.96

TABLE 11.—RISK FACTORS, SURGICAL AND NONSURGICAL, BY SPECIALTY—Continued

Medicare code	Medicare description	Nonsurgical risk factor	Surgical risk factor
40	Hand surgery	4.71	4.71
41	Optometry	1.24	2.31
43	Certified Registered Nurse Assistant	3.04	3.71
44	Infectious disease	1.55	2.09
46	Endocrinology	2.03	2.09
47	Physiological Laboratory (independent)	3.04	3.71
48	Podiatry	3.04	3.71
50	Nurse Practitioner	3.04	3.71
62	Psychologist	1.11	3.08
65	Physical therapist (independent)	1.26	1.26
66	Rheumatology	2.11	2.11
67	Occupational therapist	1.11	1.11
68	Clinical Psychologist	1.11	3.08
69	Clinical Laboratory	3.04	3.71
70	Multi-Specialty Clinic or Group Practice	3.04	3.71
74	Radiation Therapy Center	2.43	2.43
76	Peripheral Vascular Disease	6.85	6.85
77	Vascular surgery	6.85	6.85
78	Cardiac surgery	7.18	7.18
79	Addiction Medicine	1.11	3.08
80	Licensed Clinical Social Worker	1.11	3.08
81	Critical Care (Intensivists)	3.04	3.71
82	Hematology	1.77	2.26
83	Hematology/oncology	2.05	2.11
84	Preventive medicine	1.26	1.26
85	Maxillofacial Surgery	6.92	6.92
86	Neuropsychiatry	1.11	3.08
89	Certified Clinical Nurse Specialist	3.04	3.71
90	Medical Oncology	2.05	2.48
91	Surgical Oncology	6.13	6.13
92	*Radiation oncology/therapy	2.43	2.43
93	Emergency medicine	3.79	4.55
94	Interventional Radiology	2.07	2.75
96	Optician	1.24	2.31
97	Physician Assistant	3.04	3.71
98	Gynecologist/oncologist	2.15	5.63

Note: If a specialty has only one risk classification, the same classification was used for both surgery and nonsurgery.
Note: For specialties with multiple risk classifications depending on the level of surgical involvement, the highest level of surgery was selected for surgery risk factor and the lowest level of surgery was selected for nonsurgery risk factor.

(3) *Calculate malpractice RVUs for each code.* Resource-based malpractice RVUs were calculated for each procedure. The first step was to identify the percentage of services performed by each specialty for each respective procedure code. This percentage was then multiplied by each respective specialty's risk factor as calculated in Step 2. The products for all specialties for the procedure were then summed, yielding a specialty-weighted malpractice RVU reflecting the weighted malpractice costs across all specialties for that procedure. This number was then multiplied by the procedure's work RVUs to account for differences in risk-of-service. Since we were unable to find an acceptable source of data to be used in determining risk-of-service, work RVUs were used. We would welcome any suggestions for alternative data sources to be used in determining risk-of-service.

As mentioned above, certain specialties may have more than one ISO rating class and risk factor. The surgical risk factor for a specialty was used for surgical services and the nonsurgical risk factor for evaluation and management services. Also, for obstetrics/gynecology, the lower gynecology risk factor was used for all codes except those obviously surgical services, in which case the higher, surgical risk factor was used.

Certain codes have no physician work RVUs. The overwhelming majority of these codes are the technical components (TCs) of diagnostic tests, such as x-rays and cardiac catheterization, which have a distinctly separate technical component (the taking of an x-ray by a technician) and professional component (the interpretation of the x-ray by a physician). Examples of other codes with no work RVUs are audiology tests and injections. These services are usually furnished by nonphysicians, in this example, audiologists and nurses, respectively. In many cases, the nonphysician or entity furnishing the TC is distinct and separate from the physician ordering and interpreting the test. We believe it is appropriate for the malpractice RVUs assigned to TCs to be based on the malpractice costs of the nonphysician or entity, not the professional liability of the physician.

Our proposed methodology, however, would result in zero malpractice RVUs for codes with no physician work, since we propose the use of physician work RVUs to adjust for risk-of-service. We believe that zero malpractice RVUs would be inappropriate because nonphysician health practitioners and entities such as independent diagnostic testing facilities (IDTFs) also have malpractice liability and carry malpractice insurance. Therefore, we are proposing to retain the current charge-based malpractice RVUs for all services with zero work RVUs. We are open to comments and suggestions for constructing resource-based malpractice RVUs for codes with no physician work.

(4) *Rescale for budget neutrality.* The law requires that changes to fee schedule RVUs be budget neutral. The current resource-based malpractice RVUs and the proposed resource-based malpractice RVUs were constructed using entirely different malpractice premium data. Thus, the last step is to adjust for budget neutrality by rescaling the proposed malpractice RVUs so that the total proposed resource-based malpractice RVUs equal the total current resource-based malpractice RVUs. The proposed resource-based malpractice RVUs for each procedure were multiplied by the frequency count for that procedure to determine the total resource-based malpractice RVUs for each procedure. This was summed for all procedures to determine the total fee schedule proposed resource-based malpractice RVUs. This was compared to the total current resource-based malpractice RVUs, using the same calculation and cases. The total current and proposed malpractice RVUs were equal, and therefore budget neutral. Thus, no adjustments were needed to ensure that expenditures remained constant for the malpractice RVU portion of the physician fee schedule payment.

The proposed resource-based malpractice RVUs are shown in Addendum B. These values have been adjusted for budget neutrality on the basis of the most recent available data. The values do not reflect the final budget-neutrality adjustment, which we will make in the final rule based upon the more current Medicare claims data. We do not believe, however, that the values will change significantly as a result of the final budget-neutrality adjustment.

Because of the differences in the sizes of the three fee schedule components, implementation of the proposed resource-based malpractice RVUs will have a smaller payment effect than the previous implementation of resource-based practice expense RVUs. On average, work represents about 52.5 percent of the total payment for a procedure, practice expense about 43.6 percent of the total payment, and malpractice expense about 3.9 percent of the total payment. Thus, a 20 percent change in practice expense or work RVUs would yield a change in payment of about 8 to 11 percent. In contrast, a corresponding 20 percent change in malpractice values would yield a change in payment of only about 0.6 percent. Estimates of the effects on payment by specialty and selected high-volume procedures can be found in the impact section of this rule.

We are requesting comments on our proposed methodology and resource-based malpractice RVUs.

D. Coding Issues

1. Change in Global Period for CPT Code 77427, Radiation Treatment Management, Five Treatments

[If you choose to comment on issues in this section, please include the caption ''CODING-GLOBAL PERIOD'' at the beginning of your comments.]

This code was included in the November 2, 1999 physician fee schedule final rule and was effective for services beginning January 1, 2000. In that rule, and subsequent rules, we have applied a global indicator of ''xxx'' to this code, meaning that the global concept does not apply. It has been brought to our attention that this global indicator is incorrect. The global indicator should be 090 since the RUC valuation of this service reflected a global period of 90 days and we accepted this valuation. Therefore, we would correct the global indicator for this service to reflect a global period of 90 days (090).

2. Requests for Adding Services to the List of Medicare Telehealth Services

[If you choose to comment on issues in this section, please include the caption ''CODING—TELEHEALTH'' at the beginning of your comments.]

a. Background

Section 1834(m) of the Act defines telehealth services as professional consultations, office and other outpatient visits, and office psychiatry services identified as of July 1, 2000 by CPT codes 99241 through 99275, 99201 through 99215, 90804 through 90809, and 90862. In addition, the statute required us to establish a process for adding services to or deleting services from the list of telehealth services on an annual basis. In the CY 2003 final rule, we established a process for adding or deleting services to the list of Medicare telehealth services. This process provides the public an opportunity on an ongoing basis to submit requests for adding a service. For more information on submitting a request for addition to the list of Medicare telehealth services, visit our Web site at www.cms.hhs.gov/physicians/telehealth.

b. Submitted Requests for Addition to the List of Telehealth Services

Requests for adding services to the list of Medicare telehealth services must be submitted and received no later than December 31st of each calendar year to be considered for the next proposed rule. For example, requests submitted in CY 2003 are considered for the CY 2005 proposed rule.

We received the following public requests for addition in CY 2003: Inpatient hospital care, emergency department visits, hospital observation services, inpatient psychotherapy, monthly management of patients with end-stage renal disease (ESRD), speech and audiologist services, case management, and care plan oversight.

Requests for additions submitted in CY 2003 are discussed below.

Inpatient hospital care, emergency department visits, hospital observation services, and inpatient psychotherapy

The American Telemedicine Association (ATA) and an individual practitioner submitted a request to add initial and subsequent inpatient hospital care as represented by CPT codes 99221 through 99223 and 99231 through 99233; hospital observation services (CPT codes 99217, 99218 through 99220); and individual psychotherapy furnished in an inpatient, partial hospitalization, or residential care facility setting (as defined by CPT codes 90816 through 90822). The requestors argue that the addition of hospital observation services, inpatient hospital care, and inpatient psychotherapy will reduce transfers from remote facilities to tertiary care facilities, decrease length of stay, improve diagnostic accuracy, plan of care strategies and patient outcomes, and also stabilize local health care systems. The requestors emphasize that adding individual psychotherapy in the inpatient and partial hospitalization setting is crucial for providing access to mental health services for the rural population. Additionally, the requestors believe that no current Medicare telehealth service can be billed when a patient is in observation status or is admitted as an inpatient. They also noted that the current psychiatry services paid for as telehealth services are not appropriate for mental health patients in the hospital, partial hospital, or residential facility settings.

The University of Kansas Medical Center requested that we add emergency department visits as defined by CPT codes 99281 through 99285 as telehealth services. The requestor stated that, for many rural hospitals, the attending physician in emergency cases is a local primary care or family physician who may not have sufficient experience with the complexities of emergent care. The requestor believes that adding emergency department visits will provide quicker access to an expert trauma or emergency physician and that the time saved could be life-saving for the patient.

CMS Review

As discussed in the June 28, 2002 **Federal Register** (67 FR 43862), we assign requests to one of two categories for review. Category 1 is comprised of services, which are similar in nature to an office or other outpatient visit, consultation, or office psychiatry. We review category 1 services to ensure that the roles of, and interaction among, the patient, physician, or practitioner at the distant site and telepresenter (if necessary) are similar to the current telehealth services.

Category 2 services would include services that are not similar to an office or other outpatient visit, consultation, or office psychiatry. Because of the potential acuity of the patient in the hospital setting, we consider inpatient hospital care, emergency department visits, hospital observation services, and inpatient psychotherapy to fall into the second category of requests. As discussed on our website, for category 2 services, requestors must provide evidence indicating that the use of a telecommunications system produces similar diagnostic findings or therapeutic interventions as would face-to-face delivery of the same service.

For inpatient hospital care, hospital observation services, and inpatient psychotherapy, the requestors did not submit evidence indicating that the use of a telecommunications system does not affect the diagnosis or treatment plan as compared to the face-to-face delivery of the service. The requestors instead submitted various studies and articles regarding: the psychiatric diagnostic interview examination; school-based pediatric acute care to children; child and adolescent psychotherapy in clinics and schools; the use of telehealth technology to simplify case management and prior authorization; consultation on neurology cases; and nursing care to reduce hospitalization for heart failure.

These data are not directly relevant to the services that the requesters wanted to have added. They do not address whether the use of a telecommunications system produces similar diagnoses or therapeutic interventions by physicians or practitioners, as would the face-to-face delivery of inpatient hospital care, hospital observation services, and inpatient psychotherapy. With respect to emergency department visits, the requestor submitted a comparison study between emergency department telemedicine and face-to-face emergency department visits. However, this study did not take into account complex emergent care. Study participants were pre-selected based on cases with limited clinical intervention, for example, animal bites with no skin laceration or puncture wounds, insect bites without evidence of wheezing or airway compromise, sore throat, first degree burns—less than 5 percent, and nonurgent medical problems requiring a referral.

In the absence of sufficient, well-designed comparison studies showing that the use of a telecommunications system produces similar diagnoses or therapeutic interventions as would the face-to-face delivery of the requested services, we are proposing not to add these services to the list of telehealth services.

We believe that the current list of Medicare telehealth services is appropriate for hospital inpatients, emergency room cases, and patients designated as observation status. If guidance or advice is needed in these settings, a consultation could be requested from an appropriate source.

End Stage Renal Disease—Monthly Management of Patients on Dialysis

The ATA and an individual practitioner submitted a request that we add the monthly management of patients on dialysis, as represented by HCPCS codes G0308 through G0319, to the list of Medicare telehealth services. Under these codes, Medicare pays an increased monthly capitated payment amount for additional visits during the month (up to four). The requestors noted the shortage of nephrologists and the difficulty they have in visiting face-to-face with all patients on dialysis. Additionally, the requestors stated that many States, including Alaska, Hawaii, Montana, and Wisconsin, have remote community-based dialysis centers with underserved populations located a considerable distance from a nephrologist. To address this issue, consultations and patient care conferences are currently being provided using a telecommunications system to manage patients on dialysis located in communities that do not have a nephrologist, including communities in Texas, where dialysis consultations and assessments using telecommunications are paid under the State's Medicaid program. Given the claims of a shortage of nephrologists and the new face-to-face visit requirements for physicians managing patients on dialysis, the requestors believe that permitting the management of dialysis patients through telehealth services is crucial.

CMS Review

The MCP G codes represent a range of services provided during a month, including a complete assessment of the patient and subsequent visits to monitor the patient's condition. We believe the types of services provided as part of the subsequent visits included in the codes are similar to the office and other outpatient visits currently on the list of Medicare telehealth services. Therefore, we believe these services would meet the criteria set forth in Category 1 of the process for adding services described above. However, we do not believe the complete assessment aspect of the MCP G codes is similar to existing telehealth services. For example, one aspect of a complete assessment would involve examination of the vascular access site. This is a specific clinical examination that is not similar to other services on the list.

Therefore, we consider the request for addition of the complete assessment to the list of telehealth services to be a Category 2 request, requiring comparative analyses. In submitting their requests for addition to the list of Medicare telehealth services, the requestors included summaries of many studies related to renal dialysis patient monitoring. However, we do not believe the requestor provided comparative analyses illustrating that the use of a telecommunications system is an adequate substitute for the clinical examination of the vascular access site. We do not believe that the use of a telecommunications system is an adequate method for conducting a complete assessment of the ESRD beneficiary. We believe that a clinical examination of the vascular access site can be adequately performed only with a face-to-face, ''hands on'' examination of the patient.

However, we do believe the subsequent visits meet the criteria for approving a Category 1 request. That is, we believe the roles and interactions between the patient and the physician (or practitioner) are similar to those of office and other outpatient visits currently on the telehealth list. This presents a unique scenario, wherein a portion of the services represented by the MCP G codes are eligible to add to the list, but one service (the complete assessment) is not. To address this issue, we propose to add the ESRD-related services with 2 or 3 visits per month and ESRD-related services with 4 or more visits per month as described by G0308, G0309, G0311, G0312, G0314, G0315, G0317, G0318 to the list of Medicare telehealth services. However, the complete assessment of the ESRD

beneficiary would not be permitted through the use of a telecommunications system. A comprehensive visit including a clinical examination of the vascular access site must be furnished face-to-face ''hands on'' by a physician, clinical nurse specialist, nurse practitioner, or physician's assistant. An interactive telecommunications system may be used for providing additional visits required under the 2-to-3 visit MCP and the 4-or-more visit MCP.

As noted previously, the MCP G codes are unique in that they reflect the ongoing care provided to ESRD patients by the physician or practitioner, on a monthly basis. These codes also reflect a range of services, from a monthly comprehensive assessment to monitoring the patient's overall condition and addressing individual issues and concerns as they arise during the month. We believe these codes are distinguishable from other codes by the scope of services and the ongoing nature of the services provided. Therefore, we believe that it would be appropriate to permit the use of a telecommunications system for providing some of the visits required under the ESRD MCP and to add these codes to the list of Medicare telehealth services.

The MCP physician, for example, the physician or practitioner who provided the complete assessment, and other practitioners within the same group practice or employed by the same employer/entity, may furnish ESRD-related visits through a telecommunications system. However, the physician or practitioner who performs the complete assessment and establishes the plan of care should bill for the MCP in any given month.

Clinical Criteria—The complete assessment visit must be conducted face-to-face. For subsequent visits, the physician or practitioner at the distant site is required, at a minimum, to use an interactive audio and video telecommunications system that allows the physician or practitioner to provide medical management services for a maintenance dialysis beneficiary. For example, an ESRD visit conducted via telecommunications system must permit the physician or practitioner at the distant site to perform an assessment of whether the dialysis is working effectively and whether the patient is tolerating the procedure well (physiologically and psychologically). During this assessment, the physician or practitioner at the distant site must be able to determine whether alteration in any aspect of the beneficiary's prescription is indicated, due to such changes as the estimate of the patient's dry weight.

Clarification on originating sites—The statute currently defines a telehealth originating site as a physician's or practitioner's office, hospital, critical access hospital, rural health clinic, or Federally-qualified health center. ESRD facilities are not originating sites (dialysis facilities are not defined in the statute as originating sites). Subsequent visits (other than the comprehensive assessment) in any of the statutorily-covered settings could be provided via telecommunications equipment, including a physician's satellite office within a dialysis center. Adding dialysis facilities to the list of Medicare telehealth originating sites would require a legislative change.

Speech and Audiologist Services

The American Speech-Language Hearing Association (ASHA) requested that we add 36 audiology services (CPT code range 92541 through 92596) and 30 speech language pathology (SLP) services (CPT code range 31575 through 97703) to the list of Medicare telehealth services. The ASHA believes the cognitive nature of these services makes them well-suited for telehealth and noted several telehealth programs that have been successful at providing SLP and audiology services. For example, existing telehealth networks were cited as successfully providing diagnosis, treatment, and management recommendations for patients with speech language and hearing disorders.

CMS Review

Speech language pathologists and audiologists are not permitted under current law to provide and receive payment for Medicare telehealth services at the distant site. The statute permits only a physician, as defined by section 1861(r) of the Act or a practitioner as described in section 1842(b)(18)(C) of the Act (clinical nurse specialist, nurse practitioner, physician assistant, nurse midwife, clinical psychologist, and clinical social worker), to furnish Medicare telehealth services. We are exploring this issue as part of a report to Congress (required by section 223(d) of BIPA) on additional sites and settings, geographic areas, and practitioners that may be reimbursed for the provision of telehealth services. At this time, we are not adding speech and audiology services to the list of Medicare telehealth services.

Case Management and Care Plan Oversight (Team Conferences and Physician Supervision)

Two requests were submitted asking that we add medical team conferences as identified by CPT codes 99361 and 99362 and physician supervision (CPT codes 99374 and 99375) as telehealth services. Requestors stated that for these services, the use of a telecommunications system provides interdisciplinary medical teams serving remote underserved populations better access to the clinical expertise and decision making of specialty physicians. The requestors note that the current list of Medicare telehealth services, for example, consultations or office visits, cannot be used for case management and care plan oversight services because the patient is not typically present.

CMS Review

Medical team conferences and monthly physician supervision are already covered Medicare services and do not require a face-to-face encounter with the beneficiary. Under the Medicare program, the use of a telecommunications system in furnishing a telehealth service is a substitution for the face-to-face requirements of a service. Since medical team conferences and monthly physician supervision do not require a face-to-face encounter with the patient, we cannot add these services to the list of Medicare telehealth services.

Review Summary

For the reasons stated above, we propose to add ESRD-related services as described by G0308, G0309, G0311, G0312, G0314, G0315, G0317 and G0318 to the list of Medicare telehealth services.

Moreover, we would add the term ''ESRD-related visits'' to the definition of Medicare telehealth services at CFR 410.78 and 414.65 as appropriate.

We do not propose to add any additional services discussed above to the list of Medicare telehealth services for CY 2005.

3. National Pricing of G0238 and G0239 Respiratory Therapy Service Codes

[If you choose to comment on issues in this section, please include the caption ''CODING—RESPIRATORY THERAPY'' at the beginning of your comments.]

In the 2001 final rule, we created three G codes for respiratory therapy services: G0237 *Therapeutic procedures to increase strength or endurance of respiratory muscles, face-to-face, one-on-one, each 15 minutes (includes monitoring),* G0238 *Therapeutic procedures to improve*

respiratory function, other than ones described by G0237, one-on-one, face-to-face, per 15 minutes (includes monitoring) and G0239 *Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring).*

We assigned RVUs to one of the codes (G0237), and indicated that the other two codes (G0238 and G0239) would be carrier-priced. Since the services represented by these codes are frequently being performed in comprehensive outpatient rehabilitation facilities, and paid under the physician fee schedule through fiscal intermediaries, there has been some uncertainty surrounding the payment for the carrier-priced services. We believe assigning RVUs to G0238 and G0239 would alleviate some of this uncertainty. Since these services are typically performed by respiratory therapists, no physician work was assigned to G0237, and we are not proposing work RVUs for either G0238 or G0239.

Therefore, we are proposing to value these services using the nonphysician workpool.

We propose practice expense RVUS for G0238 equal to those for G0237. While these codes represent two different types of activities (G0237 involves therapeutic procedures specifically targeted at improving the strength and endurance of respiratory muscles such as pursed-lip breathing, diaphragmatic breathing, and paced breathing, and G0238 involves other activities such as teaching patients strategies for performing tasks with less respiratory effort and the performance of graded activity programs to increase endurance and strength of upper and lower extremities), we believe that the practice expense involved is substantially the same for both services and thus, propose to crosswalk the practice expense RVUs for G0237 to G0238.

G0239 represents situations in which two or more individuals are receiving services simultaneously (such as those described above in G0237 or G0238) during the same time period. Although the practitioner must be in constant attendance, he or she need not be providing one-on-one patient contact. For G0239, we believe a typical group session to be 30 minutes in length and to consist of 3 patients. Therefore, for the practice expense RVUs for G0239, we will use the practice expense RVUs of G0237 reduced by one-third to account for the fact that the service is being provided to more than one patient simultaneously and each patient in a group can be billed for the services of G0239.

We also propose a malpractice RVU of 0.02, the malpractice RVU assigned to G0237, for these two G codes.

4. Bone Marrow Aspiration and Biopsy Through the Same Incision on the Same Date of Service

[If you choose to comment on issues in this section, please include the caption ''CODING—BONE MARROW ASPIRATION'' at the beginning of your comments.]

In the physician fee schedule final rule published on June 28, 2002 (67 FR 43864), we proposed creation of a new G-code that reflects a bone marrow biopsy and aspiration procedure performed on the same date, at the same encounter, through the same incision. While some commenters were supportive of this proposal, other commenters felt that creation of a G-code was unnecessary and that any concerns with respect to payment could be addressed through application of the multiple procedure payment rules. In a final rule published on December 31, 2002 (67 FR 79992), we agreed that the code should go through the CPT process and did not make our proposal final.

To date, CPT has not addressed the issue. Therefore, we are proposing to create a G-code for this service in 2005. We believe that there is minimal incremental work associated with performing the second procedure through the same incision during a single encounter and are proposing an add-on G-code to reflect the additional physician work and practice expense. As we had stated in our previous proposal, if the two procedures, aspiration and biopsy, are performed at *different* sites (for example, contralateral iliac crests, sternum/iliac crest or two separate incisions on the same iliac crest), the –59 modifier, which denotes a distinct procedural service, would be appropriate to use and Medicare's multiple procedure rules would apply. In this instance, the CPT codes for aspiration and biopsy would each be used.

G0XX1: Bone Marrow Aspiration Performed With Bone Marrow Biopsy Through Same Incision on Same Date of Service, Add-On

The code would be used when a bone marrow aspiration and a bone marrow biopsy are performed on the same day through a single incision. The physician would use the CPT code for bone marrow biopsy (38221) and G0XX1 for the second procedure (*bone marrow aspiration*).

Based on our estimation that the time associated with this G-code is approximately 5 minutes and based on a comparison to CPT code 38220 which has 34 minutes of intraservice time and a work RVU of 1.08 work, we are proposing 0.16 work RVUs for this proposed G-code. The proposed malpractice RVUs are 0.04 which are the current malpractice RVUS assigned to CPT code 38220. We are proposing the following practice expense inputs:

—Clinical staff time: Registered nurse—5 minutes
Lab technician—2 minutes
—Equipment: Exam table

We are also proposing a ZZZ global period for this add-on code since this code is related to another service and is included in the global period of the other service.

5. Q Code for the Set-Up of Portable X-Ray Equipment

The Q-code for the set-up of portable x-ray equipment, Q0092, is currently paid under the physician fee schedule and is assigned an RVU of 0.33. In 2004, this produces a national payment of $12.32. This set-up code encompasses only a portion of the resources required to provide a portable x-ray service to patients. In 2003, portable x-ray suppliers received total Medicare payments of approximately $208 million. More than half of these payments (approximately $116 million) were for portable x-ray transportation (codes R0070 and R0075). The portable x-ray set-up code (Q0092) generated approximately $19 million in payments. The remainder of the Medicare payments for portable x-ray services (approximately $73 million) were for the actual x-ray services themselves.

Between 2002 and 2004, the Medicare carriers increased the average amount paid for portable x-ray transportation across the country from about $89 to $112, an increase of about 25 percent (transportation is carrier-priced). Nonetheless, the Conference Report accompanying the Consolidated Appropriations Bill, HR 2673 (Pub. L. 108–199, enacted January 23, 2004), urged the Secretary to review and update the RVUs for Q0092 utilizing existing data.

In 2002, the National Association of Portable X-ray Providers had requested that we use their cost data to develop practice expense RVUs for the physician fee schedule services they provide. We asked the Lewin Group to evaluate the data using the same standards of review applied to other specialty survey data. The Lewin Group found that the data as presented were not adequately detailed

to calculate a practice expense per hour based on the current practice expense methodology. Therefore, we did not use the data. However, in response to ongoing requests from the portable x-ray industry that we reexamine payments for this code, we have reevaluated this code.

This code is currently priced in the nonphysician work pool. Removing this code from the nonphysician work pool has an overall negative impact on payments to portable x-ray suppliers (as a result of decreases to radiology codes that remain in the nonphysician work pool) and has a negative impact on many of the codes remaining in the nonphysician workpool. An alternative to national pricing of portable x-ray set-up would be to require Medicare carriers to develop local pricing as they do currently for portable x-ray transportation. In 2002, we received a comment from a supplier of portable x-rays stating that the practice costs associated with set-up of portable x-ray equipment are not included in the Socioeconomic Monitoring System (SMS) and that there are sufficient differences among geographic regions in the performance of this procedure that warrant reclassifying this service as carrier-priced. We are interested in public comments on whether we should pursue national pricing for portable x-ray set-up outside of the nonphysician work pool or local carrier pricing for 2005 or whether we should continue to price the service in the nonphysician workpool.

6. Venous Mapping for Hemodialysis

We are proposing to create a new G-code (G0XX3: *Venous mapping for hemodialysis access placement* (Service to be performed by operating surgeon for preoperative venous mapping prior to creation of a hemodialysis access conduit using an autogenous graft). Autogenous grafts have longer patency rates, a lower incidence of infection and greater durability than prosthetic grafts. Use of autogenous grafts can also result in a decrease in hospitalizations and morbidity related to vascular access complications. Creation of this G-code will enable us to distinguish between CPT code 93971 (*Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study*) and G0XX3. This new code will allow us to track use of venous mapping for quality improvement purposes.

This G code would only be billed by the operating surgeon in conjunction with the following CPT codes: 36819, 36821, 36825, and 36832. Because CPT code 93971 and the new G-code would be used to describe a similar service, we would propose that we not permit payment for CPT code 93971 when this G-code is billed, unless code 93971 were being performed for a separately identifiable clinical indication in a different anatomic region.

The physician work, practice expense and professional liability expense for this new G code would be the same as those for CPT code 93971. Thus, we propose to crosswalk the RVUs for the new G-code from those of CPT code 93971. We would also assign this new G-code a global period of ''XXX'', which means that the global concept does not apply.

III. Provisions of the Medicare Modernization Act of 2003

A. Section 611—Initial Preventive Physical Examination

[If you choose to comment on issues in this section, please include the caption ''Section 611'' at the beginning of your comments.]

1. Coverage of Initial Preventive Physical Examinations

Section 611 of the MMA provides for coverage under Part B of an initial preventive physical examination for new beneficiaries, effective for services furnished on or after January 1, 2005, subject to certain eligibility and other limitations.

Previously, Medicare law had not allowed for payment for routine physical examinations or checkups. Section 1862(a)(7) of the Act states that routine physical checkups are excluded services. This exclusion is described in § 411.15(a) (Particular services excluded from coverage). In addition, we have interpreted section 1862(a)(1)(A) of the Act to exclude coverage for preventive physical examinations. This section provides that items and services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member as stated in § 411.15(k). Since preventive services are not provided for diagnosis or treatment of illness, injury, or malformation, we determined that these services are not reasonable and necessary within the meaning of the statute.

To conform the regulations to the MMA, we are specifying an exception to the list of examples of routine physical examinations excluded from coverage in § 411.15(a)(1) and § 411.15(k)(11) for initial preventive physical examinations that meet the eligibility limitation and the conditions for coverage that we are specifying under § 410.16—Initial Preventive Physical Examinations.

Coverage of initial preventive physical examinations is provided under Medicare Part B only. The MMA permits payment for one initial preventive physical examination within the first 6 months after the effective date of the beneficiary's first Part B coverage period, but only if that coverage period begins on or after January 1, 2005.

We are proposing to add § 410.16(b), Condition for Coverage of Initial Preventive Physical Examinations, and § 410.16(c), Limitation on Coverage of Initial Preventive Physical Examinations, to provide for coverage of the various initial preventive physical examination services specified in the statute.

We are proposing to define several terms, as described specifically in § 410.16, that would be used in implementing the statutory provisions, including definitions of the following terms—

(1) Eligible beneficiary;

(2) An initial preventive physical examination;

(3) Medical history;

(4) Physician;

(5) Qualified nonphysician practitioner.

(6) Social history;

(7) Review of the individual's functional ability and level of safety;

Section 611 of the MMA defines an ''initial preventive physical examination'' to mean physicians' and certain qualified nonphysician practitioners' services consisting of—

(1) A physical examination (including measurement of height, weight, blood pressure, and an electrocardiogram, but excluding clinical laboratory tests) with the goal of health promotion and disease detection; and

(2) Education, counseling, and referral with respect to screening and other covered preventive benefits separately authorized under Medicare Part B.

Specifically, section 611(b) of the MMA provides that the education, counseling, and referral of the individual by the physician or other qualified nonphysician practitioner should be with respect to the following statutory screening and other preventive services authorized under Medicare Part B:

(1) Pneumococcal, influenza, and hepatitis B vaccine and their administration.

(2) Screening mammography.

(3) Screening pap smear and screening pelvic exam services.

(4) Prostate cancer screening services.

(5) Colorectal cancer screening tests.

(6) Diabetes outpatient self-management training services;

(7) Bone mass measurements.
(8) Screening for glaucoma.
(9) Medical nutrition therapy services for individuals with diabetes or renal disease.
(10) Cardiovascular screening blood tests.
(11) Diabetes screening tests.

Based on the language of the statute, our review of the medical literature, current clinical practice guidelines, and United States Preventive Services Task Force recommendations, we are proposing to interpret the term, ''initial preventive physical examination,'' for purposes of this new benefit to include all of the following:

(1) Review of the individual's comprehensive medical and social history, as those terms are defined in paragraph (a) of proposed § 410.16.

(2) Review of the individual's potential (risk factors) for depression (including past experiences with depression or other mood disorders) based on the use of an appropriate screening instrument which the physician or other qualified nonphysician practitioner may select from various available standardized screening tests for this purpose, unless the appropriate screening instrument is defined through the national coverage determination (NCD) process.

(3) Review of the individual's functional ability and level of safety, as described in paragraph (a) of proposed § 410.16, (that is, at a minimum, a review of the following areas: hearing impairment, activities of daily living, falls risk, and home safety), based on the use of an appropriate screening instrument, which the physician or other qualified nonphysician practitioner may select from various available standardized screening tests for this purpose, unless the appropriate screening instrument is further defined through the NCD process.

(4) An examination to include measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the physician or qualified nonphysician practitioner, based on the individual's comprehensive medical and social history and current clinical standards.

(5) Performance and interpretation of an electrocardiogram.

(6) Education, counseling, and referral, as appropriate, based on the results of the previous five elements of the initial preventive physical examination.

(7) Education, counseling, and referral, including a written plan provided to the individual for obtaining the appropriate screening and other preventive services, which are separately covered under Medicare Part B benefits; that is, pneumococcal, influenza, and hepatitis B vaccines and their administration, screening mammography, screening pap smear and screening pelvic exams, prostate cancer screening tests, diabetes outpatient self-management training services, bone mass measurements, screening for glaucoma, medical nutrition therapy services, cardiovascular screening blood tests, and diabetes screening tests.

We are requesting public comments on the definition of the term ''initial preventive physical examination.'' For example, we have chosen not to define the term, ''appropriate screening instrument,'' for screening individuals for depression, functional ability, and level of safety, as specified in the proposed rule, because we anticipate that the examining physician or qualified nonphysician practitioner will want to use the test of his or her choice, based on current clinical practice guidelines. We believe that any standardized screening test for depression, functional ability, and level of safety recognized by the American Academy of Family Physicians, the American College of Physicians-American Society of Internal Medicine, the American College of Preventive Medicine, the American Geriatrics Society, the American Psychiatric Association, or the United States Preventive Services Task Force, or other recognized medical professional group, would be acceptable for purposes of meeting the ''appropriate screening instrument'' provision. We ask that commenters making specific recommendations on this or any related issue provide documentation from the medical literature, current clinical practice guidelines, or the United States Preventive Services Task Force recommendations.

We recognize that the NCD process could be used to define more specifically the type or types of appropriate screening instruments for depression, functional ability, or level of safety and propose to include in § 410.16(a) in elements (2) and (3) of the definition of an initial preventive physical examination a reference that would allow us to define these screening instruments more specifically through the national coverage determination (''NCD'') process. The NCD process would include an opportunity for public comment on the medical and scientific issues related to the coverage of the new tests that may be brought to our attention in the future. Use of an NCD to establish a change in the scope of benefits is authorized by section 1871(a)(2) of the Act.

2. Payment for Initial Preventive Physical Examination

There is no current CPT code that contains the specific elements included in the initial preventive examination. Therefore, we are proposing to establish the following new HCPCS code, G0XX2, *Initial preventive physical examination,* to be used for billing for the initial preventive examination. As required by the statute, this code includes an electrocardiogram, but does not include the other previously mentioned preventive services that are currently separately covered and paid under the Medicare Part B screening benefits. When these other preventive services are performed, they should be identified using the existing appropriate codes.

a. Basis for Payment

Payment for this new HCPCS code will be based on the following:

1. *Work RVUs*—We are proposing a work value of 1.51 RVUs for G0XX2. This value is based on our determination that this new service has equivalent resources and work intensity to those contained in CPT E/M code 99203, *new patient, office or other outpatient visit,* and CPT code 93000 *electrocardiogram, complete.* CPT code 99203 has a work RVU of 1.34 and requires a detailed history, detailed examination, and medical decision making of low complexity, which we believe to be representative of the elements contained in the initial preventive health examination. CPT code 93000, which is for a routine ECG with the interpretation and report, has a work RVU of 0.17.

2. *Malpractice RVUs*—For the malpractice component of G0XX2, we are proposing malpractice RVUs of 0.13 in the nonfacility setting based on the malpractice RVUs currently assigned to CPT code 99203 (0.10) and CPT code 93000 (0.03). In the facility setting, we are proposing malpractice RVUs of 0.11 based on the current malpractice RVUs assigned to CPT code 99203 (0.10) and 93010 (an EKG interpretation with a value of 0.01).

3. *Practice Expense RVUs*—For the practice expense component of G0XX2, we are proposing practice expense RVUs of 1.65 in the nonfacility setting based on the practice RVUs assigned to CPT code 99203 (1.14) and CPT code 93000 (0.51). In the facility setting, we are proposing practice expense RVUs of 0.54 based on the practice RVUs assigned to CPT code 99203 (0.48) and 93010 (0.06).

b. Evaluation and Management (E/M) Service

Since some of the components for a medically necessary E/M visit are reflected in this new HCPCS code, we are also proposing, when it is appropriate, to allow a medically necessary E/M service no greater than a level 2 to be reported at the same visit as the initial preventive physical examination. That portion of the visit must be medically necessary to treat the patient's illness or injury or to improve the function of a malformed body member and should be reported with modifier –25. The physician or qualified nonphysician practitioner could also bill for the screening and other preventive services currently covered and paid by Medicare Part B under separate provisions of section 1861 of the Act, if provided during this initial preventive physical examination.

c. Coinsurance and Part B Deductible

MMA did not make any provision for the waiver of the Medicare coinsurance and Part B deductible for the initial preventive physical examination. Payment for this service would be applied to the required deductible, which is $110 for CY 2005, if the deductible has not been met, and the usual coinsurance provisions would apply.

B. Section 613—Diabetes Screening Tests

[If you choose to comment on issues in this section, please include the caption ''Section 613'' at the beginning of your comments.]

Section 613 of the MMA adds section 1861(yy) to the Act and mandates coverage of diabetes screening tests.

The term ''diabetes screening tests'' is defined in section 613 as testing furnished to an individual at risk for diabetes including a fasting plasma glucose test and such other tests, and modifications to tests, as the Secretary determines appropriate, in consultation with appropriate organizations. In compliance with this directive, we consulted with the American Diabetes Association, the American Association of Clinical Endocrinologists, and the National Institute for Diabetes and Digestive and Kidney Diseases.

1. Coverage

We are proposing in § 410.18 that Medicare cover—

- A fasting plasma glucose test; and
- Post-glucose challenge tests; either an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for nonpregnant adults, or a 2-hour post-glucose challenge test alone.

We would not include a random serum or plasma glucose for persons with symptoms of uncontrolled diabetes such as excessive thirst or frequent urination in this benefit because it is already covered as a diagnostic service. This language is not intended to exclude other post-glucose challenge tests that may be developed in the future, including panels that may be created to include new diabetes and lipid screening tests. We also would include language that would allow Medicare to cover other diabetes screening tests, subject to a NCD process. We are requesting comments regarding the specific tests, definitions, and eligibility criteria. The comments that we receive will also be used to create the list of billing codes for covered tests and diagnosis codes that would be published in instructions for Medicare contractors.

The statutory provision describes an ''individual at risk for diabetes'' as having any of the following risk factors:

1. Hypertension.
2. Dyslipidemia.
3. Obesity, defined as a body mass index greater than or equal to 30 kg/m2.
4. Previous identification of an elevated impaired fasting glucose.
5. Previous identification of impaired glucose tolerance.
6. A risk factor consisting of at least two of the following characteristics:

(a) Overweight, defined as a body mass index greater than 25 kg/m2, but less than 30.

(b) A family history of diabetes.

(c) A history of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

(d) 65 years of age or older.

The statutory language directs the Secretary to establish standards regarding the frequency of diabetes screening tests that will be covered and limits the frequency to no more than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.

We are proposing that Medicare beneficiaries diagnosed with ''pre-diabetes'' be eligible for the maximum frequency allowed by the statute, that is, 2 screening tests per 12 month period. We propose to define ''pre-diabetes'' as a previous fasting glucose level of 100–125 mg/dL, or a 2-hour post-glucose challenge of 140–199 mg/dL. This definition of ''pre-diabetes'' was developed with the assistance of the American Association of Clinical Endocrinologists and complements the definition of diabetes that we published November 7, 2003 (68 FR 63195). We are specifically asking for comments regarding our new definition of ''pre-diabetes.'' We are also requesting suggestions for the definition of ''a family history of diabetes.''

For individuals not meeting the ''pre-diabetes'' criteria, we are proposing that one diabetes screening test be covered per individual per year.

2. Payment

We are proposing to pay for the screening diabetes tests at the same amounts paid for these tests when performed to diagnose an individual with signs and symptoms of diabetes. We would pay for these tests under the clinical laboratory fee schedule. We propose to pay for these tests under CPT code 82947 Glucose; quantitative, blood (except reagent strip) and CPT code 82951 Glucose; tolerance test (GTT), three specimens (includes glucose). To indicate that the purpose of the test is for diabetes screening, we would require that the laboratory include a screening diagnosis code in the diagnosis section of the claim. We propose V77.1 Special screening for diabetes mellitus as the applicable ICD–9—CM code for this purpose. Because laboratories are required and accustomed to submitting diagnosis codes when requesting payment for testing, we believe including a screening diagnosis code is appropriate for this benefit.

C. Section 612—Cardiovascular Screening Blood Tests

[If you choose to comment on issues in this section, please include the caption ''Section 612'' at the beginning of your comments.]

Section 612 of the MMA provides for Medicare coverage of cardiovascular screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk for that disease effective on or after January 1, 2005.

1. Coverage

The Act requires coverage of tests for cholesterol and other lipid or trigylcerides levels for this purpose. It also authorizes the Secretary to approve coverage of other screening tests for other indications associated with cardiovascular disease or an elevated risk for that disease, including indications measured by noninvasive testing, if the United States Preventive Services Task Force (USPSTF) recommended a blood test for that indication.

We invited comments about the types of tests from the American College of Physicians/ American Society of Internal Medicine, the American College of Cardiology, American Academy of

Family Physicians, American Heart Association, College of American Pathologists, American Society for Clinical Laboratory Science, American Society for Clinical Pathologists, American Association for Clinical Chemistry, and the American Clinical Laboratory Association. Comments were received from the American Heart Association, American Academy of Family Physicians, the American Association for Clinical Chemistry, American Society for Clinical Laboratory Science, the National Kidney Foundation, and the Vascular Disease Foundation, regarding the coverage of a number of cardiovascular screening tests in addition to the required blood lipid tests; for example, high sensitivity C-Reactive Protein (CRP), homocysteine, or Beta Naturetic Protein (BNP), electrocardiograms, Doppler and noninvasive vascular tests, and a skin reflectance test.

We also reviewed the following 2001 recommendations of the USPSTF regarding screening for lipid disorders that are associated with cardiovascular disease:

a. Clinicians should routinely screen men aged 35 years and older and women aged 45 years and older for lipid disorders and treat abnormal lipids in people who are at increased risk.

b. Clinicians should routinely screen younger adults (men aged 20 to 35 and women aged 20 to 45) for lipid disorders if they have other risk factors for coronary heart disease.

c. No recommendation was made for or against routine screening for lipid disorders in younger adults (men aged 20 to 35 or women aged 20 to 45) in the absence of known risk factors for coronary heart disease.

d. Screening for lipid disorders should include measurement of total cholesterol (TC) and high-density lipoprotein cholesterol (HDL–C).

e. Evidence is insufficient to recommend for or against trigylcerides measurement as a part of routine screening for lipid disorders.

Based on the statutory language and our review of the scientific literature, expert opinion, and the USPSTF recommendations, we are proposing coverage of the following three screening blood tests for conditions associated with cardiovascular disease:

(1) A total cholesterol test.

(2) A cholesterol test for high density lipoproteins.

(3) A triglycerides test.

These tests should be performed as part of a panel and should be done after a 12-hour fast. We are also proposing coverage of each of these tests once every 5 years. The statute provides that the Secretary shall establish frequency standards for the coverage of cardiovascular screening blood tests, provided the frequency is no more often than once every 2 years. However, the scientific literature shows that cholesterol levels are fairly stable and do not fluctuate drastically for those older than age 65. The USPSTF clinical considerations indicate that, while screening may be appropriate in older people, repeated screening is less important because lipid levels are less likely to increase after age 65. Under the USPSTF recommendations, routine measurement of total cholesterol and HDL cholesterol every 5 years is recommended by the National Cholesterol Education program Adult Treatment Panel II (ATP II), sponsored by the National Institutes of Health, and endorsed by the American Heart Association. In addition, the most recent Report of the Adult Treatment Panel (ATP III) includes similar recommendations. In all adults aged 20 years or older, a fasting lipoprotein profile (total cholesterol, LDL cholesterol, high density lipoprotein (HDL) cholesterol, and triglyceride) should be obtained once every 5 years. Since the LDL cholesterol can be calculated, the remaining tests, which are part of the lipid panel, are the tests we are proposing for coverage under this new benefit at a 5-year screening interval. We do not believe the evidence justifies or the statute allows for coverage of other cardiovascular screening blood tests at this time.

To facilitate our consideration of future coverage of other new types of cardiovascular screening blood tests, we have decided to add a provision to this proposed regulation that, in addition to the specific cardiovascular screening blood tests proposed for coverage in this proposed rule, would provide that other types of these tests may be covered under this new screening benefit, if we determine that this is appropriate through a National Coverage Determination (NCD). This provision would allow us to conduct a more timely assessment of other new types of cardiovascular screening blood tests that may have been approved for marketing by the Food and Drug Administration and recommended by the USPSTF than is possible under the standard rulemaking process. We intend to use the NCD process, which includes an opportunity for public comments, for evaluating the medical and scientific issues relating to the coverage of additional tests that may be brought to our attention in the future. Use of an NCD to establish a change in the scope of benefits is authorized by section 1871(a)(2) of the Act. These proposed coverage requirements are set forth in new section § 410.17.

2. Payment

Section 612 of the MMA provides for Medicare coverage of cardiovascular screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk for cardiovascular disease. The coverage is effective on or after January 1, 2005. We are proposing to pay for the screening cardiovascular disease tests at the same amounts paid for these tests when they are performed to diagnose an individual with signs and symptoms of cardiovascular disease. Medicare would pay for the tests under the clinical laboratory fee schedule. We propose to use the following CPT codes:

- 82465 Cholesterol, serum or whole blood, total.
- 83718 Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol).
- 84478 Triglycerides.
- 80061 Lipid Panel.

To indicate that the purpose of the test is for cardiovascular screening, we propose that the laboratory include in the diagnosis section of the claim the diagnosis code that provides the highest degree of accuracy and completeness in describing the diagnosis. We propose that the applicable ICD–9–CM codes for cardiovascular screening blood tests be selected from the following:

- V81.0 Special screening for ischemic heart disease.
- V81.1 Special screening for Hypertension.
- V81.2 Special screening for other and unspecified cardiovascular conditions.

Because laboratories are required and accustomed to submitting diagnosis codes when requesting payment for testing, we believe including a screening diagnosis code for this purpose will not be unduly burdensome to them.

D. Section 413—Physician Scarcity Areas and Health Professional Shortage Areas Incentive Payments

[If you choose to comment on issues in this section, please include the caption ''Section 413'' at the beginning of your comments.]

1. Background

Section 4043 of the Omnibus Budget Reconciliation Act (OBRA) of 1987 added section 1833(m) to the Act to provide incentive payments to physicians who furnish services to

Medicare beneficiaries in Health Professional Shortage Areas (HPSAs). Under section 1833(m) of the Act, a 5 percent payment was added, beginning January 1, 1989, to the amounts otherwise payable under the physician fee schedule to doctors who furnish covered services to Medicare patients in designated HPSAs. Section 6102 of OBRA 1989 further amended section 1833 of the Act to raise the amount of this incentive payment from 5 percent to 10 percent for services furnished after December 31, 1990. The OBRA 1989 amendment also increased eligible service areas to include both rural and urban HPSAs. The Congress established the HPSA incentive payments as incentives to attract new physicians to medically underserved communities and to encourage physicians in those areas to remain there.

Eligibility for receiving the 10 percent incentive payment is based on whether the specific location at which the service is furnished is within an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act (PHS)) as a HPSA. The Health Resources and Services Administration of the Department of Health and Human Services (HRSA) is responsible for designating shortage areas. HRSA designates several types of HPSAs. Some HPSAs are areas with shortages of primary care physicians, dentists, or psychiatrists. These shortage designations are referred to as geographic-based HPSAs. Also, there are HPSA designations based on underserved populations within an area, which are referred to as population-based HPSAs.

Section 1833(m) of the Act provides incentive payments for physicians who furnish services in areas designated as HPSAs under section 332(a)(1)(A) of the PHS Act. These include all three types of geographic-based HPSAs (primary medical care, dental, and mental health). Consequently, physicians, including psychiatrists, furnishing services in a primary medical care HPSA are eligible to receive bonus payments. Medicare HPSA bonus payments apply to all physicians who perform covered services within a primary medical care HPSA, regardless of specialty. In addition, psychiatrists furnishing services in mental health HPSAs are eligible to receive incentive payments. We do not recognize dental HPSAs for the Medicare HPSA payment program because Medicare does not cover general dental services for its beneficiaries.

Since the inception of the Medicare HPSA incentive payment program, physicians have been responsible for indicating their eligibility for the incentive payment on the Medicare billing form. To facilitate the verification of eligibility, physicians have been notified by their Medicare carriers when changes (withdrawals, revisions, or replacements) occur in HPSA designations. Using this information from carriers, physicians have been required to verify their eligibility and correctly code their Medicare claims using modifiers (QB for rural HPSAs and QU for urban HPSAs) to receive incentive payments.

2. New Legislation

a. Physician Scarcity Areas

Section 413(a) of the MMA, provides a new 5 percent incentive payment to physicians furnishing services in physician scarcity areas. The MMA adds a new section 1833(u) of the Act which provides for paying primary care physicians furnishing services in a primary care scarcity county and specialty physicians furnishing services in a specialist care scarcity county, an additional amount equal to 5 percent of the amount paid for these services. Eligible physicians furnishing services in an area qualified as a physician scarcity area (PSA) and HPSA would be entitled to receive both incentive payments, that is, a 15 percent bonus payment. Eligibility for receiving both incentive payments is time limited (January 1, 2005 to January 1, 2008) because the 5 percent PSA bonus is scheduled to sunset on December 31, 2007.

The Congress created the new 5 percent incentive payment program to make it easier to recruit and retain both primary and specialist care physicians for furnishing services to Medicare beneficiaries in PSAs.

The two measures of physician scarcity are defined by the statute as follows:

1. The primary care scarcity areas are determined by the ratio of primary care physicians to Medicare beneficiaries.

2. The specialist care scarcity areas are determined by the ratio of specialty care physicians to Medicare beneficiaries.

i. Primary Care

Consistent with section 1833(u) of the Act, we would identify eligible primary care scarcity counties by ranking each county by its ratio of primary care physicians to Medicare beneficiaries. From the list of primary care scarcity counties, only those counties with the lowest primary care ratios that represent 20 percent of the total number of Medicare beneficiaries residing in the counties will be considered eligible for the 5 percent incentive payment. For calculating the ratios, section 1833(u)(6) of the Act, as added by the MMA, defines a primary care physician as a general practitioner, family practice practitioner, general internist, obstetrician, or gynecologist. All other physicians will be considered specialists for purposes of the 5 percent incentive payment. Section 1833(u) of the Act, as added by the MMA, specifically defines ''physician'' as one described in section 1861(r)(1) of the Act. This statutory provision does not include dentists, podiatrists, optometrists, and chiropractors.

ii. Specialist Care

To identify eligible specialist care scarcity areas, we would rank each county by its ratio of specialty physicians to Medicare beneficiaries. From the list of specialist care scarcity counties, only those counties with the lowest ratios that represent 20 percent of the total number of Medicare beneficiaries residing in the counties will be considered eligible for the 5 percent incentive payment.

iii. The Goldsmith Modification

For purposes of counties identified as having a shortage of primary care or specialty care physicians, section 1833(u)(5) of the Act also requires that, to the extent feasible, we treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification) as an equivalent area. The Goldsmith modification evolved from an outreach grant program sponsored by the Office of Rural Health Policy of HRSA. This program was created to establish an operational definition of rural populations lacking easy access to health services in Large Area Metropolitan Counties (LAMCs). Dr. Harold F. Goldsmith and his associates created a methodology for identifying rural census tracts located within a large metropolitan county of at least 1,225 square miles. Using a combination of data on population density and commuting patterns, census tracts were identified as being so isolated by distance or physical features that they are more rural than urban in character.

iv. Rural-Urban Commuting Area

The original Goldsmith Modification was developed using data from the 1980 census. In order to more accurately reflect current demographic and geographic characteristics of the nation, the Office of Rural Health Policy, in partnership with the Department of Agriculture's Economic Research

Service and the University of Washington, developed the Rural-Urban Commuting Area codes (RUCAs). Rather than being limited to LAMCs, RUCAs use urbanization, population density, and daily commuting data to categorize every census tract in the country. RUCAs are the updated version of the Goldsmith Modification and are used to identify rural census tracts in all metropolitan counties.

Once all the full county PSAs are determined, we would identify, consistent with section 1833(u)(4)(C)of the Act, eligible PSAs by their 5-digit zip code area for the purpose of automatically providing the 5 percent incentive payment to eligible physicians. The zip code of the place of service is the only data element reported on the Medicare claim form that would allow automation. For zip codes that cross county boundaries, the statute specifically requires the use of the dominant county of the postal zip code (as determined by the U.S. Postal Service) if the Secretary uses the 5-digit postal zip code to identify areas eligible to receive the 5 percent payment. The statute also requires us to publish a list of eligible areas as part of the proposed and final physician fee schedule rules for the years for which PSAs are identified or revised and to post a list of PSAs on the CMS Website. Lastly, the statute provides no administrative or judicial review under sections 1869 or 1878 of the Act or otherwise, regarding the identification of a county or area, the assignment of a specialty of any physician, the assignment of a physician to a county, or the assignment of a postal ZIP Code to a county or other area.

b. Improvement to Medicare HPSA Incentive Payment Program

In addition to the creation of the 5 percent PSA incentive payment, section 413 of MMA amended section 1833(m) of the Act to mandate that we automate payment of the 10 percent HPSA incentive payment to eligible physicians for full county HPSAs without a requirement for the physician to identify the HPSA involved. When automation is not feasible, consistent with section 1833(m) of the Act as amended by section 413(b) of MMA, we plan to post a list of HPSAs on our website. When automation is not feasible, the billing of modifiers would still be required.

The statute provides for no administrative or judicial review of the identification of a county or area, the assignment of the individual physician's specialty, the assignment of a physician to a county or the assignment of a zip code to a county or area.

3. Provisions Related to Physician Scarcity Areas and HPSA Incentive Payment Program

a. Determination of Physician Scarcity Areas

As the statute prescribes, PSAs for primary care would be determined by the ratio of primary care physicians to the Medicare beneficiaries residing in that county or area. A primary care physician is defined by statute as a general practitioner, family practice practitioner, general internist, obstetrician, or gynecologist. The physician definition for determining primary care PSAs will be based on HRSA's physician designations for primary medical care HPSAs, which include all of the above physicians. In other words, the PSA definition for primary care will be identical to HRSA's, except for pediatricians. Furthermore, the statute provides that the primary care ratio include only primary care doctors in the active practice of medicine. Physicians whose practice is exclusively for the Federal Government or who provide only administrative services would not be included in the physician tally. PSAs for specialty care would be determined by the ratio of physicians who are not primary care physicians to the Medicare beneficiaries residing in that county or area. The specialist care PSA ratio would include all physicians other than primary care physicians as defined in the statute. To the extent feasible, we also plan to include rural census tracts of metropolitan statistical areas (as determined under the most recent modification of the Goldsmith Modification), as identified at the zip code level, with sufficiently low physician-to-Medicare population ratios as equivalent to qualified full county scarcity areas. The calculation of physician scarcity ratios is being made by the North Carolina Rural Research and Policy Analysis Center using the most current Medicare beneficiary and physician data available. At this time, the North Carolina Rural Research and Policy Analysis Center can only determine physician scarcity for Goldsmith areas at the zip code level due to the fact that Medicare beneficiary data is currently unavailable at the census tract level.

As previously discussed, section 1833(u) of the Act requires the automation of incentive payments for all PSAs, which we can only achieve by assigning zip codes to eligible areas. We propose the identification of qualified PSAs by zip code for automatic payment as follows:

- For zip codes that fall within a full county PSA, the bonus would be paid automatically.
- For full county PSAs, the dominant county of the 5-digit zip code, as determined by the U.S. Postal Service, would be used when the zip code area is not entirely located within the county. In some cases, a service may be provided in a county that is considered to be a PSA, but the zip code is not considered to be dominant for that area, which would not permit automation of the bonus payment. In order to receive the bonus for those areas, physicians would need to include a new physician scarcity modifier on the claim. We plan to establish and implement the new modifier through the Medicare Claims Processing Manual.
- For partial county PSAs (Goldsmith Modification), all zip code areas that are entirely located within the qualified Goldsmith area and all zip code areas that are partially located within a qualified Goldsmith area as long as the majority (51 percent) of the population located within the zip code area resides in the qualified Goldsmith area would be able to receive automatic payment.

Due to the complex nature of processing available physician and Medicare beneficiary data into a usable format to identify counties and areas with the lowest ratios, we cannot make available a list of PSAs within this proposed rule. We are working closely with HRSA and its contractors to publish these lists in the physician fee schedule final rule.

b. Incentive Payments for Physician Scarcity Areas

Similar to the Medicare HPSA bonus payment program, eligibility for receiving the 5 percent bonus payment would be based on whether the specific location at which the service is furnished is within an area that is designated as a PSA. Furthermore, the statute requires us to restrict eligibility for receiving the incentive payments for physicians' services furnished within primary care PSAs to general practitioners, family practice practitioners, general internists, obstetricians, or gynecologists. Also prescribed by statute, dentists, podiatrists, optometrists, and chiropractors are not eligible to receive incentive payments for PSAs. Section 1833(u) of the Act specifically defines a physician as one described in section 1861(r)(1) of the Act, which does not include dentists, podiatrists, optometrists, and chiropractors.

To conform our regulations to the statute, we are proposing to add § 414.66 to provide a 5 percent incentive payment to eligible physicians furnishing covered services in eligible PSAs. We propose to add § 414.66(a)(1) to specify that primary care physicians furnishing services in primary care PSAs are entitled to an additional 5 percent incentive payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005, and before January 1, 2008. The new incentive payment would apply to the professional services performed by physicians, including evaluation and management, surgery, consultation, and home, office and institutional visits. The technical component of physicians' services is not eligible because this component is not included in the definition of physicians' services at section 1861(q) of the Act as applied by the MMA. We are also proposing to add § 414.66(b) to specify that physicians, other than primary care physicians, dentists, podiatrists, optometrists, and chiropractors, furnishing services in specialist care PSAs are entitled to an additional 5 percent payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005, and before January 1, 2008.

c. Improvement to Medicare HPSA Incentive Payment Program

As of January 1, 2005, most physicians eligible for the 10 percent HPSA incentive payment would no longer be required to determine whether their service areas are eligible for incentive payments and to modify their claims to receive those payments. The MMA requires us to automate bonus payments for physicians' services furnished in full county HPSAs.

Automation of full county HPSA incentive payments involves the same issues of automation as PSA incentive payments: the zip code of the place of service is the only data element reported on the claim form that would allow automation. Similarly, zip codes need to be cross-walked to full county HPSAs. The statute allows use of the same method of automation of incentive payments for full county HPSAs as for full county PSAs. We are proposing the identification of HPSAs by zip code for automatic payment as follows:

- For zip codes that fall entirely within a full or partial county HPSA, the bonus would be paid automatically.
- When the zip code area is not entirely located within the full county HPSA, only the dominant county of the 5-digit zip code as determined by the U.S. Postal Service would be used for automatically paying the HPSA incentive payment.
- For all other zip code areas that are not entirely, but are to some extent, located within a designated HPSA (full county or partial), we would require physicians furnishing services in these areas to bill for the incentive payments by using the appropriate modifier on their Medicare claims. We propose to post on our website, prior to January 1, 2005, a list of zip codes that fully fall within a designated HPSA and a list of zip codes that partially fall within a designated HPSA, so that physicians can determine whether they would need to bill using a modifier.

Determination of zip codes eligible for automatic HPSA bonus payment would be made on an annual basis, and there would not be any mid-year updates. We would effectuate mid-year revisions made to designations by HRSA the following year for automatic bonus payment purposes.

d. Medicare HPSA Incentive Payments

The Medicare HPSA Incentive Payment program, which the Congress established under OBRA 1987, was implemented through the Medicare Claims Processing Manual. This proposed rule would create § 414.67 to conform the regulations to the law, as amended by OBRA 1987 and 1989.

We propose in § 414.67 to provide a 10 percent incentive payment to eligible physicians furnishing covered services in eligible HPSAs. Section 414.67(a) would specify that physicians, regardless of specialty, furnishing services in a primary medical care HPSA are entitled to a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule. We would also create § 414.67(c) to specify that psychiatrists furnishing services in a mental health HPSA are entitled to a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule. Psychiatrists furnishing services in mental health HPSAs that do not overlap with primary care HPSAs are the only physicians eligible to receive the 10 percent incentive payment in those areas. In other words, these stand-alone mental health HPSAs are eligible areas for psychiatrists only to receive incentive payments.

E. Section 303—Payment Reform for Covered Outpatient Drugs and Biologicals

[If you choose to comment on issues in this section, please include the caption ''Section 303'' at the beginning of your comments.]

1. Average Sales Price (ASP) Payment Methodology

a. Background

Medicare Part B covers a limited number of prescription drugs and biologicals. For the purposes of this proposed rule, the term ''drugs'' will hereafter refer to both drugs and biologicals. Medicare Part B covered drugs generally fall into the following three categories:

- Drugs furnished incident to a physician's service.
- Durable medical equipment (DME) drugs.
- Drugs specifically covered by statute (for example, immunosuppressive drugs).

Section 303(c) of the MMA revises the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. In particular, section 303(c) of the MMA amends Title XVIII of the Act by adding section 1847A. Beginning in 2005, section 1847A of the Act establishes a new ASP drug payment system. In 2005, almost all Medicare Part B drugs not paid on a cost or prospective payment basis will be paid under this system.

The new ASP drug payment system is based on data submitted to us quarterly by manufacturers. For calendar quarters beginning on or after January 1, 2004, the statute requires manufacturers to report their ASP data to us for almost all Medicare Part B drugs not paid on a cost or prospective payment basis. Manufacturers' submissions are due to us not later than 30 days after the last day of each calendar quarter.

For further information on the submission of manufacturers' ASP data, see the interim final rule titled ''Manufacturer Submission of Manufacturer's Average Sales Price (ASP) Data for Medicare Part B Drugs and Biologicals' published in the **Federal Register** on April 6, 2004 (69 FR 17935). It is accessible on the CMS Web site at *http://www.cms.hhs.gov/providers/drugs/default.asp.*

The methodology for developing Medicare drug payment allowances based on the manufacturer's submitted ASP data is described in this proposed rule and reflected in proposed revisions to the regulations at § 405.517 and new Subpart K in part 414.

b. Provisions of the Proposed Rule

i. The ASP Methodology

Beginning in 2005, section 1847A of the Act establishes an ASP payment system for certain drugs and biologicals

not paid on a cost or prospective payment basis furnished on or after January 1, 2005. The most notable exceptions are described below in sections III.E.1.c through III.E.1.e.

ii. Calculation of ASP

As described in section 1847A(b)(3)(A) of the Act for multiple source drugs and section 1847A(b)(4)(A) for single source drugs, the ASP for all drug products included within the same billing and payment code [or HCPCS code] is the volume-weighted average of the manufacturer's average sales prices reported to us across all the NDCs assigned to the HCPCS code. Specifically, section 1847A(b)(3)(A) of the Act and section 1847A(b)(4)(A) of the Act require that this amount be determined by—

- Computing the sum of the products (for each National Drug Code assigned to those drug products) of the manufacturer's average sales price and the total number of units sold; and
- Dividing that sum by the sum of the total number of units sold for all NDCs assigned to those drug products.

Note that in the following discussions, the term ''manufacturer's ASP'' refers to the ASP data submitted to us by manufacturers at the NDC level and the term ''ASP'' used in isolation refers to the weighted average sales price for all drug products included within the HCPCS [billing and payment] code.

Section 1847A(b)(5) of the Act requires that the ASP be determined without regard to any special packaging, labeling, or identifiers on the dosage form or product or package.

iii. Medicare Payment Allowances for Multiple Source Drugs

Section 1847A(b)(1)(A) of the Act requires that the Medicare payment allowance for a multiple source drug included within the same HCPCS code be equal to 106 percent of the ASP for the HCPCS code. This payment allowance is subject to applicable deductible and coinsurance. The payment limit is also subject to the two limitations described below in section III.E.1.b.v of this preamble concerning widely available market prices and average manufacturer prices in the Medicaid drug rebate program. As described in section 1847A(e) of the Act, the payment limit may also be adjusted in response to a public health emergency under section 319 of the Public Health Service Act in which there is a documented inability to access drugs and a concomitant increase in the price of the drug which is not reflected in the manufacturer's average sales price.

iv. Medicare Payment Allowances for Single Source Drugs

Section 1847A(b)(1)(B) of the Act requires that the Medicare payment allowance for a single source drug HCPCS code be equal to the lesser of 106 percent of the average sales price for the HCPCS code or 106 percent of the wholesale acquisition cost of the HCPCS code. This payment allowance is subject to applicable deductible and coinsurance. The payment limit is also subject to the two limitations described below in section III.E.1.b.v concerning widely available market prices and average manufacturer prices in the Medicaid drug rebate program. As described in section 1847A(e) of the Act, the payment limit may also be adjusted in response to a public health emergency under section 319 of the Public Health Service Act.

It has been brought to our attention that some physicians have concerns about their ability to purchase drugs at the Medicare payment amount of 106 percent of the ASP as these physicians believe that they are small purchasers of the Medicare Part B drugs subject to this proposed rule and do not have access to the average discounts. It is our understanding that many physicians are members of purchasing groups, which do obtain discounts on drugs. We encourage physicians to consider participating in such groups in order to achieve advantageous prices. We are interested in comments regarding the extent to which physicians can become members of such buying groups and the possible effects of doing so.

v. Limitations on ASP

Section 1847A(d)(1) of the Act states that ''The Inspector General of the Department of Health and Human Services shall conduct studies, which may include surveys, to determine the widely available market prices of drugs and biologicals to which this section applies, as the Inspector General, in consultation with the Secretary, determines to be appropriate.'' Section 1847A(d)(2) of the Act states that ''Based upon such studies and other data for drugs and biologicals, the Inspector General shall compare the average sales price under this section for drugs and biologicals with—

- The widely available market price for such drugs and biologicals (if any); and
- The average manufacturer price (as determined under section 1927(k)(1)) for such drugs and biologicals.''

Section 1847A(d)(3) of the Act states that ''The Secretary may disregard the average sales price for a drug or biological that exceeds the widely available market price or the average manufacturer price for such drug or biological by the applicable threshold percentage (as defined in subparagraph (B)).'' Section 1847A(d)(3)(B) states that ''the term 'applicable threshold percentage' means—

- In 2005, in the case of an average sales price for a drug or biological that exceeds widely available market price or the average manufacturer price, 5 percent; and
- In 2006 and subsequent years, the percentage applied under this subparagraph subject to such adjustment as the Secretary may specify for the widely available market price or the average manufacturer price, or both.''

Section 1847A(d)(3)(C) of the Act states that ''If the Inspector General finds that the average sales price for a drug or biological exceeds such widely available market price or average manufacturer price for such drug or biological by the applicable threshold percentage, the Inspector General shall inform the Secretary (at such times as the Secretary may specify to carry out this subparagraph) and the Secretary shall, effective as of the next quarter, substitute for the amount of payment otherwise determined under this section for such drug or biological the lesser of—

- The widely available market price for the drug or biological (if any); or
- 103 percent of the average manufacturer price (as determined under section 1927(k)(1)) for the drug or biological.''

vi. Payment Methodology in Cases Where the Average Sales Price During the First Quarter of Sales Is Unavailable

Section 1847A(c)(4) of the Act states that ''In the case of a drug or biological during an initial period (not to exceed a full calendar quarter) in which data on the prices for sales for the drug or biological is not sufficiently available from the manufacturer to compute an average sales price for the drug or biological, the Secretary may determine the amount payable under this section for the drug or biological based on—

- The wholesale acquisition cost; or
- The methodologies in effect under this part on November 1, 2003, to determine payment amounts for drugs or biologicals.''

c. Payment for Influenza, Pneumococcal, and Hepatitis B Vaccines

Section 1841(o)(1)(A)(iv) of the Act requires that influenza, pneumococcal, and hepatitis B vaccines described in subparagraph (A) or (B) of section 1861(s)(10) of the Act be paid based on 95 percent of the average wholesale price (AWP) of the drug. These AWP payments, which will be updated quarterly, have not been revised by the ASP provisions.

d. Payment for Drugs Furnished During 2005 in Connection With the Furnishing of Renal Dialysis Services if Separately Billed by Renal Dialysis Facilities.

Section 1881(b)(13)(A)(ii) of the Act indicates that payment for a drug furnished during 2005 in connection with the furnishing of renal dialysis services, if separately billed by renal dialysis facilities, will be based on the acquisition cost of the drug as determined by the Inspector General (IG) report to the Secretary required by section 623(c) of the MMA or, insofar as the IG has not determined the acquisition cost with respect to a drug, the Secretary shall determine the payment amount for the drug. In the report, ''Medicare Reimbursement for Existing End-Stage Renal Disease Drugs,'' the IG found that, on average, in 2003 the four largest chains had drug acquisition costs that were 6 percent lower than the ASP of 10 of the top drugs, including erythropoietin. A sample of the remaining independent facilities had acquisition costs that were 4 percent above the ASP. Based on this information, the overall weighted average drug acquisition cost for renal dialysis facilities is 3 percent lower than the ASP. Therefore, payment for a drug or biological furnished during 2005 in connection with renal dialysis services and separately billed by renal dialysis facilities will be based on the ASP of the drug minus 3 percent. This will be updated quarterly based on the ASP reported to us by drug manufacturers.

e. Payment for Infusion Drugs Furnished Through an Item of DME

In 2005, section 1841(o)(1)(D)(i) of the Act requires an infusion drug furnished through an item of DME covered under section 1861(n) of the Act be paid 95 percent of the average wholesale price for that drug in effect on October 1, 2003.

2. Provisions for Appropriate Reporting and Billing for Physicians' Services Associated With the Administration of Covered Outpatient Drugs

Section 1848(c)(2)(J) of the Act (as added by section 303(a) of the MMA) requires the Secretary to promptly evaluate existing drug administration codes for physicians' services to ensure accurate reporting and billing for those services, taking into account levels of complexity of the administration and resource consumption. According to section 1848(c)(2)(B)(iv) of the Act (also as amended by section 303(a) of the MMA), any changes in expenditures in 2005 or 2006 resulting from this review are exempt from the budget neutrality requirement of section 1848(c)(2)(B)(ii) of the Act. The statute further indicates that the Secretary shall use existing processes for the consideration of coding changes and, to the extent changes are made, shall use those processes to establish relative values for those services. The Secretary is also required to consult with physician specialties affected by the provisions that change Medicare payments for drugs and drug administration.

In the January 7, 2004 interim final rule with comment (69 FR 1094), we indicated that the Physicians Regulatory Issues Team (PRIT) will review Medicare payment policy for drug administration and that we plan to consult with the AMA's CPT Editorial Panel and physician specialties affected by changes in payment for drugs and drug administration. We requested that the CPT Editorial Panel review all codes related to the administration of drugs and consider whether any revisions or additional codes are needed. At its February 2004 meeting, the CPT Editorial Panel established a workgroup, with representatives from affected specialties, to make recommendations on drug administration coding to the full Panel. In addition, the workgroup will be reviewing issues related to drug administration that were identified in the public comments on the January 7, 2004 Physician Fee Schedule rule. These comments raised the following two major issues:

1. Can the current coding distinction between chemotherapy and nonchemotherapy infusions allow for recognition of the resources needed to administer drugs with high toxicity or potential for serious side effects for diagnoses other than cancer? If not, are code revisions or new codes needed?

2. Does the current coding for chemotherapy administration capture all the support services provided by oncology practices for chemotherapy patients? If not, are code revisions or new codes such as a cancer management code needed?

There were also a number of specific comments on individual codes raised by some specialties such as urology and ophthalmology. On June 21, 2004, the workgroup held a public meeting to receive input and comments about drug administration code changes under consideration. The workgroup is expected to report to the full CPT Editorial Panel on all these issues at its August 2004 meeting. Once we review the CPT Editorial Panel's work on this issue, we will consider whether it is necessary for us to make coding changes effective January 1, 2005 through the use of G codes, since the 2005 CPT book will already have been published. While the CPT Editorial Panel's work on this issue is important to us, we finally determine coding policy for Medicare; we also would welcome public comments on these issues. We would also welcome comments concerning any alternative methods of allocating practice expenses to the drug administration codes. (*See* section II.A.2. of this proposed rule for a discussion of allocation of practice expenses.) If coding changes are to be made for next year, we would announce them in the physician fee schedule final rule effective January 1, 2005.

We also plan to analyze any shift or change in utilization patterns once the payment changes for drugs and drug administration required by MMA go into effect. While we do not believe the changes will result in access problems, we plan to continue studying this issue. We also note that the MMA requires the Medicare Payment Advisory Commission (MedPAC) to study items and services furnished by oncologists and drug administration services furnished by other specialties.

3. Blood Clotting Factor—Section 303(e)(1)—Items and Services Relating to Furnishing of Blood Clotting Factors

For clotting factors furnished on or after January 1, 2005, we propose to establish a separate payment of $0.05 per unit to hemophilia treatment centers and homecare companies for the items and services associated with the furnishing of blood clotting factor.

Section 303(e)(1) of the MMA requires the Secretary, after review of the January 2003 report to the Congress by the Comptroller General of the United States, to establish a separate payment to hemophilia treatment centers and homecare companies for the items and services associated with the furnishing of blood clotting factor. In the proposed rule, Payment Reform for Part B Drugs

(68 FR 50440), published in the **Federal Register** on August 20, 2003, we indicated that we are proposing to create a payment of $0.05 per unit of clotting factor provided to Medicare beneficiaries by hemophilia treatment centers and homecare companies to appropriately pay for the administrative costs associated with furnishing the clotting factor. We did not propose the creation of separate payment for furnishing the clotting factor for individuals or entities other than hemophilia treatment centers and homecare companies.

We received comments from hemophilia organizations and specialty pharmacy providers of blood clotting factor. Most comments questioned our position to create a separate payment of $0.05 per unit, stating that this amount would jeopardize the ability of these facilities to adequately supply the clotting factor. Commenters were concerned that the $0.05 amount was too low and would cause many entities to discontinue providing the clotting factors and severely impact beneficiaries' access to clotting factor.

Based on a review of the General Accounting Office (GAO) report and data received from various clotting factor providers, we believe a separate payment amount of $0.05 per unit would cover the administrative costs associated with supplying the clotting factor. As outlined in the MMA, any separate payment amount established may include the mixing and delivery of factors, including special inventory management and storage requirements, as well as ancillary supplies and patient training necessary for the self-administration of these factors. The MMA states that, in determining the separate payment, the total amount of payments and these separate payments shall not exceed the total amount of payments that would have been made for the factors if the amendments in section 303 of the MMA had not been enacted. As indicated in the GAO report, ''[w]hen Medicare's payment for clotting factor more closely reflects acquisition costs, we recommend that the Administrator establish a separate payment for providers based on the costs of delivering clotting factor to Medicare beneficiaries. Effective January 1, 2005, payment for blood clotting factors will more closely reflect acquisition costs as payment will be based on the average sales price as reported by drug manufacturers plus 6 percent.''

Therefore, in the absence of additional data, we believe that a separate payment amount of $0.05 per unit for the cost of delivering clotting factor is an appropriate amount beginning CY 2005 and we are proposing revisions to § 410.63 to reflect this amount. However, we are also seeking updated data and comments on the GAO report, as well as information on the fixed and variable costs of furnishing clotting factor. We recognize that there may be alternatives to a fee, which varies entirely based on the number of units of clotting factor furnished. We will closely examine all data and information submitted in order to make a final determination with respect to the appropriateness of the $0.05 per unit amount. That information will enable us to effectively determine the appropriateness of the $0.05 per unit amount.

4. Supplying Fee

Section 1842(o)(6) of the Act, as added by section 303(e)(2) of the MMA, requires the Secretary to pay a supplying fee (less applicable deductible and coinsurance) to pharmacies for certain Medicare Part B drugs and biologicals, as determined appropriate by the Secretary. The types of Medicare Part B drugs and biologicals eligible for a supplying fee are immunosuppressive drugs described in section 1861(s)(2)(J) of the Act, oral anticancer chemotherapeutic drugs described in section 1861(s)(2)(Q) of the Act, and oral anti-emetic drugs used as part of an anticancer chemotherapeutic regimen described in section 1861(s)(2)(T) of the Act. As discussed in the interim final rule published on January 7, 2004 (69 FR 1084), we considered this fee to be bundled into the current payment for these drugs for 2004 where payment is based on the Average Wholesale Price (AWP).

We propose to establish a separately billable supplying fee, effective January 1, 2005, when Medicare implements a different payment system for these drugs. We believe that a separately billable supplying fee of $10 per prescription is an appropriate level, beginning CY 2005. We received data suggesting various amounts for the supplying fee. Retail chain pharmacies suggested a supplying fee of $12 to $15 per prescription. These pharmacies stated that on average it cost between $10 to $12 to dispense a prescription to a Medicare beneficiary. However, when supplying immunosuppressive and oral anti-cancer drugs to Medicare beneficiaries, they argued that costs increase due to factors such as coordination of benefits activities. The specialty pharmacies that exclusively or largely furnish immunosuppressive drugs submitted data indicating that they believe a supplying fee of $44 (weighted average) to $56 (unweighted average) was appropriate. Pharmacies have pointed to the additional Medicare billing requirements as additional costs they had to incur, in the form of extra staff and time required to fulfill the billing requirements. We believe that a supplying fee of $10 per prescription is appropriate, especially when combined with the savings the pharmacy will experience with the clarification and elimination of the billing and shipping requirements, as described below.

We point out that if we were to establish a supplying fee of $44, then we expect that Medicare would be spending more money in 2005 on the supplying fees and immunosuppressive drugs than Medicare would have paid for immunosuppressive drugs in 2005 under the former system at 95 percent of AWP, when the supplying fee was bundled into payment for the drug.

Our goal is to assure that each beneficiary who needs covered oral drugs has access to those medications. We seek comments about the appropriateness of our proposed supplying fee amount as well as the components of a supplying fee that would assure beneficiary access to oral drugs. We believe that a supplying fee is intended to cover a pharmacy's activities to get oral drugs to beneficiaries. We seek data and information on the additional services these pharmacies provide to Medicare beneficiaries, the extent to which oral drugs can be furnished without these additional services and the extent to which such services are covered under Medicare. We seek comment about whether the supplying fee should be somewhat higher during the initial month following a Medicare beneficiary's transplant to the extent that additional resources are required for example, due to more frequent changes in prescriptions for immunosuppressive drugs.

5. Billing Requirements

We propose to clarify or eliminate the following billing requirements in an effort to reduce a pharmacy's costs of supplying covered immunosuppressive and oral drugs to Medicare beneficiaries:

• *Original signed order.* We wish to clarify Medicare's policy regarding the necessity of an original signed order prior to the filling of a prescription. According to the Medicare Program Integrity Manual (section 5.1 of Chapter 5), which addresses the ordering requirement for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), including drugs, most DMEPOS items can be dispensed

based on a verbal order from a physician. A written order must be obtained before submitting a claim, but that written order may be faxed, photocopied, electronic, or pen and ink. The order for the drug must specify the name of the drug, the concentration (if applicable), the dosage, and the frequency of administration. We hope that clarification of this requirement would reduce a pharmacy's costs of supplying covered immunosuppressive and oral drugs to Medicare beneficiaries to the extent that pharmacies are currently applying an original signed prescription requirement.

• *Assignment of Benefits Form.* Currently, pharmacies must obtain a completed Assignment of Benefits form in order to receive payment from Medicare. Other payors do not impose this requirement. This requirement increases a pharmacy's cost of supplying covered drugs to Medicare beneficiaries. Section 1842(o)(3) of the Act requires that payment for drugs under Part B of Medicare can only be made on an assignment related basis. However, § 424.55(a) implies that if a beneficiary does not sign an assignment of benefits form, then Medicare will not make payment to the supplier. It has been pointed out that this requirement increases costs to suppliers that are not reimbursed by Medicare. We believe that it is not necessary for an assignment of benefit form to be filled out for drugs covered under Part B since payment for them can only be made on an assignment-related basis. We propose to eliminate use of the Assignment of Benefits form for Part B covered oral drugs as a means of reducing a pharmacy's costs of supplying such drugs to Medicare beneficiaries. (Additional discussion on assignment of Medicare claims is in section IV.G of this preamble.)

• *DMERC Information Form (DIF).* The DIF is a form created by the DMERC Medical Directors that contains information regarding the dates of the beneficiary's transplant and other diagnosis information. Pharmacies must have a completed DIF in order to receive payment. This requirement increases a pharmacy's cost of supplying covered drugs to Medicare beneficiaries. The DIF is a one-time requirement that was established to facilitate implementation of the immunosuppressive drug benefit when Medicare covered the drugs for different periods of time to distinguish between transplant and non-transplant uses for immunosuppressive drugs. Since section 1861(s)(2)(J) of the Act no longer imposes limits on the period of time for coverage of immunosuppressive drugs, we believe that the information on transplant diagnosis can be captured through other means (for example, diagnosis codes on the Part B claim form). In light of this statutory revision, we have had discussions with the DMERCs about their elimination of the use of this form when billing DMERC drugs. The DMERCs plan to eliminate the use of this form effective October 1, 2004. We believe that a pharmacy's costs of supplying Part B covered oral drugs to Medicare beneficiaries would be reduced with this change.

6. Shipping Time Frame

It has been suggested that Medicare guidelines for refill prescriptions allowed too short of a window between shipping the next month's prescription and the end of the current month. It has been argued that, as a result, a pharmacy ''effectively'' had to ship the product to a beneficiary using an overnight delivery service.

As indicated in section III.N of this preamble, on January 2, 2004, we revised the guidelines (effective February 2, 2004) regarding the time frame for subsequent deliveries of refills of DMEPOS products to occur no sooner than ''approximately 5 days prior to the end of the usage for the current product'' (see section 4.26.1 of Chapter 4—Benefit Integrity of the Medicare Program Integrity Manual). This change allows shipping of refills on ''approximately'' the 25th day of the month in the case of a month's supply. We emphasize the word ''approximately'; while we believe that normal ground service shipping would allow delivery in 5 days, if there were circumstances where ground service could not occur in 5 days, the guideline would still be met if the shipment occurs in 6 or 7 days. (''Days'' refers to business days or shipping days applicable to the shipper, that is, a 6-day week in the case of the U.S. Postal Service.) We believe that this change eliminates the need for suppliers to use overnight shipping methods and allows shipping of drugs by less expensive ground service.

F. Section 952—Revisions to Reassignment Provisions—Section 952 of the MMA

[If you choose to comment on issues in this section, please include the caption ''Section 952'' at the beginning of your comments.]

Section 1842(b)(6) of the Act requires that payment may only be made to the physician or other person who furnished a service, or to the beneficiary for whom services were furnished, unless certain specified exceptions are met. Prior to the enactment of section 952 of the MMA, Medicare did not permit the reassignment of payments for services provided by an independent contractor physician or nonphysician practitioner unless the services were performed on the premises of the facility or health care delivery system that submitted the bill. Therefore, if the services were furnished offsite, reassignment was prohibited (see section 1842(b)(6)(A)(ii) of the Act).

Section 1842(b)(6)(A)(ii) of the Act, as amended by section 952 of the MMA, allows a physician or nonphysician practitioner to reassign payment for Medicare-covered services, regardless of the site of service, as long as there is a contractual arrangement between the physician and nonphysician practitioner and the entity through which the entity submits the bill for those services. Thus, the services may be provided on or off the premises of the entity receiving the reassigned payments. The MMA Conference Agreement states that entities that retain independent contractors may enroll in the Medicare program. We note that the expanded exception created by section 952 applies to those situations when an entity seeks to obtain the medical services of a physician or nonphysician practitioner.

Section 952 states that reassignment is permissible if the contractual arrangement between the entity that submits the bill for the service and the physician or nonphysician practitioner who performs the service ''meets such program integrity and other safeguards as the Secretary may determine to be appropriate.'' The Conference Agreement supports appropriate program integrity efforts for entities with independent contractors that bill the Medicare program, including joint and several liability (that is, both the entity accepting reassignment and the physician or nonphysician practitioner providing a service are both liable for any Medicare overpayments). The Conference Agreement also recommends that physician or nonphysician practitioners have unrestricted access to the billings submitted on their behalf by entities with which they contract. We incorporated these recommended safeguards in a change to the Medicare Manual, implementing section 952 of the MMA that was published on February 27, 2004. We are proposing to revise § 424.71 and § 424.80 to reflect these safeguards, as well as the expanded exception established by section 952.

Given the myriad relationships and financial arrangements potentially permitted by section 952, the purpose of

joint and several liability is to encourage both parties to the contractual arrangement to exercise oversight of billings submitted to the Medicare program by holding them each fully accountable. Since physician or nonphysician practitioners will be subject to liability for claims that are submitted to the Medicare program by entities to which they have reassigned payments, it follows that a physician or nonphysician practitioners should have access to the billings submitted on their behalf.

We note that section 952 of the MMA revises only the statutory reassignment exceptions relevant to services provided in facilities and clinics (section 1842(b)(6)(A)(ii) of the Act). Arrangements involving reassignment must not violate any other applicable Medicare laws or regulations governing billing or claims submission, including, but not limited to, those regarding ''incident to'' services, payment for purchased diagnostic tests, and payment for purchased test interpretations.

In addition, physician group practices should be mindful that compliance with the in-office ancillary services exception to the physician self-referral prohibition requires that a physician who is engaged by a group practice on an independent contractor basis must provide services to the group practice's patients in the group's facilities. As noted in the Phase I physician self-referral final rule (66 FR 887), ''[w]e consider an independent contractor physician to be ''in the group practice'' if (1) he or she has a contractual arrangement to provide services to the group's patients in the group practice's facilities, (2) the contract contains compensation terms that are the same as those that apply to group members under section 1877(h)(4)(iv) of the Act or the contract fits in the personal services exception, and (3) the contract complies with the reassignment rules * * *.'' See also 66 FR 886. This test is codified at § 411.351 in the definition of ''physician in the group practice.''

We are aware that the changes in the reassignment rules based on section 952 of the MMA may create new fraud and abuse vulnerabilities, which may not become apparent until the program has experience with the new contractual arrangements addressed in section 952 of the MMA. Parties should be mindful that contractual arrangements involving reassignment may not be used to camouflage inappropriate fee-splitting arrangements or payments for referrals. We are soliciting public comment on potential program vulnerabilities and on possible additional program integrity safeguards to guard against such vulnerabilities. We intend to monitor reassignment arrangements for potential program abuse.

G. Section 642—Extension of Coverage of IVIG for the Treatment of Primary Immune Deficiency Diseases in the Home

[If you choose to comment on issues in this section, please include the caption ''Section 642'' at the beginning of your comments.]

Beginning for dates of service on or after January 1, 2004, Medicare pays for intravenous immune globulin administered in the home. This benefit is for the drug and not for the items or services related to the administration of the drug when administered in the home, if deemed medically appropriate. Manual instructions implementing this MMA provision have been issued and can be found at *http://www.cms.hhs.gov/manuals/pm_trans/R6BP.pdf* and *http://www.cms.hhs.gov/manuals/pm_trans/R74CP.pdf.* We are also proposing to revise § 410.10 to address this statutory change.

H. Section 623—Payment for Renal Dialysis Services

[If you choose to comment on issues in this section, please include the caption ''Section 623'' at the beginning of your comments.]

1. Background

We are proposing changes affecting payments to ESRD facilities that result from enactment of the MMA and would be effective January 1, 2005. Section 1881(b) of the Act, as amended by section 623 of the MMA, directed the Secretary to revise the current composite rate payment system. The statute has several major provisions that require the development of revised composite payment rates, as follows:

- An update of 1.6 percent.
- An add-on to the composite rate for the difference between current payments for separately billable drugs and biologicals and payments based on the revised drug pricing methodology using acquisition costs.
- Case-mix adjustments for a limited number of patient characteristics.
- Application of a budget neutrality adjustment. The statute also allows the Secretary to adjust the payment rates by a geographic index as the Secretary determines to be appropriate which would be phased-in over a multiyear period.

By January 1, 2005, we plan to implement the proposed revisions affecting the composite payment rate which would include the following:

- An increase of 1.6 percent to the basic composite payment rate.
- Proposed revisions to the pricing of separately billable drugs and biologicals.
- A drug add-on to the composite rate to reflect the difference between current payments for separately billable drugs and biologicals, and payment based on the revised drug pricing methodology using acquisition costs.

We propose to implement the patient characteristics adjustments and the related budget neutrality adjustments by April 1, 2005. (*See* detailed discussion later in this section.)

2. Legislative History

Section 2991 of the Social Security Amendments of 1972 (Pub. L. 92–603), established Medicare's End Stage Renal Disease (ESRD) Program. This law extended Medicare coverage to individuals who have permanent kidney failure, require either dialysis or transplantation, and meet certain other eligibility requirements. The End Stage Renal Disease Program Amendments of 1978 (Pub. L. 95–292) added section 1881(b)(2)(B) to title XVIII of the Act.

That legislation provided for the establishment of a prospective reimbursement methodology for the payment of dialysis treatments provided by renal dialysis facilities. Further changes to the ESRD payment system were made by section 2145 of Pub. L. 97–35, which amended section 1881 of the Act, requiring the development of a prospective reimbursement system for outpatient maintenance dialysis that promotes home dialysis. The payment system required either the reimbursement of home dialysis and in-facility dialysis under ''composite'' rates, or the use of some other more efficient method determined to promote home dialysis more effectively.

On February 12, 1982, we published a proposed rule on reimbursement for outpatient maintenance dialysis services (47 FR 6556) and we published the final rule on May 13, 1983 (48 FR 21254). This regulation implemented section 1881 of the Act, as amended by section 2145 of Pub. L. 97–35, and provided that each ESRD facility will receive a fixed composite payment rate per dialysis treatment, adjusted for geographic differences in area wage levels. Payment for in-facility and home dialysis treatments was established using a composite payment rate reflecting the costs of both modalities. Separate composite payment rates were established for hospital-based and independent dialysis facilities. The regulation also included a process under which facilities could obtain exceptions

to their composite payment rates under specified circumstances.

The average composite payment rate per treatment, effective on August 1, 1983, was $123 for independent ESRD facilities and $127 for hospital-based facilities. The composite rate was designed to provide payment for a package of goods and services needed to furnish dialysis treatments that included certain routinely provided drugs, laboratory tests, supplies, and equipment. Unless specifically included in the composite payment rate, other injectable drugs and laboratory tests medically necessary for the care of the dialysis patient are separately billable.

Prior to January 1, 2004, drugs not paid on a cost or prospective payment basis were paid based on the lower of the actual charge or 95 percent of the AWP (section 1842(o)(1) of the Act, as added by section 4556 of the BBA of 1997 (Pub. L. 105–33)). Sections 303 through 305 of the MMA make revisions to payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. For CY 2004, the MMA provides that drugs not paid on a cost or prospective payment basis will be paid at 85 percent of the AWP determined as of April 1, 2003. However, there are several exceptions to this general rule, including payment of ESRD drugs and biologicals. In CY 2004, drugs and biologicals furnished in connection with the furnishing of renal dialysis services if separately billed by renal dialysis facilities are paid at 95 percent of AWP. We note that hospital-based ESRD facilities are paid reasonable costs for separately billable drugs, except for Erythropoietin/Epoietin (EPO).

EPO is an anti-anemia drug administered to certain patients with ESRD. Medicare Part B pays for EPO and its administration if it is furnished by an approved ESRD facility as part of an outpatient dialysis service or by a supplier of home dialysis equipment and supplies to ESRD patients in their homes as part of home dialysis services. Most dialysis is furnished to ESRD patients on an outpatient basis or is self-administered in the home.

Section 1881(b)(11) of the Act expressly excludes payment for EPO furnished to ESRD patients from the composite rate for dialysis services. The costs of EPO are, therefore, billed separately by an ESRD facility or by a supplier of home dialysis equipment and supplies and are paid in addition to the facility's composite rate. Any EPO-related costs, such as the cost of its administration or overhead costs associated with its storage, however, are subsumed in the facility's composite rate.

Section 413.174(f)(3) requires that we prospectively determine the EPO amount pursuant to section 1881(b)(11)(B)(ii) of the Act. Section 4201(c) of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) (Pub. L. 101–508), however, amended section 1881(b)(11) of the Act to establish a new EPO payment methodology. OBRA 90 directed, effective January 1, 1991, that payment for EPO furnished to ESRD patients by Medicare-approved dialysis facilities or suppliers of home dialysis equipment and supplies for home use be made on a per-unit basis. OBRA 90 also established a maximum payment amount of $11 per 1,000 unit doses rounded to the nearest 100 units. Subsequently, section 13556(a)(2) of OBRA 93 was enacted, which further amended section 1881(11)(b)(B)(ii) of the Act to reduce the maximum payment level to $10 per 1,000 units effective January 1, 1994. Although we have the authority to revise the rate, we continue to pay at the rate of $10 per 1,000 units.

Section 9335(a) of Pub. L. 99–509 required the Secretary to reduce the initially established composite payment rates by $2.00 per treatment effective October 1, 1986. This reduction was partially reversed as a result of the enactment of section 4201(a)(2) of Pub. L. 101–508, which increased the composite payment rates in effect as of September 30, 1990 by $1.00 per treatment, but effectively froze the methodology for their calculation, including the data and definitions used, as of that date. Section 222 of Pub. L. 106–113, provided for a 1.2 percent increase to the payment rates effective January 1, 2000, and also provided for another 1.2 percent increase effective January 1, 2001. Section 422(a)(1) of Pub. L. 106–554, raised the amount of the January 1, 2001 payment increase by another 1.2 percent for a total increase of 2.4 percent effective January 1, 2001.

Section 422 of Pub. L. 106–554 also directed the Secretary to develop a Prospective Payment System (PPS) that expanded the bundle of routine services reflected in the composite rate to include separately billable laboratory tests and drugs ''to the maximum extent feasible''. In addition, section 422(a) of Pub. L. 106–554 prohibited the granting of new composite rate payment exceptions for services furnished after December 31, 2000. Because a bundled ESRD payment system must be periodically updated, section 422(b) of Pub. L. 106–554 also required the development of an ESRD market basket to account for changes in price inflation, with discretionary consideration of other factors known to affect costs. Section 422(c) of Pub. L. 106–554 mandated the submission of a report to the Congress on the bundled payment system and ESRD market basket.

On May 12, 2003, the Secretary submitted the required report to the Congress. The report explained the major issues that must be addressed before a bundled ESRD PPS can be implemented, presented an ESRD composite rate market basket, and discussed the results from the first phase of our sponsored research to develop a bundled payment system. The report presented the following three major findings that are relevant to our efforts to revise the composite rate payment system:

- Current data sources are adequate for proceeding to develop a bundled ESRD PPS.
- Case-mix may be an important variable for risk adjusting payments, based on preliminary analysis.
- Current data provide a sound basis for monitoring patient outcomes in a revised ESRD payment system.

3. Summary of Section 623 of MMA

The following provisions in section 623 of the MMA, effective January 1, 2005, affect the composite payment rate methodology, as well as the pricing methodology for separately billable drugs and biologicals furnished by ESRD facilities:

a. *Section 623(a)*—The last sentence of section 1881(b)(7) of the Act, as amended by MMA, provides for an increase in the current composite payment rate of 1.6 percent.

b. *Section 623(d)(1)*—Section 1881(b)(13) of the Act, as added by MMA section 623(d)(1), provides for a revision to the current AWP pricing of separately billable drugs and biologicals; payment will be based on acquisition costs as determined by the OIG's study mandated under section 623(c) of the MMA. Insofar, as the OIG has not determined the acquisition costs, with respect to a drug or biological, the Secretary shall determine the payment amount for such drug or biological.

c. *Section 623(d)(1)*—Section 1881(b)(12) of the Act, as added by MMA section 623(d)(1), also requires the establishment of a basic case-mix adjusted composite payment rate that applies certain adjustments to the composite payment rate as follows:

- Adjustments for a limited number of patient characteristics.
- An adjustment that reflects the difference between current payments for

separately billed drugs and biologicals and the revised pricing based on acquisition costs or other method as determined by the Secretary.

- A geographic adjustment, if the Secretary determines such an adjustment is appropriate with the possibility of a phase-in.
- A budget neutrality adjustment, so that aggregate payments under the basic case-mix adjusted composite payment rates for 2005 equal the aggregate payments that would have been made for the same period if section 1881(b)(12) of the Act did not apply.

4. Provisions of the Proposed Rule

a. Composite Rate Increase

The current composite payment rates applicable to urban and rural hospital-based and independent ESRD facilities were effective January 1, 2002. The current wage-adjusted rates for each urban and rural area were published in Tables III and IV of Program Memorandum A–01–19 issued February 1, 2001 and are applicable through the end of 2004. Section 623(a)(3) of the MMA requires that the composite rates in effect on December 31, 2004 be increased by 1.6 percent. We are publishing revised wage-adjusted composite rates that reflect the statutorily required 1.6 percent increase. Those rates are set forth in Tables I and II at the end of this section. These tables reflect the updated hospital-based and independent facility composite rate of $132.40 and $128.35, respectively, adjusted by the current wage index. The rates will be effective January 1, 2005. The rates shown in the tables do not include any of the basic case-mix adjustments required under section 623 of the MMA.

b. Revised Pricing Methodology for Separately Billable Drugs and Biologicals Furnished by ESRD Facilities

Section 623(d) of the MMA requires the Secretary to establish a basic case-mix adjusted PPS for dialysis services that are furnished beginning on January 1, 2005 by providers of services and renal dialysis facilities to individuals in a facility and to individuals at home. This system will include services comprising the composite rate as well as the difference between payment amounts for separately billed drugs and biologicals (including erythropoietin) furnished by ESRD facilities and acquisition costs of such drugs and biologicals as determined by the OIG reports from the studies mandated by section 623(c) of the MMA.

For 2004, the payment amounts for separately billed drugs and biologicals (other than erythropoietin) furnished by ESRD facilities are determined by 95 percent of AWP. For 2005, the payment amounts for separately billed drugs and biologicals (including erythropoietin) furnished by ESRD facilities are described in section III.E of the NRPM. Insofar as the acquisition cost has not been determined by the OIG, then the Secretary shall determine the payment amount of the drug and biological.

For 2005 and subsequent years, the payment amounts for separately billed drugs and biologicals (including erythropoietin) furnished by ESRD facilities will be the acquisition cost or the amount that is derived from the ASP methodology in section 1847A of the Act, as the Secretary may specify.

See section III.E.1.d. of this proposed rule for further explanation of payment for separately billable drugs and biologicals furnished by renal dialysis facilities.

c. Composite Rate Adjustment to Account for Changes in Pricing of Separately Billable Drugs and Biologicals

Section 1881(b)(12) of the Act, as added by section 623(d) of the MMA, contains two provisions that specify how the drug add-on adjustment is to be handled in the revised ESRD payment system. First, subparagraph (B)(ii) of such section requires an adjustment to the composite payment rates to account for the difference between payment amounts for separately billed drugs (including erythropoietin) under the current payment system and acquisition costs as determined by the OIG. Second, subparagraph (E)(i) requires that the drug add-on adjustment be budget-neutral, that is, that it be designed to result in the same aggregate amount of expenditures as would have been made without the statutory policy change.

We need to determine the composite rate adjustment for drug add-on amount that simultaneously deals with both statutory requirements. That is, the aggregate amount of the composite rate adjustment for drug add-on amount needs to equal the aggregate amount of the drug spread (the difference between drug payments under the old system and acquisition costs).

In order to ensure that we satisfy both constraints, it is necessary to consider the proposed drug pricing in developing the adjustment to the composite rates. As discussed in section III.E.1.d. of this proposed rule, we are proposing to pay for separately billable ESRD drugs using ASP minus 3 percent based on the average relationship of acquisition costs to average sales prices from the drug manufacturers as outlined in the OIG report. We have developed the proposed drug add-on adjustment using the ASP minus 3 percent drug prices. Section 2 below discusses the details of the calculation of the drug add-on adjustment. An alternative approach would be to use the 2003 acquisition prices from the OIG report, calculate the aggregate difference between such prices and payments for drugs under the AWP system, update this difference to 2005 and then apply the budget neutrality adjustment. Because the same budget-neutrality adjustment would be used in both calculations, we believe that the drug add-on adjustment for the drug spread would be the same with both approaches. Therefore, we are proposing to use the ASP minus 3 percent prices as the basis for developing the drug add-on adjustment to the composite rate.

1. Options for Applying the Drug Add-On Adjustment to the Composite Payment Rate

Currently, separately billable ESRD drugs are paid differently to hospital-based and independent ESRD facilities. EPO is currently the only drug for which payment is uniform across ESRD facilities; EPO is paid at the current rate of $10 per 1000 units. All other separately billed ESRD drugs provided by independent ESRD facilities are currently paid 95 percent of AWP prices. However, hospital based ESRD facilities are paid their reasonable cost for the other separately billed drugs they provide. Because they are paid on cost, hospital-based facilities have not made the profits from drug payment that independent facilities have enjoyed.

The statutory language describing the add-on adjustment to the composite rate does not specifically differentiate between hospital-based and independent facility composite rate adjustments. However, the drug add-on provision is included with the other provisions related to the basic case-mix adjusted composite rate system; thus, it could be argued that the drug add-on provision was intended to address ESRD industry concerns about the inadequacy of the composite payment rate. We believe these concerns apply equally to hospital-based facilities and independent facilities. Therefore, we are proposing a single adjustment to the composite payment rates for both hospital based and independent facilities.

An alternative option would be to develop a separate adjustment for hospital-based facilities for EPO and one for independent facilities for all of their separately billed drugs. The IG's report provided the acquisition costs we are

using; it did not provide different acquisition costs for hospital-based and independent facilities. We believe that it would not be appropriate for us to use these data to create two separate adjustments. The following discussion outlines the development of the drug add-on adjustment under both options—a single factor and separate factors.

2. Computation of Drug Add-On Adjustment to the ESRD Composite Payment Rate

i. Data

To develop the drug add-on adjustment we used historical total aggregate payments for separately billed ESRD drugs for half of 2000 and all of 2001 and 2002. For EPO, these payments were broken down according to type of ESRD facility (hospital-based versus independent). We also used the number of dialysis treatments performed by these two types of facilities over the same period.

ii. ASP Minus 3 Percent

We updated the ASP minus 3 percent prices, for the first quarter of 2004, to represent 2005 prices. We used the projected annual price growth factor for National Health Expenditure prescription drugs of 3.39 percent.

TABLE 12

Drugs	First quarter 2004 average sales price first minus 3 percent	Quarter 2005 average sales price minus 3 percent
Epogen	$8.74	$9.04
Calcitriol	0.66	0.68
Doxercalciferol	2.55	2.64
Iron_dextran	9.22	9.54
Iron_sucrose	0.34	0.35
Levocarnitine	7.15	7.39
Paricalcitol	3.86	3.99
Sodium_ferric_glut	4.15	4.29
Alteplase, Recombinant	27.74	28.68
Vancomycin	3.40	3.52

iii. Current Medicare Reimbursement

We updated the first quarter 2004 Medicare payment amounts (95 percent of AWP), based on the January 2004 Single Drug Pricer, for drugs other than EPO, to estimate 2005 payment amounts by using an estimated AWP growth of 3 percent. These growth factors are based on historical trends of AWPs. We did not increase the price for Epogen since payment was maintained at $10.00 per thousand units prior to MMA.

TABLE 13

Drugs	Current medicare reimbursement prices for 2005
Epogen	$10.00
Calcitriol	1.42
Doxercalciferol	5.67
Iron_dextran	18.45
Iron_sucrose	0.68
Levocarnitine	35.23
Paricalcitol	5.49
Sodium_ferric_glut	8.42
Alteplase, Recombinant	37.80
Vancomycin	7.24

iv. Dialysis Treatments

We updated the number of dialysis treatments by actuarial projected growth in the number of ESRD beneficiaries. Since Medicare covers a maximum of three treatments per week, utilization growth is limited, and therefore any increase in the number of treatments should be due to enrollment. In 2005, we project there will be a total of 36.5 million treatments performed (5.1 million treatments will be performed by hospital-based facilities and 31.4 million treatments by independent facilities).

v. Drug Payments

We updated the total aggregate Epogen drug payments for each hospital-based and independent facilities using historical trend factors. For 2003 through 2005, the 2002 payment level was increased each year by trend factors of 2.8 percent for hospital-based facilities and by 9.4 percent for independent facilities.

Using drug growth factors for drugs paid for by Medicare Part B carriers, which were calculated from historical data, we updated the aggregate spending for separately billable drugs, other than EPO, for independent facilities. We used 24.7 percent for 2003, 23.3 percent for 2004, and 21.4 percent for 2005 as factors because historical growth of ESRD drugs is similar to that for drugs paid for by Part B carriers. These factors are projected to approach the level of National Health Expenditure prescription drug growth. For 2005, we estimate that spending will reach $185 million for Epogen provided in hospital-based facilities, and $2,664 million for drugs provided in independent facilities ($1,568 million for Epogen and $1,096 million for other drugs).

vi. Add-On Calculation and Budget Neutrality

For each of the ten drugs, we calculated the percent by which ASP minus 3 percent prices are projected to be less than reimbursement amounts under the current system for 2005. For Epogen, this amount is 10 percent. We applied this 10 percent figure to the total aggregate drug payments for Epogen in hospital-based facilities, resulting in a difference of $18 million. We then calculated a weighted average of the percentages by which ASP minus 3 percent would be below current Medicare reimbursement prices for the top 10 ESRD drugs. We weighted these percentages by using the 2002 Medicare reimbursement values contained in the OIG report for the ten drugs. This procedure resulted in a weighted average of 19 percent. Since these ten drugs represented 98 percent of drugs payments, we applied the weighted average to 100 percent or all of aggregate drug spending projections for independent facilities, producing a projected difference of $516 million.

Combining the 2005 figures of $18 million and $516 million, for a total of $534 million and then distributing this over a total projected 36.5 million treatments would result in a single add-on to the per treatment composite rate

of 11.3 percent. By making this adjustment to the composite rate, we estimate that the aggregate payments to ESRD facilities would be budget neutral with respect to drug payments.

Alternatively, we could produce separate drug add-on adjustments for hospital-based and independent facilities using the same methodology. Under this option, we could distribute the $18 million difference in EPO payments to hospital-based facilities based on data projecting 5.1 million treatments resulting in a hospital-based facility drug add-on adjustment of 2.7 percent. We would distribute the $516 million difference in drug payments (including EPO) to independent facilities using projected treatments of 31.4 million, resulting in a drug add-on adjustment of 12.8 percent for independent facilities.

Drug prices used in the computation of the proposed drug add-on adjustment to the ESRD composite payment rate, may be revised based on later data and will be reflected in the final rule.

3. Composite Rate Effect of Proposed Drug Add-On Adjustment

We used a single drug add-on adjustment for both hospital-based and independent ESRD facilities, the proposed adjustment to the composite rate would be 1.113. Separate adjustments would provide a 1.128 adjustment for independent facilities and 1.027 for hospital-based facilities. The following table illustrates the effect on the composite payment rates under the two potential drug add-on options. (Case-mix budget neutrality adjustments are not reflected in this table).

TABLE 14

Facility type	CY 2005 base rate	Separate add-on	Single add-on
Independent	$128.35	$144.78	$142.85
Hospital Based	132.41	135.99	147.37

Under the single add-on, the proportionately higher rate for hospital-based facilities would be consistent with section 1881(b)(7) which requires that our payment methods differentiate between hospital-based facilities and others. Separate add-on adjustments would result in a significantly higher composite payment rate for independent facilities, than hospital-based facilities, that is, $8.79 higher per treatment.

d. Patient Characteristic Adjustments

1. Statutory Authority

The current ESRD composite payment rates do not adjust for variation in patient characteristics or case mix. Section 1881(b)(12)(A) of the Act, as added by section 623(d)(1) of the MMA, requires that the outpatient dialysis services included in the composite rate be case-mix adjusted. Specifically, the statute states that ''The Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to individuals at home. The case-mix under the system would be for a limited number of patient characteristics.'' In the following sections, we describe the development of the methodology for the proposed patient characteristic case-mix adjusters required under the MMA.

2. Background

Case-mix measures utilizing patient characteristics have been used in a number of prospective payment systems. Use of a case-mix measure permits targeting of greater payments to facilities that treat more costly resource-intensive patients. However, the legislative mandate to establish a case-mix adjustment for services included in the composite rate based on a limited number of patient characteristics presents a unique challenge.

The composite rate represents payment for a fixed bundle of routine services provided to ESRD patients as part of a dialysis treatment. Generally, the items and services needed to provide a dialysis treatment do not vary significantly across patients. Moreover, the bills for composite payment rate services furnished to ESRD patients, which are generally submitted monthly, do not identify the specific items and services provided on a case-by-case basis. In addition, the Medicare cost reports identify only aggregate costs for composite rate services at the facility level. Therefore, any case-mix adjustment based on patient characteristics obtained from the bills for outpatient ESRD services and applied to the composite rate will reflect only variation in composite rate costs at the facility level.

Earlier research by Hirth (1999) and Dor (1992) found that if case-mix adjustments applied only to composite rate items and services the adjustments played a limited role in predicting variation in costs per treatment because case-mix and dialysis treatment patterns are very similar across facilities. However, more recent analyses conducted under our contract with the University of Michigan, Kidney, Epidemiology and Cost Center (KECC) found that patient level case-mix adjustment would be more relevant in a bundled payment system that includes both composite rate and separately billable items and services. KECC's research studies relied on an extensive set of variables to define patient case-mix. These variables included patient characteristics, a large number of specific comorbidities and clinical measures (including primary diagnosis) and other (non-Medicare) insurance coverage, as well as the duration of ESRD. We relied on linear regression analyses used in the studies to assess the relationship of patient characteristics and comorbidity measures to per session cost and Medicare payments to facilities. These studies relied on data from our administrative files.

We are continuing and expanding the research project in support of the development of a fully bundled case-mix adjusted system. We are continuing to explore alternative models and options with more detailed analysis of patient characteristics as part of the legislatively mandated report to the Congress in the fall of 2005.

Despite the difficulty in developing a patient characteristic case-mix adjustment, we were able to develop case-mix adjustment factors for a limited number of patient characteristics, consistent with the legislative mandate. As expected, these adjusters are only modest predictors of variation in average costs for composite services. In developing the proposed patient characteristic adjustments, we used our available administrative data. Because facilities do not list individual composite rate items and services on the dialysis bill, billing data do not identify resources used by each patient. In

addition, facilities can underreport or not report comorbid conditions. Therefore, these bills are not useful for deriving average facility input costs. Since there are not any current requirements to list comorbid conditions on the dialysis bill, we used a combination of data sources to determine co-morbidities for ESRD patients on maintenance dialysis. These include the Medicare claims history file as well as the CMS Form 2728 (ESRD Medical Evidence Report) which provides information on the cause of ESRD and lists 20 possible co-morbidities present at the onset of a patient's ESRD. The Form 2728 is completed only at the initiation of dialysis treatment. It is not updated to reflect more recent medical conditions.

Nonetheless, we found selected variables from the Form 2728 to be valid predictors of cost per treatment for the proposed case-mix adjustment, and the Form 2728 was also useful in developing our proposed case-mix adjustments. As discussed below, the Form 2728 variables were supplemented by additional information we obtained from billing records.

3. Development of the Proposed Adjustments for Patient Characteristics

We are proposing a methodology to establish a basic case-mix adjusted composite rate system using a limited number of patient characteristic variables developed from existing our administrative files. We analyzed a number of patient level variables including age, gender, alcohol and drug dependence, inability to ambulate/transfer, current smoker, number of years since ESRD onset, weight, height, mean BUN, and mean creatinine clearance, as well as a number of comorbidities.

As a means to estimate how average cost variations among facilities are influenced by selected patient characteristics, extensive analyses were performed to develop a proposed ''basic case-mix adjusted PPS, for a limited number of patient characteristics,'' as specified in the statute. We analyzed the average cost per dialysis session (including both hemodialysis and Method I peritoneal dialysis converted to equivalent 3 times per week hemodialysis sessions) from national data gathered for the years 2000, 2001, and 2002.

A stepwise regression was used to select a limited set of variables that were predictive of average facility cost per treatment. We used data pooled over a three-year period because we found the regression coefficients to reflect a consistent pattern over three years. We used data pooled over a three-year period to minimize the potential for volatility in the regressive coefficients. The analysis controlled for selected variables that influence facility costs, but are not case-mix related. These variables included wage index, the natural log of the number of dialysis sessions provided annually by the facility, type of facility, chain affiliation, and percentage of patients with urea reduction ratio (URR) as a measure of dialysis dose equal to or greater than 65 percent. The proposed model is based not only on the predictive power of these measures, but also upon objectivity (for example, discrete variables: age/gender), clinical plausibility, and practicality (that is, availability) of data collection. The variables used were assessed for their clinical plausibility by clinicians from the University of Michigan and CMS. Physicians assessed a proposed list to determine relationship of the proposed comorbidities to ESRD patients, and clinical practice/patterns.

In addition to exploring a number of potential case-mix variables, we examined two methods, that is, linear and log linear models of the composite rate costs. We selected the log linear model in order to yield patient specific case-mix adjustments which can be multiplied by a dialysis facility's otherwise applicable composite rate payment. In this proposed rule, we provide a detailed example of the calculation of the proposed case-mix adjusted composite rate payments.

4. Proposed Patient Characteristic Adjustments

As discussed in the background section above, the basic case-mix system is constrained by the composite rate and the data available for these adjustments. While we analyzed a number of variables, four patient characteristic variables were found to be modest predictors of cost variation among ESRD facilities. These patient characteristic variables include gender, age, and two comorbidities (AIDs and PVD) (See table 3 for specific ICD 9 codes for these comorbidities). Each of the gender categories was also divided into three age categories so that one adjustment factor could be developed to encompass both gender and age. The proposed patient characteristic adjustments are discussed below.

i. Gender and Age

We are proposing adjustments for both gender and age. We found that gender and age were strong predictors of facility cost variations. In addition, data on gender and age are readily available, and are objective measures. After examining a number of options for age, we are proposing under 65, 65–79, and over 80 as the three categories for age. We attempted to develop a case-mix adjuster specific to the under 18 age group. However, the population in that age group that was included in the data used to develop the case-mix adjustments was too small, and was generally concentrated in a very small number of facilities.

While we recognize that pediatric patients are more costly to treat, those patients are generally treated in specialized pediatric facilities. As provided in MMA, those facilities can request adjustments to their composite payment rates through the exceptions process. This process will enable pediatric facilities to obtain payments that specifically recognize the higher cost associated with treating these patients. In developing the age adjustments, data for those patients were grouped into the under 65 age category. We note that adjustments for both gender and age are consistent with the MA risk adjustment models for ESRD patients.

ii. Proposed Comorbidity Adjustments

As discussed above, the effect of the costs of dialysis for a number of conditions were analyzed. These included several comorbidities that did not have a statistically significant relationship to facility costs. In other cases, the lack of data precluded inclusion of a comorbid condition in the proposed patient characteristic adjustments. That is, we are unable to propose any adjustments based on data that cannot be routinely reported, (for example, some data elements that are reported only on the Form 2728). For the reasons discussed above, the Form 2728 is not an appropriate source of information since it is not updated after a patient enters the ESRD program. Two variables not currently available on the Medicare bill are weight and height. Weight and height are used to compute a patient's body mass index (BMI). Our analysis indicates that patients with extremely low or high BMI are costly to treat. Since BMI is directly related to a patient's dialysis prescription, we believe this factor could be an important measure of resource consumption related to the composite payment rate. We also believe that the length of time a patient is dialyzed could directly affect composite rate costs. We are currently exploring the feasibility of developing a mechanism to collect these data on the ESRD bill. In addition, we are soliciting comments on other data elements that could be added to the bill

that could be relevant predictors of composite rate costs.

We also examined whether having cancer was predictive of higher resource used. We examined all cancers reported within the last 3 to 10 years as reported on our claims history file or the Form 2728. While a patient's history of cancer was associated with higher costs, we found this measure to be too broad to be clinically meaningful. We will continue to evaluate this condition as a potential variable for refinement purposes. As ESRD facilities begin reporting patient comorbidities, we expect that we will be in a better position to identify the specific cancer diagnoses that may be related to increased composite rate costs.

We also explored whether diabetes as a comorbidity is predictive of high resource use. We found that the predictive power of diabetes was dependent on whether PVD was part of the model. PVD was always statistically significant, when accounted for, while most measures of diabetes were not strongly associated with facility costs. Therefore, we are proposing a case-mix adjustment for PVD diagnoses. We believe this adjustment appropriately addresses the higher costs associated with sicker diabetic patients. We note that about 73 percent of diabetes patients included in our data also had PVD. Another comorbid condition that was found to be a significant predictor of facility cost is AIDs. This diagnosis is currently coded as part of the claims data.

Another Form 2728 variable we examined was the presence of a substance (alcohol and drugs) dependence diagnosis. While the presence of substance abuse was found to be predictive of higher facility level costs, we are not proposing an adjustment for this comorbidity at this time since the substance abuse diagnosis is underreported on the claims. We are soliciting comments on the variables included in the proposed patient characteristic adjustment as well as recommendations for the inclusion of other potential variables that may affect the costs of dialysis.

In summary, we are proposing to use a limited number of patient characteristics that do explain variation in reported costs for composite rate services consistent with the legislative requirement. The proposed adjustment factors are as follows:

TABLE 15

Female	age <65 years	1.11
	age 65–79 years	1.00
	age >79 years	1.16
Male	age <65 years	1.21
	age 65–79 years	1.17
	age >79 years	1.23
AIDS	.....	1.15
PVD	.....	1.07

While the magnitude of some of the patient specific case-mix adjustments appears to be significant, facility variation in the case-mix is limited. This is because of the overall similarity of the distribution of patients among the eight case-mix classification categories across facility classification groups. This is reflected by the average case-mix adjustment based on 2002 data for the various types of ESRD facilities shown in the table below.

TABLE 16

Facility type	Average case mix adjustment
All	1.1919
Independent	1.1917
Hospital Based	1.1936
Urban	1.1931
Rural	1.1865
Small (<5k treatments/yr.)	1.1911
Medium (5–10k treatments/yr.)	1.1910
Large (>10k treatments/yr.) ..	1.1924
Non-profit	1.1924
For-profit	1.1918

As illustrated from this table, regardless of the type of provider, the average case-mix adjustments for patient characteristics do not vary significantly. We are continuing research to develop a more fully bundled proposed model that is not constrained by the existing composite rate. We will continue to study the predictive value of comorbidities and facility and patient level variables as part of the ongoing research. In addition, we are aware that by limiting the number of variables for the patient characteristics adjustment applicable to the composite payment rate, we are limiting the predictive power of the model. We are planning to consider additional variables to refine and update the proposed patient characteristics. Once we have implemented this basic case-mix system, we will continue to analyze comorbidities (on the reported claims file) and will consider expanding the list of variables used in the patient classification adjustment. In addition, we will be working with our fiscal intermediaries to improve the reporting of comorbidities on claims.

5. Technical Description of Model Used To Develop the Proposed Patient Characteristic Adjustments

Both facility and patient level variables were used for the development of the proposed case-mix adjustment. Facility costs are based on Medicare allowable costs reported by facilities for dialysis and related services for which they are reimbursed through the composite rate. The sources of the cost data are the Medicare Independent Renal Dialysis Facility Cost Reports (Form CMS 265–94) and the Medicare Hospital Cost Reports (Form CMS 2552–96). We used the most current set of facility cost reports available (cost reports updated through December 2003 and made publicly available in March 2004).

All cost reports spanning any part of calendar years 2000, 2001 or 2002 were included in the development of the case mix adjusters. While for most facilities, especially independent facilities, a single cost report encompasses the entire calendar year; data for some facilities, most notably those whose reporting period spans two calendar years (for example, October through September rather than January through December) were pro-rated to calculate the average treatment cost during a calendar year. The resulting numbers of cost reports used in the analyses are shown in the table below by facility type and year. Note that currently there are fewer cost reports available for analysis in 2002 because many facilities have not yet submitted cost reports for that year. The final version of this regulation will contain the most recent data available.

TABLE 17

	2000	2001	2002
Independent facilities	3,027	3,034	2,508
Hospital-based facilities	477	466	456

The average treatment cost per dialysis session for each facility was calculated by dividing the total reported cost for dialysis and related services by the total number of dialysis treatments. The source of the reported cost for independent facilities was Worksheet B from Form CMS 265–94 and, for hospital-based facilities, Worksheet I–2 (Form CMS 2552–96). The source for the total number of dialysis treatments for independent facilities was worksheet Form CMS265–94 and, for hospital-based facilities, worksheet I–4 (Form CMS 2552–96). Note that, for CMS Form 2552–96 and CMS Form 265–94, values

in the fields for renal dialysis and home program dialysis were used in the cost and treatment calculations. For the CMS Form 265–94 and the CMS Form 2552–96 (Worksheet C, and worksheet I–4, respectively) values in the field home program CAPD and home program CCPD were stated in terms of patient weeks, rather than the number of treatments. These cells were multiplied by three to make them comparable to the number of hemodialysis sessions per week. The method used was consistent with the research (Dor, Held, Pauley 1992, Hirth, *et.al.*, 1999, Griffiths, *et.al.*, 1994, and Ozgen and Ozcan, 2002).

This method created an average Medicare allowable cost per dialysis treatment for each facility year of observation. Using the facility's Medicare billing number, cost report data were linked to claims data. For some facilities more than one billing number appears on claims and a list of correspondence among billing was used to link the claims to the cost report facility identifiers. This linkage was somewhat ambiguous for hospital facilities with satellite centers.

Patient level data was obtained from the Medicare claims data, and the Medical Evidence Form (CMS 2728). ESRD patients were identified using the Renal Beneficiary and Utilization System (REBUS), Medical Evidence and Master Patient File Records. Dialysis-related services (for example, the number of dialysis sessions) were identified for ESRD patients by Billing source (72x: renal dialysis facility bills), revenue center codes and the Healthcare Common Procedure Coding System (HCPCS).

6. Study Sample

Regression models for the average cost per session were used to estimate the typical cost per session. The average cost per session can be influenced by facilities with exceptional costs or with exceptional case-mix measures. To insure that the sample would characterize the patterns across the majority of facilities rather than being influenced by a few exceptional, non-representative facilities, the following facilities were excluded:

- Facilities with missing data from the cost reports or claims data. Twelve percent of the facilities lacked reported data.
- Facilities with high or low average costs.
- Facilities with exceptions.
- Facilities with extremely high or low proportions of patients with relevant medical cormorbidities.
- Small facilities.

Facilities with high or low average costs were determined based upon their composite rate. Facilities, having values for the log of the ratio of average costs to the composite rate of less than minus 0.5 or greater than 1.0 were excluded. This excluded less than 1 percent of facilities. Some facilities, that is, those with extremely high or low values based on selected patient characteristics (for example, percent of patients having a specific comorbidities such as AIDs, HIV, or alcohol and drug dependence) and selected facility characteristics (for example, facility size or URR). As with average costs, facilities with extreme variables did not represent the normal distribution of patient characteristics across facilities. This excluded 1.6 percent of the facilities. In addition, we excluded small facilities with less than 20 full patient years of dialysis during the year because it was difficult to assess the relationship between case-mix and facility costs based on the experience of a small number of patients. Facilities treating a small number of patients represented approximately 6.9 percent of the total facilities.

The sample excluded facilities with exceptional reimbursement levels. These included facilities with exceptions, facilities with higher than average payments, for example, with $3.00 or greater than the predicted composite rate payments. We excluded facilities based on our list of exceptions granted from November 1993 to July 2001. Some facilities were not included within the sample because their average payments were greater than the calculated (predicted) composite rate for the individual facility. While for the majority of the facilities, average composite rate payments were exactly as predicted, for some facilities, the payments were $3.00 greater than the predicted rate. These facilities were excluded because they were likely to be facilities with errors in reporting or facilities with exceptions. Of all of the facilities in the sample, 7.5 of the facilities were excluded from the sample.

7. Developing Case-Mix Measures at Each Facility Based on Patient-Specific Data

Facility-level case-mix measures were defined using certain demographic and comorbidity indicators for the Medicare dialysis patients in each facility for CYs 2000 to 2002. In aggregating patient data by facility, case-mix measures for each patient were weighted by the number of hemodialysis-equivalent dialysis sessions received in each facility. This process gives approximately 12 times as much weight to the characteristics of patients receiving a full year of dialysis care at a particular facility as compared to a patient receiving only one month of care at that facility. The resulting facility-level case-mix measures reflect how case-mix is distributed across individual treatments provided in the facility for Medicare dialysis patients. The number of dialysis sessions for each patient in each facility was obtained from Medicare outpatient institutional dialysis claims. The number of peritoneal dialysis patient days reported on each claim was multiplied by 3/7 to yield the number of hemodialysis-equivalent dialysis sessions provided during the time period covered by each claim. (For additional information see Phase I KECC Report, dated August 2002, p. 43).

8. Statistical Models

We explored a number of statistical methods to model the relationship between composite rate costs and patient/facility characteristics. We explored both linear and log-linear ordinary least squares regression models for each year from 2000 to 2002 to predict the natural log of the ratio of each facility's composite rate costs divided by that facility's composite payment rate (without regard to exception payments).

i. Choice of Estimation Method

We are proposing to use the log linear model in the methodology explained below in order to yield an easily administered case-mix adjuster which can be multiplied by the patient's otherwise applicable composite payment rate. This case-mix adjustment system also controls for selected variables.

We used the cost to payment ratio (that is, the natural log of the ratio of reported costs compared to the composite rate calculated for each facility) as the dependent variable in the models. The analysis that supports our decision is described in detailed below. In order to determine how reimbursement levels could be adjusted to reflect the costs of treating different patients, estimates of how the cost of providing dialysis services (that is, the composite rate) varies according to the patient characteristics (for example, age gender and comorbidities) were completed. Because the reported cost per treatment for each facility, in part, reflects the level of reimbursement (for example, Medicare payments) that the facility received, the measure of facility costs used is defined as the ratio relative to the current standard reimbursement level for each facility. For the purposes

of these analyses, the standard Medicare reimbursement payments for composite rate services (excluding those facilities with payment exceptions) were used. These currently vary across facilities based on the application of the area wage index used to develop the patient characteristics adjustment. This wage index (that is, labor costs) was used to account for regional differences in labor costs, and includes an adjustment for hospital based versus independent facility status.

As we have indicated, the costs of treatment varies from the composite rate payment for a number of reasons, including differences in the patient case-mix. The ratio of average reported costs at each facility were compared with the calculated composite rate payment in order to measure any variation in costs (that is, facility costs) from the composite rate. This cost to payment ratio measures the extent to which costs at a facility are higher or lower than the payment that would be expected based on their labor costs and facility type. Regression analysis was used to determine the extent to which the ratio varied with the average case-mix for each facility.

The analysis indicated that a log transformation of this cost to payment ratio was less skewed and a better fit (that is, the predicted variables were closer to the actual values using the log transformation).

ii. Control Variables

Apart from patient clinical and demographic characteristics, the proposed model also controls for selected other variables. These selected control variables include the wage index, the natural log of facility size (number of annual treatments), hospital-based/independent status, chain affiliation, and percent of patients with urea reduction ratios (URRs) greater than or equal to 65 percent. These control variables were included in the proposed model in order to account for the separate effect of facility variables and one readily available outcome variable on composite rate costs. These control variables were included in order to reduce potential distortion in the patient specific case-mix adjustors attributable to facility characteristics. We included the wage index to account for differences among facilities in area wage levels. We used facility size as a control factor because larger facilities, on average, have lower per treatment costs than smaller facilities. The hospital-based/independent classification was used because hospital based providers tend to have higher self-reported costs. Chain ownership is included in the model to account for differences among chains due to reporting conventions, as well as reflect similarities among facilities within chains. The URR was included as a control variable to account for a quality of care outcome measure at each facility, thereby mitigating any potential bias between composite rate costs and quality of care on the model's coefficients.

iii. The Log-Linear Model for Facility Costs

We identified a limited number of comorbidities that are strong predictors of composite rate costs and developed an estimated adjustment factor for each of these comorbidities. In order to yield an adjustor that can be multiplied with the composite rate payment, the model was used to estimate the facility's reported composite rate costs per treatment, divided by the composite payment rate calculated for each facility. The resulting ratio was modeled using case-mix and control variables. Analysis indicated that a log transformation of this ratio was less skewed and was better fit by the model (that is, predicted values were closer to actual values using the log transformation, especially for high cost facilities).

For facility j, the case-mix is measured by a vector of values, denoted by X_j. These values include both control variables and case-mix measures. The log of the ratio of cost per session (C_j) to composite rate (R_j) is denoted by $Y_j=\log(C_j/R_j)$. The multiple observations for three years are not indicated explicitly. The model equation is $Y_j = X_j \beta + \varepsilon_j$, where β is the vector of coefficients for the predictor variables and ε_j is an error term. This model is equivalent to the following model for cost for patient i, with a vector of individual characteristics X_{ij}, at facility j: $C_{ij} = R_j\, e^{X_{ij}\beta}$.

9. Identifying Factors for Case-Mix Adjustment

An evaluation of individual case-mix factors as potential risk adjusters was performed using several criteria to explain variation in facility costs. Consideration was also given to the validity of these potential case adjustors to costs based on clinical judgment, the stability of this relationship over time, the objectivity and accuracy of the data used to compute the factors, the reliability of information reported by different providers, and the feasibility of including them as risk adjusters.

Case-mix factors that explained statistically significant variation in facility costs were identified based on a regression model that used a stepwise selection method. Unless otherwise specified, case-mix measures represent the fraction of dialysis sessions in each facility that were provided to patients having the relevant characteristic or comorbidity. Case-mix measures that were considered for selection in the model included age/gender groups (ages <65, 65–79 and 80+ years, separately for females and males), less than one year of treatment for ESRD, average weight among adult dialysis patients (ages≥20), low body mass index among adult dialysis patients (BMI<18.5 kg/m^2) and the presence of individual comorbidities that were previously described that were developed from a combination of data from the Medicare claims history file and the CMS Form 2728.

10. Using the Model To Apply a Patient-Specific Case-Mix Adjustment to the Composite Rate

The regression coefficients that are estimated using facility cost model we discuss above can be used to apply a patient-specific case mix adjustment to the composite rate. This is accomplished by re-transforming the estimated coefficients to obtain relative factors for case mix adjustment. Based on a facility level cost model, where X_n is the proportion of patients in a facility having a specific characteristic (for example, a specific comorbidity), a one unit change in X_n can be used to characterize the difference between having and not having a specific patient characteristic. The coefficient for X_n,β_n, then estimates the change in the dependent variable (the natural log of the ratio of average composite rate costs to the composite rate) corresponding to whether or not a patient has that characteristic. The estimated coefficients can be re-transformed as $e^{x_{in}\beta tv}$ to obtain relative factors for n=1 to N case-mix measures included in the model.

The relative factors can then be applied multiplicatively to the composite rate in order to derive a case mix adjusted composite rate. Since these relative factors were all estimated to have values of 1.00 or greater, an adjustment to the composite rate based on these factors would necessarily lead to higher payments by Medicare. However, the MMA provision requires that the modification to the composite rate payment system be budget neutral. For the purpose of this example only, a budget neutrality factor that is less than 1.00 must, therefore, also be applied, with the same factor being applied to all patients and all facilities.

For patient i in facility j, a case-mix adjusted composite rate, AR_{ij} is

calculated as a function of the current composite rate, R_{ij}, the estimated budget neutrality factor, N (to be determined), and an overall relative factor for case mix adjustment, A_{ij}, where $AR_{ij} = R_j * N * A_{ij}$, $R_j = (\rho B_j W_j + (1-\rho)B_j$, and $A_{ij} = e^{Xij}\beta$.

In the above equations, ρ is the fraction of costs attributed to labor and therefore subject to an adjustment for geographic differences in wages, 1-ρ is the fraction of costs attributed to non-labor inputs, B_j is the base rate for facility j, W_j is the CMS/BLS wage index for facility j (with 0.9 and 1.3 representing the minimum and maximum values for W_j, respectively), X_{ij} is a vector of case-mix measures for patient i at facility j, and B is the vector of coefficients estimated by the regression model. Parameters P_j and B_j vary according to whether facilities are independent or hospital-based and may also vary over time, while W_j is determined either by the MSA in which each facility is located or by the state location for facilities not in an MSA.

As suggested by the equations above, the coefficients estimated by the cost model can be used to derive an aggregate relative adjustment factor for each patient (A_{ij}) based on their individual characteristics (X_i). By applying this factor in a multiplicative fashion to the composite rate, it is also being applied multiplicatively to the wage index, so that the dollar effect of the case-mix adjustment also varies across facilities according to regional differences in labor costs. That is, the case-mix adjustment will be larger in magnitude for facilities that face relatively high labor costs. This is appropriate if we expect the higher level of care that may be necessary for certain types of patients, such as those with PVD, to require additional staff time or more highly trained staff in locales with differential wage levels. An overall relative case-mix adjustment factor for patient i, A_i, can be calculated based on the model as $A_i = e^{Xi\beta} = e^{X1i\beta 1 + X2i\beta 2 + + Xpi\beta p}$.

However, since this is equivalent to $A_i = e^{Xi\square} = e^{X1i\square 1} * e^{X2i\square 2} * \ldots * e^{Xni\square n}$, the overall relative case-mix adjustment factor, or patient multiplier, can be calculated by multiplying together the relative adjustment factors for each case-mix measure. For every n=1 to p, X_{pi} corresponds to a 1 if that characteristic is present and a 0 if that characteristic is not present. For any characteristic that is not present, $X_{pi}=0$ and $e^{Xpi\square p}=1$, such that the equation can be simplified by including only those terms that are relevant for each patient. For characteristics that are present, $X_{pi}=1$, and the equation can be further simplified by dropping X_{pi}.

Where the individual factors for case-mix adjustment are age/gender, PVD and AIDS, the equation used to calculate the relative factor for case mix adjustment can then be expressed as $A_i = e^{\beta} = e^{\beta AS} * e^{\beta PVD} * e^{\beta AIDS}$ where $e^{\beta AS}$ is the relative factor for the appropriate age and sex category (one of six age/sex groups), $e^{\beta PVD}$ is the relative factor for the relevant PVD category (whether PVD is present or absent) and $e^{\beta AIDS}$ is the relative factor for the appropriate AIDS category (whether AIDS is present or absent).

11. Example

To illustrate, the proposed adjustment factors in section 4. above were used to derive a case-mix multiplier for a 7-year old male who has been diagnosed with PVD, but not AIDS. Using the proposed adjustment factors that correspond to males between the ages of 65 and 79 years and the presence of PVD, the overall case-mix multiplier for this patient is calculated as $A = e^{Xb} = e^{\beta AS} * e^{\beta PVD} = 1.17 \times 1.07 = 1.2519$.

A detailed example of the computation of the adjusted composite payment rate that includes the patient characteristics adjustments, as well as the applicable adjustments related to the ESRD drug payment revisions and budget neutrality, is provided later in this section I. below.

e. Geographic Index

Section 623(d)(1) of the MMA provides that the Secretary shall adjust the payment rates under this section by a geographic index as the Secretary determines to be appropriate. This section also specifies that, if the Secretary revises the current geographic adjustments applied to the composite payment rate, the revised adjustments must be phased in over a period of time. The current geographic adjustment (wage index) is a blend of two wage indexes, one based on hospital wage data collected by us from fiscal year 1986 and the other developed from 1980 hospital wage and employment data from the Bureau of Labor Statistics (BLS). The hospital and BLS proportions of the blended wage index are 40 percent and 60 percent. The actual wage index values and MSA/non-MSA designations currently used in connection with the composite rates were published in the August 15, 1986 **Federal Register** (51 FR 29412–29417). For the reasons discussed below, we have decided not to propose any changes to the current wage index adjustments at this time.

On June 6, 2003, OMB issued Bulletin 03–04 that announced new MSAs and two new sets of statistical areas, Micropolitan Statistical Areas and Combined Statistical Areas (CSAs). We recognize that the new OMB definitions will have implications for the various payment systems we administer that reflect payment distinctions based on geographic location. Any changes adopted will not only result in payment redistributions among ESRD facilities, but will also affect hospitals, home health agencies, skilled nursing facilities, and rehabilitation providers.

Therefore, it is essential that we evaluate any proposals to revise the area definitions and assess the impact of changes in geographical areas on those payment systems that incorporate adjusters for area wage levels among urban and rural locations.

Although the MMA gives the Secretary discretion to revise the outdated wage indexes used in the composite rates, we believe that we should take no action to replace them with revised measures pending completion of our assessments.

Therefore, we are proposing to take no action at this time to revise the current set of composite rate wage indexes and the urban and rural definitions used to develop them. Once revisions to the urban and rural definitions are adopted, we may be in a better position to propose revisions to the geographic adjustments applied to the case-mix adjusted composite payment rates.

For purposes of applying the required geographic adjustments to the case-mix adjusted composite rate payment system, we are proposing to continue using the wage index values and urban and rural designations that are currently applied to the composite payment rates.

Section 1881(b)(12)(E)(i) of the Act, as added by section 623(d)(1) of the MMA, requires that the basic case-mix adjusted composite rate system be designed to result in the same aggregate amount of expenditure for such services, as estimated by the Secretary, as would have been made for 2005 if that paragraph did not apply. Therefore, the drug add-on adjustment and the patient characteristics case-mix adjustment required by section 623(d)(1) of the MMA must result in the same aggregate expenditures for 2005 as if these adjustments were not made.

With respect to the drug payment add-on adjustment the total estimated difference between the current drug payment based on 95 percent of AWP and the payment amount generated from payment based on ASP minus 3 percent is reflected in the proposed adjustment which is designed so that aggregate

payments are budget neutral. (See section H.4.c.2. of this proposed rule for more detailed explanation of drug add-on adjustment).

In order to account for the payment effect related to the case-mix adjustment, we standardized the composite rate by dividing the rate by the average case-mix modifier of 1.1919. (See section 4.ii Proposed Cormorbidity Adjustments). The resulting adjustment to the composite rate is .8390. However, we were not able to simulate the case-mix effects from the ESRD billing file because comorbidities are generally not included on the ESRD bill. (See section H.3. of this proposed rule for the discussion of the data issues.) We propose to refine our adjustments for case-mix once we have more complete data on the ESRD bill.

F. Payment Exceptions and the Revised Composite Payment Rates

Before the enactment of BIPA, an ESRD facility could apply for and receive prospective adjustments or exceptions to its otherwise applicable composite payment rate under specified circumstances. Section 1881(b)(7) of the Act and § 413.182 contain the statutory and regulatory authorities for the provision of exceptions to the composite payment rates. Section 422(a)(2) of BIPA prohibited the granting of new exceptions to the composite payment rates on or after December 31, 2000, except under very limited circumstances, which expired July 1, 2001. That prohibition remains in effect, with one exception. Section 623(b) of the MMA amended section 422(a)(2) of BIPA to afford pediatric facilities the opportunity to seek exceptions provided they did not have an exception rate in effect as of October 1, 2002. The statute defines a pediatric facility as a renal facility, 50 percent of whose patients are under age 18. On April 1, 2004, we opened an exception window for pediatric facilities. The exception window closes September 27, 2004.

Section 422(a)(2)(C) of BIPA provided that any ESRD composite rate exception in effect on December 31, 2000 would continue as long as the exception rate exceeds the applicable composite payment rate. The MMA did not revise that provision. Comparisons of a provider's exception rate and the standard composite payment rate are straightforward, because each payment rate was applied on a facility specific basis, without any adjustments for case-mix. However, in this proposed rule, we are proposing revised composite payment rates that are case-mix adjusted. The wage adjusted composite payment rates listed for each urban and rural area noted in Tables I and II at the end of this section, although applied on a per treatment basis, are subject to case mix adjustments in accordance with section 623(d)(1) of the MMA. The proposed methodology for applying patient characteristic adjusters applicable to each treatment will determine the case-mix adjustment which will vary for each patient. Thus, an ESRD facility's average composite rate per treatment will depend on its unique case mix.

Our policy was not to increase any ESRD facility's exception rate when there has been a congressionally mandated update to the ESRD composite payment rates. When computing an exception amount, we take into consideration the ESRD facility's patient population and the higher costs relating to the patient mix. Since ESRD facilities can maintain their current exception rates, we would expect them to compare the exception rate to the basic case-mix adjusted composite rate to determine the best payment rate for their facility. We are proposing to allow each dialysis facility the option of continuing to be paid at its exception rate or at the basic case-mix adjusted composite rate (which includes all the MMA 623 payment adjustments). If the facility retains its exception rate, it would not be subject to any of the adjustments specified in section 623 of the MMA. Whether a provider's exception rate in effect on December 31, 2000 will exceed its average case-mix adjusted composite payment rate is impossible for us to accurately determine. We believe that projections as to whether an ESRD facility's exception rate per treatment will exceed its average case-mix adjusted composite rate per treatment are best left to the entities affected. Therefore, we are proposing that each ESRD facility with composite rate exceptions currently in effect, and each pediatric ESRD facility granted an exception, must notify its fiscal intermediary in writing if it wishes to withdraw its exception and be subject to the basic case-mix adjusted composite payment rate methodology set forth in this notice.

We are proposing to allow an ESRD facility to notify its fiscal intermediary at any time if it wishes to give up its exception rate. Once a facility has notified its fiscal intermediary of its election to give up its exception rate, it would lose that exception rate, regardless of basis or amount, and be subject to the proposed case-mix adjusted composite payment rates beginning 30 days after the intermediary's receipt of the facility's notification letter. Facilities with exception rates will be required to notify their fiscal intermediaries only if they wish to forego their exceptions. ESRD facilities electing to retain their exceptions do not need to notify their intermediaries. ESRD facilities without exceptions, of course, will be subject to the composite payment rates determined using the basic case-mix methodology described in this notice beginning January 1, 2005.

G. Summary of Composite Rate Revisions and Proposed Implementation

As set forth in this proposed rule, we will increase the ESRD composite payment rates by 1.6 percent effective January 1, 2005 in accordance with section 623(a) of the MMA. Also, the composite payment rates will be increased to reflect revisions to the drug pricing methodology for separately billable drugs, as discussed in section H.4.b. of this proposed rule. That increase represents the spread or difference between the payment amounts for separately billable drugs and biologicals and their acquisition costs based on the OIG's May 2004 report to the Secretary. The development and computation of the drug add-on adjustment are described in section H.4.c of this proposed rule. We have also proposed a basic case-mix methodology for adjusting the composite payment rates based on a limited number of patient characteristics, as prescribed in section 623(d) of the MMA. The development and application of the case-mix adjusters are explained in section H.4.d.4 of this proposed rule. The MMA requires that the basic case-mix adjusted composite payment rates be effective for services furnished beginning January 1, 2005. Despite the law's specificity with respect to effective date, the systems and operational changes necessary to apply the case-mix adjusters cannot be completed in time for a prospective January 1, 2005 effective date.

The 1.6 percent statutory increase and 11.3 drug add-on for independent and hospital-based facilities for separately billable drugs will be applied to the composite rates for all ESRD facilities beginning January 1, 2005. However, the computation of the case mix adjusters depends on age, sex, and specific comorbidities which must be obtained from the bills for each ESRD facility. Therefore, the combination of case-mix adjusters used to increase a provider's otherwise applicable composite payment rate depends on a provider's unique patient profile and is facility-specific. The correct computation of these facility-specific case-mix adjusters will require numerous programming,

systems, billing, and instructional changes by us, fiscal intermediaries, and system maintainers. In addition, providers and their fiscal intermediaries will require education and training not only on the basic features of the new ESRD PPS, but also on the proper reporting of patient and clinical information on the bills, essential for an accurate case mix adjustment in connection with each patient's claims.

Given these requirements, the lead time necessary for systems changes, and the anticipated time necessary for providers and their fiscal intermediaries to familiarize themselves with and correctly apply the basic case-mix adjustments, we are proposing an April 1, 2005 effective date.

As an alternative to an April 1, 2005 effective date for the patient characteristic case mix adjustments, we considered two options for an April 1, 2005 prospective implementation date that would effectively comply with the MMA's January 1, 2005 effective date. Under the first option, we would implement the patient characteristic adjustments on April 1, 2005 and reprocess bills and adjust payments to January 1, 2005. Under this option, the budget neutrality adjustment related to the patient characteristic factors would not be applied to the composite rate until bills are reprocessed.

The second option that we considered was to make payment to facilities starting January 1, 2005, at the budget neutralized composite rate, until the systems changes for the case-mix adjustment can be implemented, April 1, 2005. Payment at this rate would avoid overpayments, and thus, the need to recoup moneys that may occur when we retroactively process the claims for case-mix adjustments on April 1, 2005. Under this option, facilities would receive approximately 16 percent less than they would otherwise be entitled to on January 1, 2005.

We rejected both of these alternatives. Both options require the reprocessing and adjustment of bills for the first quarter of 2005. In addition, because of the likelihood of payment error due to the complexity of the process and costly implementation and potential disruption of payment to ESRD facilities, we believe that these options are problematic. Given that the expected impact of the patient characteristic adjustments on ESRD facility payments will, for the most part, be minimal, we believe that applying the adjustments prospectively from April 1, 2005 provides a smoother transition to the new payment methodology.

Finally, this notice provides for a budget neutrality reduction of .8390 percent to the case-mix adjusted composite payment rates. Our budget neutrality methodology is explained in section H.4.f. of this proposed rule. Because section 623(d) of the MMA requires that budget neutrality be applied in the context of implementing the case-mix adjusted composite rate payment system, we are proposing that the effective date of the budget neutrality adjustment should also be April 1, 2005. If we applied the budget neutrality adjustment in January, rather than when the case-mix adjustment is applied in April, the result would be that all the composite rates would go down.

We are specifically soliciting comments on these options of the proposed rule. However, the 1.6 percent statutory increase to the composite payment rates, and the drug add-on for separately billable drugs, will be effective January 1, 2005, as these adjustments are easily implemented prospectively.

IV. Example of Payment Calculation Under the Proposed Case-Mix Adjusted Composite Rate System

The following example presents 2 patients dialyzing at Neighbor Dialysis, an independent facility in Baltimore, MD. Patient #1, John Smith, is a 71-year old male who has been diagnosed with PVD and AIDS. Patient #2, Jane Doe, is a 59-year old female who has been diagnosed with PVD.

Calculation of Basic Composite Rate for Neighbor Dialysis

Wage adjusted Composite Rate for independent facilities in Baltimore, Md. (Table I): $134.93

Wage adjusted Composite Rate increased by proposed drug add-on adjustment ($134.93 x 1.113): $150.18

Adjusted Facility Composite Rate after budget neutrality (150.18 x .8490): $126.00

Calculation of Case-mix Adjusted Payments

Patient #1—John Smith:

Male age 65–79 years: 1.17

AIDS: 1.15

PVD: 1.07

Case-mix adjusted rate for John Smith ($126.00 x 1.17 x 1.15 x 1.07): $181.40

Patient #2—Jane Doe:

Female age < 65 years: 1.11

PVD: 1.07

Case-mix adjusted rate for Jane Doe ($126.00 x 1.11 x 1.07): $149.65

TABLE 18.—COMPOSITE PAYMENT RATES EFFECTIVE JANUARY 1, 2005

[For urban renal facilities]

MSA code	Name of MSA	State	Hospital	Independent
0040	ABILENE	TX	127.58	123.18
0060	AGUADILLA	PR	127.57	123.18
0080	AKRON	OH	137.39	133.68
0120	ALBANY	GA	127.57	123.18
0160	ALBANY-SCHENECTADY-TROY	NY	129.93	125.70
0200	ALBUQUERQUE	NM	135.60	131.77
0220	ALEXANDRIA	LA	129.70	125.46
0240	ALLENTOWN-BETHLEHEM	PA-NJ	134.75	130.87
0280	ALTOONA	PA	133.79	129.84
0320	AMARILLO	TX	130.03	125.80
0360	ANAHEIM-SANTA ANA	CA	145.72	142.64
0380	ANCHORAGE	AK	146.35	146.35
0400	ANDERSON	IN	131.74	127.63
0405	ANDERSON	SC	127.57	123.18
0440	ANN ARBOR	MI	145.80	142.71
0450	ANNISTON	AL	127.57	123.18
0460	APPLETON-OSHKOSH-NEENAH	WI	132.60	128.56
0470	ARECIBO	PR	127.57	123.18
0480	ASHEVILLE	NC	130.57	126.39
0500	ATHENS	GA	127.57	123.18

TABLE 18.—COMPOSITE PAYMENT RATES EFFECTIVE JANUARY 1, 2005—Continued

[For urban renal facilities]

MSA code	Name of MSA	State	Hospital	Independent
0520	ATLANTA	GA	130.07	125.84
0560	ATLANTIC CITY	NJ	134.72	130.82
0600	AUGUSTA	GA-SC	130.08	125.85
0620	AURORA-ELGIN	IL	140.21	136.70
0640	AUSTIN	TX	135.14	131.29
0680	BAKERSFIELD	CA	141.64	138.25
0720	BALTIMORE	MD	138.55	134.93
0733	BANGOR	ME	129.34	125.09
0760	BATON ROUGE	LA	131.80	127.71
0780	BATTLE CREEK	MI	134.05	130.11
0840	BEAUMONT-PORT ARTHUR	TX	130.85	126.67
0845	BEAVER COUNTY	PA	138.52	134.89
0860	BELLINGHAM	WA	132.87	128.85
0870	BENTON HARBOR	MI	127.57	123.18
0875	BERGEN-PASSAIC	NJ	142.22	140.71
0880	BILLINGS	MT	132.16	128.08
0920	BILOXI-GULFPORT	MS	127.57	123.18
0960	BINGHAMTON	NY	130.00	125.77
1000	BIRMINGHAM	AL	131.83	127.73
1010	BISMARCK	ND	130.64	126.47
1020	BLOOMINGTON	IN	129.78	125.54
1040	BLOOMINGTON-NORMAL	IL	129.69	125.45
1080	BOISE CITY	ID	135.23	131.39
1123	BOSTON-SALEM-BROCKTON	MA	139.45	135.89
1125	BOULDER-LONGMONT	CO	140.62	137.15
1140	BRADENTON	FL	128.79	124.47
1145	BRAZORIA	TX	134.02	130.08
1150	BREMERTON	WA	129.14	124.87
1163	BRIDGEPORT-NORWALK-DANBURY	CT	141.49	138.08
1240	BROWNSVILLE-HARLINGEN	TX	129.79	125.56
1260	BRYAN-COLLEGE STATION	TX	128.68	124.37
1280	BUFFALO	NY	133.55	129.59
1300	BURLINGTON	NC	127.57	123.18
1303	BURLINGTON	VT	131.37	127.24
1310	CAGUAS	PR	127.57	123.18
1320	CANTON	OH	131.51	127.40
1350	CASPER	WY	136.29	132.52
1360	CEDAR RAPIDS	IA	131.05	126.92
1400	CHAMPAIGN-URBANA-RANTOUL	IL	133.39	129.39
1440	CHARLESTON	SC	131.44	127.33
1480	CHARLESTON	WVA	135.86	132.06
1520	CHARLOTTE-ROCK HILL	NC-SC	129.79	125.57
1540	CHARLOTTESVILLE	VA	133.15	129.15
1560	CHATTANOOGA	TN-GA	132.45	128.39
1580	CHEYENNE	WY	131.21	127.06
1600	CHICAGO	IL	142.79	139.48
1620	CHICO	CA	139.53	135.98
1640	CINCINNATI	OH-KY-IN	137.22	133.50
1660	CLARKSVILLE-HOPKINSVILLE	TN-KY	127.57	123.18
1680	CLEVELAND	OH	141.66	138.27
11720	COLORADO SPRINGS	CO	135.83	132.03
1740	COLUMBIA	MO	140.08	136.56
1760	COLUMBIA	SC	130.43	126.24
1800	COLUMBUS	GA-AL	128.15	123.79
1840	COLUMBUS	OH	134.12	130.19
1880	CORPUS CHRISTI	TX	131.52	127.41
1900	CUMBERLAND	MD-WVA	128.22	123.87
1920	DALLAS	TX	134.47	130.56
1950	DANVILLE	VA	127.57	123.18
1960	DAVENPORT-MOLINE	IA-IL	133.12	129.11
2000	DAYTON-SPRINGFIELD	OH	137.82	134.14
2020	DAYTONA BEACH	FL	127.85	123.47
2030	DECATUR	AL	127.57	123.18
2040	DECATUR	IL	131.69	127.57
2080	DENVER	CO	143.60	140.35
2120	DES MOINES	IA	135.21	131.36
2160	DETROIT	MI	143.03	139.73
2180	DOTHAN	AL	127.57	123.18
2200	DUBUQUE	IA	132.63	128.61
2240	DULUTH	MN-WI	130.10	125.88
2290	EAU CLAIRE	WI	128.84	124.53

TABLE 18.—COMPOSITE PAYMENT RATES EFFECTIVE JANUARY 1, 2005—Continued

[For urban renal facilities]

MSA code	Name of MSA	State	Hospital	Independent
2320	EL PASO	TX	128.41	124.08
2330	ELKHART-GOSHEN	IN	129.30	125.01
2335	ELMIRA	NY	132.63	128.60
2340	ENID	OK	129.51	125.24
2360	ERIE	PA	131.82	127.74
2400	EUGENE-SPRINGFIELD	OR	133.37	129.37
2440	EVANSVILLE	IN-KY	134.10	130.16
2520	FARGO-MOORHEAD	ND-MN	133.83	129.88
2560	FAYETTEVILLE	NC	127.57	123.18
2580	FAYETTEVILLE-SPRINGDALE	AR	127.57	123.18
2640	FLINT	MI	141.83	138.45
2650	FLORENCE	AL	127.57	123.18
2655	FLORENCE	SC	127.57	123.18
2670	FORT COLLINS-LOVELAND	CO	131.49	127.38
2680	FT LAUDERDALE-POMPANO BEACH	FL	137.23	133.51
2700	FORT MYERS-CAPE CORAL	FL	129.73	125.49
2710	FORT PIERCE	FL	130.09	125.87
2720	FORT SMITH	AR-OK	128.97	124.67
2750	FORT WALTON BEACH	FL	127.57	123.18
2760	FORT WAYNE	IN	129.32	125.05
2800	FORT WORTH-ARLINGTON	TX	133.06	129.04
2840	FRESNO	CA	142.09	138.72
2880	GADSDEN	AL	128.48	124.17
2900	GAINESVILLE	FL	130.25	126.06
2920	GALVESTON-TEXAS CITY	TX	137.86	134.20
2960	GARY-HAMMOND	IN	138.47	134.85
2975	GLENS FALLS	NY	128.98	124.68
2985	GRAND FORKS	ND	129.26	124.98
3000	GRAND RAPIDS	MI	133.41	129.44
3040	GREAT FALLS	MT	132.09	128.01
3060	GREELEY	CO	134.34	130.43
3080	GREEN BAY	WI	133.34	129.33
3120	GREENSBORO-WINSTON SALEM-HIGH PT	NC	129.67	125.42
3160	GREENVILLE-SPARTANBURG	SC	130.15	125.95
3180	HAGERSTOWN	MD	132.79	128.78
3200	HAMILTON-MIDDLETOWN	OH	134.87	130.98
3240	HARRISBURG-LEBANON-CARLISLE	PA	133.92	129.97
3283	HARTFORD-NEW BRITAIN-BRISTOL	CT	140.38	136.90
3290	HICKORY	NC	127.57	123.18
3320	HONOLULU	HI	141.73	138.34
3350	HOUMA-THIBODAUX	LA	128.02	123.66
3360	HOUSTON	TX	137.24	133.53
3400	HUNTINGTON-ASHLAND	WVA-KY-OH	130.11	125.88
3440	HUNTSVILLE	AL	127.57	123.18
3480	INDIANAPOLIS	IN	135.16	131.30
3500	IOWA CITY	IA	143.23	140.37
3520	JACKSON	MI	134.43	130.53
3560	JACKSON	MS	128.82	124.51
3580	JACKSON	TN	127.57	123.18
3600	JACKSONVILLE	FL	130.77	126.58
3605	JACKSONVILLE	NC	127.75	123.37
3620	JANESVILLE-BELOIT	WI	128.39	124.05
3640	JERSEY CITY	NJ	138.46	134.84
3660	JOHNSON CITY-BRISTOL	TN-VA	127.57	123.18
3680	JOHNSTOWN	PA	133.36	129.36
3690	JOLIET	IL	140.66	137.19
3710	JOPLIN	MO	127.97	123.61
3720	KALAMAZOO	MI	143.25	139.98
3740	KANKAKEE	IL	130.84	126.66
3760	KANSAS CITY	MO-KS	133.22	129.21
3800	KENOSHA	WI	137.39	133.69
3810	KILLEEN-TEMPLE	TX	128.12	123.75
3840	KNOXVILLE	TN	127.83	123.45
3850	KOKOMO	IN	132.39	128.34
3870	LA CROSSE	WI	131.00	126.87
3880	LAFAYETTE	LA	132.84	128.83
3920	LAFAYETTE	IN	128.65	124.33
3960	LAKE CHARLES	LA	130.17	125.97
3965	LAKE COUNTY	IL	141.41	137.98
3980	LAKELAND-WINTER HAVEN	FL	127.57	123.18
4000	LANCASTER	PA	135.38	131.54

TABLE 18.—COMPOSITE PAYMENT RATES EFFECTIVE JANUARY 1, 2005—Continued

[For urban renal facilities]

MSA code	Name of MSA	State	Hospital	Independent
4040	LANSING-EAST LANSING	MI	135.98	132.18
4080	LAREDO	TX	127.57	123.18
4100	LAS CRUCES	NM	127.57	123.18
4120	LAS VEGAS	NV	141.01	137.58
4150	LAWRENCE	KS	131.82	127.73
4200	LAWTON	OK	130.27	126.08
4243	LEWISTON-AUBURN	ME	128.39	124.06
4280	LEXINGTON-FAYETTE	KY	130.21	126.01
4320	LIMA	OH	133.29	129.29
4360	LINCOLN	NE	129.96	125.72
4400	LITTLE ROCK-N LITTLE ROCK	AR	135.96	132.17
4420	LONGVIEW-MARSHALL	TX	127.57	123.18
4440	LORAIN-ELYRIA	OH	134.22	130.30
4480	LOS ANGELES-LONG BEACH	CA	146.35	145.02
4520	LOUISVILLE	KY-IN	134.40	130.50
4600	LUBBOCK	TX	129.87	125.63
4640	LYNCHBURG	VA	128.00	123.63
4680	MACON-WARNER ROBINS	GA	129.46	125.19
4720	MADISON	WI	135.45	131.63
4763	MANCHESTER-NASHUA	NH	131.20	127.04
4800	MANSFIELD	OH	130.40	126.20
4840	MAYAGUEZ	PR	127.57	123.18
4880	MCALLEN-EDINBURG-MISSION	TX	127.57	123.18
4890	MEDFORD	OR	133.00	128.99
4900	MELBOURNE-TITUSVILLE	FL	130.19	125.99
4920	MEMPHIS	TN-AR-MS	135.10	131.23
4940	MERCED	CA	138.45	134.83
5000	MIAMI-HIALEAH	FL	138.47	134.85
5015	MIDDLESEX-HUNTERDON	NJ	134.87	130.99
5040	MIDLAND	TX	135.10	131.24
5080	MILWAUKEE	WI	136.75	133.02
5120	MINNEAPOLIS-ST PAUL	MN-WI	136.11	132.33
5160	MOBILE	AL	129.00	124.70
5170	MODESTO	CA	138.05	134.41
5190	MONMOUTH-OCEAN	NJ	133.08	129.06
5200	MONROE	LA	129.18	124.90
5240	MONTGOMERY	AL	130.14	125.92
5280	MUNCIE	IN	131.36	127.22
5320	MUSKEGON	MI	131.68	127.57
5345	NAPLES	FL	130.55	126.35
5360	NASHVILLE	TN	132.71	128.70
5380	NASSAU-SUFFOLK	NY	146.35	144.35
5403	NEW BEDFORD-FALL RIVER-ATTELBORO	MA	131.79	127.70
5483	NEW HAVEN-WATERBURY-MERIDEN	CT	137.50	133.80
5523	NEW LONDON-NORWICH	CT	137.24	133.52
5560	NEW ORLEANS	LA	130.68	126.50
5600	NEW YORK	NY	146.35	146.35
5640	NEWARK	NJ	141.09	137.67
5700	NIAGARA FALLS	NY	130.31	126.11
5720	NORFOLK-NEWPORT NEWS	VA	129.67	125.42
5775	OAKLAND	CA	146.35	145.92
5790	OCALA	FL	128.79	124.48
5800	ODESSA	TX	129.63	125.38
5880	OKLAHOMA CITY	OK	134.67	130.78
5910	OLYMPIA	WA	135.49	131.66
5920	OMAHA	NE-IA	132.99	128.98
5950	ORANGE COUNTY	NY	132.46	128.39
5960	ORLANDO	FL	132.46	128.39
5990	OWENSBORO	KY	127.57	123.18
6000	OXNARD-VENTURA	CA	146.28	145.05
6015	PANAMA CITY	FL	127.57	123.18
6020	PARKERSBURG-MARIETTA	WVA-OH	130.89	126.73
6025	PASCAGOULA	MS	135.50	131.67
6080	PENSACOLA	FL	128.26	123.91
6120	PEORIA	IL	136.83	133.10
6160	PHILADELPHIA	PA-NJ	141.48	138.07
6200	PHOENIX	AZ	137.96	134.32
6240	PINE BLUFF	AR	127.57	123.18
6280	PITTSBURGH	PA	138.69	135.09
6323	PITTSFIELD	MA	133.87	129.91
6360	PONCE	PR	127.57	123.18

TABLE 18.—COMPOSITE PAYMENT RATES EFFECTIVE JANUARY 1, 2005—Continued

[For urban renal facilities]

MSA code	Name of MSA	State	Hospital	Independent
6403	PORTLAND	ME	132.96	128.94
6440	PORTLAND	OR	139.91	136.40
6453	PORTSMOUTH-DOVER-ROCHESTER	NH-ME	128.29	123.95
6460	POUGHKEEPSIE	NY	135.84	132.03
6483	PROVIDENCE-PAWTUCKET-WOONSOCKET	RI	134.58	130.69
6520	PROVO-OREM	UT	130.42	126.22
6560	PUEBLO	CO	137.23	133.52
6600	RACINE	WI	129.52	125.26
6640	RALEIGH-DURHAM	NC	132.93	128.90
6660	RAPID CITY	SD	128.78	124.47
6680	READING	PA	133.16	129.15
6690	REDDING	CA	138.98	135.39
6720	RENO	NV	144.32	142.52
6740	RICHLAND-KENNEWICK	WA	131.96	127.89
6760	RICHMOND-PETERSBURG	VA	129.76	125.53
6780	RIVERSIDE-SAN BERNARDINO	CA	143.65	140.40
6800	ROANOKE	VA	130.33	126.13
6820	ROCHESTER	MN	134.23	130.31
6840	ROCHESTER	NY	134.50	130.60
6880	ROCKFORD	IL	136.62	132.85
6920	SACRAMENTO	CA	144.16	141.12
6960	SAGINAW-BAY CITY-MIDLAND	MI	138.22	134.57
6980	ST CLOUD	MN	129.55	125.29
7000	ST JOSEPH	MO	132.19	128.12
7040	ST LOUIS	MO-IL	135.07	131.21
7080	SALEM	OR	136.70	132.96
7120	SALINAS-SEASIDE-MONTEREY	CA	144.09	140.88
7160	SALT LAKE CITY-OGDEN	UT	131.27	127.13
7200	SAN ANGELO	TX	127.57	123.18
7240	SAN ANTONIO	TX	129.30	125.03
7320	SAN DIEGO	CA	144.75	142.04
7360	SAN FRANCISCO	CA	146.35	145.92
7400	SAN JOSE	CA	146.35	145.68
7440	SAN JUAN	PR	127.57	123.18
7480	SANTA BARBARA-LOMPOC	CA	139.14	135.58
7485	SANTA CRUZ	CA	140.64	137.18
7490	SANTA FE	NM	129.81	125.59
7500	SANTA ROSA-PETALUMA	CA	146.35	145.59
7510	SARASOTA	FL	131.98	127.90
7520	SAVANNAH	GA	129.72	125.48
7560	SCRANTON-WILKES BARRE	PA	133.66	129.70
7600	SEATTLE	WA	136.87	133.14
7610	SHARON	PA	132.08	128.00
7620	SHEBOYGAN	WI	129.28	125.01
7640	SHERMAN-DENISON	TX	127.57	123.18
7680	SHREVEPORT	LA	133.23	129.23
7720	SIOUX CITY	IA-NE	132.47	128.40
7760	SIOUX FALLS	SD	130.62	126.44
7800	SOUTH BEND-MISHAWAKA	IN	130.13	125.92
7840	SPOKANE	WA	138.38	134.75
7880	SPRINGFIELD	IL	137.27	133.56
7920	SPRINGFIELD	MO	129.48	125.21
8003	SPRINGFIELD	MA	133.39	129.39
8050	STATE COLLEGE	PA	137.91	134.25
8080	STEUBENVILLE-WEIRTON	OH-WVA	131.46	127.35
8120	STOCKTON	CA	146.35	145.06
8160	SYRACUSE	NY	141.36	139.77
8200	TACOMA	WA	136.53	132.76
8240	TALLAHASSE	FL	129.91	125.67
8280	TAMPA-ST PETERSBURG-CLEARWATER	FL	132.27	128.21
8320	TERRE HAUTE	IN	127.57	123.18
8360	TEXARKANA	TX-AR	135.59	131.75
8400	TOLEDO	OH	140.91	137.45
8440	TOPEKA	KS	135.89	132.10
8480	TRENTON	NJ	135.66	131.82
8520	TUCSON	AZ	134.02	130.07
8560	TULSA	OK	133.31	129.30
8600	TUSCALOOSA	AL	133.86	129.91
8640	TYLER	TX	132.17	128.09
8680	UTICA-ROME	NY	130.41	126.22
8720	VALLEJO-FAIRFIELD-NAPA	CA	146.35	146.18

TABLE 18.—COMPOSITE PAYMENT RATES EFFECTIVE JANUARY 1, 2005—Continued

[For urban renal facilities]

MSA code	Name of MSA	State	Hospital	Independent
8725	VANCOUVER	WA	139.12	135.53
8750	VICTORIA	TX	127.57	123.18
8760	VINELAND-MILLVILLE-BRIDGETON	NJ	132.48	128.41
8780	VISALIA-PORTERVILLE	CA	142.02	140.48
8800	WACO	TX	127.81	123.43
8840	WASHINGTON	DC-MD-VA	141.74	138.35
8920	WATERLOO-CEDAR FALLS	IA	129.50	125.24
8940	WAUSAU	WI	130.90	126.74
8960	WEST PALM & DELRAY BEACH	FL	131.84	127.75
9000	WHEELING	WVA-OH	131.83	127.74
9040	WICHITA	KS	136.67	132.93
9080	WICHITA FALLS	TX	127.57	123.18
9140	WILLIAMSPORT	PA	130.24	126.04
9160	WILMINGTON	DE-NJ-MD	136.71	132.97
9200	WILMINGTON	NC	128.74	124.42
9243	WORCESTER-LEOMINSTER	MA	132.43	128.37
9260	YAKIMA	WA	132.24	128.18
9280	YORK	PA	132.45	128.39
9320	YOUNGSTOWN-WARREN	OH	137.25	133.54
9340	YUBA CITY	CA	137.02	133.29

TABLE 19.—COMPOSITE PAYMENT RATES EFFECTIVE JANUARY 1, 2005

[For rural renal facilities]

MSA Code	Name of MSA	State	Hospital	Independent
AL	ALABAMA	AL	127.57	123.18
AK	ALASKA	AK	146.35	146.35
AZ	ARIZONA	AZ	128.68	124.35
AR	ARKANSAS	AR	127.57	123.18
CA	CALIFORNIA	CA	137.00	133.27
CO	COLORADO	CO	128.21	123.86
CT	CONNECTICUT	CT	136.02	132.22
DE	DELAWARE	DE	128.76	124.44
FL	FLORIDA	FL	127.75	123.37
GA	GEORGIA	GA	127.57	123.18
HI	HAWAII	HI	140.40	136.92
ID	IDAHO	ID	127.83	123.45
IL	ILLINOIS	IL	127.57	123.18
IN	INDIANA	IN	127.57	123.18
IA	IOWA	IA	127.57	123.18
KS	KANSAS	KS	127.57	123.18
KY	KENTUCKY	KY	127.57	123.18
LA	LOUISIANA	LA	127.57	123.18
ME	MAINE	ME	127.57	123.18
MD	MARYLAND	MD	130.27	126.08
MA	MASSACHUSETTS	MA	135.99	132.19
MI	MICHIGAN	MI	132.98	128.97
MN	MINNESOTA	MN	127.57	123.18
MS	MISSISSIPPI	MS	127.57	123.18
MO	MISSOURI	MO	127.57	123.18
MT	MONTANA	MT	127.87	123.50
NE	NEBRASKA	NE	127.57	123.18
NV	NEVADA	NV	133.20	129.20
NH	NEW HAMPSHIRE	NH	132.24	128.18
NM	NEW MEXICO	NM	128.68	124.36
NY	NEW YORK	NY	127.78	123.40
NC	NORTH CAROLINA	NC	127.57	123.18
ND	NORTH DAKOTA	ND	127.70	123.31
OH	OHIO	OH	128.66	124.34
OK	OKLAHOMA	OK	127.57	123.18
OR	OREGON	OR	132.66	128.64
PA	PENNSYLVANIA	PA	132.54	128.48
PR	PUERTO RICO	PR	127.57	123.18
RI	RHODE ISLAND	RI	130.86	126.69
SC	SOUTH CAROLINA	SC	127.57	123.18
SD	SOUTH DAKOTA	SD	127.57	123.18
TN	TENNESSEE	TN	127.57	123.18
TX	TEXAS	TX	127.57	123.18

TABLE 19.—COMPOSITE PAYMENT RATES EFFECTIVE JANUARY 1, 2005—Continued

[For rural renal facilities]

MSA Code	Name of MSA	State	Hospital	Independent
UT	UTAH	UT	128.56	124.24
VT	VERMONT	VT	127.57	123.18
VA	VIRGINIA	VA	127.57	123.18
WA	WASHINGTON	WA	131.35	127.21
WV	WEST VIRGINIA	WV	128.43	124.09
WI	WISCONSIN	WI	127.57	123.18
WY	WYOMING	WY	131.29	127.15

TABLE 20.—COMORBIDITIES

AIDS	
042	Human immunodeficiency disease
Peripheral vascular disease	
0400	Gas gangrene
4151	Pulmonary embolism and infarction
41511	Pulmonary embolism and infarction, iatrogenic pulmonary embolism and infarction
440	Atherosclerosis
4400	Atherosclerosis of aorta
4401	Atherosclerosis of renal artery
4402	Atherosclerosis of native arteries of the extremities
44020	Atherosclerosis of native arteries of the extremities, unspecified
44021	Atherosclerosis of native arteries of the extremities, with intermittent claudication
44022	Atherosclerosis of native arteries of the extremities, with rest pain
44023	Atherosclerosis of the extremities with ulceration
44024	Atherosclerosis of the extremities with gangrene
44029	Atherosclerosis of native arteries of the extremities, with ulceration
4403	Atherosclerosis of bypass graft of the extremities
44030	Atherosclerosis of bypass graft of the extremities of unspecified graft
44031	Atherosclerosis of bypass graft of the extremities of autologous vein bypass graft
44032	Atherosclerosis of bypass graft of the extremities of nonautologous biological bypass graft
441	Aortic aneurysm and dissection
4410	Aortic aneurysm and dissection, dissection of aorta
44100	Aortic aneurysm and dissection, dissection of aorta, unspecified site
44101	Aortic aneurysm and dissection, dissection of aorta, thoracic
44102	Aortic aneurysm and dissection, dissection of aorta, abdominal
44103	Aortic aneurysm and dissection, dissection of aorta, thoracoabdominal
4411	Thoracic aneurysm, ruptured
4412	Thoracic aneurysm without mention of rupture
4413	Abdominal aneurysm, ruptured
4414	Abdominal aneurysm without mention of rupture
4415	Aortic aneurysm of unspecified site, ruptured
4416	Thoracoabdominal aneurysm, ruptured
4417	Thoracoabdominal aneurysm without mention of rupture
4419	Aortic aneurysm and dissection of unspecified site without mention of rupture
442	Other aneurysm
4420	Other aneurysm of artery of upper extremity
4421	Other aneurysm of renal artery
4422	Other aneurysm of iliac artery
4423	Other aneurysm of artery of lower extremity
4428	Other aneurysm of other specified artery
44281	Other aneurysm of other specified artery, artery of neck
44282	Other aneurysm of other specified artery, subclavian artery
44283	Other aneurysm of other specified artery, splenic artery
44284	Other aneurysm of other specified artery, other visceral artery
44289	Other aneurysm of other specified artery, other
4429	Other aneurysm of unspecified site
443	Other peripheral vascular disease
4430	Other peripheral vascular disease, Raynaud's syndrome
4431	Other peripheral vascular disease, thromboangiitis obliterans [Buerger's disease]
4432	Other peripherovascular diseases, other arterial dissection
44321	Other peripherovascular diseases, other arterial dissection, dissection of carotid artery
44322	Other peripherovascular diseases, other arterial dissection, dissection of iliac artery
44323	Other peripherovascular diseases, other arterial dissection, dissection of renal artery
44324	Other peripherovascular diseases, other arterial dissection, dissection of vertebral artery
44329	Other peripherovascular diseases, other arterial dissection, dissection of other artery
4438	Other peripheral vascular disease, other specified peripheral vascular disease
44381	Other peripheral vascular disease, other specified peripheral vascular disease, peripheral angiopathy in diseases classified elsewhere
44389	Other peripheral vascular disease, other specified peripheral vascular disease, other
4439	Peripheral vascular disease, unspecified

TABLE 20.—COMORBIDITIES

444	Arterial embolism and thrombosis
4440	Arterial embolism and thrombosis, of abdominal aorta
4441	Arterial embolism and thrombosis, of thoracic aorta
4442	Arterial embolism and thrombosis, of arteries of the extremities
44421	Arterial embolism and thrombosis, of arteries of the extremities, upper extremity
44422	Arterial embolism and thrombosis, of arteries of the extremities, lower extremity
4448	Arterial embolism and thrombosis, of other specified artery
44481	Arterial embolism and thrombosis, of other specified artery, upper extremity
44489	Arterial embolism and thrombosis, of other specified artery, lower extremity
449	Arterial embolism and thrombosis, of unspecified artery
4450	Atheroembolism, of extremities
44501	Atheroembolism, of extremities, upper extremity
44502	Atheroembolism, of extremities, lower extremity
446	Polyarteritis nodosa and allied conditions
4460	Polyarteritis nodosa and allied conditions, polyarteritis nodosa
451	Phlebitis and thrombophlebitis
4510	Phlebitis and thrombophlebitis of superficial vessels of lower extremities
4511	Phlebitis and thrombophlebitis, of deep vessels of lower extremities
45111	Phlebitis and thrombophlebitis, of deep vessels of lower extremities, femoral vein
45119	Phlebitis and thrombophlebitis, of deep vessels of lower extremities, other
4512	Phlebitis and thrombophlebitis, of lower extremities, unspecified
45181	Phlebitis and thrombophlebitis, of other sites, iliac vein
45182	Phlebitis and thrombophlebitis, of other sites, of superficial veins of upper extremities
45183	Phlebitis and thrombophlebitis, of other sites, of deep veins of upper extremities
45184	Phlebitis and thrombophlebitis, of upper extremities, unspecified
45189	Phlebitis and thrombophlebitis, other
4519	Phlebitis and thrombophlebitis, unspecified
453	Other venous embolism and thrombosis
4530	Other venous embolism and thrombosis, Budd-Chiari syndrome
4531	Other venous embolism and thrombosis, Thrombophlebitis migrans
4532	Other venous embolism and thrombosis of vena cava
4533	Other venous embolism and thrombosis of renal vein
4538	Other venous embolism and thrombosis of other specified sites
4539	Other venous embolism and thrombosis of unspecified site

I. Section 731(b)—Coverage for Routine Costs of Category A Clinical Trials

[If you choose to comment on issues in this section, please include the caption ''Section 731(b)'' at the beginning of your comments.]

Section 1862(m) of the Act, as added by Section 731(b) of the MMA, prohibits the Secretary from excluding payment for the routine costs of care furnished to a Medicare beneficiary participating in a clinical trial of a Category A device based on a determination that such care is not ''reasonable and necessary'' under section 1862(a)(1). In effect, this section authorizes Medicare to cover the routine costs of clinical trials involving Category A devices. Category A (experimental/investigational) devices are defined in § 405.201 as innovative medical devices about which the Food and Drug Administration (FDA) has major questions about safety and effectiveness.

For a trial to qualify for payment of routine costs, it must meet certain criteria established by the Secretary to ensure that the trial conforms to appropriate scientific and ethical standards. Current criteria are established in the National Coverage Determination Manual (CMS Pub. 100–3, Manual section 310.1).

In addition, the MMA established additional criteria for trials initiated before January 1, 2010 to ensure that the devices involved in these trials be intended for use in the diagnosis, monitoring, or treatment of an immediately life-threatening disease or condition. Guidelines for determining if a device meets this requirement will be defined through the NCD process.

Section 411.15(o) currently precludes Medicare payment for Category A devices. We would not revise this section because the MMA does not require Medicare to pay for the cost of the Category A device (as opposed to the cost of routine care associated with the trial of a Category A device).

We are proposing changes to § 405.207. As currently written, this section precludes coverage of services related to a noncovered device. Since the Category A device is noncovered, we would amend this section to allow coverage of routine care services related to a noncovered Category A device. In addition, we propose language to cross-reference § 405.201 concerning coverage of Category B (nonexperimental/investigational) devices. We would not be changing coverage of Category B devices, but providing consistency by placing information on Category A and Category B devices in the same section.

J. Section 629—Part B Deductible

[If you choose to comment on issues in this section, please include the caption ''Section 629'' at the beginning of your comments.]

Section 629 of the MMA provides for regular updates to the Medicare Part B deductible in consideration of inflationary changes in the nation's economy. Since 1991, the Medicare Part B deductible has been $100 per year. The MMA stipulates that the Medicare Part B deductible will be $110 for calendar year 2005, and, for a subsequent year, the deductible will be the previous year's deductible increased by the annual percentage increase in the monthly actuarial rate under section 1839(a)(1) of the Act, ending with that subsequent year (rounded to the nearest dollar). Section 1839(a)(1) of the Act requires the Secretary of Health and Human Services to calculate the monthly actuarial rate for Medicare enrollees age 65 and over.

We propose to update § 410.160(f), ''Amount of the Part B annual deductible,'' to conform to the MMA and to reflect that the Medicare Part B deductible is $100 for calendar years

1991 through 2004. Finally, we plan to publish an annual notification in the **Federal Register**, announcing each upcoming year's Part B deductible. This notification for the Part B deductible will be included as part of the annual notice we currently publish announcing Medicare's Part B premiums and actuarial rates.

K. Section 512—Hospice Consultation

[If you choose to comment on issues in this section, please include the caption ''Section 512'' at the beginning of your comments.]

1. Coverage of Hospice Consultation Services

Effective January 1, 2005, section 512 of the MMA provides for payment to be made to a hospice for specified services furnished by a physician who is either the medical director of or employee of a hospice agency. Payment will be made on behalf of a beneficiary who is terminally ill (which is defined as having a prognosis of 6 months or less if the disease or illness runs its normal course), has not made a hospice election, and has not previously received the pre-election hospice services specified in section 1812(a)(1)(5) of the Act as added by section 512 of the MMA. These services comprise an evaluation of an individual's need for pain and symptom management, counseling the individual regarding hospice and other care options, and may include advising the individual regarding advanced care planning.

The decision to elect hospice services is a personal choice and is generally a decision made between the individual and his or her physician (probably the physician making the terminal diagnosis). Therefore, we believe that most individuals will seek this type of service from their own physician. Thus, we do not expect that the services of a hospice physician would be necessary for all individuals who elect hospice. However, a beneficiary, or his/her physician may seek the expertise of a hospice medical director or physician employee of a hospice to assure that a beneficiary's end-of-life options for care and pain management are discussed and evaluated.

Currently, beneficiaries are able to receive this evaluation, pain management, counseling, and advice through other Medicare benefits. For example, physicians, typically those who determine the beneficiary's terminal diagnoses, can provide for these evaluation and management services as well as for pain and symptom management under the physician fee schedule. Beneficiaries may also obtain assistance with decisions pertaining to end-of life issues through discharge planning in hospitals and through services of social workers, case managers, and other health care professionals. To the extent that beneficiaries have already received Medicare-covered evaluation and counseling with respect to end-of-life care, the hospice evaluation and counseling would seem duplicative. We intend to monitor data regarding these services to assess whether Medicare is paying for duplicative services.

We are proposing to cover the services described above for a terminally ill beneficiary, at the request of the beneficiary or the beneficiary's physician. The service would, in accordance with the statute, be available on a one-time basis to a beneficiary who has not elected or previously used the hospice benefit, but who might benefit from evaluation and counseling with a hospice physician regarding the beneficiary's decision-making process or to provide recommendations for pain and symptom management. Since the beneficiary or his/her physician decides to obtain this service from the hospice medical director or physician employee, the evaluation and counseling service may not be initiated by the hospice, that is, the entity receiving payment for the service.

The statute specifies that payment will be made to the hospice when the physician providing the service is an employee physician or medical director of a hospice. Therefore, other hospice personnel, such as nurse practitioners, nurses, or social workers, cannot furnish the services. The statute requires the physicians to be employed by a hospice; therefore, the service cannot be furnished by a physician under contractual arrangements with the hospice or by the beneficiary's physician, if that physician is not an employee of the hospice. Moreover, if the beneficiary's physician is also the medical director or physician employee of a hospice, that physician already possesses the expertise necessary to furnish end-of-life evaluation, management, and counseling services and is providing these services to the beneficiary and is receiving payment for these services through the use of evaluation and management (E&M) codes.

In the event that the individual's physician initiates the request for services of the hospice medical director or physician, we would expect that appropriate documentation guidelines would be followed. The request or referral would be in writing, and the hospice medical director or employee physician would be expected to provide a written note on the patient's medical chart. The hospice employee physician providing these services would be required to maintain a written record of this service. If the beneficiary initiates the services, we would expect that the hospice agency would maintain a written record of the service and that communication between the hospice medical director or physician and the beneficiary's physician would occur, with the beneficiary's permission, to the extent necessary to ensure continuity of care.

We propose to add new § 418.205 and § 418.304(d) to implement section 512 of the MMA.

2. Payment for Hospice Consultation Services

Section 512(b) of the MMA amends section 1414(i) of the Act and establishes payment for this service at an amount ''equal to an amount established for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity and requiring medical decision-making of low complexity under the physician fee schedule, other than the portion of such amount attributable to the practice expense component.'' No existing CPT or HCPCS code specifically represents these services. We are proposing to establish a new HCPCS code, G0xx4 *Hospice—evaluation and counseling services, pre-election*. The hospice would use this HCPCS code to submit claims to the Regional Home Health Intermediary (RHHI) for payment for these services. Utilization of this code would allow us to provide payment for this service as well as enable us to monitor the frequency with which the code is used and to assess whether the code is used appropriately. Payments by hospices to physicians or others in a position to refer patients for services furnished under this provision may implicate the Federal anti-kickback statute.

In accordance with the statute, we are proposing that the payment amount for this service would be based on the work and malpractice expense RVUs for CPT code 99203 multiplied by the CF (1.34 Work RVU + 0.10 Malpractice RVU)* (CF). This CPT code for an office or outpatient visit for the evaluation and management of a new patient represents a detailed history, detailed examination and medical decision making of low complexity, which, we believe, is quite similar to the components of this new service provided by a medical director or physician employed by the hospice

agency. Assuming that there are no changes in RVUs for CPT code 99203 and that the CY 2005 update to the physician fee schedule is the 1.5 percent specified in the MMA, the national payment amount for this service would be $54.57 for this service (1.44 * 37.8975).

L. Section 302—Clinical Conditions for Coverage of Durable Medical Equipment (DME)

[If you choose to comment on issues in this section, please include the caption ''Section 302'' at the beginning of your comments.]

1. Legislative Requirement

Section 1832(a)(1)(E) of the Act, as added by section 302(a)(2) of the MMA, requires the Secretary to establish clinical conditions for payment of covered items of durable medical equipment (DME). The law requires the Secretary to establish types or classes of covered items that require a face-to-face examination of the individual by a physician or practitioner and also require a prescription for these items.

Covered items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) have already been divided into classes of covered items, as established by the local medical review policies (LMRP) and local coverage determinations (LCD) issued by the durable medical equipment regional carriers (DMERCs). For example, the contractors have developed policies on long term home oxygen therapy, canes, crutches, wheelchairs, hospital beds, urological supplies, spinal orthoses, surgical dressing, and enteral and parenteral nutrition therapy. These and other policies for each of the four DMERCs are entered into the Medicare Coverage Database at *http://www.cms.hhs.gov/coverage*.

These policies are developed based on clinical evidence and after discussion with clinical experts in the area. There are already a number of local coverage determinations and national coverage determinations that outline the clinical conditions for which these items are covered. These determinations outline the conditions for coverage, payment, and the documentation or testing necessary to establish medical necessity. We propose to continue developing these clinical conditions of coverage through the local and national coverage determination process.

We are also proposing to expand the requirement for clinical conditions of coverage to medical supplies, appliances and devices defined in 42 CFR 410.36. These are commonly referred to as prosthetics, orthotics and supplies (POS). We believe items of POS require the same level of medical intervention and skill as DME. As with DME, there are already a number of local and national coverage determinations outlining appropriate clinical conditions for coverage and propose to continue this process.

From a clinical perspective, we believe that it is appropriate for beneficiaries requiring DMEPOS to be under the care of a physician and for DMEPOS orders to occur in the context of routine clinical care. We believe it is good clinical practice for the beneficiary to be seen by the physician for their medical condition and the physician to decide whether or not an item of DMEPOS is appropriate during the face-to-face examination of the beneficiary. Since we expect a beneficiary to be seen by their physician for a specific medical condition, we do not believe that a requirement for a face-to-face examination for initial orders and at the time of the prescription renewals for items of continued need (those DMEPOS items where an order is good for only a certain period of time and requires a follow-up examination by the physician) would place a burden on the physician or beneficiary, as it would be part of a necessary examination. We believe this to be the current practice in most cases.

Our goal is to encourage quality care, to mitigate any proliferation of use of these products and ensure that only patients that need items of DMEPOS receive them. To comply with the requirements of section 302(a)(2) of the MMA and to enhance quality and reduce fraud, we would establish basic requirements that apply to all items of durable medical equipment, prosthetics, orthotics, and supplies. We have identified a proliferation of use for some items of DMEPOS and we believe that engaging the physician or practitioner early in the process of ordering DMEPOS will assist us in mitigating any unnecessary proliferation of use.

This regulation proposes to make a face-to-face exam by the physician to determine the medical necessity and ordering an item of DMEPOS an explicit requirement for all initial orders of DMEPOS and at the time of prescription renewal for all DMEPOS continued need items. However, we seek specific comments about whether specific items of DMEPOS should be exempt from the face-to-face examination requirement.

In order for us to verify the medical necessity for an item, the prescribing physician's or practitioner's records must document the need at the time the physician or practitioner examines the beneficiary. For example, a letter to the supplier or to us dated months after the date the examination was conducted and the order was written would not be sufficient verification.

2. Provisions Related to DMEPOS

To implement the provisions of the MMA, we would—

- Establish a requirement for a face-to-face examination by a physician, physician assistant (PA), clinical nurse specialist (CNS), or nurse practitioner (NP), as they are defined in the Act (the prescribing physician or practitioner) to determine the medical necessity of durable medical equipment, orthotics and prosthetics.
- Require that the prescribing physician or practitioner be independent from the DMEPOS supplier and may not be a contractor or an employee of the supplier.
- Establish a requirement that the face-to-face examination should be for the purpose of evaluating and treating the patient's medical condition and not for the sole purpose of obtaining the prescribing physician's or practitioner's order for the DMEPOS. We expect the prescribing physician or practitioner to conduct a sufficient examination of the patient's medical condition to ascertain the appropriate overall treatment plan and to order the DMEPOS as only one aspect of that treatment plan.
- Require an order prior to delivery for all items of durable medical equipment, prosthetics, or orthotics.
- Require that the order be dated and signed within 30 days after the face-to-face examination and include verification of the examination. We are soliciting comments on the appropriate verification process.
- Require the prescribing physician or practitioner to maintain appropriate and timely documentation in the medical records that support the need for all DMEPOS ordered.
- Provide that we would promulgate through contractor instructions other criteria required for payment, such as for prescription renewal requirements, repair, minor revisions and replacement. We are interested in comments on whether the Agency should establish national renewal requirements or permit contractor discretion.
- Provide that we would promulgate through the national coverage determination process or through the local coverage determination process additional clinical conditions for items of DMEPOS.

We propose to revise language in § 410.36 and § 410.38 to implement section 302(a)(2) of the MMA.

M. Section 614—Payment for Certain Mammography Services

[If you choose to comment on issues in this section, please include the caption ''Section 614'' at the beginning of your comments.]

Medicare covers an annual screening mammogram for all beneficiaries who are women age 40 and older, and one baseline mammogram for beneficiaries who are women age 35 through 39. Medicare also covers medically necessary diagnostic mammograms. Payment for screening mammography, regardless of setting, is paid under the physician fee schedule, but diagnostic mammography performed in the hospital outpatient department is currently paid under the hospital outpatient prospective payment system (OPPS).

Section 614 of the MMA amended section 1833(t)(1)(B)(iv) of the Act to exclude payment for screening and diagnostic mammograms from the OPPS. In the OPPS proposed rule, we will discuss our proposal for payment for diagnostic mammograms using the payments established under the physician fee schedule. This proposal will parallel the current practice used for the payment of screening mammography services provided in the OPPS setting and will be effective January 1, 2005.

N. Section 305—Payment for Inhalation Drugs

[If you choose to comment on issues in this section, please include the caption ''Section 305'' at the beginning of your comments.]

1. Background

Lung diseases such as chronic obstructive pulmonary disease (COPD) affect large numbers of Medicare beneficiaries. COPD is the fourth largest cause of death in America behind heart disease, certain cancers, and stroke. We hope to reduce the number of new COPD cases by educating Americans about the disease, its causes, and ways to prevent it. We hope to improve the lives of Medicare beneficiaries and improve beneficiary access to treatment for those who already suffer from these conditions.

Depending on an individual's age and health, a number of steps can be taken to treat or prevent this. Because approximately 85 percent of those with COPD are smokers, the first step to avoid the disease is to stop smoking. Smoking has been linked to a large number of health problems and is a leading cause of cancer and pulmonary disease. The Department of Health and Human Services (HHS) has been actively encouraging Americans to quit smoking through its smoking cessation initiatives. Americans who quit smoking will enjoy longer, healthier lives and avoid diseases such as COPD.

We have also recently approved services to address the needs of Americans suffering from COPD, including lung-volume reduction surgery, which, performed in more serious cases, removes the diseased lung tissue, allowing the rest of the lung to function better. Specifically, effective January 1, 2004, Medicare expanded coverage of lung volume reduction surgery to include patients, who are not high-risk surgical patients, who either have severe, upper-lobe emphysema, or have severe, non-upper-lobe emphysema with low exercise capacity.

A number of drugs are available to treat the persons with asthma or who develop COPD. These include agents, often inhaled, that expand the bronchial tubes, allowing the patient to breathe more freely. Access to these drugs for Medicare beneficiaries has been expanded by the MMA.

Nebulizers and metered dose inhalers (MDIs) are two different delivery methods to administer inhalation drugs to a beneficiary. A nebulizer works by aerosolizing liquefied inhalation drugs so that the medication can be more easily inhaled into the lungs. For about 10 to 30 minutes, a beneficiary breathes the mist via compressor tubing hooked up to the nebulizer. An MDI consists of a canister of pressurized medication that is propelled directly into the airways of the lungs when a beneficiary presses on the inhaler and breathes in through the mouth, thereby allowing the medicine to take effect quickly.

Medicare Part B currently pays for nebulizers and inhalation drugs. However, Medicare Part B does not cover MDIs and, therefore, does not pay for inhalation drugs delivered by an MDI. An MDI is considered to be an item of disposable medical equipment (for which there is no current Part B benefit category) while a nebulizer is considered to be an item of DME.

The Part D drug benefit improves beneficiary access to inhalation therapy by covering MDIs (including the inhalation drugs they furnish) beginning January 1, 2006. In addition, the prescription drug discount card began offering discounts on MDIs effective June 1, 2004.

Since Medicare currently covers inhalation drugs provided through nebulizers, but not alternative forms of inhalation therapy, there are strong financial incentives toward use of the former compared to alternatives. Our review of the literature over the past decade did not find that bronchodilators delivered via nebulizers were more effective than bronchodilators delivered via metered dose inhalers.

Since one delivery method is not clinically superior to the other, when Medicare covers both methods of delivery of inhalation therapy, the decision to prescribe one over the other will be made by the physician and beneficiary based on beneficiary needs and preferences consistent with applicable standards of medical practice. It would not be unlikely for many beneficiaries to choose the convenience of MDIs over nebulizers once the Medicare coverage imbalance is removed in 2006. Since MDIs are less expensive, very portable, and easier to use, it is likely there will be a substantial shift of Medicare beneficiaries from nebulizers to MDIs beginning in 2006, even absent the Medicare payment changes for nebulizers and inhalation drugs in 2005.

2. What Medicare Part B Currently Covers

Medicare Part B currently covers and pays for five separate items related to nebulizers. All of the items are subject to the standard Part B deductible and coinsurance.

a. Nebulizers

Medicare Part B currently covers the rental of nebulizers. Nebulizers are in the ''capped rental'' category of DME for payment purposes. Payment is made on a monthly basis during the period of medical need. Medicare pays 10 percent of the payment amount during the first three months and 7.5 percent during the next 12 months. Section 1834(a) of the Act specifies that the payment amount is equal to the amount paid for purchase of the nebulizer in 1986, indexed to current levels by the cumulative DME update factor specified in this subsection. Thus, Medicare will pay up to a cumulative total of 120 percent of the payment amount for 15 months of renting a nebulizer.

If the beneficiary needs a nebulizer for more than 15 months, and continues to rent it, Medicare makes no further payment for the equipment because the equipment has already been paid for. Medicare does continue to pay for maintenance and servicing of the nebulizer, as well as the inhalation drugs, but the supplier retains title to the equipment.

During the 10th month of continuous rental of a nebulizer, the supplier is required to offer the beneficiary a purchase option, and if the beneficiary accepts the offer and exercises the

purchase option, the supplier transfers title to the nebulizer in the 13th month. In this case, Medicare would make its final monthly rental payment in the 13th month, and the title then would transfer to the beneficiary. About 3 percent of beneficiaries exercise the purchase option.

In 2003, the average Medicare monthly rental payment for nebulizers was $19.07 for the first three months and $14.30 for the fourth through fifteenth month. Thus, Medicare would pay $228.81 for a nebulizer if the beneficiary's period of medical need were 15 months. There are various types of nebulizers (compressor, ultrasonic, portable, disposable) and nebulizer accessories (breathing circuits, air filters, tubing extensions, mouthpieces, spare battery packs, DC adapters) available. Internet prices for compressor nebulizers range from $50 to $100, and prices for portable nebulizers range from $100 to $200, depending on the specific features of the nebulizer. The Medicare payment amount includes payment for delivery of the equipment. (Shipping costs for nebulizers available for purchase on the Internet range from free shipping up to $25).

b. Maintenance and Servicing of Nebulizers

Medicare Part B makes an additional separate payment to the supplier for maintenance and servicing of the equipment (for parts and labor not covered by the supplier's or manufacturer's warranty). For nebulizers that are not purchased, but are used for more than 21 months, the servicing fee covers six-month periods beginning after the 21st month of use. As required by section 1834(a)(7) of the Act, Medicare's payment for maintenance and servicing is equal to the lesser of a reasonable and necessary maintenance and servicing fee, or 10 percent of the total purchase price of the equipment. For nebulizers that are purchased, Medicare may make a payment to the supplier for any necessary maintenance and servicing that is performed.

In 2003, the average service fee for nebulizers was $19.07 per six-month period. Other than routine cleaning of the unit (that is, cleaning and changing filters, cleaning and disinfecting nebulizers, tubing, and mouthpieces), very little maintenance is required to maintain a nebulizer's peak performance. There is usually no scheduled maintenance for the nebulizer. Medicare pays for the usual frequency for replacement of accessories. Maintenance kits and replacement parts are available through online suppliers for approximately $5 to $15.

c. Inhalation Drugs

Medicare Part B pays for drugs that the nebulizer furnishes to a beneficiary. Unlike nebulizers, inhalation drugs are not an explicit benefit covered by statute. However, there was an administrative decision made early in the program's history to cover inhalation drugs as a supply so that the nebulizer could work. Without the inhalation drugs, the nebulizer would not be effective for a beneficiary.

The two most common inhalation drugs used by beneficiaries are albuterol sulfate (a beta-adrenergic bronchodilator) and ipratropium bromide (an anticholinergic bronchodilator). A beneficiary may use one or the other of these inhalation drugs, and they are frequently prescribed together. Both albuterol sulfate and ipratropium bromide are manufactured in powder form, but are generally liquefied and furnished to beneficiaries in liquid form for use in a nebulizer. The beneficiary may use a solution of one drug, or a combination of both drugs, in addition to saline if necessary, with the nebulizer. The beneficiary may mix the solution, or the supplier may furnish the drug in a pre-mixed form (either commercially pre-mixed or pharmacy compounded). The shelf life of these drugs is at least 18 to 24 months, and they do not require any special storage arrangements such as refrigeration.

Medicare also pays for other inhalation drugs, such as budesonide (an inhaled corticosteroid), which are used in conjunction with albuterol sulfate and ipratropium bromide. These drugs can also be administered using a nebulizer or an MDI.

d. Dispensing Fee

Medicare has paid a monthly $5 dispensing fee for each covered inhalation drug or combination of drugs used in a nebulizer. The dispensing fee is paid for each drug dispensed, not the number of unit dose vials provided to the beneficiaries. Additionally, if two or more drugs are combined in single unit dose vials, only one dispensing fee will be paid per drug combination per month. A dispensing fee for saline is not separately billable or payable. Inhalation drugs are the only drugs for which Medicare Part B currently pays a separate dispensing fee.

e. Beneficiary Training.

In 2003, CPT code 94664 was revised to include beneficiary training by a physician or physician's staff regarding use of a nebulizer, MDI, aerosol generator, or intermittent positive pressure breathing (IPPB) machine. The narrative terminology for the code currently is—Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB machine.'' The 2004 Medicare physician fee schedule payment for this service is $13.44. This service has no physician work relative value units reflecting that the training is typically performed by physician office staff. In 2004, this service has 0.32 practice expense relative value units (RVUs) and 0.04 malpractice RVUs. Additionally, the supplier of the nebulizer, under § 424.57(c)(12), must ''document that it or another qualified party has at an appropriate time, provided beneficiaries with necessary information and instructions on how to use Medicare covered-items safely and effectively.'' Beneficiary training by a physician or physician's staff regarding use of a nebulizer would meet the definition of ''another qualified party'' for purposes of this supplier requirement.

3. Medicare Spending for Nebulizers and Inhalation Drugs

In 2003, Medicare spent about $1.6 billion for nebulizers and inhalation drugs. This amount includes—

(a) About $130 million for nebulizers (both rental and purchase) and nebulizer related accessories and supplies;

(b) About $13 million for servicing/maintenance fees;

(c) About $1.3 billion for albuterol sulfate and ipratropium bromide and another $120 million for other inhalation drugs for a total of approximately $1.4 billion. (This represents about 88 percent of Medicare spending for inhalation therapy.);

(d) About $35.5 million for 7.1 million dispensing fees; and

(e) About $4.5 million for beneficiary training under CPT code 94664 (though this figure also includes training for other items as well as nebulizers).

Medicare spending for inhalation drugs has grown rapidly. Preliminary data indicate that between 2001 and 2003, Medicare spending increased by 77 percent for albuterol sulfate and ipratropium bromide.

4. Inspector General and General Accounting Office Studies

The HHS IG issued 10 reports between February 1996 and January 2004 about Medicare payments for albuterol sulfate and ipratropium bromide in excess of acquisition costs. In a report issued in September 2001,

the General Accounting Office (GAO) also concluded that Medicare payment for these drugs was in excess of acquisition costs.

Table 1 of the Interim Final Rule regarding Changes to Medicare Payment for Drugs and Physician Fee Schedule Payments for Calendar Year 2004, published in the January 7, 2004 **Federal Register** (69 FR 1084), showed that the acquisition cost (averaging IG and GAO results) was 34 percent of the Average Wholesale Price (AWP) for ipratropium bromide and 17 percent for albuterol sulfate. Prior to 2004, Medicare paid 95 percent of the AWP for each of these drugs and beneficiary coinsurance was 20 percent of the Medicare payment amount. In the case of albuterol sulfate, the beneficiary coinsurance was more than the actual acquisition cost for the drug. During 2004, Medicare payment is 80 percent of the AWP for each of these drugs. Beginning with 2005, Medicare payment will be 106 percent of the Average Sales Price (ASP).

The IG report issued in January 2004 again concluded that Medicare payments were far in excess of acquisition costs for both albuterol sulfate and ipratropium bromide. The IG found that the Medicare 2004 payment (and payment in prior years) was a multiple of the actual acquisition costs for both drugs based on a comparison to the median price that the drug was available through wholesalers/distributors and group purchasing organizations (GPOs) and comparison to the manufacturer-reported Wholesale Acquisition Cost (WAC).

5. Inhalation Drug Spread

In 2003, ipratropium bromide and albuterol sulfate were the third and seventh largest drugs in terms of Medicare spending for carrier paid drugs. The differences between Medicare's payment amount and acquisition costs (that is, spread) for albuterol sulfate and ipratropium bromide are among the largest spreads for drugs studied by the IG and GAO. Based on the actual acquisition costs determined by IG and GAO studies, in 2003, Medicare paid an estimated nearly $900 million in excess of acquisition costs for albuterol sulfate and ipratropium bromide.

The IG and GAO findings of large differences between Medicare payment amounts and acquisition costs for inhalation drugs provided the foundation for Congressional enactment of section 305 of the MMA. This section of the MMA sets Medicare payment for inhalation drugs at 106 percent of the ASP. (The Congressional Budget Office's November 20, 2003 pricing of the MMA estimated section 305 as having savings of $4.2 billion over 10 years.)

Suppliers argue that inhalation drug spread has allowed them to fund activities related to care for beneficiaries with asthma or COPD that otherwise do not have a Medicare Part B benefit category. These other activities may include the following:

- Respiratory therapists on staff or in networks available on-call for home visits or telephone consultations.
- On-call pharmacists.
- Monthly calls to schedule medication refills.
- Continuous education on disease states, including monthly follow-ups.
- 24-hour support lines.
- On-call and/or monthly home delivery of medication and supplies.
- Quality improvement programs.

6. Nebulizers vs. MDIs

Medicare Part B currently covers only one type of inhalation therapy, nebulizers and inhalation drugs. Although Medicare Part B does not cover MDIs and the inhalation drugs they furnish, the new Part D benefit beginning in 2006 will cover these alternative hand-held inhalation therapy devices (MDIs). In addition, the discount card and $600 transitional assistance payment for low-income beneficiaries will help seniors buy inhalers in 2004 and 2005, helping to bridge the gap until 2006 when coverage begins.

MDIs are the quickest and easiest way to take inhalation medication for most asthmatics and patients with COPD. The medication is propelled directly into the lungs, allowing it to take effect more quickly, and with fewer medication side effects. An MDI contains a specific number of ''metered inhalations,'' and is made to deliver the prescribed amount of medication for the labeled number of doses (typically 200 doses, which is 8 doses per day for 25 days). Inhalation accessory devices, such as holding chambers and spacers, are used to improve the direction and deposition of medication delivered by MDIs, making it easier for beneficiaries to use an MDI and making the MDI more effective in delivering the medicine to the lungs.

Since Medicare currently covers nebulizers and inhalation drugs, but not alternative forms of inhalation therapy, there are strong financial incentives toward use of the former compared to alternatives. Our review of the literature over the past decade, including two meta-analyses and over two dozen individual studies applicable to adults, did not find that bronchodilators delivered via nebulizer were more effective than when delivered via metered dose inhaler.

Since one delivery method is not clinically superior to the other, when Medicare covers both methods of delivery of inhalation therapy, the decision to prescribe one over the other will be made by the physician and beneficiary based on beneficiary needs and preferences consistent with applicable standards of medical practice. It would not be unlikely for many beneficiaries to choose the convenience of MDIs over nebulizers once the Medicare coverage imbalance is removed in 2006. Since MDIs are less expensive, very portable, and easier to use, it is likely there will be a substantial shift of Medicare beneficiaries from nebulizers to MDIs beginning in 2006, even absent the Medicare payment changes for nebulizers and inhalation drugs in 2005.

Some claim that beneficiaries cannot use MDIs because they do not have the dexterity to use them. Use of an MDI requires proper inhalation techniques in order to receive the full benefit possible from the amount of medication included in each dose. Spacers and holding chambers extend the mouthpiece of the inhaler and increase the air volume into which the medication is atomized, allowing more time for the patient to breathe the medication and avoid misdirecting the medication onto the soft tissues inside the mouth where it will have little effect on lung function.

A nebulizer may also require a certain level of dexterity (that is, operating, maintaining, and cleaning the nebulizer correctly). There may also be beneficiaries who do not have the dexterity to use either an MDI or nebulizer, which would require the availability of alternative therapies, such as an IPPB machine to aid in the delivery of aerosol medication by increasing the depth of breathing more than the patient alone can achieve.

7. Payments Beginning in 2005 Including Provisions of the Proposed Rule

Our goal is to assure that each beneficiary who needs inhalation therapy has access to the most appropriate medication and delivery method. We expect that the combined changes to cover MDIs, adjust payments for inhalation drugs, and provide for an appropriate dispensing fee will improve beneficiary access and choice. We seek comments about an appropriate amount for a dispensing fee that would assure beneficiary access to inhalation medications provided through nebulizers.

We believe that a dispensing fee is intended to cover a pharmacy's activities to get inhalation drugs to beneficiaries. We seek data and information on the additional services these pharmacies provide to Medicare beneficiaries, the extent to which inhalation drugs can be furnished without these additional services and the extent to which such services are covered under Medicare. We are concerned about significant shifts in beneficiary access to inhalation therapy prior to implementation of the Part D drug benefit in light of the reduction in Medicare payment for inhalation drugs beginning in 2005, and also seek comments about whether the dispensing fee should include a somewhat higher, transitional payment.

Below we discuss, changes in payment for inhalation drugs and nebulizers beginning in 2005.

a. Nebulizers

Section 1834(a)(21) of the Act, as amended by section 302(c)(2) of the MMA, requires a reduction in Medicare payment, beginning with 2005, for specified items of DME, including nebulizers paid under code E0570. The reduction is the difference in payment amounts under Medicare and the median Federal Employees Health Benefits (FEHB) plan, as identified in IG testimony before the Senate Committee of Appropriations on June 12, 2002. Other codes for nebulizers and related equipment are not affected by the payment reduction.

b. Maintenance and Servicing of Nebulizers

Since the maintenance and servicing fee is equal to the first month's rental payment, the maintenance and servicing fee for nebulizers will also be reduced in 2005.

c. Inhalation Drugs

As discussed in the ASP payment section of this proposed rule, for the first quarter of 2005, the Medicare payment at ASP plus 6 percent is estimated to be $0.04 per milligram for albuterol sulfate and $0.30 per milligram for ipratropium bromide. While these figures represent estimated reductions from 2004 payment levels of about 90 percent, they are not necessarily the actual payment amounts for the first quarter of 2005. The actual payment amounts will be based on ASP's calculated from the manufacturer ASP to be submitted for the third quarter of 2004.

Both albuterol sulfate and ipratropium bromide are generic drugs that have multiple manufacturers. Since these ASPs are average figures across all manufacturers, a pharmacy should be able to acquire albuterol sulfate and ipratropium bromide at these prices. Moreover, to the extent there is price variation among manufacturers, there will be some manufacturers with lower prices than others. In this case, a pharmacy might be able to obtain albuterol sulfate and ipratropium bromide at a price below the average.

The Medicare payment amount includes a 6 percent add-on. Assuming that ASP remains constant between the first and third quarters of 2004, the 6 percent add-on would be about $1.00 for a typical month's supply of 450 milligrams of albuterol sulfate and about $3.00 for a 90-day supply. Similarly, the 6 percent add-on would be about $1.60 for a typical month's supply of 93 milligrams of ipratropium bromide and about $4.80 for a 90-day supply. Because albuterol sulfate and ipratropium bromide are often prescribed together, Medicare payment at 106 percent of ASP would include, as additional payments above the acquisition cost of the drugs, a total payment to the supplier of about $2.60 for a 30-day supply and about $7.80 for a 90-day supply of both drugs.

d. Dispensing Fee

Given the overall reduction in payment for inhalation drugs, we are concerned about beneficiary access to these drugs. Because shipping, handling, compounding, and other pharmacy activities would usually exceed the 6 percent payment above the drug acquisition cost, we believe that it is appropriate for Medicare to continue to pay a separate dispensing fee to pharmacies that furnish inhalation drugs to beneficiaries.

We propose to establish a separate dispensing fee for inhalation drugs. This separate dispensing fee will be in addition to the difference between the supplier's acquisition cost and the Medicare payment for the drug. For example, if a supplier is acquiring albuterol and ipratropium bromide for the average sales price, the supplier would receive a separate dispensing fee amount plus their acquisition cost plus $7.80 for a 90-day supply. The $7.80 is the amount included in the payment for the drug itself since Medicare pays 6 percent above the average sales price.

As noted above, Medicare has paid a $5 monthly dispensing fee for each covered inhalation drug or combination of drugs used in a nebulizer. Dispensing fees are paid by Medicaid and private insurers; we seek information about these dispensing fees for inhalation drugs and their applicability to Medicare. In addition, we seek comments about an appropriate dispensing fee amount to cover the shipping, handling, compounding, and other pharmacy activities required to get these inhalation medications to Medicare beneficiaries. We seek data and information that explains the direct labor and non-labor costs as well as indirect costs of overhead for these pharmacy activities as they relate to dispensing of inhalation drugs.

Consideration of dispensing fees needs to be viewed in the context of several important changes and clarifications in Medicare policy and billing requirements.

First, we are proposing to allow a prescription for inhalation drugs covering a 90-day period to be written by a physician and filled by a pharmacy. Current guidelines are that a pharmacy generally should not fill a prescription for inhalation drugs for more than a month's supply for a beneficiary. We believe that this requirement needs revision in the case of inhalation drugs for two key reasons. Most beneficiaries who use inhalation drugs use them for extended periods of time and often use them for the rest of their lives. In addition, we understand that many inhalation drugs are delivered to a beneficiary through the mail. We understand that a mail-order prescription drug model works well for a 90-day prescription. We believe that there will be significant savings in shipping for a 90-day prescription rather than a monthly prescription.

We would expect that reasonableness would govern filling a monthly vs. a 90-day prescription with a physician writing and a pharmacy filling a monthly or a 90-day prescription depending on the circumstances of the beneficiary. For example, it would be reasonable to expect that the first time a beneficiary receives a prescription for a nebulizer and inhalation drugs that the prescription would be for a month. Similarly, it would be reasonable to expect that refill prescriptions for beneficiaries would be for a 90-day period. Carriers would continue to assess claims for dispensed quantities greater than what would be reasonable based on usual dosing guidelines. We would expect that the bulk of prescriptions would be for 90-day periods.

Second, we recently revised the guidelines regarding the time frame for delivery of refills of DMEPOS products to occur no sooner than ''approximately 5 days prior to the end of the usage for the current product''. As previously noted, inhalation drugs are often furnished to a beneficiary by mail. It has

been suggested that Medicare guidelines for refill prescriptions allowed too short of a window between shipping the next month's prescription and the end of the current month. It was argued that as a result, a pharmacy ''effectively'' had to ship the product to a beneficiary using an overnight delivery service.

On January 2, 2004, we revised the guidelines (effective February 2, 2004) regarding the time frame for subsequent deliveries of refills of DMEPOS products to occur no sooner than ''approximately 5 days prior to the end of the usage for the current product'' (see section 4.26.1 of Chapter 4—Benefit Integrity of the Medicare Program Integrity Manual). This change allows shipping of inhalation drugs on ''approximately'' the 25th day of the month in the case of a month's supply, and on ''approximately'' the 85th day in the case of a 90-day supply. We emphasize the word ''approximately''; while we believe that normal ground service shipping would allow delivery in 5 days, if there were circumstances where ground service could not occur in 5 days, the guideline would still be met if the shipment occurs in 6 or 7 days. (''Days'' refers to business days or shipping days applicable to the shipper, that is, a 6 day week in the case of the U.S. Postal Service.). We believe that this change eliminates the need for suppliers to use overnight shipping methods and allows shipping of inhalation drugs by less expensive ground service.

Third, we understand that some pharmacies believe that Medicare has a requirement that a pharmacy must obtain an original signed prescription before each prescription is dispensed. The Program Integrity Manual (section 5.1 of Chapter 5) addresses the ordering requirement for DMEPOS items. The Manual indicates that most DMEPOS items, including drugs, can be dispensed based on a verbal order from a physician. The Manual further indicates that a written order must be obtained before submitting a claim, but that such written order may be faxed, photocopied, electronic or pen and ink. The order for inhalation drugs must specify the name of the drug, the concentration (if applicable), dosage, and frequency of administration. We hope that clarification of this requirement would reduce a pharmacy's costs of supplying covered inhalation drugs to Medicare beneficiaries to the extent that pharmacies are currently applying an original signed prescription requirement.

Fourth, Medicare regulations (§ 424.57) specify the requirements a DMEPOS supplier must meet in order to receive payment for a Medicare covered item. Section 424.57(c)(12) contains the proof of delivery requirement and indicates that a ''supplier must be responsible for the delivery of Medicare covered items to beneficiaries and maintain proof of delivery.'' We recently revised the Program Integrity Manual (section 4.26 of Chapter 4) to address proof of delivery requirements for suppliers. As discussed in the Manual, the burden of proving delivery is left to the supplier. The Manual provides examples of the types of proof that are reasonable and acceptable, but it does not provide an all-inclusive list. Other acceptable proof-of-delivery methods may exist and may be employed by suppliers. This documentation is normally only requested by the contractor when a complaint is received that the item was not provided or received. The documentation is necessary to investigate the allegation. We believe that the current provisions on proof of delivery are adequate and appropriate for inhalation drugs.

Fifth, in section IV.H (Assignment of Medicare Claims—Payment to the Supplier) of this proposed rule, we propose to change current regulations at § 424.55 to eliminate the requirement that beneficiaries assign claims to suppliers in situations where suppliers are required by section 1842(o)(3) of the Act to accept assignment. This change would eliminate the need for suppliers to have a signed Assignment of Benefits (AOB) form from a beneficiary in order for Medicare to make payment. Because such section of the Act requires Medicare to make payment for drugs only on an assigned basis, this change would eliminate a billing requirement for drugs, including inhalation drugs. We believe that this change would reduce a pharmacy's costs of supplying covered inhalation drugs to Medicare beneficiaries to the extent that pharmacies are requiring a signed AOB form before submitting a claim.

We believe that the amount of dispensing fee needs to be considered in conjunction with—

(1) Our proposal to allow 90-day prescriptions;

(2) Our recent revision to allow the next month's refill prescription to be shipped approximately 5 business days prior to the end of usage for the product, that is, to allow shipping on the 25th of the month for a month's supply, and shipping or 85th day in the case of a 90-day period;

(3) Our policy clarification regarding signed original orders before a prescription is filled;

(4) Our proof of delivery requirement revisions; and

(5) Our proposed change regarding the Assignment of Benefits form.

e. Beneficiary Training

Medicare Part B will continue to pay for beneficiary training by a physician's staff regarding use of a nebulizer, MDI, aerosol generator, or IPPB machine. Section 424.57(c)(12) specifies that ''The supplier must document that it or another qualified party has at an appropriate time, provided beneficiaries with necessary information and instructions on how to use Medicare covered-items safely and effectively.'' Beneficiary training by a physician or physician's staff regarding use of a nebulizer would meet the definition of ''another qualified party'' for purposes of this supplier requirement.

IV. Other Issues

A. Proposals Related to Therapy Services

1. Outpatient Therapy Services Performed ''Incident To'' Physicians' Services

[If you choose to comment on issues in this section, please include the caption ''Therapy—Incident To'' at the beginning of your comments.]

In last year's proposed rule, we requested comments on clarifying that the personnel qualifications of therapists in home health settings at § 484.4 apply consistently to all therapy settings, including the offices of physical and occupational therapists, physicians, and nonphysician practitioners. We received comments from therapists, physicians, nontherapist health care providers and their representative organizations. After consideration of all comments, we now propose to revise 42 CFR 410.26, 410.59, 410.60 and 410.62 to reflect that physical therapy, occupational therapy, and speech-language pathology services provided incident to a physician's professional services are subject to certain limitations as described at section 1862(a)(20) of the Act.

Regulations in 42 CFR 485.705 specify that, in almost all settings, outpatient rehabilitative therapy services, (physical therapy (PT), occupational therapy (OT), or speech-language pathology (SLP)) can be furnished only by the following individuals meeting the qualifications in § 484.4: physical therapists, occupational therapists, appropriately supervised physical therapist assistants, appropriately supervised occupational therapy assistants, and speech-language pathologists. Some States permit licensed physicians, physician assistants, clinical nurse specialists, and nurse practitioners to furnish PT, OT,

and SLP services also. Therapy services, and those who provide therapy services, must also meet the standards and conditions as specified in Medicare manuals.

Section 1862(a)(20) of the Act permits payment for therapy services furnished incident to a physician's professional services only if the practitioner meets the standards and conditions that would apply to such therapy services if they were furnished by a therapist, with the exception of the licensing requirement. We are proposing to amend the regulations to include the statutory requirement that only individuals meeting the existing qualification and training standards for therapists (with the exception of licensure) consistent with § 484.4 qualify to provide therapy services incident to physicians' services.

Section 1862(a)(20) of the Act refers only to PT, OT, and SLP services and not to any other type of therapy or service. This section applies to services of the type described in section 1861(p), 1861(g) and 1861(ll) of the Act; it does not, for example, apply to therapy provided by qualified clinical psychologists. This section also does not apply to services that are not covered either as therapy or as evaluation and management services provided incident to a physician or nonphysician practitioner such as recreational therapy, relaxation therapy, athletic training, exercise physiology, kinesiology, or massage therapy services.

2. Qualification Standards and Supervision Requirements in Therapy Private Practice Settings

[If you choose to comment on issues in this section, please include the caption ''Therapy Standards and Requirements'' at the beginning of your comments.]

Section 1861(p) includes services furnished to individuals by physical and occupational therapists meeting licensing and other standards prescribed by the Secretary if the services meet the necessary conditions for standards for health and safety. These services include those furnished in the therapist's office or the individual's home. By regulation, we have defined therapists under this provision as physical or occupational therapists in private practice (PTPPs and OTPPs).

Under Medicare Part B, outpatient therapy services, including physical and occupational therapy services, are generally covered when reasonable and necessary and when provided by physical and occupational therapists meeting the qualifications set forth at § 484.4. Services provided by qualified therapy assistants, including physical therapist assistants (PTAs) and occupational therapy assistants (OTAs), may also be covered by Medicare when furnished under the specified level of therapist supervision that is required for the setting in which the services are provided (institutions and private practice therapist offices). For PTPPs and OTPPs, the regulations specify that the PT or OT meets only State licensure or certification standards and do not currently refer to the professional qualification requirements at § 484.4.

Since 1999, when therapy services are provided by PTAs and OTAs in the PT or OT private practice setting, the services must be personally supervised by the PTPP or OTPP. In response to a requirement to report to Congress on State standards for supervision of PTAs, CMS contracted with the Urban Institute. The Urban Institute found that no State has the strict, full-time ''personal'' supervision requirement, for any setting, that Medicare places on PTAs in PTPPs (the report only examined PTAs, which are more heavily regulated than OTAs). The Urban Institute study found that only 7 States require any ''personal'' PTA supervision by the PT, and all 7 required this level of supervision only periodically, every 14, 30 or 60 days. The remaining States and Washington, DC all have less stringent PTA supervision requirements, including: 7 States and Washington, DC require full-time on-site supervision, which corresponds to Medicare's direct supervision level; 16 States require the equivalent of Medicare's general supervision level, which does not require the PT to be on site, but requires the PT to be in contact via telecommunication; and another 16 States have rules for periodic on-site PT visits. Most States permit a supervision level similar to the Medicare ''general'' supervision requirement for physical therapy services delivered in institutional settings. To provide a consistent therapy assistant supervision policy, we are proposing to revise the regulations at 410.59 and 410.60 to require direct supervision of PTAs and OTAs when therapy services are provided by PTs or OTs in private practice. This proposed change would no longer require the personal presence of the PTPP or OTPP when their PTAs or OTAs provide services in the private practice setting. We are particularly interested in receiving comments regarding the proposed PTA supervision change, from personal to direct, for the private practice setting as whether or not it will have implications for the quality of services provided, or for Medicare spending, either through increased capacity to provide these services, or, alternatively, in the event that the Congress again extends the moratorium on the implementation of the limits on Medicare reimbursement for therapy services imposed by the Balanced Budget Act of 1997.

Currently, the OTPP or PTPP regulations at § 410.59(c) and § 410.60(c) do not reference qualification requirements for therapy assistants, or other staff, working for PTs and OTs in private practices. These qualification requirements were removed during 1998 rulemaking—when the coverage conditions requiring survey and certification, at § 486 Subpart D, for independently practicing PTs and OTs were replaced with a simplified carrier enrollment process for PTPPs and OTPPs. In our 1998 rule, at 63 FR 58868, we deleted the references at § 410.59 and § 410.60 to the requirements at § 484.4 for PTs and OTs in private practice. At that time, the qualifications for the staff of the PTPP and OTPP, including PTAs and OTAs, were inadvertently removed because the coverage conditions at § 486 Subpart D were no longer applicable. In order to provide a consistent policy regarding requirements for therapists and therapy assistants, we are proposing to restore the qualifications by adding at § 410.59 and § 410.60 the cross-reference to the qualifications at § 484.4 for privately practicing therapists and their therapy assistants.

3. Other Technical Revisions

[If you choose to comment on issues in this section, please include the caption ''Therapy Technical Revisions'' at the beginning of your comments.]

We are making technical corrections to § 410.62 to refer consistently to speech-language pathology in this section (currently the terms ''speech pathology'' and ''speech-language pathology'' are used interchangeably) and are revising § 410.62(a)(2)(iii) to appropriately reference § 410.61 (the current reference is to § 410.63).

We are also removing subpart D, Conditions for Coverage: Outpatient Physical Therapy Services Furnished by Physical Therapists, from part 486. Our November 1998 rule (63 FR 58868) discussed replacing this subpart with a simplified carrier enrollment process for physical or occupational therapists in private practice; however, the conforming regulatory change to remove Subpart D was never made.

In addition, we are making a technical change at § 484.4 to correct the title ''physical therapy assistant'' to ''physical therapist assistant.''

We are also amending § 410.59(e) and § 410.60(e) to include a reference to the 2-year moratorium on the therapy caps established by section 624 of the MMA.

B. Low Osmolar Contrast Media

[If you choose to comment on issues in this section, please include the caption ''LOW OSMOLAR CONTRAST MEDIA'' at the beginning of your comments.]

Contrast media are used to enhance the images produced by various types of diagnostic radiological procedures. High osmolar contrast media (HOCM), initially developed for use with these procedures, was relatively inexpensive and payment for HOCM is subsumed in the payment for the technical component of these procedures. When the more expensive low osmolar contrast media (LOCM) were developed, estimates showed that if *all* radiologic studies requiring contrast media were to use LOCM, the costs to the Medicare program would have been substantial. At that time, there were no definitive studies showing that the benefits of using LOCM justified the very high additional costs.

When the Medicare physician fee schedule was established, findings of studies of patients receiving both types of contrast media had been published, and the American College of Radiology (ACR) had adopted criteria for the use of LOCM. We determined that the older, less expensive contrast media (HOCM) could be used safely in a large percentage of the Medicare population. However, we also decided that separate payment for LOCM should be made for patients with certain medical characteristics. We adopted the ACR criteria, with some modification, as the basis for a policy that separate payments be made for the use of LOCM in radiological procedures for patients meeting certain criteria. These criteria were established at § 414.38. Specifically, separate payment is made for all intrathecal, intravenous, and intra-arterial injections of LOCM, when it is used for nonhospital patients who have one or more of the following five medical conditions—

- A history of previous adverse reactions to contrast media, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting;
- A history of asthma or allergy;
- Significant cardiac dysfunction, including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;
- Generalized debilitation;
- Sickle cell disease.

Under these conditions, we pay for LOCM, utilizing HCPCS codes A4644 through A4646. The payment amount for LOCM is calculated according to the rules applicable to drugs provided incident to a physician's service. The amount is reduced by 8 percent to account for the allowance for contrast media already included in the technical component of the service.

ACR has requested that we allow further separate payment for LOCM by either expanding or eliminating the conditions. According to ACR, use of LOCM has become the standard in most radiology practices and benefits both physicians and patients. The benefits of uniform use of LOCM would include—

- The reduction of patient discomfort arising when HOCM is used instead of LOCM; and
- A reduction in physician resources now required to screen for high-risk patients.

The price differential between HOCM and LOCM is also decreasing. Universal use of LOCM, along with declining prices, will result in an efficient, and safer alternative to HOCM.

We are proposing to revise the regulations at § 414.38 to eliminate the restrictive criteria for the payment of LOCM. This proposal would make Medicare payment for LOCM consistent across settings. Before January 1, 2003, the criteria in § 414.38 were also used to determine payment in the hospital setting. However, as instructed in our Program Memorandum A–02–120, issued November 22, 2002, hospitals that are subject to the outpatient prospective payment system (OPPS) no longer use these criteria. Instead, payment for both ionic and non-ionic contrast media (including LOCM) is packaged into the APC payment for the procedure. Under OPPS there is no longer a payment difference between LOCM and other contrast materials.

Effective January 1, 2005, payment for LOCM would be made on the basis of the average sales price plus six percent in accordance with the standard methodology for drug pricing established by the MMA. However, because the technical portions of radiology services are currently valued in the nonphysician workpool and the CPEP inputs for these services are not used in calculating payment, we will continue to reduce payment for LOCM by eight percent to avoid any duplicate payment for contrast media.

C. Payments for Physicians and Practitioners Managing Patients on Dialysis

[If you choose to comment on issues in this section, please include the caption ''MANAGING PATIENTS ON DIALYSIS'' at the beginning of your comments.]

1. ESRD-Related Services Provided to Patients in Observation Settings

In response to comments received on billing procedures when the patient is hospitalized during the month, we stated in the November 7, 2003 **Federal Register** (68 FR 63220) that the physician may bill the code that reflects the number of visits during the month on days when the patient was not in the hospital (either admitted as an inpatient or in observation status). (We refer to Medicare's payment amount below as the monthly capitation payment or MCP and the patient's normal attending physician for ESRD-related services as the MCP physician).

In comments on the August 15, 2003 proposed rule, the Renal Physicians Association (RPA) indicated that the observation area is not an uncommon setting for outpatient face-to-face encounters to occur and the observation area should be an approved site-of-service for physician-dialysis patient encounters that count toward the MCP visit total. We indicated in the final rule, however, that observation services would not be counted as a visit under the MCP, but would be paid separately. Prior to this, long-standing Medicare policy had subsumed ESRD-related observation visits within the MCP.

Upon further review of this issue, we now agree with RPA's comment and propose that ESRD-related visits provided to patients by the MCP physician in an observation setting would be counted as visits for purposes of billing the MCP codes.

2. Payment for Outpatient ESRD-Related Services for Partial Month Scenarios

Since changing our payments for managing patients on dialysis, we have received a number of comments from the nephrology community requesting guidance on billing for outpatient ESRD-related services provided to transient patients and in partial month scenarios where the comprehensive visit may not have been furnished: for example, when the patient is hospitalized during the month, or receives a kidney transplant before the monthly comprehensive visit is furnished. To address this issue, we propose to change the description of the G codes for ESRD-related home dialysis services, less than full month, as

identified by G0324 through G0327. The new descriptor would include other partial month scenarios, in addition to patients dialyzing at home. The proposed descriptors for G0324 through G0327 are as follows:

''G0324: End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients under two years of age.''

''G0325: End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients between two and eleven years of age.''

''G0326: End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients between twelve and nineteen years of age.''

''G0327: End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients twenty years of age and over.''

The G codes G0324 through G0327 would be used to bill for outpatient ESRD-related services provided in the following scenarios:

- Transient patients—Patients traveling away from home (less than full month);
- Home Dialysis Patients (less than full month);
- Partial month where there was one or more face-to-face visits without the comprehensive visit and either the patient was hospitalized before a complete assessment was furnished, dialysis stopped due to death, or the patient had a transplant.

We believe that modifying the definition of the per diem G codes (as identified by G0324 through G0327) would provide a consistent way to bill for these partial month scenarios. However, this proposed change to the descriptions of G0324 through G0327 is intended to accommodate unusual circumstances when the outpatient ESRD-related services would not be paid for under the MCP. Use of these per diem codes would be limited to the scenarios listed above. Physicians who have an on-going formal agreement with the MCP physician to provide cursory visits during the month (for example ''rounding physicians'') may not use the per diem codes.

Clarification on Billing for Transient Patients

For transient patients who are away from their home dialysis site, and at another site for fewer than 30 consecutive days, the revised per diem G codes (G0324 through G0327) would be billed by the physician or practitioner responsible for the transient patient's ESRD-related care. Only the physician or practitioner responsible for the traveling ESRD patient's care would be permitted to bill for ESRD-related services using the per diem G codes (G0324 through G0327).

If the transient patient is under the care of a physician or practitioner other than his or her regular MCP physician for a complete month, the physician or practitioner responsible for the transient patient's ESRD-related care cannot bill using the per diem codes. In this case the transient physician or practitioner treating the patient must furnish a complete assessment and bill for ESRD-related services under the MCP.

We are currently evaluating the criteria for defining a transient patient and welcome comments on when a patient should be considered transient.

D. Technical Revision

[If you choose to comment on issues in this section, please include the caption ''TECHNICAL REVISION'' at the beginning of your comments.]

In § 411.404, Medicare noncoverage of all obesity-related services is used as an example. Since we are currently revising this coverage policy, we are proposing to omit this example.

E. Diagnostic Psychological Tests

[If you choose to comment on issues in this section, please include the caption ''DIAGNOSTIC PSYCHOLOGICAL TESTS'' at the beginning of your comments.]

All diagnostic tests covered under section 1861(s)(3) of the Act and payable under the physician fee schedule must be furnished under the appropriate level of supervision by a physician as defined in section 1861(r) of the Act. Additionally, the physician or nonphysician practitioner who is treating the patient must order all diagnostic tests in order for these tests to be considered reasonable and necessary. These tests must be furnished under at least a general level of physician supervision, that is, the test is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.

However, certain diagnostic tests require either direct or personal supervision. Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed. Personal supervision means the physician must be in attendance in the room during the performance of the procedure. Physician supervision at the specified level is required throughout the performance of the test. Services furnished without the required level of supervision are not reasonable and necessary, and Medicare payment is precluded.

Section 410.32(b)(2)(iii) does permit an exception to these physician supervision level requirements for clinical psychologists and independently practicing psychologists (who are not clinical psychologists) to personally perform diagnostic psychological testing services without physician supervision. However, diagnostic psychological tests performed by anyone other than a clinical psychologist or independently practicing psychologist must be provided under the general supervision of a physician as defined above. Accordingly, clinical psychologists and independently practicing psychologists have not been permitted to supervise others in the administration of diagnostic psychological tests.

In § 410.71(d), we require a clinical psychologist who furnishes diagnostic, assessment, preventive, and therapeutic services directly to individuals to hold a doctoral degree in psychology and to be licensed or certified, on the basis of the doctoral degree in psychology, by the State in which he or she practices. Program instructions define an independently practicing psychologist as an individual who is not a clinical psychologist and practices independently of an institution, agency, or physician's office. Examples include, but are not limited to, educational psychologists and counseling psychologists. Any psychologist who is licensed or certified to practice psychology in the State or jurisdiction where he or she is furnishing services may qualify as an independent psychologist. It is our understanding that all States, the District of Columbia, and Puerto Rico license psychologists, but that some trust territories do not. In the jurisdictions that do not issue licenses, an independently practicing psychologist may be any practicing psychologist.

The American Psychological Association (APA) requested that we re-evaluate our regulations regarding clinical psychologists' supervision of diagnostic psychological tests. The APA also provided additional information concerning provision of these services.

According to the APA, clinical psychologists generally have seven years of graduate education in the study of human behavior and are highly trained in the selection, administration,

and interpretation of psychological tests. In addition, according to our payment data, the majority of health care practitioners, other than physicians, performing psychological and neuropsychological testing services under the central nervous system codes (CPT codes 96100 through 96117) are psychologists. We agree that clinical psychologists possess core knowledge in test measurement and development, psychometric theory, specialized psychological assessment techniques, statistics, and the psychology of behavior that uniquely qualifies them to direct test selection and interpret test data.

Therefore, we are proposing to change the supervision requirements regarding who can supervise diagnostic psychological testing services.

Having ancillary staff supervised by clinical psychologists would enable these practitioners with a higher level of expertise to oversee psychological testing. It could also potentially relieve burdens on physicians and healthcare facilities.

Additionally, in rural areas, we anticipate that permitting psychologists to supervise diagnostic psychological testing services would reduce delays in testing, diagnosis, and treatment that could result from the unavailability of physicians to supervise the tests.

We propose that the appropriate level of supervision of diagnostic psychological tests by clinical psychologists be general supervision, the level required of physicians supervising the same services.

We are proposing to revise the regulations at § 410.32(b)(2)(iii) to permit clinical psychologists to supervise the performance of diagnostic psychological and neuropsychological testing services. This proposal extends solely to clinical psychologists, and it does not include independently practicing psychologists.

F. Care Plan Oversight

[If you choose to comment on issues in this section, please include the caption ''CARE PLAN OVERSIGHT'' at the beginning of your comments.]

Care Plan Oversight (CPO) refers to the supervision of patients under Medicare-covered home health or hospice care requiring complex multi-disciplinary care modalities, including regular development and review of plans of care. In the December 8, 1994 physician fee schedule final rule (59 FR 63423), we established separate payment for CPO when performed by physicians. The Balanced Budget Act (BBA) of 1997 extended to nonphysician practitioners (NPPs) the right to receive payment for Medicare physicians' services that fall within their scope of practice under State law. In the November 1, 2000 final rule (65 FR 65407), we created HCPCS codes G0181 and G0182 for reporting home health and hospice CPO, respectively. We also clarified in that rule that services of NPPs, practicing within the scope of State law applicable to their services, could be billed as CPO services.

To certify a patient for home health services, a physician must review the patient records and sign the plan of care. Our policy has been that the physician who bills for CPO must be the same physician who signs the plan of care and that, according to the statute, (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act), only a physician can sign the plan of care for home health services. The effect of these two provisions, both of which were in place prior to the BBA of 1997, created a problem with respect to an NPP billing for CPO in the home health setting.

We propose to revise § 414.39 to clarify that NPPs can perform home health CPO even though they cannot certify a patient for home health services and sign the plan of care. However, we are also proposing the conditions under which NPP services may be billed for CPO; we established these conditions in consultation with our contractor medical directors and CMS medical staff. In general, the proposed conditions are meant to ensure that the NPP has seen and examined the patient and that the appropriate and established relationship exists between the physician who certifies the patient for home health services and the NPP who will provide the home health CPO.

G. Assignment of Medicare Claims—Payment to the Supplier

[If you choose to comment on issues in this section, please include the caption ''Assignment'' at the beginning of your comments.]

Current regulations require the beneficiary (or the person authorized to request payment on the beneficiary's behalf) to assign a claim to the supplier for an assignment to be effective. Over time, however, the Act has been amended in various sections to require suppliers, in some instances, to accept assignment for a Medicare covered service regardless of whether or not the beneficiary actually assigns the claim to the supplier. (This would include situations in which services are furnished by a participating physician or supplier.) In these instances, the requirement in our current regulations at § 424.55(a) that the beneficiary assign the claim to the supplier is now unnecessary. Therefore, we are proposing to create an exception to the general rule in § 424.55(a). New § 424.55(c) would eliminate the requirement that beneficiaries assign claims to suppliers in situations where suppliers are required by statute to accept assignment.

We believe the creation of this exception to the requirement for beneficiaries to assign benefits in situations where benefits can by statute only be paid on an assigned basis will reduce the paperwork burden on beneficiaries and suppliers.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether OMB should approve an information collection, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Section 410.16 requires the furnishing of education, counseling, and referral services as part of an initial preventive physical examination, a written plan for obtaining the appropriate screening and other preventive services which are also covered as separate Medicare B Part services.

The burden associated with this requirement is the time required of the physician or practitioner to provide beneficiaries with education, counseling, and referral services and to develop and provide a written plan for obtaining screening and other preventive services.

While these requirements are subject to the PRA, we believe the burden associated with these requirements to be reasonable and customary business practice; therefore, the burden for this collection requirement is exempt under 5 CFR 1320.3(b)(2)&(3).

Section 411.404 requires that written notice must be given to a beneficiary, or someone acting on his or her behalf, that

the services were not covered because they did not meet Medicare coverage guidelines.

Although this section is subject to the PRA, the burden associated with this requirement is currently captured and accounted for in two currently approved information collections under OMB numbers 0938–0566 and 0938–0781.

Sections 410.36 and 410.38 require that the physician must document in the medical records the need for the prosthetic, orthotic, durable medical equipment, and/or supplies being ordered.

While these information collection requirements are subject to the PRA, the burden associated with them is exempt as defined in 5 CFR 1320.3(b)(2).

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Attn: Melissa Musotto (CMS–1429–P), Room C5–13–28, 7500 Security Boulevard, Baltimore, MD 21244–1850; and Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Christopher Martin, CMS Desk Officer (CMS–1429–P), *Christopher__Martin@omb.eop.gov.* FAX (202) 395–6974.

VI. Response to Comments

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

VII. Regulatory Impact Analysis

[If you choose to comment on issues in this section, please include the caption ''IMPACT'' at the beginning of your comments.]

We have examined the impact 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 responsibilities of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis must be prepared for proposed rules with economically significant effects (that is, a proposed rule that would have an annual effect on the economy of $100 million or more in any 1 year, or would adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities). As indicated in more detail below, we estimate that the physician fee schedule provisions included in this proposed rule will redistribute more than $100 million in 1 year. We are also estimating that the combined effect of several provisions of the MMA implemented in this proposed rule will increase spending by more than $100 million. Other MMA provisions implemented in this proposed rule are estimated to reduce spending by more than $100 million. We are considering this proposed rule to be economically significant because its provisions are estimated to result in an increase, decrease or aggregate redistribution of Medicare spending that will exceed $100 million. Therefore, this proposed rule is a major rule and we have prepared a regulatory impact analysis.

The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a regulatory flexibility analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 100 beds. We have determined that this proposed rule would have minimal impact on small hospitals located in rural areas. Of 431 hospital-based ESRD facilities located in rural areas, only 40 are affiliated with hospitals with fewer than 100 beds.

For purposes of the RFA, physicians, nonphysician practitioners, and suppliers are considered small businesses if they generate revenues of $6 million or less. Approximately 95 percent of physicians are considered to be small entities. There are about 875,000 physicians, other practitioners and medical suppliers that receive Medicare payment under the physician fee schedule. There are in excess of 20,000 physicians and other practitioners that receive Medicare payment for drugs. (As noted previously in this proposed rule and described further below, we are proposing significant changes to the payments for drugs.) These physicians are concentrated in the specialties of oncology, urology, and rheumatology. Of the physicians in these specialties, approximately 40 percent are in oncology and 45 percent in urology.

For purposes of the RFA, approximately 98 percent of suppliers of durable medical equipment (DME) and prosthetic devices are considered small businesses according to the Small Business Administration's (SBA) size standards. We estimate that 106,000 entities bill Medicare for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) each year. Total annual estimated Medicare revenues for DME suppliers exceed approximately $4.0 billion. Of this amount, approximately $1.6 billion are for DME drugs.

In addition, most ESRD facilities are considered small entities, either based on nonprofit status, or by having revenues of $29 million or less in any year. We consider a substantial number of entities to be affected if the proposed rule is estimated to impact more than 5 percent of the total number of small entities. Based on our analysis of the 697 nonprofit ESRD facilities considered small entities in accordance with the above definitions, we estimate that the combined impact of the proposed changes to payment for renal dialysis services included in this rule would have a 1.6 percent increase in payments relative to current composite rate payments.

The analysis and discussion provided in this section, as well as elsewhere in this proposed rule, complies with the RFA requirements. 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 expenditures in any year by State, local,

or tribal governments, in the aggregate, or by the private sector, of $110 million. Medicare beneficiaries are considered to be part of the private sector for this purpose. The net impact of the provisions of this rule, including those related to the MMA, are estimated to result in a savings to beneficiaries of nearly $270 million for FY 2005. The specific effects of the provisions being implemented in this proposed rule are explained in greater detail below.

We have examined this proposed rule in accordance with Executive Order 13132 and have determined that this regulation would not have any significant impact on the rights, roles, or responsibilities of State, local, or tribal governments.

We have prepared the following analysis, which, together with the information provided in the rest of this preamble, meets all assessment requirements. It explains the rationale for and purposes of the rule; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we propose to use to minimize the burden on small entities. As indicated elsewhere in this proposed rule, we propose to refine resource-based practice expense RVUs and make a variety of other changes to our regulations, payments, or payment policy to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. We are also proposing several changes resulting from the MMA, including changes to Medicare payment rates for outpatient drugs, changes to the payment for renal dialysis services, creating new preventive health care benefits and creating incentive payment program improvements for physician scarcity.

We are providing information for each of the policy changes in the relevant sections of this proposed rule. We are unaware of any relevant Federal rules that duplicate, overlap or conflict with this proposed rule. The relevant sections of this proposed rule contain a description of significant alternatives if applicable.

A. Resource-Based Practice Expense and Malpractice Relative Value Units

Under section 1848(c)(2) of the Act, adjustments to RVUs may not cause the amount of expenditures to differ by more than $20 million from the amount of expenditures that would have resulted without such adjustments. We are proposing several changes that would result in a change in expenditures that would exceed $20 million if we made no offsetting adjustments to either the conversion factor or RVUs.

With respect to practice expense, our policy has been to meet the budget-neutrality requirements in the statute by incorporating a rescaling adjustment in the practice expense methodologies. That is, we estimate the aggregate number of practice expense RVUs that will be paid under current and proposed policy in CY 2005. We apply a uniform adjustment factor to make the aggregate number of proposed practice expense RVUs equal the number estimated that would be paid under current policy.

Table 21 shows the specialty level impact on payment of changes being proposed for CY 2005. Our estimates of changes in Medicare revenues for physician fee schedule services compare payment rates for 2005 with payment rates for 2004 using 2003 Medicare utilization for both years. We are using 2003 Medicare claims processed and paid through June 30, 2004 that we estimate are 96.7 complete and have adjusted the figures to reflect a full year of data. Thus, because we are using a single year of utilization, the estimated changes in revenues reflect payment changes only between 2004 and 2005. To the extent that there are year-to-year changes in the volume and mix of services provided by physicians, the actual impact on total Medicare revenues will be different than those shown here. The payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician would be different from the average, based on the mix of services the physician provides. The average change in total revenues would be less than the impact displayed here because physicians furnish services to both Medicare and non-Medicare patients and specialties may receive substantial Medicare revenues for services that are not paid under the physician fee schedule. For instance, independent laboratories receive approximately 80 percent of their Medicare revenues from clinical laboratory services that are not paid under the physician fee schedule. The table shows only the payment impact on physician fee schedule services.

We modeled the impact of changes to the practice expense methodology and illustrated the effect in table 21 below. The column labeled ''Practice Expense RVU Refinements'' shows the effect of the refinements we are making to the practice expense methodology for 2005. For instance, we are incorporating refined practice expense inputs recommended by the PEAC into the methodology as well as updating the prices of medical equipment. We are also adding 2003 utilization data for codes that did not exist in the 1997 through 2002 period.

In general, updating the methodology with 2003 utilization data has little or no impact on total payments to a specialty but the practice expense values for specific services may change. In general, the largest changes to a practice expense RVU will occur when a code was established after 2002 and we did not have any Medicare utilization data to determine the specialty that performs the service. In these cases, we either assigned the code to a specialty cost pool based on the specialty most likely to do the service or we used the ''all physician'' scaling factors to determine the code's practice expense RVUs. While we are trying to minimize instability in the practice expense RVUs for new services by assigning the specialty that is most likely to perform the service when we have no utilization data, the addition of utilization to the methodology may still result in some change to the practice expense RVUs during the first few years a code is in existence.

The practice expense refinements will reduce payments to audiologists by approximately 4 percent. Virtually all of the reduction in payment is due to the refinement of procedure code 92547. We accepted the PEAC recommendation to reduce the clinical staff time of the audiologist involved in this add-on service from 71 minutes to 1 minute. The refinement of clinical staff and equipment resulted in a reduction from 1.15 to 0.08 practice expense RVUs producing the nearly 4 percent reduction in payments shown in table 21.

Payments to vascular surgeons will increase approximately 3 percent as a result of the refinements. The increase in payment is attributed to the repricing of medical equipment used in performing noninvasive vascular diagnostic tests that will increase the practice expense RVUs for procedure codes 93880, 93923, 93925, 93970 and other codes in that family. The estimated 2 percent increase in payment from the practice expense refinements for interventional radiology is primarily due to the establishment of nonfacility pricing for procedure codes 35470 to 35476. The 3 percent increase in payment to oral and maxillofacial surgeons is largely attributed to the refinement of medical supplies for procedure codes 21210 and 21215. The 1 percent decrease in payment to nurse practitioners and geriatricians is attributed to the refinement of the nonfacility practice expense RVUs for

nursing facility visits (procedure codes 99301 through 99316). As stated in the November 7, 2003 **Federal Register** (68 FR 63204), the changes to the nonfacility practice expense RVUs for these codes were delayed by 1 year to allow the PEAC to reconsider its earlier recommendation to us to reflect input from representatives of specialties that provide these services in nursing homes. The PEAC reconsidered its recommendations with input from these specialties. Our acceptance of the PEAC recommendations is resulting in a decrease in the nonfacility practice expense RVUs for the nursing facility visit codes.

The column labeled ''Survey Data'' shows the impact on payment from using the supplemental practice expense survey from the College of American Pathologists (CAP). Using this survey together with making the technical component practice expense RVUs equal to the difference between the global and professional component practice expense RVUs and the other practice expense refinements will increase payments to pathologists by approximately 2 percent and independent laboratories by more than 6 percent. As we indicated above, independent laboratories receive approximately 20 percent of their total Medicare revenues from physician fee schedule services. The remaining 80 percent of their Medicare revenues are from clinical diagnostic laboratory services that will be unchanged by use of the CAP survey data. Thus, total Medicare revenues to independent laboratories as a result of using the CAP survey will increase by slightly more than 1 percent (or 20 percent of the 6 percent increase in physician fee schedule revenues). There will be little or no impact on all other specialties from use of the CAP survey.

The column labeled ''Total'' in Table 21 below shows the payment impact by specialty of all the changes described above. If we change any of these proposals following our consideration of comments, these figures may change.

TABLE 21.—IMPACT OF PRACTICE EXPENSE RVU CHANGES ON TOTAL MEDICARE ALLOWED CHARGES BY PHYSICIAN, PRACTITIONER AND SUPPLIER SUBCATEGORY

Specialty	Medicare allowed charges ($ in millions)	Practice expense RVU refinements (percent)	Survey data (percent)	Total (percent)
Physicians:				
ALLERGY/IMMUNOLOGY	161	−1	0	−1
ANESTHESIOLOGY	1,416	0	0	0
CARDIAC SURGERY	359	0	0	0
CARDIOLOGY	6,583	0	0	0
COLON AND RECTAL SURGERY	111	0	0	0
CRITICAL CARE	130	0	0	0
DERMATOLOGY	1,870	0	0	0
EMERGENCY MEDICINE	1,672	0	0	0
ENDOCRINOLOGY	280	0	0	0
FAMILY PRACTICE	4,448	0	0	0
GASTROENTEROLOGY	1,636	0	0	0
GENERAL PRACTICE	998	0	0	0
GENERAL SURGERY	2,258	0	0	0
GERIATRICS	117	−1	0	−1
HAND SURGERY	57	1	0	1
HEMATOLOGY/ONCOLOGY	1,753	0	0	0
INFECTIOUS DISEASE	401	0	0	0
INTERNAL MEDICINE	8,846	0	0	0
INTERVENTIONAL RADIOLOGY	190	2	0	2
NEPHROLOGY	1,248	1	0	1
NEUROLOGY	1,200	0	0	0
NEUROSURGERY	490	0	0	0
NUCLEAR MEDICINE	85	0	0	0
OBSTETRICS/GYNECOLOGY	582	0	0	0
OPHTHALMOLOGY	4,583	−1	0	−1
ORTHOPEDIC SURGERY	2,902	0	0	0
OTOLARNGOLOGY	815	0	0	0
PATHOLOGY	869	−1	3	2
PEDIATRICS	59	−1	0	−1
PHYSICAL MEDICINE	677	0	0	0
PLASTIC SURGERY	281	0	0	0
PSYCHIATRY	1,093	0	0	0
PULMONARY DISEASE	1,446	0	0	0
RADIATION ONCOLOGY	1,164	0	0	0
RADIOLOGY	4,690	0	0	0
RHEUMATOLOGY	413	0	0	0
THORACIC SURGERY	463	0	0	0
UROLOGY	1,699	0	0	0
VASCULAR SURGERY	487	3	0	3
Practitioners:				
AUDIOLOGIST	28	−4	0	−4
CHIROPRACTOR	656	0	0	0
CLINICAL PSYCHOLOGIST	490	0	0	0
CLINICAL SOCIAL WORKER	313	0	0	0
NURSE ANESTHETIST	481	0	0	0

TABLE 21.—IMPACT OF PRACTICE EXPENSE RVU CHANGES ON TOTAL MEDICARE ALLOWED CHARGES BY PHYSICIAN, PRACTITIONER AND SUPPLIER SUBCATEGORY—Continued

Specialty	Medicare allowed charges ($ in millions)	Practice expense RVU refinements (percent)	Survey data (percent)	Total (percent)
NURSE PRACTITIONER	552	−1	0	−1
OPTOMETRY	664	0	0	0
ORAL/MAXILLOFACIAL SURGERY	36	3	0	3
PHYSICAL/OCCUPATIONAL THERAPY	990	−1	0	−1
PHYSICIAN ASSISTANT	410	0	0	0
PODIATRY	1,383	0	0	0
Suppliers:				
DIAGNOSTIC TESTING FACILITY	876	1	0	1
INDEPENDENT LABORATORY	530	0	6	6
PORTABLE X-RAY SUPPLIER	91	0	0	0
Other:				
ALL OTHER	93	0	2	2
ALL PHYSICIAN FEE SCHEDULE	66,395	0	0	0

As discussed in Section II.C of this rule, we are proposing changes to the malpractice RVUs based on more current malpractice premium data. As anticipated from past revisions to the malpractice RVUs, use of more current malpractice premium data results in minimal proposed impacts on the specialty level payments. See Table 22, ''Specialty Impact of Malpractice RVUs Revisions'', for a breakdown of the impacts of these revisions on individual specialties. Of the 54 specialties shown, 15 specialties (representing a total of 40 percent of Medicare allowed charges) experience no estimated change. Total Medicare payments for an additional 32 specialties are estimated to increase or decrease between 0.1 percent and 0.5 percent. We estimate that 7 specialties will experience a total payment increase or decrease of more than 0.5 percent as a result of the malpractice RVU changes. If we change any of these proposals following our consideration of comments, these figures may change.

TABLE 22.—SPECIALTY IMPACT OF MALPRACTICE RVU REVISIONS

Specialty	Allowed charges [1]	Percent of total charges	Percent change [2]
DERMATOLOGY	1,870,318,730	2.8	0.7
PLASTIC SURGERY	280,508,065	0.4	0.6
ORAL/MAXILLOFACIAL SURGERY	35,598,814	0.1	0.6
COLON AND RECTAL SURGERY	110,683,908	0.2	0.6
GASTROENTEROLOGY	1,635,616,057	2.5	0.5
GENERAL SURGERY	2,257,836,035	3.4	0.5
CRITICAL CARE	130,256,300	0.2	0.5
INFECTIOUS DISEASE	395,195,230	0.6	0.4
GERIATRICS	116,547,182	0.2	0.3
PSYCHIATRY	1,092,801,668	1.7	0.3
PULMONARY DISEASE	1,445,180,432	2.2	0.3
NURSE PRACTITIONER	549,723,060	0.8	0.2
PATHOLOGY	868,617,850	1.3	0.2
NEUROLOGY	1,199,069,489	1.8	0.2
PHYSICAL MEDICINE	676,516,230	1.0	0.2
INDEPENDENT LABORATORY	529,571,661	0.8	0.2
OPTOMETRY	664,163,601	1.0	0.2
NEPHROLOGY	1,247,164,211	1.9	0.1
VASCULAR SURGERY	486,263,563	0.7	0.1
OBSTETRICS/GYNECOLOGY	578,322,768	0.9	0.1
INTERNAL MEDICINE	8,821,789,552	13.4	0.1
ENDOCRINOLOGY	279,359,088	0.4	0.1
ANESTHESIOLOGY	1,415,251,017	2.1	0.0
HEMATOLOGY/ONCOLOGY	1,553,937,401	2.4	0.0
CARDIOLOGY	6,580,625,617	10.0	0.0
OPHTHALMOLOGY	4,583,221,470	7.0	0.0
NURSE ANESTHETIST	481,060,016	0.7	0.0
THORACIC SURGERY	463,428,857	0.7	0.0
RADIATION ONCOLOGY	1,162,754,357	1.8	0.0
ALL OTHER	92,826,859	0.1	0.0
CLINICAL SOCIAL WORKER	313,327,455	0.5	0.0
GENERAL PRACTICE	995,188,403	1.5	0.0
UROLOGY	1,689,047,785	2.6	0.0
INTERVENTIONAL RADIOLOGY	189,980,663	0.3	0.0
EMERGENCY MEDICINE	1,671,773,516	2.5	0.0
FAMILY PRACTICE	4,442,795,644	6.7	0.0
DIAGNOSTIC TESTING FACILITY	876,242,174	1.3	0.0

TABLE 22.—SPECIALTY IMPACT OF MALPRACTICE RVU REVISIONS—Continued

Specialty	Allowed charges [1]	Percent of total charges	Percent change [2]
PHYSICIANS ASSISTANT	409,700,298	0.6	-0.1
PEDIATRICS	58,880,964	0.1	-0.1
AUDIOLOGIST	27,930,180	0.0	-0.1
CLINICAL PSYCHOLOGIST	490,006,176	0.7	-0.1
CARDIAC SURGERY	359,324,850	0.5	-0.1
PORTABLE X-RAY SUPPLIER	91,026,934	0.1	-0.1
HAND SURGERY	56,595,222	0.1	-0.1
OTOLARNGOLOGY	814,914,443	1.2	-0.1
RHEUMATOLOGY	405,622,764	0.6	-0.1
NUCLEAR MEDICINE	85,239,821	0.1	-0.1
CHIROPRACTOR	656,312,519	1.0	-0.2
RADIOLOGY	4,689,652,801	7.1	-0.3
PODIATRY	1,382,552,109	2.1	-0.4
ORTHOPEDIC SURGERY	2,902,084,841	4.4	-0.4
NEUROSURGERY	489,366,546	0.7	-0.6
ALLERGY/IMMUNOLOGY	160,728,139	0.2	-0.9
PHYSICAL/OCCUPATIONAL THERAPY	990,284,755	1.5	-1.3

[1] 2003 Allowed Charges
[2] Percent change based upon percent change in total payment.

Section 1848(d) and (f) of the Act requires the Secretary to set the physician fee schedule update under the sustainable growth rate (SGR) system. For 2004 and 2005, the statute requires the update to be no less than 1.5 percent. We believe it is highly likely that the statutory formula in section 1848(d)(4) will produce an update of less than 1.5 percent for 2005. Therefore, we estimate that the physician fee schedule update for 2005 will be 1.5 percent. We are currently forecasting payment reductions under the SGR system for 2006 and later years. As in the past, we will include a complete discussion of our methodology for calculating the SGR in the final rule.

Table 23 below shows the estimated change in average payments by specialty resulting from changes to the practice expense and malpractice RVUs and the 2005 physician fee schedule update. (Please note that the table does not include the specialties of Hematology/Oncology, Urology, Rheumatology and Obstetrics/Gynecology. There are unique issues related to drug administration that will further affect these specialties that are presented in detail below).

TABLE 23.—IMPACT OF PRACTICE EXPENSE AND MALPRACTICE RVU CHANGES AND PHYSICIAN FEE SCHEDULE UPDATE ON TOTAL MEDICARE ALLOWED CHARGES BY PHYSICIAN, PRACTITIONER AND SUPPLIER SUBCATEGORY

Speciality	Medicare allowed charges ($ in Millions)	Practice expenses & malpractice RVU changes (percent)	Physician fee schedule update (percent)	Total (percent)
Physicians:				
ALLERGY/IMMUNOLOGY	161	−2	1.5	0
ANESTHESIOLOGY	1,416	0	1.5	2
CARDIAC SURGERY	359	0	1.5	1
CARDIOLOGY	6,583	0	1.5	2
COLON AND RECTAL SURGERY	111	1	1.5	2
CRITICAL CARE	130	0	1.5	2
DERMATOLOGY	1,870	1	1.5	3
EMERGENCY MEDICINE	1,672	0	1.5	2
ENDOCRINOLOGY	280	0	1.5	2
FAMILY PRACTICE	4,448	0	1.5	1
GASTROENTEROLOGY	1,636	0	1.5	2
GENERAL PRACTICE	998	0	1.5	1
GENERAL SURGERY	2,258	1	1.5	2
GERIATRICS	117	−1	1.5	1
HAND SURGERY	57	0	1.5	2
INFECTIOUS DISEASE	401	0	1.5	2
INTERNAL MEDICINE	8,846	0	1.5	1
INTERVENTIONAL RADIOLOGY	190	2	1.5	4
NEPHROLOGY	1,248	1	1.5	2
NEUROLOGY	1,200	0	1.5	2
NEUROSURGERY	490	−1	1.5	1
NUCLEAR MEDICINE	85	0	1.5	1
OPHTHALMOLOGY	4,583	−1	1.5	0
ORTHOPEDIC SURGERY	2,902	0	1.5	1
OTOLARNGOLOGY	815	0	1.5	2
PATHOLOGY	869	2	1.5	4

TABLE 23.—IMPACT OF PRACTICE EXPENSE AND MALPRACTICE RVU CHANGES AND PHYSICIAN FEE SCHEDULE UPDATE ON TOTAL MEDICARE ALLOWED CHARGES BY PHYSICIAN, PRACTITIONER AND SUPPLIER SUBCATEGORY—Continued

Speciality	Medicare allowed charges ($ in Millions)	Practice expenses & malpractice RVU changes (percent)	Physician fee schedule update (percent)	Total (percent)
PEDIATRICS	59	−1	1.5	1
PHYSICAL MEDICINE	677	0	1.5	2
PLASTIC SURGERY	281	1	1.5	2
PSYCHIATRY	1,093	0	1.5	2
PULMONARY DISEASE	1,446	0	1.5	2
RADIATION ONCOLOGY	1,164	0	1.5	1
RADIOLOGY	4,690	0	1.5	1
THORACIC SURGERY	463	0	1.5	2
VASCULAR SURGERY	487	3	1.5	4
Practitioners:				
AUDIOLOGIST	28	−4	1.5	−2
CHIROPRACTOR	656	−1	1.5	1
CLINICAL PSYCHOLOGIST	490	0	1.5	1
CLINICAL SOCIAL WORKER	313	0	1.5	1
NURSE ANESTHETIST	481	0	1.5	2
NURSE PRACTITIONER	552	−1	1.5	0
OPTOMETRY	664	0	1.5	1
ORAL/MAXILLOFACIAL SURGERY	36	4	1.5	5
PHYSICAL/OCCUPATIONAL THERAPY	990	−2	1.5	−1
PHYSICIAN ASSISTANT	410	0	1.5	1
PODIATRY	1,383	−1	1.5	1
Suppliers:				
DIAGNOSTIC TESTING FACILITY	876	1	1.5	3
INDEPENDENT LABORATORY	530	6	1.5	8
PORTABLE X-RAY SUPPLIER	91	0	1.5	1
Other:				
ALL OTHER	93	2	1.5	3
ALL PHYSICIAN FEE SCHEDULE	66,395	0	1.5	2

Table 24 shows the impact on payments for selected high-volume procedures of all of the changes previously discussed. We selected these procedures because they are the most commonly provided procedures by a broad spectrum of physician specialties, or they are of particular interest to the physician community (for example, the preventive office visit, G0XX2). This table shows the combined impact of the change in the practice expense and malpractice RVUs and the estimated physician fee schedule update on total payment for the procedure. There are separate columns that show the change in the facility rates and the nonfacility rates. For an explanation of facility and nonfacility practice expense refer to § 414.22(b)(5)(i). The table shows the estimated change in payment rates based on provisions of this proposed rule and the estimated physician fee schedule update. If we change any of the provisions following the consideration of public comments, these figures may change.

TABLE 24.—IMPACT OF PROPOSED RULE AND PHYSICIAN FEE SCHEDULE UPDATE ON MEDICARE PAYMENT FOR SELECTED PROCEDURES

CODE	MOD	Description	Non-facility			Facility		
			Old	New	Percent change	Old	New	Percent change
11721		Debride nail, 6 or more	$ 38.08	$ 38.28	1	$ 29.87	$ 29.94	0
17000		Destroy benign/premlg lesion	60.49	61.39	1	35.84	45.48	27
27130		Total hip arthroplasty	N/A	N/A	N/A	1,370.28	1,382.50	1
27236		Treat thigh fracture	N/A	N/A	N/A	1,088.01	1,103.20	1
27244		Treat thigh fracture	N/A	N/A	N/A	1,115.27	1,133.51	2
27447		Total knee arthroplasty	N/A	N/A	N/A	1,475.95	1,492.02	1
33533		CABG, arterial, single	N/A	N/A	N/A	1,882.18	1,905.49	1
35301		Rechanneling of artery	N/A	N/A	N/A	1,114.89	1,122.90	1
43239		Upper GI endoscopy, biopsy	321.85	336.15	4	159.43	162.58	2
45385		Lesion removal colonoscopy	497.71	514.65	3	288.24	293.71	2
66821		After cataract laser surgery	240.83	237.62	−1	237.09	230.80	−3
66984		Cataract surg w/iol, 1 stage	N/A	N/A	N/A	684.39	683.67	0
67210		Treatment of retinal lesion	577.98	599.92	4	560.81	573.01	2
71010	26	Chest x-ray	9.33	9.47	2	9.33	9.47	2
71020	26	Chest x-ray	11.20	11.37	2	11.20	11.37	2
76091	26	Mammogram, both breasts	96.33	97.40	1	N/A	N/A	N/A
76091		Mammogram, both breasts	44.80	45.10	1	44.80	45.10	1

TABLE 24.—IMPACT OF PROPOSED RULE AND PHYSICIAN FEE SCHEDULE UPDATE ON MEDICARE PAYMENT FOR SELECTED PROCEDURES—Continued

CODE	MOD	Description	Non-facility			Facility		
			Old	New	Percent change	Old	New	Percent change
76092	26	Mammogram, screening	84.76	85.27	1	N/A	N/A	N/A
76092		Mammogram, screening	36.22	36.38	0	36.22	36.38	0
77427		Radiation tx management, x5	169.14	172.05	2	169.14	172.05	2
78465	26	Heart image (3d), multiple	76.17	77.31	1	76.17	77.31	1
88305	26	Tissue exam by pathologist	41.44	42.07	2	41.44	42.07	2
90801		Psy dx interview	150.84	153.48	2	142.26	144.39	1
90806		Psytx, off, 45–50 min	97.45	98.91	1	93.72	95.12	1
90807		Psytx, off, 45–50 min w/e&m	103.80	104.98	1	101.18	102.32	1
90862		Medication management	51.15	52.30	2	48.17	49.27	2
90935		Hemodialysis, one evaluation	N/A	N/A	N/A	72.06	73.14	1
92004		Eye exam, new patient	126.57	129.61	2	89.24	90.58	2
92012		Eye exam established pat	63.47	65.18	3	36.22	37.14	3
92014		Eye exam & treatment	93.34	96.26	3	58.99	60.64	3
92980		Insert intracoronary stent	N/A	N/A	N/A	812.09	829.58	2
92982		Coronary artery dilation	N/A	N/A	N/A	602.63	615.83	2
93000		Electrocardiogram, complete	26.51	26.91	2	N/A	N/A	N/A
93010		Electrocardiogram report	8.96	9.10	2	8.96	9.10	2
93015		Cardiovascular stress test	106.78	108.01	1	N/A	N/A	N/A
93307	26	Echo exam of heart	49.29	49.27	0	49.29	49.27	0
93510	26	Left heart catheterization	252.77	257.32	2	252.77	257.32	2
98941		Chiropractic manipulation	36.22	36.76	1	31.74	31.83	0
99203		Office/outpatient visit, new	95.96	97.40	2	71.69	72.38	1
99204		Office/outpatient visit, new	135.53	137.57	2	105.66	107.25	2
99205		Office/outpatient visit, new	172.13	174.71	1	140.39	142.49	1
99211		Office/outpatient visit, est	21.28	21.98	3	8.96	9.10	2
99212		Office/outpatient visit, est	37.71	38.66	3	23.52	24.25	3
99213		Office/outpatient visit, est	52.65	53.06	1	35.47	35.24	−1
99214		Office/outpatient visit, est	82.14	83.00	1	57.87	58.74	2
99215		Office/outpatient visit, est	119.11	121.27	2	93.34	95.12	2
99221		Initial hospital care	N/A	N/A	N/A	66.83	68.22	2
99222		Initial hospital care	N/A	N/A	N/A	111.27	112.93	1
99223		Initial hospital care	N/A	N/A	N/A	154.95	157.27	1
99231		Subsequent hospital care	N/A	N/A	N/A	33.23	34.11	3
99232		Subsequent hospital care	N/A	N/A	N/A	54.89	56.09	2
99233		Subsequent hospital care	N/A	N/A	N/A	78.04	79.58	2
99236		Observ/hosp same date	N/A	N/A	N/A	226.26	223.60	−1
99238		Hospital discharge day	N/A	N/A	N/A	69.82	70.87	2
99239		Hospital discharge day	N/A	N/A	N/A	95.21	91.71	−4
99241		Office consultation	50.03	50.40	1	33.98	34.49	2
99242		Office consultation	91.48	92.47	1	69.45	70.11	1
99243		Office consultation	120.60	122.79	2	92.22	93.99	2
99244		Office consultation	170.63	172.81	1	136.65	138.70	2
99245		Office consultation	220.29	224.35	2	181.09	184.56	2
99251		Initial inpatient consult	N/A	N/A	N/A	35.84	36.00	0
99252		Initial inpatient consult	N/A	N/A	N/A	71.69	72.76	1
99253		Initial inpatient consult	N/A	N/A	N/A	97.45	98.91	1
99254		Initial inpatient consult	N/A	N/A	N/A	140.39	142.12	1
99255		Initial inpatient consult	N/A	N/A	N/A	193.03	195.55	1
99261		Follow-up inpatient consult	N/A	N/A	N/A	22.40	22.36	0
99262		Follow-up inpatient consult	N/A	N/A	N/A	44.80	45.48	2
99263		Follow-up inpatient consult	N/A	N/A	N/A	66.09	67.46	2
99282		Emergency dept visit	N/A	N/A	N/A	27.63	27.67	0
99283		Emergency dept visit	N/A	N/A	N/A	61.61	62.15	1
99284		Emergency dept visit	N/A	N/A	N/A	95.58	7.02	2
99285		Emergency dept visit	N/A	N/A	N/A	149.72	151.97	2
99291		Critical care, first hour	242.69	257.32	6	203.12	207.68	2
99292		Critical care, add'l 30 min	107.91	114.45	6	101.56	103.84	2
99301		Nursing facility care	71.69	66.32	−7	61.61	66.32	8
99302		Nursing facility care	97.82	87.92	−10	82.52	87.92	7
99303		Nursing facility care	120.97	108.39	−10	102.68	108.39	6
99311		Nursing fac care, subseq	40.70	34.49	−15	30.62	34.49	13
99312		Nursing fac care, subseq	63.10	56.85	−10	51.53	56.85	10
99313		Nursing fac care, subseq	86.25	79.96	−7	72.43	79.96	10
99348		Home visit, est patient	75.42	72.01	−5	N/A	N/A	N/A
99350		Home visit, est patient	169.89	165.23	−3	N/A	N/A	N/A
G0317		ESRDrelsvc 4+/mo;20+yr	303.18	307.73	2	303.18	307.73	2
G0318		ESRDrelsvc 2–3/mo;20+yr	252.40	256.19	2	252.40	256.19	2
G0319		ESRDrelsvc 1/mo;20+yr	201.62	204.65	2	201.62	204.65	2

TABLE 24.—IMPACT OF PROPOSED RULE AND PHYSICIAN FEE SCHEDULE UPDATE ON MEDICARE PAYMENT FOR SELECTED PROCEDURES—Continued

CODE	MOD	Description	Non-facility			Facility		
			Old	New	Percent change	Old	New	Percent change
G0XX2	.....	Preventive Office Visit	N/A	124.30	N/A	N/A	82.24	N/A

Section 303(a)(1) of the MMA amended section 1848(c)(2) of the Act to require increased work and practice expense RVUs for drug administration services. Section 303(a)(4) of the MMA required an additional temporary increase in payment to specific drug administration services (procedure codes 90780 through 90788, 96400, 96408 through 96425, 96520, and 96530) of 32 percent for 2004 and 3 percent for 2005. Table 25 shows the payment amounts for selected high-volume drug administration CPT codes from 2002 to 2006 including the effect of the transition adjustment of 32 percent required for 2004 and 3 percent for 2005 and 0 percent for 2006. The amounts shown in the table include the effect of the 1.5 percent update for 2004 and 2005. The 2006 payment amount shown in the table reflects the 2005 conversion factor because the 2006 physician fee schedule update is currently unknown.

With the exception of procedure code 96412 declining by 17 percent (which occurred because resource-based pricing replaced the use of charge-based RVUs when the services were removed from the nonphysician work pool), the MMA permanently increases payment for all of these services from a low of 17 percent for procedure code 90781 to 321 percent for procedure code 90782. The volume-weighted average permanent increase in payment among these drug administration services is approximately 105 percent (109 percent for oncologists and 94 percent for other physicians). Including the effect of the transition makes the volume-weighted increase in payment for these codes more than 170 percent from 2003 to 2004 and 110 percent from 2003 to 2005. The payment amount for procedure code 96400 in 2002 was $5.07. Payment for this code increased substantially to $37.52 in 2003 when, at the request of the American Urological Association (see 67 FR 79981 published on December 31, 2002), we removed this code from the nonphysician work pool. Including the effect of the additional changes required by MMA, we expect payment for this code to be $49.65 by 2006. Thus, the payment increase for procedure code 96400 between 2002 and 2006 is 879 percent. As indicated earlier, we are continuing to consider coding and RVU changes for drug administration services for 2005 based on the results of the CPT review and our consideration of public comments. If we change any of the RVUs for these codes as a result of CPT's review or the consideration of public comments, these figures may change.

TABLE 25.—IMPACT OF PROPOSED RULE AND PHYSICIAN FEE SCHEDULE UPDATE ON MEDICARE PAYMENT FOR SELECTED DRUG ADMINISTRATION SERVICES

Code Description	Non-facility payment						
	2002 Payment	2003 Payment	2004 Payment	2005 Payment * w/Current PE RVUs	2006 Payment * w/Current PE RVUs	Percent change 2003 to 2006	Percent change 2002 to 2006
90780 IV infusion therapy, 1 hour	$40.54	$42.67	$117.79	$92.90	$90.20	111	122
90781 IV infusion, additional hour	20.27	21.70	33.02	26.15	25.39	17	25
90782 Injection, sc/im	3.98	4.41	24.64	19.13	18.57	321	367
96400 Chemotherapy, sc/im	5.07	37.52	64.07	51.14	49.65	32	879
96408 Chemotherapy, push technique	35.11	37.52	154.76	122.96	119.38	218	240
96410 Chemotherapy,infusion method	55.75	59.22	217.35	171.75	166.75	182	199
96412 Chemo, infuse method add-on	41.63	44.14	48.30	37.86	36.76	–17	–12

* Payment amounts reflect the current practice expense RVUs and a 1.5 percent update for 2005. The 2006 update is currently unknown. The payment amounts for 2006 were calculated using the 2005 conversion factor. If we were to make further revisions to the practice expense RVUs following the consideration of public comments and/or the CPT coding process, the payment amounts will be different.

Table 26 below shows the impact of the drug and physician fee schedule changes for selected specialties that receive a significant portion of their total Medicare revenues from drugs. Table 27 shows the combined payment impact of the drug and physician fee schedule payment changes on combined Medicare revenues. The first column ("Estimated Medicare Drug Revenues'') shows estimated 2004 Medicare Drug Revenues using 2003 utilization adjusted for drug payment changes required in 2004 by the MMA. The next column ("% Change Medicare Drug Revenues'') shows the payment impact of the adoption of the average sales price plus 6 percent (ASP+6) drug payment methodology in 2005 relative to 2004 on specialty drug payments. The payment impacts are based on ASP submissions from the 1st quarter of 2004. The ASP prices that will be used to determine payment in 2005 will begin with the 3rd quarter 2004 ASP submission and will be updated quarterly. To model the impact illustrated, we assumed an average increase in ASP prices of 3.39 percent (the national health expenditure prescription drug price growth factor) from the 1st quarter 2004 submission to the prices that will be used to determine 2005 payments. Table xxxxxxx follows table xxxxxx and shows the drug prices we used to determine the payment impact. The drug payment impacts are based on those high volume drugs where we have validated the ASP price submission that represent the following percentages of 2003 drug payments: 72 percent for Hematology/Oncology, 94

percent for Urology, 97 percent for Rheumatology and 73 percent for Obstetrics/Gynecology. For drugs in which we did not complete our validation of the ASP submission before completing the proposed rule, we used the average payment change for other drugs provided by the specialty unless a special circumstance applied. (that is, for Hematology/Oncology and Obstetrics/Gynecology, we calculated the average reduction in payment for drugs excluding J9265, J2430, and J9390, three drugs having an unusually large reduction in payment as a result of coming off patent. We do not believe these reductions will be typical of other drugs furnished by oncologists and obstetrician/gynecologists).

Our estimates of changes in Medicare revenues for drugs and physician fee schedule services compare payment rates for 2005 with payment rates for 2004 using 2003 Medicare utilization for both years. We are using 2003 Medicare claims processed and paid through June 30, 2004 that we estimate are 96.7 complete and have adjusted the figures to reflect a full year of data. Thus, because we are using a single year of utilization, the estimated changes in revenues reflect payment changes only between 2004 and 2005. To the extent that there are year-to-year changes in the volume and mix of drugs and physician fee schedule services provided by physicians, the actual impact on total Medicare revenues will be different than those shown here.

Assuming no change in utilization, we estimate that Medicare drug revenues for oncologists would decline by less than 8 percent as a result of policies adopted in this proposed rule. Oncologists administer a number of drugs that are changing in payments by different amounts. For instance, oncologists' highest Medicare revenue drug, Q0136 (EPOGEN; PROCRIT), would decline in payment by 7 percent while its second highest revenue drug, J9310 (RITUXAN), would increase in payment by 7 percent. Three drugs supplied by oncologists, J9265 (ONXOL TAXOL), J2430 (PAMIDRONATE DISODIUM), and J9390 (NAVELBINE), are coming off patent and their price would decline respectively by 81 percent, 71 percent, and 12 percent. The 2004 Medicare payment amounts for these three drugs respectively were equal to 81, 85 and 81 percent of the April 1, 2003 average wholesale price levels that applied or did not decrease proportionally after the drugs came off patent. These three drugs are estimated to account for only 7 percent of oncologists adjusted 2004 Medicare drug revenues but contribute more than 5 percent of the approximate 8 percent total reduction in Medicare drug revenues that oncologists would experience as a result of adopting the ASP+6 payment methodology. While Medicare revenues to oncologists would decline from the reductions in payment for these three drugs, the cost to acquire these drugs has already declined. Thus, Medicare's payment, as with all other drugs experiencing payment changes, will be much closer to the cost the physician pays to acquire the drug.

Adoption of ASP+6 prices would reduce Medicare drug revenues for urologists by approximately 36 percent. This large reduction can be attributed to a 35 percent reduction in payment for two drugs: J9202 (ZOLADEX) and J9217 (LUPRON DEPOT–PED). While we estimate an even larger reduction in the ASP+6 price for J9217, our payment impact assumes that nearly all Medicare carriers are using the ''least costly alternative'' pricing and paying code J9217 at the J9202 price.

We estimate a 6 percent reduction in Medicare drug revenues for rheumatology. Nearly all of this reduction can be attributed to a 6 percent reduction in Medicare payment for J1745 (REMICADE).

We estimate less than an 18 percent decrease in Medicare drug revenues for obstetrics/gynecology. However, much of this revenue reduction can be attributed to an 81 percent reduction in payment for J9265 (ONXOL TAXOL) coming off patent. Even though this one drug is estimated to account for only 16 percent of obstetrics/gynecology adjusted 2004 Medicare drug revenues, it contributes 13 percent of the approximate 18 percent total reduction in Medicare drug revenues that obstetrics/gynecologists would experience as a result of adopting the ASP+6 payment methodology. As explained above, while Medicare revenues to obstetrics/gynecology would decline as a result of the price reduction for this code, Medicare's payment will be much closer to the price physicians pay to acquire the drug. We are estimating an average approximate reduction of 6 percent across other drugs supplied by obstetrics/gynecology.

The remaining columns of Table 26 show the potential impact on physician fee schedule services of changes being contemplated for 2005 for the specialties shown. The column labeled ''Practice Expense and Malpractice RVU Changes'' show the combined impact of the changes previously illustrated for these specialties in Tables 21 and 22. The column labeled ''Drug Administration Payment Changes'' shows a range of potential physician fee schedule impacts for 2005. The left side of this column shows the impact of the changes required in payment by section 303(a)(4) of the MMA (that is, the change in the transition payment from 2004 to 2005) if we were to make no further changes to the payments or codes for drug administration services. However, because we are considering further changes to the payments or codes for drug administration once the AMA's CPT Panel review of this issue is complete, the right hand side of the column labeled ''Drug Administration Payment Changes'' reflects the amount that physician fee schedule payments would have to increase to make the net reduction across all Medicare revenues for these specialties equal to 2 percent. The next column shows the physician fee schedule update of 1.5 percent and the final column labeled ''Total Physician Fee Schedule'' Changes'' shows the combined effect of all of the changes previously described. The left hand side of the column shows the combined effect of (1) the practice expense and malpractice RVU changes, (2) the maximum reduction in payment that could occur if we made no further changes to payments for drug administration and (3) the physician fee schedule update. The right hand side of the column shows the combined effect of (1) the practice expense and malpractice RVU changes, (2) the amount physician fee schedule revenues would have to increase to make the reduction in total revenues equal to 2 percent and (3) the physician fee schedule update.

If we made no further changes to drug administration, physician fee schedule revenues would decline by 9 percent for oncology, be unchanged for urology and rheumatology, and increase by 1 percent for obstetrics/gynecology. Physician fee schedule revenues would have to increase by 12 percent for oncology, 19 percent for urology, 2 percent for rheumatology and 1 percent for obstetrics/gynecology for total revenues to these specialties to decline by 2 percent from adoption of the ASP+6 percent drug payment methodology.

Table 27 shows the combined impact of changes we are making to Medicare drug and physician fee schedule payments for the same specialties shown in table 26. The column labeled ''% of Total Medicare Revenues from Drugs'' shows the proportion of total Medicare revenues received from drugs, while the next column shows the payment impact from adoption of the ASP+6 drug payment methodology. The following columns show the proportion of total Medicare revenues received

from physician fee schedule services and the payment impact from physician fee schedule changes. All of the payment impacts are the same as those shown in Table 26. We note that these impacts and percentages represent averages for each specialty or supplier. The percentages and impacts for any individual physician are dependent on the mix of drugs and physician fee schedule services they provide to Medicare beneficiaries. These tables are intended to illustrate, assuming constant utilization, the combined impact of payment changes from 2004 to 2005 across all of the services that these specialties perform using the most recent data available to us. Thus, the last 3 columns show combined Medicare revenues from all sources and the combined Medicare payment impact from the earlier described changes being proposed or considered for 2005.

For example, as indicated in the Table 27, we estimate that approximately 70 percent of total 2004 Medicare revenues for oncologists are attributed to drugs. We estimate that Medicare revenues from drugs will decline by approximately 8 percent for oncology as a result of policies adopted in this proposed rule. Physician fee schedule services account for approximately 28 percent of oncology's 2004 Medicare revenues. If we made no other changes to the RVUs or codes for drug administration services and if there is no change in the utilization of services, we estimate that physician fee schedule payments to oncology would decline by approximately 9 percent from 2004 to 2005. In this scenario, combined Medicare payments to oncology would decline approximately 8 percent. However, if we were to make further changes to physician fee schedule payments so they increased by 12 percent, we estimate the combined revenue reduction to oncology would be 2 percent.

We estimate that urology receives approximately 37 percent of their 2004 total revenues from drugs and 60 percent from physician fee schedule services. Because urology and other physician specialties receive a smaller share of their total Medicare revenues from drug administration services than oncology, they are less affected than oncology by the reduction in the drug administration transition payment percentage from 32 to 3 percent from 2004 to 2005. If we made no other changes to the RVUs or codes for drug administration services, we estimate that physician fee schedule revenues for urologists would increase by approximately 1 percent from 2004 to 2005. (While the reduction in payment for drug administration alone would slightly reduce urologists' physician fee schedule revenues, we estimate that any reduction would be offset by the physician fee schedule update). In this scenario, combined Medicare payments to urologists would decline approximately 13 percent. However, if we were to make further changes to physician fee schedule payments so that they increased by 19 percent, we estimate the combined revenue reduction to urology would be 2 percent.

Rheumatology revenues from drugs are estimated to account for approximately 46 percent of their total revenues and would decline approximately 6 percent from adoption of the ASP+6 drug payment methodology. If we made no other changes to the RVUs or codes for drug administration services, we estimate that physician fee schedule revenues would be either unchanged or decline slightly in the aggregate and estimate a reduction in total Medicare revenues to rheumatology of approximately 3 percent. However, if we were to make further changes to physician fee schedule payments so they increased by 2 percent, we estimate the combined revenue reduction to rheumatologists would be 2 percent.

Medicare drug revenues represent 13 percent of total Medicare revenues for obstetrics/gynecology while physician fee schedule revenues account for 85 percent. We estimate that Medicare drug revenues for obstetrics/gynecology would decline by 18 percent and physician fee schedule revenues would increase 1 percent if we make no further changes to the RVUs or codes for drug administration services. In this scenario, obstetrics/gynecology's combined Medicare revenues would decline by 2 percent. Any change to the drug administration codes that increases their payments would make the net revenue reduction equal to or less than 2 percent for obstetrics/gynecology.

TABLE 26.—IMPACT OF DRUG AND PHYSICIAN FEE SCHEDULE PAYMENT CHANGES ON TOTAL MEDICARE ALLOWED CHARGES FOR SELECTED SPECIALTIES

Specialty	Drugs			Physician fee schedule			
	Estimated medicare drug revenues ($ in millions)	Percent change medicare drug revenues	Medicare allowed charges ($ in millions)	Practice expense & malpractice RVU changes (percent)	Drug administration payment changes	Physician fee schedule update (percent)	Total physician fee schedule changes
HEMATOLOGY/ONCOLOGY	$4,363	−8	$1,753	0	−10 to 10	1.5	−9% to 12%
UROLOGY	1,061	−36	1,699	0	−1% to 17%	1.5	0% to 19%
RHEUMATOLOGY	373	−6	413	0	−2% to 0%	1.5	0% to 2%
OBSTETRICS/GYNECOLOGY	88	−18	582	0	−1% to −1%	1.5	1% to 1%

The amounts shown on the left-hand side of the column labeled "Drug Administration Payment Changes" offset a part of the increase these specialties received in 2004 as shown in the January 7, 2004 **Federal Register** (69 FR 1100). We estimate the 2003–2005 increase in physician fee schedule payments to these specialties (before application of the physician fee schedule update) to be 28 percent for oncology, 2 percent for obstetrics/gynecology, 4 percent for rheumatology and 2 percent for urology. Urology received an additional 2 percent increase in total physician fee schedule payments (again, before application of the update) from 2002 to 2003 (see 67 FR 80035–80036 published on December 31, 2002) as a result of the large increase in payment for CPT code 96400 making the 2002–2005 payment increase exceed 4 percent.

TABLE 27.—COMBINED PAYMENT IMPACT DRUG AND PHYSICIAN FEE SCHEDULE PAYMENT CHANGES FOR SELECTED SPECIALTIES

Specialty	Drugs		Physician fee schedule		All revenues	
	Percent of total medicare revenues from drugs	Percent change medicare drug revenues	Percent of total medicare revenues from fee schedule	Percent change physician fee schedule revenues	Combined medicare revenues all sources ($ in millions)	Combined percent change all medicare revenues
HEMATOLOGY/ONCOLOGY.	70	−8	28	−9% to 12%	$6,251	−8% to −2%
UROLOGY	37	−36	60	0% to 19%	2,842	−13% to −2%
RHEUMATOLOGY	46	−6	51	0% to 2%	818	−3% to −2%
OBSTETRICS/GYNECOLOGY.	13	−18	85	1% to 1%	684	−2% to −2%

The above tables show those specialties that receive significant revenues from drugs and physician fee schedule services that could be further affected by the review of drug administration coding currently undertaken by the CPT Editorial Panel and any changes we may make after further consideration of this effort and public comments.

Although infectious disease physicians do receive significant revenues from drugs and drug administration, we are not showing them in this table because we have validated only drug payment data accounting for 27 percent of their allowed charges for drugs. Based on these data, we estimate an 11 percent reduction in their Medicare drug payments that account for approximately 6 percent of their total Medicare revenues. If total drug payment were to decline by 11 percent, we estimate that net revenues to infectious disease physicians will remain unchanged, absent any further changes in drug and drug administration coding. We are not showing DME and Other Medical Suppliers in the above table because they do not receive significant revenues for physician fee schedule services and will be unaffected by any further changes made to drug administration coding or RVUs because they do not bill for these services. However, they do receive a substantial portion of their total Medicare revenues from drugs that are affected by the change to ASP+6 pricing. For DME/Other Medical Suppliers, 40 and 60 percent of Medicare revenues respectively are received from drugs and DME fee schedule services. These suppliers would receive an approximate reduction of 70 percent in their Medicare drug revenues from the adoption of ASP+6 drug prices due to the large reduction in payment for two high volume inhalation drugs (J7619 and J7644). These impacts will be reduced somewhat by the dispensing fee we are proposing for inhalation drugs. We estimate the total reduction in payment across all of the services provided by DME suppliers as a result of provisions of this proposed rule would be approximately 28 percent.

TABLE 28.—DRUG PRICING TABLE USED FOR PAYMENT IMPACTS

Code	Short description	Trade name	CY 2004 Pay allowance limit	Estimated CY 2005 allowance limit 6%)	Percent change
J0152	Adenosine injection	ADENOSCAN	$66.56	$69.78	5%
J0585	Botulinum toxin a per unit	BOTOX	4.43	4.69	6
J0880	Darbepoetin alfa injection	ARANESP	21.20	18.10	−15
J1441	Filgrastim 480 mcg injection	NEUPOGEN	267.79	267.04	0
J1745	Infliximab injection	REMICADE	58.79	53.32	−9
J2430	Pamidronate disodium/30 MG	AREDIA, PAMIDRONATE DISODIUM, ...	237.88	67.27	−72
J2505	Injection, pegfilgrastim 6mg	NEULASTA	2,507.50	2,260.77	−10
J2792	Rho(D) immune globulin h, sd	WINRHO	18.39	13.04	−29
J3395	Verteporfin injection	VISUDYNE	1,404.26	1,368.79	−3
J3487	Zoledronic acid	ZOMETA	194.54	202.50	4
J7192	Factor viii recombinant	KOGENATE, HELIXATE, RECOMBINATE, REFACTO, BIOCLATE,.	1.29	0.92	−29
J7317	Sodium hyaluronate injection	HYALGAN, SUPARTZ, ORTHOVISC	124.11	110.07	−11
J7320	Hylan G-F 20 injection	SYNVISC	204.03	188.88	−7
J7507	Tacrolimus oral per 1 MG	PROGRAF	3.13	3.19	2
J7517	Mycophenolate mofetil oral	CELLCEPT	2.55	2.54	0
J7619	Albuterol inh sol u d	PROVENTIL, ALBUTEROL SULFATE, VENTOLIN.	0.39	0.04	−89
J7626	Budesonide inhalation sol	PULMICORT	4.04	3.91	−3
J7644	Ipratropium brom inh sol u d	IPRATROPIUM BROMIDE	2.82	0.30	−89
J9045	Carboplatin injection	PARAPLATIN	137.54	131.77	−4
J9170	Docetaxel	TAXOTERE	301.40	287.59	−5
J9201	Gemcitabine HCl	GEMZAR	111.33	107.46	−3
J9202	Goserelin acetate implant	ZOLADEX	375.99	234.28	−38
J9206	Irinotecan injection	CAMPTOSAR	130.24	123.86	−5
J9217*	Leuprolide acetate suspnsion	LUPRON DEPOT, ELIGARD, LUPRON DEPOT-PED.	500.58	234.28	−53

TABLE 28.—DRUG PRICING TABLE USED FOR PAYMENT IMPACTS—Continued

Code	Short description	Trade name	CY 2004 Pay allowance limit	Estimated CY 2005 allowance limit 6%)	Percent change
J9219	Leuprolide acetate implant	VIADUR	4,831.40	2,190.71	−55
J9265	Paclitaxel injection	TAXOL, ONXOL, NOV-ONXOL	138.28	25.84	−81
J9310	Rituximab cancer treatment	RITUXAN	427.28	438.38	3
J9350	Topotecan	HYCAMTIN	706.17	731.46	4
J9355	Trastuzumab	HERCEPTIN	52.01	50.84	−2
J9390	Vinorelbine tartrate/10 mg	NAVELBINE	76.19	64.67	−15
Q0136	Non esrd epoetin alpha inj	PROCRIT	11.62	10.37	−11
**Unlisted ...	.....	ALOXI	307.80	202.51	−34

*The figures here for J9217 reflect the ASP prices submitted by the drug manufacturer. However, we assumed that Medicare carriers are applying ''least costly alternative'' pricing and are using the J9202 price for J9217.

**Aloxi is the brand name for an antiemetic that is paid in 2004 at 95% of AWP using an unlisted code because the drug was approved by the FDA in the fall of 2003. Even though we do not have a code or volume for this drug from 2003 like we do for the other drugs shown in the table, we are showing it here because it is the highest growth injectable antiemetic drug currently on the market.

B. Geographic Practice Cost Indices

As discussed in section II.B, in this rule, we are proposing changes to the work and practice expense GPCIs based on new census data. The resulting geographic redistributions would not result in an overall increase in the current geographic adjustment indices by more than 3.5 percent or a decrease by more than 1.6 percent for any given locality in 2005. These geographic redistributions would not result in an overall increase in the current geographic adjustment indices by more than 7 percent or a decrease by more than 3.5 percent for any given locality in 2006. Addenda E and F illustrate the locality specific overall impact of this proposal. The GAF, as displayed in addenda E and F is a weighted composite index of the individual proposed revisions to the work, practice expense, and malpractice expense GPCIs, respectively. The malpractice GPCI was updated as part of the November 7, 2003 final rule, and the MMA provisions were addressed in the final rule published on January 7, 2004.

C. Coding Issues

1. Revisions to Global Period

In section II.D.1, we are proposing a change in the global period for procedure code 77427, *Radiation treatment management, five treatments* from a global indicator of ''xxx'' (meaning that the global concept does not apply) to ''090'' (meaning that there is a 90-day global period). We are not changing any of the RVUs for procedure code 77427 because this service was valued to reflect a global period of 90 days. The implication of this change is that any visit services provided in the 90-day global period that are related to procedure code 77427 will no longer be paid separately. We reviewed Medicare data and found that physicians rarely bill for services during the 90-day period following the date-of-service for procedure code 77427. Therefore, we believe this proposal will have little effect on Medicare program expenditures and our payments to physicians.

2. Additions to the List of Medicare Telehealth Services

In section II.D.2, we are proposing to add end stage renal disease (ESRD) services, as represented by HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, G03178 to the list of telehealth services. We believe that this change will have little effect on Medicare expenditures.

3. National Pricing of G0238/G0239 (Respiratory Therapy Service Codes)

As discussed earlier in the preamble, we are proposing to use the nonphysician workpool to value two respiratory therapy service codes (G0238 and G0239) that are currently carrier priced. We believe that this proposed change will eliminate the uncertainty surrounding payment of these codes when performed in comprehensive outpatient rehabilitation facilities that are paid under the physician fee schedule through fiscal intermediaries. We do not anticipate that nationally pricing these services would have a significant impact on Medicare expenditures.

4. New HCPCS Code for Bone Marrow Aspiration

We are proposing a new HCPCS code for instances when a bone marrow aspiration and a bone marrow biopsy are performed on the same day through a single incision. Currently, we do not allow payment for both of these procedures on the same day. While this coding change will allow for a small additional payment for the second procedure performed through a single incision on the same day, we anticipate that the costs will be insignificant.

5. New HCPCS Code for Venous Mapping

As stated earlier in the preamble, we are proposing a new HCPCS code for venous mapping for hemodialysis access placement. The primary reason for this new code is to enable us to track the use of venous mapping for quality improvement purposes. Since pricing for this service is not changing, there will be no impact on Medicare expenditures.

D. MMA Provisions

1. Section 611—Preventive Physical Examination

As discussed earlier in this preamble, the MMA authorizes coverage of an initial preventive physical examination effective January 1, 2005, subject to certain eligibility and other limitations. We estimate that this new benefit will result in an increase in Medicare expenditures. These new payments will be made to physicians and other practitioners who provide these examinations and for any medically necessary follow-up tests, counseling, or treatment that may be required as a result of the coverage of these examinations. The impact of this provision is shown in the following table.

TABLE 29.—MEDICARE COST ESTIMATES FOR MMA PROVISION 611

(in millions)

MMA provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Sec. 611	65	75	75	75	75

2. Section 613—Diabetes Screening

Section 613 of the MMA adds subsection (yy) to section 1861 of the Social Security Act and mandates coverage of diabetes screening tests, effective on or after January 1, 2005. We estimate that this change in coverage for certain beneficiaries will result in an increase in Medicare payments. These payments will be made to physicians' office laboratories and other laboratory suppliers who perform these tests as a result of the increased frequency of coverage of these tests. The impact of this provision is shown in Table 30 that follows.

3. Section 612—Cardiovascular Screening

Section 612 of the MMA provides for Medicare coverage for cholesterol and other lipid or triglyceride levels of cardiovascular screening blood tests for the early detection of abnormalities associated with an elevated risk for such diseases effective on or after January 1, 2005. We estimate that this change in coverage for certain beneficiaries will result in an increase in Medicare payments. These payments will be made to physician office laboratories and other laboratory suppliers who perform these tests as a result of the increased frequency of coverage of these tests. Increased Medicare program expenditures for this provision are shown in Table 30 below.

TABLE 30.—MEDICARE COST ESTIMATES FOR MMA PROVISIONS 612 AND 613

(in millions)

MMA provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Sec. 612 Cholesterol and Blood Lipid	50	80	90	90	100
Sec. 613 Diabetes Screening.	20	40	50	60	80

4. Section 413—Incentive Payment for Physician Scarcity

a. Physician Scarcity Areas

Section 413(a) of the MMA provides a new 5-percent incentive payment to physicians who furnish services in physician scarcity areas. The MMA provides for paying primary care physicians furnishing services in a primary care scarcity area, and specialty physicians furnishing services in a specialist care scarcity county, an additional amount equal to 5 percent of the amount paid for their professional services under the fee schedule from January 1, 2005 to December 31, 2007. We estimate that this new incentive payment for physician services will result in an increase in Medicare payments that are shown in Table 31.

b. Improvement to Medicare HPSA Incentive Payment Program

Section 413(b) of the MMA amended section 1833(m) of the Act to mandate that we automate payment of the 10 percent HPSA incentive payment to eligible physicians. Since the inception of the HPSA incentive payment program, physicians have been required to determine their eligibility and correctly code their Medicare claims using modifiers. We estimate that this change to the HPSA incentive payment program to provide for automation of payment will result in an increase in Medicare payments because many eligible physicians are not applying for bonuses due to the burden of verifying eligibility. The impact of this provision is shown in Table 31.

TABLE 31.—MEDICARE COST ESTIMATES FOR MMA PROVISIONS

(in millions)

MMA provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Sec. 413(a) Physician Scarcity Areas	30	50	50	20	0
Sec. 413(b) Improvement to HPSA	20	30	30	30	30

5. Sections 303–304—Payment for Covered Outpatient Drugs and Biologicals and Section 305—Payment for Inhalation Drugs

Sections 303 and 304 of the MMA make changes to Medicare payment for covered outpatient drugs and biologicals and changes to the administration of those drugs. Section 305 makes changes to payment for inhalation drugs. We implemented provisions of sections 303 through 305 changing payments in 2004 for drugs and their administration in the January 7, 2004 **Federal Register** (69 FR 1084). In this proposed rule, we are making further changes to Medicare's payment for drugs and drug administration for 2005 required by sections 303 through 305 of the MMA. We estimate that adoption of the ASP+6 payment methodology will result in Medicare savings for FY 2005 of $180 million for section 303 of the MMA, $140 million for section 304 of the MMA, and $210 million for section 305 of the MMA. If we were to make no further changes to the coding or payment for drug administration services, we estimate Medicare savings of $90 million for section 303 of the MMA and $40 million for section 304 of the MMA. In addition, we are also proposing to pay a supplying fee of $10 per Medicare Part B oral drug prescription. We estimate this proposal will increase Medicare expenditures by $52 million from FY 2005 through FY 2009, assuming an average of two prescriptions per month. We are also

proposing to pay a furnishing fee of $0.05 per unit off clotting factor. This proposal is estimated to cost $13 million from FY 2005 through FY 2009.

6. Section 952—Reassignment

The reassignment provisions discussed in section III.F is currently estimated to have no significant impact on Medicare expenditures.

7. Section 623—Payment for Renal Dialysis Services

a. Effects on the Medicare Program (Budgetary Effect)

Because the proposed basic case mix adjusted composite payment rate and the revised payment for ESRD drugs must be budget neutral in accordance with section 623(d)(1) of the MMA, except for the statutorily required 1.6 percent increase set forth in section 623(a), we estimate that there would be no budgetary impact for the Medicare program beyond this increase. The impact of this provision (net of beneficiary liability) is shown in the following table.

TABLE 32.—MEDICARE COST ESTIMATES FOR MMA PROVISION 623

(in millions)

MMA provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Section 623	40	50	50	60	60

b. Impact on ESRD Providers

In order to understand the impact of the proposed changes affecting payments to ESRD facilities that result from enactment of the MMA on different categories of ESRD facilities, it is necessary to compare estimated payments under the current payment system (current payments) to estimated payments under the proposed revisions to the composite rate payment system as set forth in this proposed rule (proposed payments). To estimate the impact among various classes of ESRD facilities, it is imperative that the estimates of current payments and proposed payments contain similar inputs. Therefore, we simulated proposed payments only for those ESRD facilities for which we are able to calculate both current payment and proposed payment.

Due to data limitations, we are unable estimate current and proposed payments for 592 facilities that bill for ESRD drugs. Of these 592 facilities, 174 are hospital based and 418 are independent. Therefore, 29 percent of hospital-based facilities and 11 percent of independent facilities are not shown in the impact table. ESRD providers were grouped into the categories based on characteristics provided in the Online Survey and Certification and Reporting (OSCAR) file and the most recent cost report data from HCRIS. We also used the December 2003 update of CY 2003 Standard Analytical File (SAF) claims as a basis for Medicare dialysis treatments and separately billable drugs and biologicals. While the December 2003 update of the 2003 SAF file is not complete, we wanted to use the most recent data available, and plan to use an updated version of the 2003 SAF file for the final rule.

TABLE 33.—IMPACT OF MMA SECTION 623 PAYMENTS TO HOSPITAL BASED AND INDEPENDENT ESRD FACILITIES (INCLUDES DRUG AND COMPOSITE RATE PAYMENTS)

[Percent change in total payments to ESRD facilities (both program and beneficiaries)]

	Number of facilities	Number of dialysis treatments (in millions)	Effect of changes in drug payments 1/	Effect of 1.6% composite rate update on total payments 2/	Effect of case mix 3/	Overall effect 4/
All	3,671	29.2	0.0	1.0	0.0	1.0
Independent	3,240	26.1	−0.6	1.0	−0.0	0.4
Hospital Based	431	3.1	5.7	1.1	0.1	7.0
Size:						
Small <5000 treatment per year	1,313	4.0	−0.6	1.0	−0.1	0.3
Medium 5000–10000 treatments per yr	1,414	10.2	−0.7	1.0	−0.1	0.2
Large > 10000 treatments per year	944	15.0	0.6	1.0	0.0	1.7
Type of Ownership:						
Not-for-profit	697	5.2	2.9	1.1	0.0	4.1
For-profit	2,710	21.9	−0.6	1.0	−0.0	0.4
Other	264	2.1	−0.1	1.0	0.0	1.0
Urban	2,701	23.6	0.1	1.0	0.1	1.2
Rural	970	5.6	−0.5	1.0	−0.5	−0.0
Region:						
New England	125	1.2	1.3	1.1	0.1	2.4
Middle Atlantic	475	4.0	0.5	1.0	0.9	2.4
East North Central	540	4.5	0.4	1.0	−0.1	1.3
West North Central	255	1.7	1.4	1.1	−0.5	2.0
South Atlantic	886	6.9	−1.0	1.0	0.0	0.0
East South Central	309	2.2	−1.0	1.0	−0.7	−0.7
West South Central	522	4.1	−1.0	1.0	−0.2	−0.1
Mountain	194	1.3	0.6	1.1	−0.5	1.1
Pacific	339	3.0	1.4	1.1	−0.2	2.3

TABLE 33.—IMPACT OF MMA SECTION 623 PAYMENTS TO HOSPITAL BASED AND INDEPENDENT ESRD FACILITIES (INCLUDES DRUG AND COMPOSITE RATE PAYMENTS)—Continued

[Percent change in total payments to ESRD facilities (both program and beneficiaries)]

	Number of facilities	Number of dialysis treatments (in millions)	Effect of changes in drug payments 1/	Effect of 1.6% composite rate update on total payments 2/	Effect of case mix 3/	Overall effect 4/
Puerto Rico	26	0.4	0.8	1.0	1.4	3.3

[1] This column shows the effect of the changes in drug payments to ESRD providers. These include changes in payment for separately billable drugs and the 11.3% drug add-on.

[2] This column shows the effect of the 1.6% update to the composite rate on total payments to ESRD providers. Note that ESRD providers receive an average of 36% of their total revenues from separately billable drugs which results in an average net increase of 1.0%.

[3] This column shows impact of case-mix adjustments only.

[4] This column shows percent change between the proposed and current payments to ESRD facilities. The proposed payments includes the 1.6% increase, the 11.3% drug add-on, and the case-mix adjustments times treatments plus proposed payment for separately billable drugs. The current payment to ESRD facilities includes the current composite rate times treatments plus current drug payments for separately billable drugs.

Table 33 shows the impact of MMA Section 623 on hospital based and independent facilities. We have included both composite rate payments as well as payments for separately billable drugs and biologicals because both are effected by Section 623. The first column of Table 33 identifies the type of ESRD provider, the second column indicates the number of ESRD facilities for each type, and the third column indicates the number of dialysis treatments.

The fourth column shows the effect of the changes in drug payments to ESRD providers. The overall effect of changes in drug payments is budget-neutral as required by MMA. The drug add-on adjustment is designed to result in the same aggregate amount of expenditures as would have been made without the statutory policy change.

Current payments for drugs represent 2005 Medicare reimbursement using 95 percent of AWP prices for the top ten drugs. Medicare spending for drugs other than EPO is estimated using 2004 AWP prices updated by a 3 percent inflation factor times actual drug utilization from 2003 claims. EPO is priced $10 per 1000 units (EPO units are estimated using payments because the units field on bills represents the number of EPO administrations rather than the number EPO units). Spending under the proposed change is 2004 ASP minus 3 percent for the top ten drugs plus 3.39 percent inflation factor times actual drug utilization from 2003 claims.

Proposed payment for drugs under MMA also includes the 11.3 percent drug add-on to the composite rate. This amount is computed by multiplying the composite rate for each provider (with the 1.6 percent increase) times dialysis treatments from 2003 claims. Column 4 is computed by comparing spending under the proposed payment for drugs including the 11.3 percent drug add-on amount to spending under current payments for drugs. In order to make column 4 comparable with rest of Table 33, current composite rate payments to ESRD facilities were included in both current and proposed spending calculations.

Column 5 shows the effect of the 1.6 percent increase to the composite rate on total payments to ESRD providers. While all ESRD providers will get a 1.6 percent increase to their composite rate, this table shows the net effect of this increase on ESRD providers total Medicare revenues (both drug and composite rate payments combined), and therefore does not show a 1.6 percent increase.

On average, ESRD providers receive an average of 36 percent of their total revenues from separately billable drugs and 64 percent of their total revenues from composite rate payment. Since the 1.6 percent increase is applied to the 64 percent portion of their total Medicare revenues, the 1.6 percent composite rate increase is also arithmetically equal to a 1.0 percent increase in ESRD providers' total Medicare revenues. Column 5 is computed by combining proposed payment for drugs (including the 11.3 percent drug add-on amount) with: (1) Current composite rate times dialysis treatments from 2003 claims or (2) composite rate with 1.6 percent increase times dialysis treatments from 2003 claims. The difference between these two combinations is the net effect of the 1.6 percent increase on total payments to ESRD providers. In order to isolate the effect of the 1.6 percent increase, the computation in Column 5 assumes that drug payments to ESRD providers remain constant.

Column 6 shows the impact of the case-mix adjustments as described in section H.4.d of this proposed rule. Because MMA requires this adjustment be budget-neutral in the aggregate, there is no overall impact to the ESRD providers as a whole. While the case-mix adjustment will have an impact within the various provider types, Column 6 shows that the effect between provider groupings is minimal. Column 6 is computed as the difference between proposed payments to ESRD providers with the case-mix adjustments compared to payments to providers without the case-mix adjustments. As described in section H.4.f, we standardized the composite rate to meet the MMA requirement that payment be budget-neutral with respect to aggregate payments. Therefore, there is no change for ESRD providers in aggregate. We note that when applying the case-mix adjustments, we did so at the summary level as shown in Table 33.

Column 7 shows the overall effect of all changes in drug and composite rate payments to ESRD providers. The overall effect measured as the difference between proposed payment with all MMA changes as proposed in this rule and current payment. Proposed payment is computed by multiplying the composite rate for each provider (with both 1.6 percent increase and the 11.3 percent add-on) times dialysis treatments from 2003 claims times the appropriate case-mix adjustment by provider category. In addition, proposed payment includes payments for separately billable drugs under the revised pricing methodology as described in section III–E–Section 303–Payment Reform for Outpatient Drugs and Biologicals, Subsection 1.d. Current payment is the current composite rate for each provider times dialysis treatments from 2003 claims plus current drug payments for separately billable drugs.

The overall impact to ESRD providers in aggregate is 1.0 percent. Among the three separately shown effects, the effect

of changes in drug payments has the most variation among provider type and contributes most to the overall effect. Separately billable ESRD drugs are paid differently to hospital-based and independent ESRD providers. As discussed in section H.4.c, we are proposing a single drug add-on to the composite rates for both hospital based and independent facilities. The 7.0 percent increase in payments to hospital-based providers is largely due to the proposed single drug add-on to the composite rate. Many hospital based providers are not-for-profit, which may explain the larger than average increase in payments.

8. Section 731—Coverage of Routine Costs for Category A Clinical Trials

The coverage of routine costs associated with certain Category A clinical trials as discussed in MMA section 731(b) has no significant impact on Medicare expenditures.

9. Section 629—Part B Deductible

As explained earlier in the preamble, section 629 of the MMA provides for annual updates to the Medicare Part B deductible. The MMA stipulates that the Medicare Part B deductible will be $110 for calendar year 2005, and, for subsequent years, the deductible will be the previous year's deductible increased by the annual percentage increase in the monthly actuarial rate under section 1839(a)(1) of the Act, ending with that subsequent year (rounded to the nearest dollar). We note that while this MMA provision results in a savings to the Medicare program, it also increases beneficiary costs by an equal amount.

TABLE 34.—ESTIMATED MEDICARE SAVINGS FOR MMA PROVISION 629

[in millions]

MMA provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Sec. 629	110	290	440	590	770

10. Section 512—Hospice Consultation Service

As explained in section III.K, effective January 1, 2005, section 512 of the MMA provides for payment to be made to a hospice for specified services furnished by a physician who is either the medical director of, or an employee of, a hospice agency. We estimate that this MMA provision will increase Medicare expenditures by $10 million per year beginning in 2005.

11. Section 302—Clinical Conditions for Coverage of Durable Medical Equipment (DME)

As explained earlier in the preamble, to comply with the requirements of section 302 of the MMA and to enhance quality and reduce fraud, we are proposing to establish basic requirements that apply to all items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). The impact to the Medicare program will be to improve quality of care because we are involving the physician early in the process when determining the medical necessity for items of DMEPOS. The physician community has stated that they are often asked to order an item of DMEPOS for their patient when they do not think the item is reasonable and necessary. We believe these requirements will result in no costs or savings to Medicare because if any additional spending from more physician visits occur it will be offset by savings from Medicare paying for less DMEPOS. However, we expect to continue evaluating this issue.

E. Other Issues

1. Outpatient Therapy Services Performed ''Incident to'' Physicians'' Services

As discussed in section IV.A, we are proposing to amend the regulations to include the statutory requirement that only individuals meeting the existing qualification and training standards for therapists (with the exception of licensure) consistent with § 484.4 qualify to provide therapy services incident to physicians' services. We believe that while this will have little impact on Medicare expenditures, it will assist in ensuring the quality of services provided to beneficiaries.

2. Supervision Requirements for Therapy Assistants in Private Practice

As discussed earlier in section IV.A.2, we are proposing to revise the regulations at § 410.59 and § 410.60 to replace a requirement to provide personal supervision and instead require direct supervision of physical therapist assistants and occupational therapy assistants when therapy services are provided by physical therapists or occupational therapists in private practice. This proposed policy change would provide beneficiaries access to medically necessary therapy services, under a physician-certified plan of care. We believe that this change would result in a 5 percent increase in therapy billing in therapy private practice settings with an estimated cost of $9 million for FY 2005. Projected costs for FY 2006 are $17 million while each subsequent year would only increase by $1 million each year, assuming the therapy caps are applied.

3. Low Osmolar Contrast Media

As discussed earlier in the preamble, we are proposing to revise the regulations at § 414.38 to eliminate the restrictive criteria for the payment of LOCM. This proposal will make payment for LOCM consistent across Medicare payment systems. By identifying contrast-enhanced procedures that most commonly use LOCM, the typical ranges of LOCM amounts used by modality, and the cost ranges for LOCM in the marketplace, we estimate program costs as shown in the following table:

TABLE 35

Regulatory Provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
LOCM	20	30	30	30	30

4. Payments for Physicians and Practitioners Managing Patients on Dialysis

We believe that the proposals with respect to ESRD-related services furnished to patients in observation settings and payment for outpatient ESRD-related services for partial month scenarios discussed earlier in section 1V. E. provide clarification of current policy surrounding these issues. We do not believe these proposals would have a significant impact on Medicare expenditures.

5. Supervision of Clinical Psychological Testing

We are proposing to change the supervision requirements regarding who can supervise diagnostic psychological testing services. As previously discussed, having ancillary staff supervised by clinical psychologists would enable these practitioners with a higher level of expertise to oversee psychological testing and potentially relieve burdens on physicians and healthcare facilities.

Additionally, in rural areas, we anticipate that permitting psychologists to supervise diagnostic psychological testing services would reduce delays in testing, diagnosis, and treatment that could result from the unavailability of physicians to supervise the tests. We believe that this proposal will have little impact on Medicare expenditures.

6. Care Plan Oversight

As discussed in section IV.G, we are proposing to revise § 414.39 to clarify that NPPs can perform home health care plan oversight even though they cannot certify a patient for home health services and sign the plan of care. We do not expect that this proposal would have an impact on Medicare expenditures, since it is only clarifying that an NPP or a physician can provide care plan oversight for home health care.

7. Assignment of Medicare Claims

The proposed changes with respect to assignment of Medicare claims are currently estimated to have no significant impact on Medicare expenditures. However, as stated earlier in this preamble at section IV.H, we believe the proposed changes will reduce the paperwork burden on beneficiaries and suppliers.

F. Alternatives Considered

This proposed rule contains a range of policies, including proposals related to specific MMA provisions. The preamble provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised and presents rationale for our decisions and, when possible, alternatives that were considered.

The following is a discussion of additional points on the proposed changes required by section 302 of the MMA involving ordering items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

In developing the proposed changes to implement section 302 of the MMA, we did consider establishing ''the face-to-face requirement,'' and ''the order prior to delivery'' requirement only for specific items of DMEPOS for which there has been an identified proliferation of use. However, we believe it is important that the physician or nonphysician practitioner determine the medical need for all items of DME. It is good clinical practice for beneficiaries to be seen by the physician for their medical condition and at that time the physician will decide whether an item of DME is appropriate. It is our intent to make Medicare more consistent with private payers in that beneficiaries be seen by their physician for their medical condition, who then makes a diagnosis and orders any supplies needed to address their needs. Since we expect beneficiaries to be seen by their doctor for a specific medical condition, we do not believe that this would place a burden on the physician, as it would be part of a necessary examination.

We also note that in establishing these proposed requirements we do make exceptions for items of continued need, such as, glucose test strips or support surfaces. Once the physician has initially established the need, we do not require additional visits or additional documentation.

G. Impact on Beneficiaries

There are a number of changes made in this proposed rule that would have an effect on beneficiaries. In general, we believe these changes will improve beneficiary access to services that are currently covered or will expand the Medicare benefit package to include new services. As explained in more detail below, the MMA or regulatory provisions may increase beneficiary liability in some cases. Any changes in aggregate beneficiary liability from a particular provision will be a function of the coinsurance (20 percent if applicable for the particular provision after the beneficiary has met the deductible) and the effect of the aggregate cost (savings) of the provision on the calculation of the Medicare Part B premium rate (generally 25 percent of the provision's cost or savings). Taking into account the MMA and regulatory provisions of this proposed rule, we estimate beneficiary savings in FY 2005 of $270 million. This figure could be less if we make further changes to Medicare's drug administration payments.

The MMA provisions that expand Medicare benefits include: section 611, adding a preventive office visit for newly eligible Medicare beneficiaries; section 612 providing coverage of cardiovascular screening blood tests; and section 613, providing coverage for diabetes screening tests for Medicare beneficiaries at risk for diabetes. While the preventive office visit for newly eligible Medicare beneficiaries is subject to deductible and coinsurance, we believe Medicare beneficiaries will continue to benefit from expanded coverage for this service. We believe many beneficiaries have supplemental insurance coverage or Medicaid that pays the Medicare deductible on their behalf and there will be no immediate additional out-of-pocket cost. Further, even if a beneficiary pays nearly all of the costs of this new benefit, the preventive office visit will substitute for another service a beneficiary may need to meet the annual deductible and the beneficiary will receive more covered benefits at little additional cost. There are no out-of-pocket costs to the beneficiary for the cardiovascular screening blood tests and diabetes screening tests.

Other proposals in this rule related to the MMA will also impact beneficiary liability, with the most significant related to indexing of the part B deductible (section 629 of the MMA) and the drug administration payment changes (sections 303 and 305 of the MMA). Indexing of the Part B deductible will result in an estimated cost to beneficiaries of $110 million in 2005. MMA provisions that improve administration of the 10 percent HPSA bonus and provide an additional 5 percent bonus payment to physicians in Medicare scarcity areas will have no impact on beneficiary liability because the bonus payments are applied to the amount Medicare pays the physician net of beneficiary liability. These provisions will also improve access for Medicare beneficiaries by increasing payments to physicians in areas that traditionally have had a low ratio of physicians to population.

The implementation of MMA provisions related to drugs and drug administration will reduce Medicare beneficiary liability for Medicare covered services. We estimate that implementation of sections 303 through 305 of the MMA will reduce Medicare

beneficiary liability for drugs by $360 million in FY 2005. If we were to make no further changes to Medicare's payments for drug administration, we estimate additional savings to Medicare beneficiaries of $120 million in FY 2005. Provisions of this proposed rule that increase the supplying fee for immunosuppressive drugs and the furnishing fee for the clotting factor are estimated to increase beneficiary liability by $36 million and $10 million respectively, from FY 2005 through FY 2009.

We do not believe that the drug and drug administration payment changes required by the MMA are intended to lessen beneficiary access to care. By reducing beneficiary liability, we believe it is likely that beneficiary access to care will be improved. As indicated earlier, without any further change in payment for drug administration, the MMA increased payment for drug administration by more than 105 percent from 2003 to 2005 while making payment for drugs at 6 percent more than their average sales price. Nevertheless, we acknowledge that there is a concern among physicians and others that the large changes in Medicare's payments may affect their ability or willingness to continue making drugs and related services available.

As indicated above, we are considering making further changes to Medicare payment for drug administration based on the results of CPT's review of this issue or in response to public comment. Further, we are gathering Medicare utilization for drugs and drug administration beginning in 2002 and plan to analyze shifts or changes in utilization patterns as the information becomes available to us once the payment changes required by the MMA go into effect. While we do not believe the payment changes for drugs and drug administration will result in access problems, we plan to continue studying this issue. We also note that the MMA requires the Medicare Payment Advisory Commission (MedPAC) to study related issues. Specifically, section 303(a)(5) of the MMA requires MedPAC to study items and services furnished by oncologists and drug administration services furnished by other specialists. Similarly, section 305(b) requires the General Accounting Office to study the adequacy of Medicare payments for inhalation therapy.

We are also undertaking several changes using our administrative authority that will affect Medicare beneficiaries. Our proposal to remove restrictions that limit Medicare payment for use of low osmolar contrast material to specific indications would update Medicare's payment policy to be consistent with the standard practice of medicine and will improve the quality of care for beneficiaries.

We believe early involvement of the physician in determining the medical necessity for items of DMEPOS will assist in improving the accuracy of Medicare program payments and the quality of care. In addition, it will also reduce out-of-pocket costs for unnecessary DMEPOS that may have otherwise been provided to Medicare beneficiaries.

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

List of Subjects

42 CFR Part 405

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

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements

42 CFR Part 418

Health facilities, Hospice care, Medicare, Reporting and recordkeeping requirements

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements

42 CFR Part 484

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

42 CFR Part 486

Grant programs-health, Health facilities, Medicare, Reporting and recordkeeping requirements, X-rays

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

1. The authority citation for part 405 continues to read as follows:

Authority: Secs. 1102, 1861, 1862(a), 1871, 1874, 1881, and 1886(k) of the Social Security Act (42 U.S.C. 1302, 1395x, 1395y(a), 1395hh, 1395kk, 1395rr, and 1395ww(k)), and sec. 353 of the Public Health Service Act (42 U.S.C. 263a).

2. Section 405.207 is amended by revising paragraph (b) to read as follows:

§ 405.207 Services related to a noncovered device.

* * * * *

(b) *When payment is made.* Medicare payment may be made for—

(1) Covered services to treat a condition or complication that arises due to the use of a noncovered device or a noncovered device-related service; or

(2) Routine care services related to experimental/investigational (Category A) devices as defined in § 405.201(b); and furnished in conjunction with an FDA-approved clinical trial. The trial must meet criteria established through the national coverage determination process; and if the trial is initiated before January 1, 2010, the device must be determined as intended for use in the diagnosis, monitoring or treatment of an immediate life-threatening disease or condition.

(3) Routine care services related to a non-experimental/investigational (Category B) device defined in § 405.201(b) that is furnished in conjunction with an FDA-approved clinical trial.

3. Section 405.517 is amended by adding a new paragraph (a)(3) to read as follows:

§ 405.517 Payment for drugs and biologicals that are not paid on a cost or prospective payment basis.

(a) *Applicability.* * * *

(3) *Payment for drugs and biologicals on or after January 1, 2005.* Effective January 1, 2005, payment for drugs and biologicals that are not paid on a cost or prospective payment basis are paid in accordance with part 414, subpart K of this chapter.

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

4. The authority citation for part 410 continues to read as follows:

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

5. Section 410.10 is amended by adding new paragraph (y) to read as follows:

§ 410.10 Medical and other health services: Included services.

* * * * *

(y) Intravenous immune globulin administered in the home for the treatment of primary immune deficiency diseases.

6. Section 410.16 is added to read as follows:

§ 410.16 Initial preventive physical examination: Conditions for and limitations on coverage.

(a) *Definitions.* As used in this section, the following definitions apply—

Eligible beneficiary means individuals who receive their initial preventive physical examinations within 6 months after the effective date of their first Medicare Part B coverage period, but only if their first Part B coverage period begins on or after January 1, 2005.

Initial preventive physical examination means all of the following services furnished to an individual by a physician or other qualified nonphysician practitioner with the goal of health promotion and disease detection:

(1) Review of the individual's comprehensive medical and social history.

(2) Review of the individual's potential (risk factors) for depression, including past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument, which the physician or other qualified nonphysician practitioner may select unless the appropriate screening instrument is further defined through a national coverage determination.

(3) Review of the individual's functional ability, and level of safety, based on the use of an appropriate screening instrument, which the physician or other qualified nonphysician practitioner may select unless the appropriate screening instrument is defined through a national coverage determination.

(4) An examination to include measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on the individual's medical and social history, and current clinical standards.

(5) Performance and interpretation of an electrocardiogram.

(6) Education, counseling, and referral, as deemed appropriate by the physician or qualified nonphysician practitioner, based on the results of the review and evaluation services described in this section.

(7) Education, counseling, and referral, including a written plan provided to the individual for obtaining the appropriate screening and other preventive services for the individual that are covered as separate Medicare Part B benefits as described in section 1861(s)(10), section 1861(jj), section 1861(nn), section 1861(oo), section 1861(pp), section 1861(qq)(1), section 1861(rr), section 1861(uu), section 1861(vv), section 1861(xx)(1), and section 1861(yy) of the Social Security Act (the Act).

Medical history is defined to include, at a minimum, the following:

(1) Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries and treatments.

(2) Current medications and supplements, including calcium and vitamins.

(3) Family history, including a review of medical events in the patient's family, including diseases that may be hereditary or place the individual at risk.

Physician for purposes of this provision means a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act).

Qualified nonphysician practitioner for purposes of this provision means a physician assistant, nurse practitioner, or clinical nurse specialist (as authorized under section 1861(s)(2)(K)(i) and section 1861(s)(2)(K)(ii) of the Act and defined in section 1861(aa)(5) of the Act, or in regulations at § 410.74, § 410.75, and § 410.76).

Review of the individual's functional ability and level of safety. Review of the individual's functional ability and level of safety must include, at a minimum, a review of the following areas:

(1) Hearing impairment.

(2) Activities of daily living.

(3) Falls risk.

(4) Home safety.

Social history is defined to include, at a minimum, the following:

(1) History of alcohol, tobacco, and illicit drug use.

(2) Work and travel history.

(3) Diet.

(4) Social activities.

(5) Physical activities.

(b) *Condition for coverage of an initial preventive physical examination.* Medicare Part B pays for an initial preventive physical examination provided to an eligible beneficiary, as described in paragraph (a) of this section, if it is furnished by a physician or other qualified nonphysician practitioner, as defined in paragraphs (a) of this section.

(c) *Limitations on coverage of initial preventive physical examinations.* Payment may not be made for an initial preventive physical preventive examination that is performed for an individual who is not an eligible beneficiary as described in paragraph (a) of this section.

7. A new § 410.17 is added to read as follows:

§ 410.17 Cardiovascular disease screening tests.

(a) *Definition.* For purposes of this subpart, the following definition applies:

Cardiovascular screening blood test means:

(1) A lipid panel consisting of a total cholesterol, HDL cholesterol, and triglyceride. The test is performed after a 12-hour fasting period.

(2) Other blood tests, previously recommended by the U.S. Preventive Services Task Force (USPSTF), as determined by the Secretary through a national coverage determination process.

(3) Other non-invasive tests, for indications that have a blood test recommended by the USPSTF, as determined by the Secretary through a national coverage determination process.

(b) *General conditions of coverage.* Medicare Part B covers cardiovascular disease screening tests when ordered by the physician who is treating the beneficiary (see § 410.32(a)) for the purpose of early detection of cardiovascular disease in individuals without apparent signs or symptoms of cardiovascular disease.

(c) *Limitation on coverage of cardiovascular screening tests.* Payment may be made for cardiovascular screening tests performed for an asymptomatic individual only if the individual has not had the screening tests paid for by Medicare during the preceding 59 months following the month in which the last cardiovascular screening tests were performed.

8. A new § 410.18 is added to read as follows:

§ 410.18 Diabetes screening tests.

(a) *Definitions.* For purposes of this section, the following definitions apply:

Diabetes means diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting blood sugar

greater than or equal to 126 mg/dL on two different occasions; a 2-hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions; or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Pre-diabetes means a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting glucose level of 100–125 mg/dL, or a 2-hour post-glucose challenge of 140–199 mg/dL. The term pre-diabetes includes the following conditions:

(1) Impaired fasting glucose.

(2) Impaired glucose tolerance.

(b) *General conditions of coverage.* Medicare Part B covers diabetes screening tests after a referral from a physician or qualified nonphysician practitioner to an individual at risk for diabetes for the purpose of early detection of diabetes.

(c) *Types of tests covered.* The following tests are covered if all other conditions of this subpart are met:

(1) Fasting plasma glucose test.

(2) Post-glucose challenges including, but not limited to, an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults, a 2-hour post glucose challenge test alone.

(3) Other tests as determined by the Secretary through a national coverage determination.

(d) *Amount of testing covered.* Medicare covers the following for individuals:

(1) Diagnosed with pre-diabetes Medicare, two screening tests per calendar year.

(2) Previously tested who were not diagnosed with pre-diabetes, or who have never been tested before, one screening test per year.

(e) *Eligible risk factors.* Individuals with the following risk factors are eligible to receive the benefit:

(1) Hypertension.

(2) Dyslipidemia.

(3) Obesity, defined as a body mass index greater than or equal to 30 kg/m2.

(4) Prior identification of impaired fasting glucose or glucose intolerance.

(5) Any two of the following characteristics:

(i) Overweight, defined as body mass index greater than 25, but less than 30, kg/m2.

(ii) A family history of diabetes.

(iii) 65 years of age or older.

(iv) A history of birthing a baby weighing more than 9 pounds.

(f) *Individuals not covered.* For individuals previously diagnosed as diabetic, no coverage.

9. Section 410.26 is amended by revising paragraph (c) to read as follows:

§ 410.26 Services and supplies incident to a physician's professional services: Conditions.

* * * * *

(c) *Limitations.* (1) Drugs and biologicals are also subject to the limitations specified in § 410.29.

(2) Physical therapy, occupational therapy and speech-language pathology services provided incident to a physician's professional services are subject to the provisions established in § 410.59(a)(3)(iii), § 410.60(a)(3)(iii), and § 410.62(a)(3)(ii).

10. Section 410.32 is amended by revising paragraph (b)(2)(iii) to read as follows:

§ 410.32 Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.

* * * * *

(b) * * *

(2) * * *

(iii) Diagnostic psychological testing services when—

(A) Personally furnished by a clinical psychologist or an independently practicing psychologist as defined in program instructions; or

(B) Furnished under the general supervision of a physician or a clinical psychologist.

* * * * *

11. Section 410.36 is amended by—

A. Revising the section heading.

B. Adding to paragraph (a), the paragraph heading ''Condition for coverage medical supplies, appliances, and devices.''

C. Revising paragraph (b).

D. Adding new paragraphs (c) and (d).

The additions and revisions read as follows:

§ 410.36 Medical supplies, appliances, and devices: Conditions for and limitations on coverage.

(a) *Conditions for coverage of medical supplies, appliances, and medical devices.* * * *

(b) *Conditions for coverage.* Medicare Part B pays for the medical supplies, appliances, and devices listed in paragraph (a) of this section when:

(1) The medical supplies, appliances, and devices are ordered by a physician, physician assistant, clinical nurse specialist, or nurse practitioner as defined in the Act.

(2) The physician or prescribing practitioner—

(i) Conducts a face-to-face examination to determine the medical necessity for medical supplies, appliances, and devices.

(ii) Conducts the face-to-face examination only for the initial order and at the time of the prescription renewal for items of continued need, such as glucose testing supplies.

(iii) Is independent from the DME supplier and may not be an employee or contractor of the supplier.

(3) A written order is completed and signed before delivery of these medical supplies, appliances, and devices to the beneficiary.

(4) The physician's or prescribing practitioner's order is dated and signed within 30 days after the face-to-face examination and the beneficiary's medical record includes verification of the face-to-face examination.

(5) The physician or prescribing practitioner documents in the beneficiary's medical record the need for the medical supplies, appliances, and devices being ordered.

(6) CMS may determine other criteria, such as prescription renewal requirements, repairs, minor revisions and replacement, through contractor instructions.

(c) *Limitation.* Medicare does not pay for a face-to-face examination for the sole purpose of the beneficiary's obtaining the physician or prescribing practitioner's order for the medical supplies, appliances, and devices.

(d) *Clinical conditions for coverage.* Clinical conditions for coverage, other than those set forth in paragraph (b) of this section, of medical supplies, appliances, and devices are determined through the national or local coverage determination process.

12. Section 410.38 is amended by—

A. Revising paragraph (g).

B. Adding paragraphs (h) and (i).

The revision and additions read as follows:

§ 410.38 Durable medical equipment: Scope and conditions.

* * * * *

(g) *Conditions for coverage.* (1) Medicare Part B pays for durable medical equipment ordered by a physician, physician assistant, clinical nurse specialist, or nurse practitioner, as defined in the Act.

(2) The physician or prescribing practitioner must—

(i) Conduct a face-to-face examination to determine the medical necessity of each item of durable medical equipment.

(ii) Conduct the face-to-face examination for the initial order and at the time of the prescription renewal for items of continued need, such as infusion pumps or hospital beds.

(iii) Be independent from the DME supplier and cannot be an employee or contractor of the supplier.

(3) A written order must be completed and signed before delivery of any

durable medical equipment to the beneficiary.

(4) The physician's or prescribing practitioner's order must be dated and signed within 30 days after the face-to-face examination and the beneficiary's medical record must include verification of the face-to-face examination.

(5) The physician or prescribing practitioner must document in the beneficiary's medical record the need for the durable medical equipment being ordered.

(6) CMS may determine other additional payment criteria, such as prescription renewal requirements, repairs, minor revisions and replacement, through contractor instructions.

(h) *Limitation.* Medicare does not pay for a face-to-face examination for the sole purpose of the beneficiary's obtaining the physician's or prescribing practitioner's order for the durable medical equipment.

(i) *Clinical conditions for coverage.* Clinical conditions for coverage, not defined in paragraph (g) of this section, of durable medical equipment are determined through the national or local coverage determination process.

13. Section 410.59 is amended by—

A. Revising paragraph (a) introductory text and paragraph (a)(3)(ii).

B. Adding new paragraph (a)(3)(iii).

C. Revising paragraph (b) heading.

C. Revising paragraph (c)(2).

D. Adding new paragraph (e)(1)(iii).

The additions and revisions read as follows:

§ 410.59 Outpatient occupational therapy services: Conditions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(iii) of this section, Medicare Part B pays for outpatient occupational therapy services only if they are furnished by an individual meeting the qualifications in § 484.4 for an occupational therapist or by an appropriately supervised occupational therapy assistant who meets the following conditions: * * *

(3) * * *

(ii) By, or under the direct supervision of, an occupational therapist in private practice as described in paragraph (c) of this section; or

(iii) By, or incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform occupational therapy services within the scope of their State practice. When an occupational therapy service is provided incident to the service of a physician, physician assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service must meet the standards and conditions that apply to occupational therapy and occupational therapists, except that a license to practice occupational therapy in the State is not required.

(b) *Conditions for coverage of outpatient therapy services furnished to certain inpatients of a hospital or a CAH or SNF.* * * *

* * * * *

(c) *Special provisions for services furnished by occupational therapists in private practice.* * * *

(2) *Supervision of occupational therapy services.* Occupational therapy services are performed by, or under the direct supervision of, an occupational therapist in private practice. All services not performed personally by the therapist must be performed by employees of the practice, directly supervised by the therapist, and included in the fee for the therapist's services.

* * * * *

(e) *Annual limitation on incurred expenses.*

(1) * * *

(iii) The limitation is not applied for services furnished from December 8, 2003 through December 31, 2005.

* * * * *

14. Section 410.60 is amended by—

A. Revising paragraph (a) introductory text.

B. Revising paragraph (a)(3)(ii).

C. Adding new paragraph (a)(3)(iii).

D. Revising paragraph (b) heading.

E. Revising paragraph (c)(2).

F. Adding new paragraph (e)(1)(iii).

The additions and revisions read as follows:

§ 410.60 Outpatient physical therapy services: Conditions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(iii) of this section, Medicare Part B pays for outpatient physical therapy services only if they are furnished by an individual meeting the qualifications in § 484.4 for a physical therapist or by an appropriately supervised physical therapist assistant who meets the following conditions:

* * * * *

(3) * * *

(ii) By or under the direct supervision of a physical therapist in private practice as described in paragraph (c) of this section; or

(iii) By, or incident to, the service of a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform physical therapy services within the scope of their State practice. When a physical therapy service is provided incident to the service of a physician, physician's assistant, clinical nurse specialist, or nurse practitioner, the service and person who furnishes the service must meet the standards and conditions that apply to physical therapy and physical therapists, except that a license to practice physical therapy in the State is not required.

(b) *Condition for coverage of outpatient physical therapy services furnished to certain inpatients of a hospital or a CAH or SNF.* * * *

(c) Special provisions for services furnished by physical therapists in private practice. * * *

(2) *Supervision of physical therapy services.* Physical therapy services are performed by, or under the direct supervision of, a physical therapist in private practice. All services not performed personally by the therapist must be performed by employees of the practice, directly supervised by the therapist, and included in the fee for the therapist's services.

* * * * *

(e) *Annual limitation on incurred expenses.*

(1) * * *

(iii) The limitation is not applied for services furnished from December 8, 2003 through December 31, 2005.

* * * * *

15. Section 410.62 is amended by—

A. Revising paragraph (a) introductory text and (a)(2)(i), (a)(2)(iii) and (a)(3).

B. Revising paragraphs (b) and (c).

The revisions read as follows:

§ 410.62 Outpatient speech-language pathology services: Conditions and exclusions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(ii) of this section, Medicare Part B pays for outpatient speech-language pathology services only if they are furnished by an individual who meets the qualifications for a speech-language pathologist in § 484.4 of this chapter if they meet the following conditions: * * *

(2) * * *

(i) Is established by a physician or, effective January 1, 1982, by either a physician or the speech-language pathologist who provides the services to the particular individual;

(ii) * * *

(iii) Meets the requirements of § 410.61.

(3) They are furnished—

(i) By a provider as defined in § 489.2 of this chapter, or by others under arrangements with, and under the supervision of, a provider; or

(ii) By, or incident to, the service of a physician, physician assistant, clinical

nurse specialist, or nurse practitioner when those professionals may perform speech-language pathology services within the scope of their State practice. When a speech-language pathology service is provided incident to the services of a physician, physician's assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service must meet the standards and conditions that apply to speech-language pathology and speech-language pathologists, except that a license to practice speech-language pathology services in the State is not required.

(b) *Condition for coverage of outpatient speech-language pathology services to certain inpatients of a hospital, CAH, or SNF.* Medicare Part B pays for outpatient speech-language pathology services furnished to an inpatient of a hospital, CAH, or SNF who requires the services but has exhausted or is otherwise ineligible for benefit days under Medicare Part A.

(c) *Excluded services.* No service is included as an outpatient speech-language pathology service if it is not included as an inpatient hospital service if furnished to a hospital or CAH inpatient.

* * * * *

16. Section 410.63 is amended by—

A. Revising paragraph (b) section heading.

B. Adding a new paragraph (c).

The revision and addition reads as follows:

§ 410.63 Hepatitis vaccine and blood clotting factors: Conditions.

(b) *Blood clotting factors: Conditions.*

* * *

(c) *Blood clotting factors: Separate payment.* Effective January 1, 2005, Medicare pays hemophilia treatment centers and homecare companies that furnish blood clotting factor a separate payment of $0.05 per unit for the items and services associated with the furnishing of the blood clotting factor. These items and services include the mixing and delivery of factors, including special inventory management and storage requirements, as well as ancillary supplies and patient training necessary for the self-administration of these factors.

17. Section 410.78 is amended by—

A. Revising paragraph (a)(4).

B. Revising paragraph (b) introductory text.

The revisions read as follows:

§ 410.78 Telehealth services.

(a) * * *

(4) *Originating site* means the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. For asynchronous store and forward telecommunications technologies, the only originating sites are Federal telemedicine demonstration programs conducted in Alaska or Hawaii.

(b) *General rule.* Medicare Part B pays for office and other outpatient visits, professional consultation, psychiatric diagnostic interview examination, individual psychotherapy, monthly end stage renal disease (ESRD) related evaluation and management services and pharmacologic management furnished by an interactive telecommunications system if the following conditions are met:

* * * * *

18. Section 410.160 is amended by revising paragraph (f) to read as follows:

§ 410.160 Part B annual deductible.

* * * * *

(f) *Amount of the Part B annual deductible.* (1) Beginning with expenses for services furnished during calendar year 2006, and for all succeeding years, the annual deductible is the previous year's deductible plus the annual percentage increase in the monthly actuarial rate for Medicare enrollees age 65 and over, rounded to the nearest dollar.

(2) For 2005, the deductible is $110.

(3) From 1991 through 2004, the deductible was $100.

(4) From 1982 through 1990, the deductible was $75.

(5) From 1973 through 1981, the deductible was $60.

(6) From 1966 through 1972, the deductible was $50.

* * * * *

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

19. The authority citation for part 411 continues to read as follows:

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

20. Section 411.15 is amended by—

A. Revising paragraph (a)(1).

B. Adding paragraph (k)(11).

The revision and addition read as follows:

§ 411.15 Particular services excluded from coverage.

* * * * *

(a) * * *

(1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening mammography, colorectal cancer screening tests, screening pelvic exams, prostate cancer screening tests, glaucoma screening exams, or initial preventive physical examinations that meet the criteria specified in paragraphs (k)(6) through (k)(11) of this section.

* * * * *

(k) * * *

(11) In the case of initial preventive physical examinations, with the goal of health promotion and disease prevention, subject to the conditions and limitations specified in § 410.16 of this chapter.

* * * * *

21. Section 411.404 is amended by revising paragraph (b) to read as follows:

§ 411.404 Criteria for determining that a beneficiary knew that services were excluded from coverage as custodial care or as not reasonable and necessary.

* * * * *

(b) *Written notice.* Written notice is given to the beneficiary, or to someone acting on his or her behalf, that the services were not covered because they did not meet Medicare coverage guidelines. A notice concerning similar or reasonably comparable services furnished on a previous occasion also meets this criterion. After a beneficiary is notified that there is no Medicare payment for a service that is not covered by Medicare, he or she is presumed to know that there is no Medicare payment for any form of subsequent treatment for the non-covered condition.

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES.

22. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

§ 414.38 [Removed]

23. Section 414.38 is removed.

24. Section 414.39 is amended by—

A. Revising paragraph (a).

B. Adding paragraph (c).

The revision and addition read as follows:

§ 414.39 Special rules for payment of care plan oversight.

(a) *General.* Except as specified in paragraphs (b) and (c) of this section, payment for care plan oversight is included in the payment for visits and other services under the physician fee schedule. For purposes of this section a nonphysician practitioner (NPP) is a nurse practitioner, clinical nurse specialist or physician assistant.

* * * * *

(c) *Special rules for payment of care plan oversight provided by nonphysician practitioners for beneficiaries who receive HHA services covered by Medicare.* (1) An NPP can perform physician care plan oversight without certifying a patient for home health services (only a physician can certify a patient for home health care) if the relationship with the physician who signs the plan of care meets one of the following conditions:

(i) The physician and NPP are part of the same group practice;

(ii) If the NPP is a nurse practitioner or clinical nurse specialist, the physician signing the plan of care also has a collaborative agreement with the NPP;

(iii) If the NPP is a physician assistant, the physician signing the plan of care is also the physician who provides general supervision of physician assistant services for the practice; or

(iv) The physician signing the plan of care provides regular ongoing care under the same plan of care as does the NPP billing for care plan oversight.

(2) Payment may be made for care plan oversight services furnished by an NPP when:

(i) The NPP providing the care plan oversight has seen and examined the patient;

(ii) The NPP providing care plan oversight is not functioning as a consultant whose participation is limited to a single medical condition rather than multi-disciplinary coordination of care; or

(iii) The NPP providing care plan oversight integrates his or her care with that of the physician who signed the plan of care.

25. Section 414.65 is amended by revising paragraph (a)(1) to read as follows:

§ 414.65 Payment for telehealth services.

(a) * * *

(1) The Medicare payment amount for office or other outpatient visits, consultation, individual psychotherapy, psychiatric diagnostic interview examination, monthly end stage renal disease (ESRD) related evaluation and management services and pharmacologic management furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

* * * * *

26. Section 414.66 is added to read as follows:

§ 414.66 Incentive payments for physicians scarcity areas.

(a) *Definition.* As used in this section, the following definition applies—

Primary care physician is defined as a general practitioner, family practice practitioner, general internist, obstetrician or gynecologist.

(b) Physicians' services furnished to a beneficiary in a Physician Scarcity Area (PSA) for primary or specialist care are eligible for a 5 percent incentive payment.

(c) Primary care physicians furnishing services in primary care PSAs are entitled to an additional 5 percent incentive payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005 and before January 1, 2008.

(d) Physicians (other than dentists, podiatrists, optometrists, chiropractors, and those identified in paragraph (a) of this section) furnishing services in specialist care PSAs are entitled to an additional 5 percent payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005 and before January 1, 2008.

27. Section 414.67 is added to read as follows:

§ 414.67 Incentive payments for Health Professional Shortage Areas.

(a) Physicians' services furnished to a beneficiary in a geographic-based Health Professional Shortage Area (HPSA) are eligible for a 10 percent incentive payment.

(b) Physicians furnishing services in a geographic-based primary medical care HPSA are entitled to a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule.

(c) Psychiatrists furnishing services in a mental health HPSA are entitled to a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule. (The only physicians eligible to receive the 10 percent incentive payment in mental health HPSAs that do not overlap with primary care HPSAs are psychiatrists.)

28. Part 414 is amended by adding a new subpart K to read as follows:

Subpart K—Payment for Drugs and Biologicals in 2005

Sec.

Subpart K—Payment for Drugs and Biologicals in 2005

§ 414.900 Basis.

(a) This subpart implements section 1842(o) of the Social Security Act by specifying the methodology for determining the payment allowance limit for drugs and biologicals covered under Medicare Part B that are not paid on a cost or prospective payment system basis.

(b) Examples of drugs that are subject to the requirements specified in this subpart are:

(1) Drugs furnished incident to a physician's service; durable medical equipment (DME) drugs.

(2) Separately billable drugs at independent dialysis facilities not under the ESRD composite rate.

(3) Statutorily covered drugs, for example—

(i) Influenza

(ii) Pneumococcal and hepatitis vaccines.

(iii) Antigens.

(iv) Hemophilia blood clotting factor.

(v) Immunosuppressive drugs.

(vi) Certain oral anti-cancer drugs.

§ 414.902 Definitions.

As used in this subpart, unless the context indicates otherwise—

Drug means both drugs and biologicals.

Manufacturer's average sales price means the price calculated and reported by a manufacturer under part 414, subpart J of this chapter.

Multiple source drug means a drug described by section 1847A(c)(6)(C) of the Act.

Single source drug means a drug described by section 1847A(c)(6)(D) of the Act.

Unit is defined as in part 414, subpart J of this chapter.

Wholesale acquisition cost (WAC) means the price described by section 1847A(c)(6)(B) of the Act.

§ 414.904 Basis of payment.

(a) *Method of payment.* Payment for a drug for calendar year 2005 is based on the lesser of—

(1) The actual charge on the claim for program benefits; or

(2) 106 percent of the average sales price, subject to the applicable limitations specified in paragraph (d) of this section or subject to the exceptions described in paragraph (e) of this section.

(b) *Multiple source drugs.* (1) *Average sales prices.* The average sales price for all drug products included within the same multiple source drug billing and payment code is the volume-weighted

average of the manufacturers' average sales prices for those drug products.

(2) *Calculation of the average sales price.* The average sales price is determined by—

(i) Computing the sum of the products (for each National Drug Code assigned to the drug products) of the manufacturer's average sales price and the total number of units sold; and

(ii) Dividing that sum by the sum of the total number of units sold for all NDCs assigned to the drug products.

(c) *Single source drugs.* (1) *Average sales price.* The average sales price is the volume-weighted average of the manufacturers' average sales prices for all National Drug Codes assigned to the drug or biological product.

(2) *Calculation of the average sales price.* The average sales price is determined by computing—

(i) The sum of the products (for each National Drug Code assigned to the drug product) of the manufacturer's average sales price and the total number of units sold; and

(ii) Dividing that sum by the sum of the total number of units sold for all NDCs assigned to the drug product.

(d) *Limitations on the average sales price.* (1) *Wholesale acquisition cost for a single source drug.* The payment limit for a single source drug product is the lesser of 106 percent of the average sales price for the product or 106 percent of the wholesale acquisition cost for the product.

(2) *Payment limit for a drug furnished to an end-stage renal disease patient.* The payment for a drug furnished to an end-stage renal disease patient that is separately billed by an end stage renal disease facility, including erythropoietin, cannot exceed 97 percent of the average sales price.

(3) *Widely available market price and average manufacturer price.* If the Inspector General finds that the average sales price exceeds the widely available market price or the average manufacturer price by 5 percent or more in calendar year 2005, the payment limit in the quarter following the transmittal of this information to the Secretary is the lesser of the widely available market price or 103 percent of the average manufacturer price.

(e) *Exceptions to the average sales price.* (1) *Vaccines.* The payment limits for hepatitis B vaccine furnished to individuals at high or intermediate risk of contracting hepatitis B (as determined by the Secretary), pneumococcal vaccine, and influenza vaccine and are calculated using 95 percent of the average wholesale price.

(2) *Infusion drugs furnished through a covered item of durable medical equipment.* The payment limit for an infusion drug furnished through a covered item of durable medical equipment is calculated using 95 percent of the average wholesale price in effect on October 1, 2003 and is not updated in 2005.

(3) *Blood and blood products.* In the case of blood and blood products (other than blood clotting factors), the payment limits are determined in the same manner as the payment limits were determined on October 1, 2003.

(4) *Payment limit in a case where the average sales price during the first quarter of sales is unavailable.* In the case of a drug during an initial period (not to exceed a full calendar quarter) in which data on the prices for sales of the drug are not sufficiently available from the manufacturer to compute an average sales price for the drug, the payment limit is based on the wholesale acquisition cost or the applicable Medicare Part B drug payment methodology in effect on November 1, 2003.

(f) Except as otherwise specified (see paragraph (e)(2)of this section) for infusion drugs, the payment limits are updated quarterly.

(g) The payment limit is computed without regard to any special packaging, labeling, or identifiers on the dosage form or product or package.

(h) The payment amount is subject to applicable deductible and coinsurance.

PART 418—HOSPICE CARE

29. The authority citation for part 418 continues to read as follows:

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

30. Section 418.205 is added to read as follows:

§ 418.205 Special requirements for hospice pre-election evaluation and counseling services.

(a) *Definition.* For purposes of this section, the following definition applies:

Terminal illness is defined as having a prognosis of 6 months or less if the disease or illness runs its normal course.

(b) *Effective date for payment and requirements.* Effective January 1, 2005, payment for hospice pre-election evaluation and counseling services as specified in § 418.304(d) may be made to a hospice agency on behalf of a Medicare beneficiary who is terminally ill if the requirements of this section are met.

(1) *The beneficiary:* (i) Is certified as having a terminal illness.

(ii) Has not made a hospice election.

(iii) Has not previously received hospice pre-election evaluation and consultation services specified under this section.

(2) *Services provided.* The hospice pre-election services include—(i) An evaluation of an individual's need for pain and symptom management;

(ii) Counseling regarding hospice and other care options; and

(iii) May include advising the individual regarding advanced care planning.

(3) *Provider of pre-election hospice services.* (i) The physician furnishing these services must be an employee or medical director of the hospice billing for this service.

(ii) The services cannot be furnished by other hospice personnel, such as but not limited to nurse practitioners, nurses, or social workers, physicians under contractual arrangements with the hospice or by the beneficiary's physician, if that physician is not an employee of the hospice.

(iii) If the beneficiary's physician is also the medical director or a physician employee of the hospice, the attending physician is not required to request or provide this service because that physician already possesses the expertise necessary to furnish end-of-life evaluation and management, and counseling services.

(4) *Documentation.* (i) If the individual's physician initiates the request for services of the hospice medical director or physician, appropriate documentation is required.

(ii) The request or referral must be in writing, and the hospice medical director or physician employee is expected to provide a written note on the patient's medical record.

(iii) The hospice agency employing the physician providing these services is required to maintain a written record of the services rendered.

(iv) If the services are initiated by the beneficiary, the hospice agency is required to maintain a record of the services and that communication between the hospice medical director or physician and the beneficiary's physician occurs, with the beneficiary's permission, to the extent necessary to ensure continuity of care.

31. Section 418.304 is amended by adding paragraph (d) to read as follows.

§ 418.304 Payment for physician services.

* * * * *

(d) *Payment for hospice evaluation and counseling services—pre-election.* The intermediary makes payment for these services established in § 418.205 to the hospice. As directed by the statute, payment for this service is set at an amount established for an office or other outpatient visit for evaluation and

management associated with presenting problems of moderate severity and requiring medical decision-making of low complexity under the physician fee schedule, other than the portion of such amount attributable to the practice expense component. Payment for this pre-election service is not calculated towards the hospice cap amount.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

32. The authority citation for part 424 continues to read as follows:

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

33. Section 424.55 is amended by adding new paragraph (c) to read as follows:

§ 424.55 Payment to the supplier.

* * * * *

(c) *Exception.* In situations when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating physician or supplier, the beneficiary (or the person authorized to request payment on the beneficiary's behalf) is not required to assign the claim to the supplier in order for an assignment to be effective.

34. Section 424.71 is amended as follows:

A. The definition of ''Health care delivery system or system'' is removed.

B. The definition of the term ''Entity'' is added in alphabetical order.

The addition reads as follows:

§ 424.71 Definitions.

* * * * *

Entity means a person, group, or facility that is enrolled in the Medicare program.

* * * * *

35. Section 424.80 is amended by—

A. Revising paragraph (b)(2).

B. Removing paragraph (b)(3).

C. Redesignating paragraphs (b)(4) through (6) as paragraphs (b) (3) through (5), respectively.

D. Revising paragraph (c).

E. Adding a new paragraph (d).

The revisions and addition read as follows:

§ 424.80 Prohibition of reassignment of claims by suppliers.

* * * * *

(b) * * *

(1) * * *

(2) *Payment to an entity under a contractual arrangement.* Medicare may pay an entity enrolled in the Medicare program if there is a contractual arrangement between the entity and the supplier under which the entity bills for the supplier's services, subject to the provisions of paragraph (d) of this section.

* * * * *

(c) *Rules applicable to an employer or entity.* An employer or entity that may receive payment under paragraph (b)(1) or (b)(2) of this section is considered the supplier of those services for purposes of subparts C, D, and E of this part, subject to the provisions of paragraph (d) of this section.

(d) *Reassignment to an entity under a contractual arrangement: Conditions and limitations.* (1) *Liability of the parties.* An entity enrolled in the Medicare program that receives payment under a contractual arrangement under paragraph (b)(2) of this section and the supplier that otherwise receives payment are jointly and severally responsible for any Medicare overpayment to that entity.

(2) *Access to records.* The supplier furnishing the service has unrestricted access to claims submitted by an entity for services provided by that supplier.

PART 484–HOME HEALTH SERVICES

36. The authority citation for part 484 continues to read as follows:

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

§ 484.4 [Amended]

37. In § 484.4 in the definition of physical therapy assistant the term ''physical therapy assistant'' is removed and the term ''physical therapist assistant'' is added in its place wherever it appears.

PART 486—CONDITIONS FOR COVERAGE OF SPECIALIZED SERVICES FURNISHED BY SUPPLIERS

38. The authority citation for part 486 continues to read as follows:

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

Subpart D [Removed and Reserved]

39. Part 486 subpart D, consisting of § 486.150 through § 486.163, is removed and reserved.

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

Dated: July 13, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: July 23, 2004.

Tommy G. Thompson,

Secretary.

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

Addendum A—Explanation and Use of Addenda B

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in 2005. Addendum B contains the RVUs for work, non-facility practice expense, facility practice expense, and malpractice expense, and other information for all services included in the physician fee schedule.

In previous years, we have listed many services in Addendum B that are not paid under the physician fee schedule. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes and most alpha-numeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) in Addendum B.

Addendum B—2005 Relative Value Units and Related Information Used in Determining Medicare Payments for 2005

This addendum contains the following information for each CPT code and alphanumeric HCPCS code, except for alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for nonphysicians' services or items), or L (orthotics), and codes for anesthesiology.

1. *CPT/HCPCS code.* This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at the end of this addendum.

2. *Modifier.* A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier –26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code: One for the global values (both professional and technical); one for modifier –26 (PC); and one for modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier –53 is shown for a discontinued procedure. There will be RVUs for the code (CPT code 45378) with this modifier.

3. *Status indicator.* This indicator shows whether the CPT/HCPCS code is in the physician fee schedule and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the fee schedule if covered. There will be RVUs for codes with this status. The presence of an ''A'' indicator does not mean that Medicare has made a national decision regarding the coverage of the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payment for covered services is always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient.)

C = Carrier-priced code. Carriers will establish RVUs and payment amounts for these services, generally on a case-by-case basis following review of documentation, such as an operative report.

D = Deleted code. These codes are deleted effective with the beginning of the calendar year.

E = Excluded from physician fee schedule by regulation. These codes are for items or services that we chose to exclude from the physician fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the physician fee schedule for these codes. Payment for them, if they are covered, continues under reasonable charge or other payment procedures.

F = Deleted/discontinued codes. Code not subject to a 90-day grace period.

G = Code not valid for Medicare purposes. Medicare does not recognize codes assigned this status. Medicare uses another code for reporting of, and payment for, these services.

H = Deleted modifier. Either the TC or PC component shown for the code has been deleted, and the deleted component is shown in the data base with the H status indicator. (Code subject to a 90-day grace period.)

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment for these services. (Code NOT subject to a 90-day grace period.)

N = Noncovered service. These codes are noncovered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

P = Bundled or excluded code. There are no RVUs for these services. No separate payment should be made for them under the physician fee schedule.

—If the item or service is covered as incident to a physician's service and is furnished on the same day as a physician's service, payment for it is bundled into the payment for the physician's service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician's service).

—If the item or service is covered as other than incident to a physician's service, it is excluded from the physician fee schedule (for example, colostomy supplies) and is paid under the other payment provisions of the Act.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

T = Injections. There are RVUs for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Exclusion by law. These codes represent an item or service that is not within the definition of ''physicians' services'' for physician fee schedule payment purposes. No RVUs are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. *Description of code.* This is an abbreviated version of the narrative description of the code.

5. *Physician work RVUs.* These are the RVUs for the physician work for this service in 2005. Codes that are not used for Medicare payment are identified with a ''+.''

6. *Facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for facility settings.

7. *Non-facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for non-facility settings.

8. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 2005.

9. *Facility total.* This is the sum of the work, fully implemented facility practice expense, and malpractice expense RVUs.

10. *Non-facility total.* This is the sum of the work, fully implemented non-facility practice expense, and malpractice expense RVUs.

11. *Global period.* This indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

MMM = The code describes a service furnished in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. *See* the 1999 Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the carrier (for example, unlisted surgery codes).

ZZZ = Code related to another service that is always included in the global period of the other service. (**Note:** Physician work and practice expense are associated with intra service time and in some instances the post service time.)

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
10021		A	Fna w/o image	1.27	2.16	0.54	0.11	3.54	1.92	XXX
10022		A	Fna w/image	1.27	2.55	0.42	0.08	3.90	1.77	XXX
10040		A	Acne surgery	1.18	1.01	0.79	0.10	2.29	2.07	010
10060		A	Drainage of skin abscess	1.17	1.21	0.94	0.10	2.48	2.21	010
10061		A	Drainage of skin abscess	2.40	1.82	1.50	0.21	4.43	4.11	010
10080		A	Drainage of pilonidal cyst	1.17	3.12	1.12	0.11	4.40	2.40	010
10081		A	Drainage of pilonidal cyst	2.45	4.10	1.51	0.26	6.81	4.22	010
10120		A	Remove foreign body	1.22	2.19	0.99	0.11	3.52	2.32	010
10121		A	Remove foreign body	2.69	3.53	1.79	0.30	6.52	4.78	010
10140		A	Drainage of hematoma/fluid	1.53	1.77	1.29	0.15	3.45	2.97	010
10160		A	Puncture drainage of lesion	1.20	1.61	1.09	0.12	2.93	2.41	010
10180		A	Complex drainage, wound	2.25	3.00	1.98	0.32	5.57	4.55	010
11000		A	Debride infected skin	0.60	0.58	0.21	0.05	1.23	0.86	000
11001		A	Debride infected skin add-on	0.30	0.23	0.11	0.02	0.55	0.43	ZZZ
11010		A	Debride skin, fx	4.19	6.89	2.62	0.59	11.67	7.40	010
11011		A	Debride skin/muscle, fx	4.94	8.19	2.33	0.69	13.82	7.96	000
11012		A	Debride skin/muscle/bone, fx	6.87	12.09	3.83	1.11	20.07	11.81	000
11040		A	Debride skin, partial	0.50	0.52	0.21	0.04	1.06	0.75	000
11041		A	Debride skin, full	0.82	0.66	0.33	0.07	1.55	1.22	000
11042		A	Debride skin/tissue	1.12	0.97	0.44	0.11	2.20	1.67	000
11043		A	Debride tissue/muscle	2.38	3.40	2.59	0.27	6.05	5.24	010
11044		A	Debride tissue/muscle/bone	3.06	4.47	3.75	0.38	7.91	7.19	010
11055		R	Trim skin lesion	0.43	0.56	0.17	0.03	1.02	0.63	000
11056		R	Trim skin lesions, 2 to 4	0.61	0.63	0.23	0.05	1.29	0.89	000

[1] CPT codes and descriptions only are copyright 2004 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.

[2] Copyright 2004 American Dental Association. All rights reserved.

[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
11057		R	Trim skin lesions, over 4	0.79	0.74	0.30	0.06	1.59	1.15	000
11100		A	Biopsy, skin lesion	0.81	1.25	0.36	0.07	2.13	1.24	000
11101		A	Biopsy, skin add-on	0.41	0.33	0.19	0.03	0.77	0.63	ZZZ
11200		A	Removal of skin tags	0.77	1.05	0.76	0.07	1.89	1.60	010
11201		A	Remove skin tags add-on	0.29	0.16	0.12	0.03	0.48	0.44	ZZZ
11300		A	Shave skin lesion	0.51	0.99	0.21	0.04	1.54	0.76	000
11301		A	Shave skin lesion	0.85	1.11	0.38	0.07	2.03	1.30	000
11302		A	Shave skin lesion	1.05	1.30	0.46	0.09	2.44	1.60	000
11303		A	Shave skin lesion	1.24	1.58	0.52	0.11	2.93	1.87	000
11305		A	Shave skin lesion	0.67	0.84	0.27	0.06	1.57	1.00	000
11306		A	Shave skin lesion	0.99	1.10	0.42	0.08	2.17	1.49	000
11307		A	Shave skin lesion	1.14	1.29	0.49	0.10	2.53	1.73	000
11308		A	Shave skin lesion	1.41	1.45	0.59	0.12	2.98	2.12	000
11310		A	Shave skin lesion	0.73	1.12	0.32	0.07	1.92	1.12	000
11311		A	Shave skin lesion	1.05	1.23	0.49	0.09	2.37	1.63	000
11312		A	Shave skin lesion	1.20	1.42	0.55	0.11	2.73	1.86	000
11313		A	Shave skin lesion	1.62	1.79	0.72	0.15	3.56	2.49	000
11400		A	Exc tr-ext b9+marg 0.5 < cm	0.85	2.00	0.88	0.09	2.94	1.82	010
11401		A	Exc tr-ext b9+marg 0.6-1 cm	1.23	2.06	1.02	0.13	3.42	2.38	010
11402		A	Exc tr-ext b9+marg 1.1-2 cm	1.51	2.23	1.08	0.17	3.91	2.76	010
11403		A	Exc tr-ext b9+marg 2.1-3 cm	1.79	2.40	1.32	0.21	4.40	3.32	010
11404		A	Exc tr-ext b9+marg 3.1-4 cm	2.06	2.71	1.40	0.25	5.02	3.71	010
11406		A	Exc tr-ext b9+marg > 4.0 cm	2.76	3.07	1.66	0.33	6.16	4.75	010
11420		A	Exc h-f-nk-sp b9+marg 0.5 <	0.98	1.76	0.93	0.10	2.84	2.01	010
11421		A	Exc h-f-nk-sp b9+marg 0.6-1	1.42	2.06	1.11	0.15	3.63	2.68	010
11422		A	Exc h-f-nk-sp b9+marg 1.1-2	1.63	2.25	1.34	0.18	4.06	3.15	010
11423		A	Exc h-f-nk-sp b9+marg 2.1-3	2.01	2.58	1.45	0.23	4.82	3.69	010
11424		A	Exc h-f-nk-sp b9+marg 3.1-4	2.43	2.80	1.60	0.28	5.51	4.31	010
11426		A	Exc h-f-nk-sp b9+marg > 4 cm	3.77	3.49	2.10	0.44	7.70	6.31	010
11440		A	Exc face-mm b9+marg 0.5 < cm	1.06	2.21	1.31	0.10	3.37	2.47	010
11441		A	Exc face-mm b9+marg 0.6-1 cm	1.48	2.34	1.49	0.16	3.98	3.13	010
11442		A	Exc face-mm b9+marg 1.1-2 cm	1.72	2.54	1.57	0.20	4.46	3.49	010
11443		A	Exc face-mm b9+marg 2.1-3 cm	2.29	2.92	1.81	0.26	5.47	4.36	010
11444		A	Exc face-mm b9+marg 3.1-4 cm	3.14	3.47	2.17	0.35	6.96	5.66	010
11446		A	Exc face-mm b9+marg > 4 cm	4.48	4.04	2.76	0.47	8.99	7.71	010
11450		A	Removal, sweat gland lesion	2.73	5.06	2.02	0.35	8.14	5.10	090
11451		A	Removal, sweat gland lesion	3.94	6.64	2.54	0.52	11.10	7.00	090
11462		A	Removal, sweat gland lesion	2.51	5.14	2.01	0.31	7.96	4.83	090
11463		A	Removal, sweat gland lesion	3.94	6.85	2.68	0.51	11.30	7.13	090
11470		A	Removal, sweat gland lesion	3.25	5.09	2.26	0.38	8.72	5.89	090
11471		A	Removal, sweat gland lesion	4.40	6.74	2.76	0.54	11.68	7.70	090
11600		A	Exc tr-ext mlg+marg 0.5 < cm	1.31	2.64	0.97	0.13	4.08	2.41	010
11601		A	Exc tr-ext mlg+marg 0.6-1 cm	1.80	2.70	1.22	0.18	4.68	3.20	010
11602		A	Exc tr-ext mlg+marg 1.1-2 cm	1.95	2.83	1.26	0.20	4.98	3.41	010
11603		A	Exc tr-ext mlg+marg 2.1-3 cm	2.19	3.07	1.33	0.24	5.50	3.76	010
11604		A	Exc tr-ext mlg+marg 3.1-4 cm	2.40	3.38	1.39	0.28	6.06	4.07	010
11606		A	Exc tr-ext mlg+marg > 4 cm	3.42	4.06	1.73	0.40	7.88	5.55	010
11620		A	Exc h-f-nk-sp mlg+marg 0.5 <	1.19	2.60	0.95	0.13	3.92	2.27	010
11621		A	Exc h-f-nk-sp mlg+marg 0.6-1	1.76	2.70	1.24	0.19	4.65	3.19	010
11622		A	Exc h-f-nk-sp mlg+marg 1.1-2	2.09	2.97	1.38	0.23	5.29	3.70	010
11623		A	Exc h-f-nk-sp mlg+marg 2.1-3	2.61	3.33	1.58	0.31	6.25	4.50	010
11624		A	Exc h-f-nk-sp mlg+marg 3.1-4	3.06	3.74	1.77	0.38	7.18	5.21	010
11626		A	Exc h-f-nk-sp mlg+mar > 4 cm	4.29	4.64	2.38	0.50	9.43	7.17	010
11640		A	Exc face-mm malig+marg 0.5 <	1.35	2.66	1.11	0.15	4.16	2.61	010
11641		A	Exc face-mm malig+marg 0.6-1	2.16	3.02	1.52	0.24	5.42	3.92	010
11642		A	Exc face-mm malig+marg 1.1-2	2.59	3.40	1.71	0.30	6.29	4.60	010
11643		A	Exc face-mm malig+marg 2.1-3	3.10	3.80	1.95	0.37	7.27	5.42	010
11644		A	Exc face-mm malig+marg 3.1-4	4.02	4.67	2.44	0.49	9.18	6.95	010
11646		A	Exc face-mm mlg+marg > 4 cm	5.94	5.74	3.46	0.67	12.35	10.07	010
11719		R	Trim nail(s)	0.17	0.25	0.07	0.01	0.43	0.25	000
11720		A	Debride nail, 1-5	0.32	0.34	0.12	0.03	0.69	0.47	000
11721		A	Debride nail, 6 or more	0.54	0.43	0.21	0.04	1.01	0.79	000
11730		A	Removal of nail plate	1.13	1.03	0.43	0.09	2.25	1.65	000
11732		A	Remove nail plate, add-on	0.57	0.44	0.22	0.05	1.06	0.84	ZZZ
11740		A	Drain blood from under nail	0.37	0.56	0.36	0.03	0.96	0.76	000
11750		A	Removal of nail bed	1.86	2.16	1.75	0.15	4.17	3.76	010
11752		A	Remove nail bed/finger tip	2.67	2.99	2.99	0.28	5.94	5.94	010
11755		A	Biopsy, nail unit	1.31	1.57	0.77	0.11	2.99	2.19	000
11760		A	Repair of nail bed	1.58	2.63	1.79	0.18	4.39	3.55	010
11762		A	Reconstruction of nail bed	2.89	2.88	2.34	0.27	6.04	5.50	010
11765		A	Excision of nail fold, toe	0.69	1.78	0.76	0.06	2.53	1.51	010
11770		A	Removal of pilonidal lesion	2.61	3.50	1.50	0.32	6.43	4.43	010
11771		A	Removal of pilonidal lesion	5.73	5.66	3.31	0.72	12.11	9.76	090
11772		A	Removal of pilonidal lesion	6.97	7.54	5.08	0.88	15.39	12.93	090
11900		A	Injection into skin lesions	0.52	0.65	0.21	0.04	1.21	0.77	000

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[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
11901		A	Added skin lesions injection	0.80	0.66	0.35	0.07	1.53	1.22	000
11920		R	Correct skin color defects	1.61	3.69	1.09	0.22	5.52	2.92	000
11921		R	Correct skin color defects	1.93	3.95	1.27	0.28	6.16	3.48	000
11922		R	Correct skin color defects	0.49	1.13	0.25	0.07	1.69	0.81	ZZZ
11950		R	Therapy for contour defects	0.84	1.14	0.39	0.09	2.07	1.32	000
11951		R	Therapy for contour defects	1.19	1.49	0.51	0.15	2.83	1.85	000
11952		R	Therapy for contour defects	1.69	1.85	0.68	0.24	3.78	2.61	000
11954		R	Therapy for contour defects	1.85	2.43	0.90	0.17	4.45	2.92	000
11960		A	Insert tissue expander(s)	9.07	NA	10.37	1.23	NA	20.67	090
11970		A	Replace tissue expander	7.05	NA	6.12	1.04	NA	14.21	090
11971		A	Remove tissue expander(s)	2.13	9.13	3.78	0.30	11.56	6.21	090
11976		R	Removal of contraceptive cap	1.78	1.73	0.68	0.20	3.71	2.66	000
11980		A	Implant hormone pellet(s)	1.48	1.08	0.54	0.13	2.69	2.15	000
11981		A	Insert drug implant device	1.48	1.70	0.68	0.11	3.29	2.27	XXX
11982		A	Remove drug implant device	1.78	1.94	0.83	0.18	3.90	2.79	XXX
11983		A	Remove/insert drug implant	3.30	2.28	1.46	0.24	5.82	5.00	XXX
12001		A	Repair superficial wound(s)	1.70	2.00	0.78	0.15	3.85	2.63	010
12002		A	Repair superficial wound(s)	1.86	2.06	0.91	0.17	4.09	2.94	010
12004		A	Repair superficial wound(s)	2.24	2.35	1.02	0.21	4.80	3.47	010
12005		A	Repair superficial wound(s)	2.86	2.85	1.21	0.27	5.98	4.34	010
12006		A	Repair superficial wound(s)	3.66	3.42	1.52	0.37	7.45	5.55	010
12007		A	Repair superficial wound(s)	4.11	3.86	1.82	0.44	8.41	6.37	010
12011		A	Repair superficial wound(s)	1.76	2.15	0.79	0.16	4.07	2.71	010
12013		A	Repair superficial wound(s)	1.99	2.30	0.95	0.18	4.47	3.12	010
12014		A	Repair superficial wound(s)	2.46	2.59	1.07	0.22	5.27	3.75	010
12015		A	Repair superficial wound(s)	3.19	3.16	1.26	0.29	6.64	4.74	010
12016		A	Repair superficial wound(s)	3.92	3.59	1.53	0.37	7.88	5.82	010
12017		A	Repair superficial wound(s)	4.70	NA	1.89	0.48	NA	7.07	010
12018		A	Repair superficial wound(s)	5.52	NA	2.25	0.58	NA	8.35	010
12020		A	Closure of split wound	2.62	3.84	1.92	0.30	6.76	4.84	010
12021		A	Closure of split wound	1.84	1.83	1.42	0.23	3.90	3.49	010
12031		A	Layer closure of wound(s)	2.15	2.28	0.96	0.22	4.65	3.33	010
12032		A	Layer closure of wound(s)	2.47	3.85	1.81	0.24	6.56	4.52	010
12034		A	Layer closure of wound(s)	2.92	3.20	1.46	0.31	6.43	4.69	010
12035		A	Layer closure of wound(s)	3.42	5.22	2.16	0.39	9.03	5.97	010
12036		A	Layer closure of wound(s)	4.04	5.59	2.55	0.52	10.15	7.11	010
12037		A	Layer closure of wound(s)	4.66	6.13	2.96	0.61	11.40	8.23	010
12041		A	Layer closure of wound(s)	2.37	2.54	1.13	0.24	5.15	3.74	010
12042		A	Layer closure of wound(s)	2.74	3.27	1.47	0.26	6.27	4.47	010
12044		A	Layer closure of wound(s)	3.14	3.23	1.61	0.32	6.69	5.07	010
12045		A	Layer closure of wound(s)	3.63	5.30	2.28	0.41	9.34	6.32	010
12046		A	Layer closure of wound(s)	4.24	6.55	2.75	0.49	11.28	7.48	010
12047		A	Layer closure of wound(s)	4.64	6.39	3.08	0.57	11.60	8.29	010
12051		A	Layer closure of wound(s)	2.47	3.27	1.45	0.25	5.99	4.17	010
12052		A	Layer closure of wound(s)	2.77	3.22	1.44	0.26	6.25	4.47	010
12053		A	Layer closure of wound(s)	3.12	3.24	1.54	0.30	6.66	4.96	010
12054		A	Layer closure of wound(s)	3.45	3.56	1.64	0.34	7.35	5.43	010
12055		A	Layer closure of wound(s)	4.42	4.49	2.12	0.46	9.37	7.00	010
12056		A	Layer closure of wound(s)	5.23	6.76	3.05	0.53	12.52	8.81	010
12057		A	Layer closure of wound(s)	5.95	6.16	3.75	0.64	12.75	10.34	010
13100		A	Repair of wound or lesion	3.12	4.05	2.30	0.33	7.50	5.75	010
13101		A	Repair of wound or lesion	3.91	4.66	2.68	0.40	8.97	6.99	010
13102		A	Repair wound/lesion add-on	1.24	1.17	0.57	0.15	2.56	1.96	ZZZ
13120		A	Repair of wound or lesion	3.30	4.14	2.35	0.35	7.79	6.00	010
13121		A	Repair of wound or lesion	4.32	4.85	2.79	0.43	9.60	7.54	010
13122		A	Repair wound/lesion add-on	1.44	1.51	0.63	0.18	3.13	2.25	ZZZ
13131		A	Repair of wound or lesion	3.78	4.36	2.68	0.39	8.53	6.85	010
13132		A	Repair of wound or lesion	5.94	5.58	3.80	0.56	12.08	10.30	010
13133		A	Repair wound/lesion add-on	2.19	1.66	1.03	0.24	4.09	3.46	ZZZ
13150		A	Repair of wound or lesion	3.80	4.87	2.76	0.41	9.08	6.97	010
13151		A	Repair of wound or lesion	4.44	4.80	3.14	0.45	9.69	8.03	010
13152		A	Repair of wound or lesion	6.32	6.03	4.03	0.62	12.97	10.97	010
13153		A	Repair wound/lesion add-on	2.38	1.93	1.14	0.28	4.59	3.80	ZZZ
13160		A	Late closure of wound	10.46	NA	7.15	1.48	NA	19.09	090
14000		A	Skin tissue rearrangement	5.88	7.82	5.43	0.70	14.40	12.01	090
14001		A	Skin tissue rearrangement	8.46	9.39	7.03	1.00	18.85	16.49	090
14020		A	Skin tissue rearrangement	6.58	8.58	6.48	0.77	15.93	13.83	090
14021		A	Skin tissue rearrangement	10.04	9.96	8.23	1.10	21.10	19.37	090
14040		A	Skin tissue rearrangement	7.86	8.78	7.16	0.83	17.47	15.85	090
14041		A	Skin tissue rearrangement	11.47	10.58	8.64	1.13	23.18	21.24	090
14060		A	Skin tissue rearrangement	8.49	8.78	7.41	0.88	18.15	16.78	090
14061		A	Skin tissue rearrangement	12.27	11.59	9.46	1.20	25.06	22.93	090
14300		A	Skin tissue rearrangement	11.74	11.11	9.13	1.40	24.25	22.27	090
14350		A	Skin tissue rearrangement	9.60	NA	7.14	1.22	NA	17.96	090
15000		A	Skin graft	3.99	3.79	2.18	0.47	8.25	6.64	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
15001		A	Skin graft add-on	1.00	1.35	0.41	0.13	2.48	1.54	ZZZ
15050		A	Skin pinch graft	4.29	6.92	5.11	0.55	11.76	9.95	090
15100		A	Skin split graft	9.04	12.55	7.82	1.24	22.83	18.10	090
15101		A	Skin split graft add-on	1.72	3.72	1.17	0.24	5.68	3.13	ZZZ
15120		A	Skin split graft	9.82	10.72	7.79	1.19	21.73	18.80	090
15121		A	Skin split graft add-on	2.67	4.49	1.84	0.36	7.52	4.87	ZZZ
15200		A	Skin full graft	8.02	9.41	6.19	1.02	18.45	15.23	090
15201		A	Skin full graft add-on	1.32	2.56	0.62	0.18	4.06	2.12	ZZZ
15220		A	Skin full graft	7.86	9.18	6.67	0.97	18.01	15.50	090
15221		A	Skin full graft add-on	1.19	2.31	0.56	0.17	3.67	1.92	ZZZ
15240		A	Skin full graft	9.03	10.20	7.94	1.08	20.31	18.05	090
15241		A	Skin full graft add-on	1.86	2.44	0.91	0.24	4.54	3.01	ZZZ
15260		A	Skin full graft	10.04	10.21	8.57	0.97	21.22	19.58	090
15261		A	Skin full graft add-on	2.23	2.68	1.40	0.26	5.17	3.89	ZZZ
15342		A	Cultured skin graft, 25 cm	1.00	1.86	0.55	0.10	2.96	1.65	010
15343		A	Culture skn graft addl 25 cm	0.25	0.09	0.09	0.03	0.37	0.37	ZZZ
15350		A	Skin homograft	3.99	6.44	3.84	0.48	10.91	8.31	090
15351		A	Skin homograft add-on	1.00	0.36	0.36	0.14	1.50	1.50	ZZZ
15400		A	Skin heterograft	3.99	4.01	4.01	0.39	8.39	8.39	090
15401		A	Skin heterograft add-on	1.00	1.89	0.44	0.12	3.01	1.56	ZZZ
15570		A	Form skin pedicle flap	9.20	11.30	6.75	1.30	21.80	17.25	090
15572		A	Form skin pedicle flap	9.26	9.49	6.44	1.29	20.04	16.99	090
15574		A	Form skin pedicle flap	9.87	10.67	7.77	1.22	21.76	18.86	090
15576		A	Form skin pedicle flap	8.68	9.75	6.87	0.95	19.38	16.50	090
15600		A	Skin graft	1.91	7.61	3.06	0.27	9.79	5.24	090
15610		A	Skin graft	2.42	4.74	3.42	0.33	7.49	6.17	090
15620		A	Skin graft	2.94	7.76	3.87	0.36	11.06	7.17	090
15630		A	Skin graft	3.27	7.03	4.14	0.38	10.68	7.79	090
15650		A	Transfer skin pedicle flap	3.96	7.14	4.20	0.49	11.59	8.65	090
15732		A	Muscle-skin graft, head/neck	17.81	18.03	12.20	1.98	37.82	31.99	090
15734		A	Muscle-skin graft, trunk	17.76	18.12	12.36	2.52	38.40	32.64	090
15736		A	Muscle-skin graft, arm	16.25	18.14	11.20	2.38	36.77	29.83	090
15738		A	Muscle-skin graft, leg	17.89	17.91	11.70	2.58	38.38	32.17	090
15740		A	Island pedicle flap graft	10.23	10.14	8.25	1.01	21.38	19.49	090
15750		A	Neurovascular pedicle graft	11.39	NA	9.02	1.51	NA	21.92	090
15756		A	Free myo/skin flap microvasc	35.18	NA	20.52	4.51	NA	60.21	090
15757		A	Free skin flap, microvasc	35.18	NA	21.55	4.05	NA	60.78	090
15758		A	Free fascial flap, microvasc	35.05	NA	21.53	3.91	NA	60.49	090
15760		A	Composite skin graft	8.73	10.02	7.25	0.94	19.69	16.92	090
15770		A	Derma-fat-fascia graft	7.51	NA	6.67	1.01	NA	15.19	090
15775		R	Hair transplant punch grafts	3.95	2.97	1.30	0.52	7.44	5.77	000
15776		R	Hair transplant punch grafts	5.53	5.33	2.80	0.72	11.58	9.05	000
15780		A	Abrasion treatment of skin	7.28	11.57	8.24	0.75	19.60	16.27	090
15781		A	Abrasion treatment of skin	4.84	6.91	5.36	0.47	12.22	10.67	090
15782		A	Abrasion treatment of skin	4.31	9.92	6.56	0.35	14.58	11.22	090
15783		A	Abrasion treatment of skin	4.28	6.87	4.18	0.42	11.57	8.88	090
15786		A	Abrasion, lesion, single	2.03	3.35	1.32	0.18	5.56	3.53	010
15787		A	Abrasion, lesions, add-on	0.33	1.10	0.16	0.03	1.46	0.52	ZZZ
15788		R	Chemical peel, face, epiderm	2.09	6.72	3.08	0.19	9.00	5.36	090
15789		R	Chemical peel, face, dermal	4.91	8.09	4.82	0.43	13.43	10.16	090
15792		R	Chemical peel, nonfacial	1.86	7.11	4.45	0.17	9.14	6.48	090
15793		A	Chemical peel, nonfacial	3.73	6.29	4.39	0.32	10.34	8.44	090
15810		A	Salabrasion	4.73	NA	3.90	0.34	NA	8.97	090
15811		A	Salabrasion	5.38	5.47	4.76	0.80	11.65	10.94	090
15819		A	Plastic surgery, neck	9.37	NA	7.17	0.91	NA	17.45	090
15820		A	Revision of lower eyelid	5.14	6.93	5.52	0.48	12.55	11.14	090
15821		A	Revision of lower eyelid	5.71	7.32	5.68	0.46	13.49	11.85	090
15822		A	Revision of upper eyelid	4.44	5.82	4.47	0.39	10.65	9.30	090
15823		A	Revision of upper eyelid	7.04	7.84	6.40	0.50	15.38	13.94	090
15831		A	Excise excessive skin tissue	12.38	NA	8.15	1.69	NA	22.22	090
15832		A	Excise excessive skin tissue	11.57	NA	8.33	1.63	NA	21.53	090
15833		A	Excise excessive skin tissue	10.62	NA	8.20	1.48	NA	20.30	090
15834		A	Excise excessive skin tissue	10.83	NA	7.68	1.60	NA	20.11	090
15835		A	Excise excessive skin tissue	11.65	NA	7.53	1.63	NA	20.81	090
15836		A	Excise excessive skin tissue	9.33	NA	6.77	1.31	NA	17.41	090
15837		A	Excise excessive skin tissue	8.42	8.63	7.36	1.19	18.24	16.97	090
15838		A	Excise excessive skin tissue	7.12	NA	6.05	0.63	NA	13.80	090
15839		A	Excise excessive skin tissue	9.37	8.87	6.39	1.15	19.39	16.91	090
15840		A	Graft for face nerve palsy	13.24	NA	9.96	1.39	NA	24.59	090
15841		A	Graft for face nerve palsy	23.23	NA	14.98	2.79	NA	41.00	090
15842		A	Flap for face nerve palsy	37.90	NA	22.88	2.91	NA	63.69	090
15845		A	Skin and muscle repair, face	12.55	NA	9.29	0.86	NA	22.70	090
15850		B	Removal of sutures	0.78	1.57	0.29	0.05	2.40	1.12	XXX
15851		A	Removal of sutures	0.86	1.70	0.31	0.06	2.62	1.23	000
15852		A	Dressing change not for burn	0.86	1.87	0.33	0.09	2.82	1.28	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
15860		A	Test for blood flow in graft	1.95	0.83	0.78	0.25	3.03	2.98	000
15920		A	Removal of tail bone ulcer	7.94	NA	5.55	0.97	NA	14.46	090
15922		A	Removal of tail bone ulcer	9.89	NA	7.20	1.41	NA	18.50	090
15931		A	Remove sacrum pressure sore	9.23	NA	5.68	1.23	NA	16.14	090
15933		A	Remove sacrum pressure sore	10.83	NA	7.84	1.48	NA	20.15	090
15934		A	Remove sacrum pressure sore	12.67	NA	8.03	1.76	NA	22.46	090
15935		A	Remove sacrum pressure sore	14.55	NA	10.31	2.06	NA	26.92	090
15936		A	Remove sacrum pressure sore	12.36	NA	8.21	1.74	NA	22.31	090
15937		A	Remove sacrum pressure sore	14.19	NA	9.80	2.01	NA	26.00	090
15940		A	Remove hip pressure sore	9.33	NA	6.17	1.30	NA	16.80	090
15941		A	Remove hip pressure sore	11.41	NA	9.43	1.63	NA	22.47	090
15944		A	Remove hip pressure sore	11.44	NA	8.59	1.63	NA	21.66	090
15945		A	Remove hip pressure sore	12.67	NA	9.63	1.80	NA	24.10	090
15946		A	Remove hip pressure sore	21.54	NA	14.34	3.09	NA	38.97	090
15950		A	Remove thigh pressure sore	7.53	NA	5.41	1.02	NA	13.96	090
15951		A	Remove thigh pressure sore	10.70	NA	7.85	1.48	NA	20.03	090
15952		A	Remove thigh pressure sore	11.37	NA	7.74	1.58	NA	20.69	090
15953		A	Remove thigh pressure sore	12.61	NA	8.97	1.83	NA	23.41	090
15956		A	Remove thigh pressure sore	15.50	NA	10.75	2.18	NA	28.43	090
15958		A	Remove thigh pressure sore	15.46	NA	11.02	2.17	NA	28.65	090
16000		A	Initial treatment of burn(s)	0.89	0.87	0.26	0.08	1.84	1.23	000
16010		A	Treatment of burn(s)	0.87	0.66	0.63	0.08	1.61	1.58	000
16015		A	Treatment of burn(s)	2.35	NA	1.15	0.30	NA	3.80	000
16020		A	Treatment of burn(s)	0.80	1.31	0.59	0.08	2.19	1.47	000
16025		A	Treatment of burn(s)	1.85	1.77	0.96	0.19	3.81	3.00	000
16030		A	Treatment of burn(s)	2.08	2.18	1.12	0.22	4.48	3.42	000
16035		A	Incision of burn scab, initi	3.74	NA	1.58	0.42	NA	5.74	090
16036		A	Escharotomy; add-l incision	1.50	NA	0.60	0.20	NA	2.30	ZZZ
17000		A	Destroy benign/premlg lesion	0.60	0.97	0.55	0.05	1.62	1.20	010
17003		A	Destroy lesions, 2-14	0.15	0.11	0.07	0.01	0.27	0.23	ZZZ
17004		A	Destroy lesions, 15 or more	2.79	2.30	1.59	0.23	5.32	4.61	010
17106		A	Destruction of skin lesions	4.58	4.58	3.33	0.44	9.60	8.35	090
17107		A	Destruction of skin lesions	9.15	7.17	5.43	0.87	17.19	15.45	090
17108		A	Destruction of skin lesions	13.18	9.25	7.64	1.33	23.76	22.15	090
17110		A	Destruct lesion, 1-14	0.65	1.63	0.71	0.05	2.33	1.41	010
17111		A	Destruct lesion, 15 or more	0.92	1.68	0.81	0.08	2.68	1.81	010
17250		A	Chemical cautery, tissue	0.50	1.22	0.34	0.05	1.77	0.89	000
17260		A	Destruction of skin lesions	0.91	1.28	0.68	0.08	2.27	1.67	010
17261		A	Destruction of skin lesions	1.17	1.61	0.83	0.10	2.88	2.10	010
17262		A	Destruction of skin lesions	1.58	1.88	1.02	0.13	3.59	2.73	010
17263		A	Destruction of skin lesions	1.79	2.05	1.09	0.15	3.99	3.03	010
17264		A	Destruction of skin lesions	1.94	2.22	1.12	0.16	4.32	3.22	010
17266		A	Destruction of skin lesions	2.34	2.50	1.22	0.20	5.04	3.76	010
17270		A	Destruction of skin lesions	1.32	1.70	0.87	0.11	3.13	2.30	010
17271		A	Destruction of skin lesions	1.49	1.77	0.98	0.13	3.39	2.60	010
17272		A	Destruction of skin lesions	1.77	1.99	1.11	0.15	3.91	3.03	010
17273		A	Destruction of skin lesions	2.05	2.20	1.21	0.17	4.42	3.43	010
17274		A	Destruction of skin lesions	2.59	2.56	1.44	0.22	5.37	4.25	010
17276		A	Destruction of skin lesions	3.20	2.94	1.68	0.29	6.43	5.17	010
17280		A	Destruction of skin lesions	1.17	1.61	0.81	0.10	2.88	2.08	010
17281		A	Destruction of skin lesions	1.72	1.90	1.09	0.15	3.77	2.96	010
17282		A	Destruction of skin lesions	2.04	2.15	1.24	0.17	4.36	3.45	010
17283		A	Destruction of skin lesions	2.64	2.54	1.49	0.22	5.40	4.35	010
17284		A	Destruction of skin lesions	3.21	2.92	1.74	0.28	6.41	5.23	010
17286		A	Destruction of skin lesions	4.43	3.67	2.43	0.41	8.51	7.27	010
17304		A	1 stage mohs, up to 5 spec	7.59	8.22	3.55	0.64	16.45	11.78	000
17305		A	2 stage mohs, up to 5 spec	2.85	3.88	1.34	0.24	6.97	4.43	000
17306		A	3 stage mohs, up to 5 spec	2.85	3.90	1.35	0.24	6.99	4.44	000
17307		A	Mohs addl stage up to 5 spec	2.85	2.63	1.36	0.24	5.72	4.45	000
17310		A	Mohs any stage > 5 spec each	0.95	1.62	0.46	0.09	2.66	1.50	ZZZ
17340		A	Cryotherapy of skin	0.76	0.37	0.36	0.06	1.19	1.18	010
17360		A	Skin peel therapy	1.43	1.44	0.87	0.12	2.99	2.42	010
19000		A	Drainage of breast lesion	0.84	1.98	0.31	0.08	2.90	1.23	000
19001		A	Drain breast lesion add-on	0.42	0.25	0.14	0.04	0.71	0.60	ZZZ
19020		A	Incision of breast lesion	3.56	6.36	2.68	0.45	10.37	6.69	090
19030		A	Injection for breast x-ray	1.53	2.88	0.50	0.09	4.50	2.12	000
19100		A	Bx breast percut w/o image	1.27	2.08	0.42	0.15	3.50	1.84	000
19101		A	Biopsy of breast, open	3.18	4.51	1.91	0.36	8.05	5.45	010
19102		A	Bx breast percut w/image	2.00	3.83	0.66	0.15	5.98	2.81	000
19103		A	Bx breast percut w/device	3.69	11.53	1.23	0.30	15.52	5.22	000
19110		A	Nipple exploration	4.29	5.82	2.87	0.56	10.67	7.72	090
19112		A	Excise breast duct fistula	3.66	6.11	2.69	0.48	10.25	6.83	090
19120		A	Removal of breast lesion	5.55	4.55	3.06	0.72	10.82	9.33	090
19125		A	Excision, breast lesion	6.05	4.79	3.28	0.79	11.63	10.12	090
19126		A	Excision, addl breast lesion	2.93	NA	1.00	0.38	NA	4.31	ZZZ

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[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
19140		A	Removal of breast tissue	5.13	7.18	3.41	0.69	13.00	9.23	090
19160		A	Removal of breast tissue	5.98	NA	3.43	0.78	NA	10.19	090
19162		A	Remove breast tissue, nodes	13.51	NA	6.34	1.74	NA	21.59	090
19180		A	Removal of breast	8.79	NA	5.03	1.14	NA	14.96	090
19182		A	Removal of breast	7.72	NA	4.77	1.03	NA	13.52	090
19200		A	Removal of breast	15.47	NA	7.98	1.82	NA	25.27	090
19220		A	Removal of breast	15.70	NA	8.25	1.97	NA	25.92	090
19240		A	Removal of breast	15.98	NA	8.23	2.06	NA	26.27	090
19260		A	Removal of chest wall lesion	15.42	NA	11.17	2.01	NA	28.60	090
19271		A	Revision of chest wall	18.87	NA	17.99	2.51	NA	39.37	090
19272		A	Extensive chest wall surgery	21.52	NA	18.97	3.01	NA	43.50	090
19290		A	Place needle wire, breast	1.27	2.89	0.42	0.08	4.24	1.77	000
19291		A	Place needle wire, breast	0.63	1.22	0.21	0.04	1.89	0.88	ZZZ
19295		A	Place breast clip, percut	0.00	2.70	NA	0.01	2.71	NA	ZZZ
19316		A	Suspension of breast	10.67	NA	7.52	1.60	NA	19.79	090
19318		A	Reduction of large breast	15.60	NA	11.12	2.79	NA	29.51	090
19324		A	Enlarge breast	5.84	NA	4.87	0.84	NA	11.55	090
19325		A	Enlarge breast with implant	8.44	NA	6.53	1.28	NA	16.25	090
19328		A	Removal of breast implant	5.67	NA	5.02	0.89	NA	11.58	090
19330		A	Removal of implant material	7.58	NA	6.02	1.24	NA	14.84	090
19340		A	Immediate breast prosthesis	6.32	NA	3.10	1.03	NA	10.45	ZZZ
19342		A	Delayed breast prosthesis	11.18	NA	8.89	1.77	NA	21.84	090
19350		A	Breast reconstruction	8.91	13.79	7.15	1.38	24.08	17.44	090
19355		A	Correct inverted nipple(s)	7.56	10.25	4.70	1.07	18.88	13.33	090
19357		A	Breast reconstruction	18.13	NA	13.76	2.79	NA	34.68	090
19361		A	Breast reconstruction	19.23	NA	11.71	2.84	NA	33.78	090
19364		A	Breast reconstruction	40.94	NA	23.49	5.85	NA	70.28	090
19366		A	Breast reconstruction	21.25	NA	11.16	3.07	NA	35.48	090
19367		A	Breast reconstruction	25.69	NA	16.45	3.84	NA	45.98	090
19368		A	Breast reconstruction	32.37	NA	20.12	4.63	NA	57.12	090
19369		A	Breast reconstruction	29.78	NA	19.66	4.29	NA	53.73	090
19370		A	Surgery of breast capsule	8.04	NA	6.87	1.27	NA	16.18	090
19371		A	Removal of breast capsule	9.34	NA	7.79	1.65	NA	18.78	090
19380		A	Revise breast reconstruction	9.13	NA	7.67	1.42	NA	18.22	090
19396		A	Design custom breast implant	2.17	1.08	0.99	0.26	3.51	3.42	000
20000		A	Incision of abscess	2.12	2.70	1.73	0.19	5.01	4.04	010
20005		A	Incision of deep abscess	3.41	3.50	2.25	0.41	7.32	6.07	010
20100		A	Explore wound, neck	10.06	NA	4.46	1.19	NA	15.71	010
20101		A	Explore wound, chest	3.22	5.94	1.62	0.41	9.57	5.25	010
20102		A	Explore wound, abdomen	3.93	7.50	1.91	0.50	11.93	6.34	010
20103		A	Explore wound, extremity	5.29	8.60	3.39	0.70	14.59	9.38	010
20150		A	Excise epiphyseal bar	13.67	NA	7.04	1.43	NA	22.14	090
20200		A	Muscle biopsy	1.46	3.05	0.75	0.22	4.73	2.43	000
20205		A	Deep muscle biopsy	2.35	4.07	1.19	0.31	6.73	3.85	000
20206		A	Needle biopsy, muscle	0.99	6.63	0.63	0.07	7.69	1.69	000
20220		A	Bone biopsy, trocar/needle	1.27	4.89	0.80	0.09	6.25	2.16	000
20225		A	Bone biopsy, trocar/needle	1.87	26.72	1.13	0.18	28.77	3.18	000
20240		A	Bone biopsy, excisional	3.23	NA	2.56	0.41	NA	6.20	010
20245		A	Bone biopsy, excisional	7.77	NA	6.59	1.19	NA	15.55	010
20250		A	Open bone biopsy	5.02	NA	3.50	0.91	NA	9.43	010
20251		A	Open bone biopsy	5.55	NA	4.15	1.05	NA	10.75	010
20500		A	Injection of sinus tract	1.23	2.27	1.53	0.10	3.60	2.86	010
20501		A	Inject sinus tract for x-ray	0.76	2.98	0.25	0.05	3.79	1.06	000
20520		A	Removal of foreign body	1.85	2.93	1.77	0.20	4.98	3.82	010
20525		A	Removal of foreign body	3.49	9.14	2.62	0.47	13.10	6.58	010
20526		A	Ther injection, carp tunnel	0.94	0.97	0.51	0.10	2.01	1.55	000
20550		A	Inj tendon sheath/ligament	0.75	0.71	0.23	0.08	1.54	1.06	000
20551		A	Inj tendon origin/insertion	0.75	0.69	0.33	0.08	1.52	1.16	000
20552		A	Inj trigger point, 1/2 muscl	0.66	0.72	0.20	0.07	1.45	0.93	000
20553		A	Inject trigger points, =/> 3	0.75	0.82	0.22	0.05	1.62	1.02	000
20600		A	Drain/inject, joint/bursa	0.66	0.65	0.35	0.06	1.37	1.07	000
20605		A	Drain/inject, joint/bursa	0.68	0.76	0.36	0.07	1.51	1.11	000
20610		A	Drain/inject, joint/bursa	0.79	0.95	0.42	0.10	1.84	1.31	000
20612		A	Aspirate/inj ganglion cyst	0.70	0.71	0.36	0.07	1.48	1.13	000
20615		A	Treatment of bone cyst	2.28	3.53	1.84	0.19	6.00	4.31	010
20650		A	Insert and remove bone pin	2.23	2.36	1.55	0.25	4.84	4.03	010
20660		A	Apply, rem fixation device	2.51	3.05	1.61	0.54	6.10	4.66	000
20661		A	Application of head brace	4.88	NA	5.06	1.11	NA	11.05	090
20662		A	Application of pelvis brace	6.06	NA	5.58	0.53	NA	12.17	090
20663		A	Application of thigh brace	5.42	NA	4.89	0.33	NA	10.64	090
20664		A	Halo brace application	8.05	NA	7.15	1.68	NA	16.88	090
20665		A	Removal of fixation device	1.31	2.21	1.35	0.19	3.71	2.85	010
20670		A	Removal of support implant	1.74	11.52	2.09	0.26	13.52	4.09	010
20680		A	Removal of support implant	3.34	8.77	3.71	0.52	12.63	7.57	090
20690		A	Apply bone fixation device	3.51	NA	2.54	0.58	NA	6.63	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
20692		A	Apply bone fixation device	6.40	NA	3.77	0.99	NA	11.16	090
20693		A	Adjust bone fixation device	5.85	NA	5.73	0.98	NA	12.56	090
20694		A	Remove bone fixation device	4.15	7.13	4.04	0.69	11.97	8.88	090
20802		A	Replantation, arm, complete	41.09	NA	21.49	4.51	NA	67.09	090
20805		A	Replant forearm, complete	49.93	NA	35.25	4.64	NA	89.82	090
20808		A	Replantation hand, complete	61.56	NA	43.10	5.37	NA	110.03	090
20816		A	Replantation digit, complete	30.89	NA	38.46	4.37	NA	73.72	090
20822		A	Replantation digit, complete	25.55	NA	35.14	3.46	NA	64.15	090
20824		A	Replantation thumb, complete	30.89	NA	37.30	4.15	NA	72.34	090
20827		A	Replantation thumb, complete	26.37	NA	37.15	3.73	NA	67.25	090
20838		A	Replantation foot, complete	41.35	NA	22.78	10.71	NA	74.84	090
20900		A	Removal of bone for graft	5.57	8.44	5.66	0.85	14.86	12.08	090
20902		A	Removal of bone for graft	7.54	NA	7.06	1.21	NA	15.81	090
20910		A	Remove cartilage for graft	5.33	NA	5.26	0.66	NA	11.25	090
20912		A	Remove cartilage for graft	6.34	NA	6.15	0.70	NA	13.19	090
20920		A	Removal of fascia for graft	5.30	NA	4.40	0.58	NA	10.28	090
20922		A	Removal of fascia for graft	6.60	7.54	4.87	0.68	14.82	12.15	090
20924		A	Removal of tendon for graft	6.47	NA	6.06	0.97	NA	13.50	090
20926		A	Removal of tissue for graft	5.52	NA	4.99	0.81	NA	11.32	090
20931		A	Spinal bone allograft	1.81	NA	0.93	0.42	NA	3.16	ZZZ
20937		A	Spinal bone autograft	2.79	NA	1.45	0.49	NA	4.73	ZZZ
20938		A	Spinal bone autograft	3.02	NA	1.55	0.57	NA	5.14	ZZZ
20950		A	Fluid pressure, muscle	1.26	6.83	0.99	0.19	8.28	2.44	000
20955		A	Fibula bone graft, microvasc	39.15	NA	25.19	4.72	NA	69.06	090
20956		A	Iliac bone graft, microvasc	39.21	NA	25.05	7.16	NA	71.42	090
20957		A	Mt bone graft, microvasc	40.59	NA	19.21	4.32	NA	64.12	090
20962		A	Other bone graft, microvasc	39.21	NA	26.71	6.19	NA	72.11	090
20969		A	Bone/skin graft, microvasc	43.85	NA	27.63	4.68	NA	76.16	090
20970		A	Bone/skin graft, iliac crest	43.00	NA	25.97	6.77	NA	75.74	090
20972		A	Bone/skin graft, metatarsal	42.93	NA	20.56	3.44	NA	66.93	090
20973		A	Bone/skin graft, great toe	45.69	NA	25.46	5.61	NA	76.76	090
20974		A	Electrical bone stimulation	0.62	0.69	0.54	0.10	1.41	1.26	000
20975		A	Electrical bone stimulation	2.60	NA	1.71	0.46	NA	4.77	000
20979		A	Us bone stimulation	0.62	0.80	0.33	0.09	1.51	1.04	000
20982		A	Ablate, bone tumor(s) perq	7.27	109.89	2.97	0.69	117.85	10.93	000
21010		A	Incision of jaw joint	10.12	NA	7.14	1.02	NA	18.28	090
21015		A	Resection of facial tumor	5.28	NA	5.43	0.70	NA	11.41	090
21025		A	Excision of bone, lower jaw	10.04	12.22	9.35	1.30	23.56	20.69	090
21026		A	Excision of facial bone(s)	4.84	7.85	6.31	0.63	13.32	11.78	090
21029		A	Contour of face bone lesion	7.70	9.34	6.99	0.90	17.94	15.59	090
21030		A	Excise max/zygoma b9 tumor	4.49	6.32	5.03	0.86	11.67	10.38	090
21031		A	Remove exostosis, mandible	3.24	5.16	3.62	0.47	8.87	7.33	090
21032		A	Remove exostosis, maxilla	3.24	5.34	3.51	0.46	9.04	7.21	090
21034		A	Excise max/zygoma mlg tumor	16.15	15.88	12.63	1.74	33.77	30.52	090
21040		A	Excise mandible lesion	4.49	6.38	4.72	0.57	11.44	9.78	090
21044		A	Removal of jaw bone lesion	11.84	NA	9.37	1.10	NA	22.31	090
21045		A	Extensive jaw surgery	16.15	NA	12.34	1.57	NA	30.06	090
21046		A	Remove mandible cyst complex	12.98	NA	11.86	0.88	NA	25.72	090
21047		A	Excise lwr jaw cyst w/repair	18.72	NA	13.42	0.88	NA	33.02	090
21048		A	Remove maxilla cyst complex	13.48	NA	12.08	0.88	NA	26.44	090
21049		A	Excis uppr jaw cyst w/repair	17.97	NA	13.00	0.88	NA	31.85	090
21050		A	Removal of jaw joint	10.75	NA	9.43	1.36	NA	21.54	090
21060		A	Remove jaw joint cartilage	10.21	NA	8.60	1.51	NA	20.32	090
21070		A	Remove coronoid process	8.19	NA	7.10	1.16	NA	16.45	090
21076		A	Prepare face/oral prosthesis	13.40	12.34	9.99	1.91	27.65	25.30	010
21077		A	Prepare face/oral prosthesis	33.70	31.27	25.96	5.03	70.00	64.69	090
21079		A	Prepare face/oral prosthesis	22.31	21.46	17.12	3.09	46.86	42.52	090
21080		A	Prepare face/oral prosthesis	25.06	24.45	19.33	3.68	53.19	48.07	090
21081		A	Prepare face/oral prosthesis	22.85	22.26	17.45	3.10	48.21	43.40	090
21082		A	Prepare face/oral prosthesis	20.84	19.30	15.69	2.95	43.09	39.48	090
21083		A	Prepare face/oral prosthesis	19.27	18.76	14.41	2.55	40.58	36.23	090
21084		A	Prepare face/oral prosthesis	22.48	22.40	17.67	2.28	47.16	42.43	090
21085		A	Prepare face/oral prosthesis	8.99	8.27	6.77	1.17	18.43	16.93	010
21086		A	Prepare face/oral prosthesis	24.88	23.73	19.39	3.19	51.80	47.46	090
21087		A	Prepare face/oral prosthesis	24.88	23.23	19.14	3.58	51.69	47.60	090
21100		A	Maxillofacial fixation	4.21	11.59	4.76	0.35	16.15	9.32	090
21110		A	Interdental fixation	5.20	9.57	8.35	0.62	15.39	14.17	090
21116		A	Injection, jaw joint x-ray	0.81	4.36	0.33	0.06	5.23	1.20	000
21120		A	Reconstruction of chin	4.92	10.62	7.48	0.49	16.03	12.89	090
21121		A	Reconstruction of chin	7.63	9.73	7.81	0.93	18.29	16.37	090
21122		A	Reconstruction of chin	8.51	NA	8.62	0.98	NA	18.11	090
21123		A	Reconstruction of chin	11.14	NA	10.78	0.91	NA	22.83	090
21125		A	Augmentation, lower jaw bone	10.60	55.70	8.31	0.76	67.06	19.67	090
21127		A	Augmentation, lower jaw bone	11.10	42.76	9.44	1.66	55.52	22.20	090
21137		A	Reduction of forehead	9.81	NA	7.71	1.13	NA	18.65	090

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[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
21138		A	Reduction of forehead	12.17	NA	9.50	0.61	NA	22.28	090
21139		A	Reduction of forehead	14.59	NA	11.04	1.68	NA	27.31	090
21141		A	Reconstruct midface, lefort	18.07	NA	13.75	2.41	NA	34.23	090
21142		A	Reconstruct midface, lefort	18.78	NA	12.94	2.26	NA	33.98	090
21143		A	Reconstruct midface, lefort	19.55	NA	14.30	1.09	NA	34.94	090
21145		A	Reconstruct midface, lefort	19.91	NA	14.02	2.58	NA	36.51	090
21146		A	Reconstruct midface, lefort	20.68	NA	15.44	3.09	NA	39.21	090
21147		A	Reconstruct midface, lefort	21.74	NA	15.13	1.83	NA	38.70	090
21150		A	Reconstruct midface, lefort	25.20	NA	16.75	3.04	NA	44.99	090
21151		A	Reconstruct midface, lefort	28.26	NA	22.88	4.22	NA	55.36	090
21154		A	Reconstruct midface, lefort	30.47	NA	23.07	4.55	NA	58.09	090
21155		A	Reconstruct midface, lefort	34.40	NA	23.85	6.61	NA	64.86	090
21159		A	Reconstruct midface, lefort	42.32	NA	29.02	6.31	NA	77.65	090
21160		A	Reconstruct midface, lefort	46.37	NA	27.46	4.91	NA	78.74	090
21172		A	Reconstruct orbit/forehead	27.76	NA	14.01	2.83	NA	44.60	090
21175		A	Reconstruct orbit/forehead	33.12	NA	18.18	3.43	NA	54.73	090
21179		A	Reconstruct entire forehead	22.22	NA	14.72	3.24	NA	40.18	090
21180		A	Reconstruct entire forehead	25.15	NA	15.92	3.08	NA	44.15	090
21181		A	Contour cranial bone lesion	9.89	NA	7.78	1.37	NA	19.04	090
21182		A	Reconstruct cranial bone	32.14	NA	19.47	3.42	NA	55.03	090
21183		A	Reconstruct cranial bone	35.26	NA	21.18	3.51	NA	59.95	090
21184		A	Reconstruct cranial bone	38.18	NA	22.37	6.84	NA	67.39	090
21188		A	Reconstruction of midface	22.43	NA	18.83	2.97	NA	44.23	090
21193		A	Reconst lwr jaw w/o graft	17.12	NA	12.84	2.10	NA	32.06	090
21194		A	Reconst lwr jaw w/graft	19.81	NA	13.91	2.11	NA	35.83	090
21195		A	Reconst lwr jaw w/o fixation	17.21	NA	14.79	1.22	NA	33.22	090
21196		A	Reconst lwr jaw w/fixation	18.88	NA	15.66	2.03	NA	36.57	090
21198		A	Reconstr lwr jaw segment	14.14	NA	12.69	1.41	NA	28.24	090
21199		A	Reconstr lwr jaw w/advance	15.98	NA	9.15	1.39	NA	26.52	090
21206		A	Reconstruct upper jaw bone	14.08	NA	12.62	1.78	NA	28.48	090
21208		A	Augmentation of facial bones	10.21	22.32	9.56	1.11	33.64	20.88	090
21209		A	Reduction of facial bones	6.71	10.78	8.06	0.90	18.39	15.67	090
21210		A	Face bone graft	10.21	24.84	9.33	1.37	36.42	20.91	090
21215		A	Lower jaw bone graft	10.75	41.85	9.35	1.51	54.11	21.61	090
21230		A	Rib cartilage graft	10.75	NA	8.46	1.20	NA	20.41	090
21235		A	Ear cartilage graft	6.71	9.83	6.40	0.68	17.22	13.79	090
21240		A	Reconstruction of jaw joint	14.03	NA	12.17	2.28	NA	28.48	090
21242		A	Reconstruction of jaw joint	12.93	NA	11.66	2.29	NA	26.88	090
21243		A	Reconstruction of jaw joint	20.76	NA	17.37	3.05	NA	41.18	090
21244		A	Reconstruction of lower jaw	11.84	NA	12.07	1.24	NA	25.15	090
21245		A	Reconstruction of jaw	11.84	14.35	9.83	1.12	27.31	22.79	090
21246		A	Reconstruction of jaw	12.45	NA	9.03	1.24	NA	22.72	090
21247		A	Reconstruct lower jaw bone	22.60	NA	17.43	3.23	NA	43.26	090
21248		A	Reconstruction of jaw	11.46	12.11	9.38	1.67	25.24	22.51	090
21249		A	Reconstruction of jaw	17.49	16.70	12.67	2.02	36.21	32.18	090
21255		A	Reconstruct lower jaw bone	16.69	NA	16.15	2.57	NA	35.41	090
21256		A	Reconstruction of orbit	16.17	NA	12.03	1.36	NA	29.56	090
21260		A	Revise eye sockets	16.50	NA	12.75	0.98	NA	30.23	090
21261		A	Revise eye sockets	31.44	NA	24.21	3.09	NA	58.74	090
21263		A	Revise eye sockets	28.38	NA	19.17	2.61	NA	50.16	090
21267		A	Revise eye sockets	18.87	NA	19.72	1.64	NA	40.23	090
21268		A	Revise eye sockets	24.44	NA	20.22	2.43	NA	47.09	090
21270		A	Augmentation, cheek bone	10.21	11.66	7.24	1.04	22.91	18.49	090
21275		A	Revision, orbitofacial bones	11.22	NA	8.63	1.29	NA	21.14	090
21280		A	Revision of eyelid	6.02	NA	5.95	0.46	NA	12.43	090
21282		A	Revision of eyelid	3.48	NA	4.58	0.27	NA	8.33	090
21295		A	Revision of jaw muscle/bone	1.53	NA	2.54	0.15	NA	4.22	090
21296		A	Revision of jaw muscle/bone	4.24	NA	4.90	0.35	NA	9.49	090
21300		A	Treatment of skull fracture	0.72	2.39	0.26	0.11	3.22	1.09	000
21310		A	Treatment of nose fracture	0.58	2.30	0.15	0.05	2.93	0.78	000
21315		A	Treatment of nose fracture	1.51	4.23	1.88	0.14	5.88	3.53	010
21320		A	Treatment of nose fracture	1.85	3.91	1.62	0.18	5.94	3.65	010
21325		A	Treatment of nose fracture	3.76	NA	8.61	0.34	NA	12.71	090
21330		A	Treatment of nose fracture	5.37	NA	9.64	0.61	NA	15.62	090
21335		A	Treatment of nose fracture	8.60	NA	9.60	0.75	NA	18.95	090
21336		A	Treat nasal septal fracture	5.71	NA	9.57	0.56	NA	15.84	090
21337		A	Treat nasal septal fracture	2.70	6.49	3.56	0.27	9.46	6.53	090
21338		A	Treat nasoethmoid fracture	6.45	NA	13.90	0.75	NA	21.10	090
21339		A	Treat nasoethmoid fracture	8.08	NA	13.77	0.92	NA	22.77	090
21340		A	Treatment of nose fracture	10.75	NA	8.59	0.97	NA	20.31	090
21343		A	Treatment of sinus fracture	12.93	NA	15.39	1.67	NA	29.99	090
21344		A	Treatment of sinus fracture	19.69	NA	16.42	2.45	NA	38.56	090
21345		A	Treat nose/jaw fracture	8.15	9.84	7.16	1.11	19.10	16.42	090
21346		A	Treat nose/jaw fracture	10.59	NA	12.18	1.22	NA	23.99	090
21347		A	Treat nose/jaw fracture	12.67	NA	16.03	1.57	NA	30.27	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
21348		A	Treat nose/jaw fracture	16.66	NA	11.21	1.62	NA	29.49	090
21355		A	Treat cheek bone fracture	3.76	6.24	3.49	0.28	10.28	7.53	010
21356		A	Treat cheek bone fracture	4.14	7.10	4.53	0.47	11.71	9.14	010
21360		A	Treat cheek bone fracture	6.45	NA	5.92	0.71	NA	13.08	090
21365		A	Treat cheek bone fracture	14.93	NA	10.79	1.72	NA	27.44	090
21366		A	Treat cheek bone fracture	17.74	NA	11.52	1.90	NA	31.16	090
21385		A	Treat eye socket fracture	9.15	NA	8.27	0.83	NA	18.25	090
21386		A	Treat eye socket fracture	9.15	NA	7.06	1.04	NA	17.25	090
21387		A	Treat eye socket fracture	9.69	NA	8.93	0.96	NA	19.58	090
21390		A	Treat eye socket fracture	10.11	NA	7.91	0.92	NA	18.94	090
21395		A	Treat eye socket fracture	12.66	NA	9.21	1.60	NA	23.47	090
21400		A	Treat eye socket fracture	1.40	2.64	1.90	0.14	4.18	3.44	090
21401		A	Treat eye socket fracture	3.26	8.05	3.49	0.27	11.58	7.02	090
21406		A	Treat eye socket fracture	7.00	NA	6.26	0.82	NA	14.08	090
21407		A	Treat eye socket fracture	8.60	NA	7.05	0.94	NA	16.59	090
21408		A	Treat eye socket fracture	12.36	NA	9.10	1.39	NA	22.85	090
21421		A	Treat mouth roof fracture	5.13	9.33	8.31	0.61	15.07	14.05	090
21422		A	Treat mouth roof fracture	8.31	NA	8.06	0.97	NA	17.34	090
21423		A	Treat mouth roof fracture	10.38	NA	9.30	1.20	NA	20.88	090
21431		A	Treat craniofacial fracture	7.04	NA	9.51	1.05	NA	17.60	090
21432		A	Treat craniofacial fracture	8.60	NA	8.05	0.87	NA	17.52	090
21433		A	Treat craniofacial fracture	25.31	NA	16.66	3.07	NA	45.04	090
21435		A	Treat craniofacial fracture	17.22	NA	12.82	2.81	NA	32.85	090
21436		A	Treat craniofacial fracture	28.00	NA	18.25	3.23	NA	49.48	090
21440		A	Treat dental ridge fracture	2.70	7.10	6.16	0.35	10.15	9.21	090
21445		A	Treat dental ridge fracture	5.37	9.73	8.36	0.68	15.78	14.41	090
21450		A	Treat lower jaw fracture	2.97	7.38	6.92	0.37	10.72	10.26	090
21451		A	Treat lower jaw fracture	4.86	9.34	8.40	0.65	14.85	13.91	090
21452		A	Treat lower jaw fracture	1.98	13.11	4.61	0.20	15.29	6.79	090
21453		A	Treat lower jaw fracture	5.53	10.73	10.71	0.71	16.97	16.95	090
21454		A	Treat lower jaw fracture	6.45	NA	6.50	0.76	NA	13.71	090
21461		A	Treat lower jaw fracture	8.08	24.43	12.64	0.95	33.46	21.67	090
21462		A	Treat lower jaw fracture	9.78	27.59	12.69	0.94	38.31	23.41	090
21465		A	Treat lower jaw fracture	11.89	NA	9.99	1.63	NA	23.51	090
21470		A	Treat lower jaw fracture	15.32	NA	12.18	1.97	NA	29.47	090
21480		A	Reset dislocated jaw	0.61	1.77	0.19	0.06	2.44	0.86	000
21485		A	Reset dislocated jaw	3.98	8.22	7.67	0.49	12.69	12.14	090
21490		A	Repair dislocated jaw	11.84	NA	9.84	1.79	NA	23.47	090
21493		A	Treat hyoid bone fracture	1.27	NA	0.55	0.07	NA	1.89	090
21494		A	Treat hyoid bone fracture	6.27	NA	3.53	0.53	NA	10.33	090
21495		A	Treat hyoid bone fracture	5.68	NA	8.41	0.46	NA	14.55	090
21497		A	Interdental wiring	3.85	8.44	7.63	0.44	12.73	11.92	090
21501		A	Drain neck/chest lesion	3.80	6.47	3.83	0.45	10.72	8.08	090
21502		A	Drain chest lesion	7.11	NA	5.67	0.93	NA	13.71	090
21510		A	Drainage of bone lesion	5.73	NA	5.70	0.79	NA	12.22	090
21550		A	Biopsy of neck/chest	2.06	3.59	1.72	0.19	5.84	3.97	010
21555		A	Remove lesion, neck/chest	4.34	5.53	3.20	0.54	10.41	8.08	090
21556		A	Remove lesion, neck/chest	5.56	NA	4.08	0.66	NA	10.30	090
21557		A	Remove tumor, neck/chest	8.87	NA	5.41	1.09	NA	15.37	090
21600		A	Partial removal of rib	6.88	NA	5.77	0.95	NA	13.60	090
21610		A	Partial removal of rib	14.59	NA	9.11	2.49	NA	26.19	090
21615		A	Removal of rib	9.86	NA	6.70	1.39	NA	17.95	090
21616		A	Removal of rib and nerves	12.02	NA	8.04	1.72	NA	21.78	090
21620		A	Partial removal of sternum	6.78	NA	6.03	0.93	NA	13.74	090
21627		A	Sternal debridement	6.80	NA	6.43	0.95	NA	14.18	090
21630		A	Extensive sternum surgery	17.35	NA	11.89	2.45	NA	31.69	090
21632		A	Extensive sternum surgery	18.11	NA	11.13	2.45	NA	31.69	090
21685		A	Hyoid myotomy & suspension	12.98	NA	9.96	1.05	NA	23.99	090
21700		A	Revision of neck muscle	6.18	NA	4.44	0.72	NA	11.34	090
21705		A	Revision of neck muscle/rib	9.59	NA	5.60	1.21	NA	16.40	090
21720		A	Revision of neck muscle	5.67	2.45	2.45	0.86	8.98	8.98	090
21725		A	Revision of neck muscle	6.98	NA	5.63	0.78	NA	13.39	090
21740		A	Reconstruction of sternum	16.48	NA	8.56	2.06	NA	27.10	090
21750		A	Repair of sternum separation	10.75	NA	6.11	1.44	NA	18.30	090
21800		A	Treatment of rib fracture	0.96	NA	1.37	0.09	NA	2.42	090
21805		A	Treatment of rib fracture	2.75	NA	3.38	0.35	NA	6.48	090
21810		A	Treatment of rib fracture(s)	6.85	NA	5.01	0.93	NA	12.79	090
21820		A	Treat sternum fracture	1.28	1.84	1.79	0.15	3.27	3.22	090
21825		A	Treat sternum fracture	7.40	NA	6.68	0.99	NA	15.07	090
21920		A	Biopsy soft tissue of back	2.06	3.29	1.48	0.20	5.55	3.74	010
21925		A	Biopsy soft tissue of back	4.48	5.20	3.24	0.59	10.27	8.31	090
21930		A	Remove lesion, back or flank	4.99	5.73	3.40	0.63	11.35	9.02	090
21935		A	Remove tumor, back	17.93	NA	10.24	2.46	NA	30.63	090
22100		A	Remove part of neck vertebra	9.72	NA	7.73	1.68	NA	19.13	090
22101		A	Remove part, thorax vertebra	9.80	NA	7.99	1.80	NA	19.59	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
22102		A	Remove part, lumbar vertebra	9.80	NA	8.25	1.57	NA	19.62	090
22103		A	Remove extra spine segment	2.34	NA	1.21	0.39	NA	3.94	ZZZ
22110		A	Remove part of neck vertebra	12.72	NA	9.38	2.24	NA	24.34	090
22112		A	Remove part, thorax vertebra	12.79	NA	9.46	1.92	NA	24.17	090
22114		A	Remove part, lumbar vertebra	12.79	NA	9.45	2.13	NA	24.37	090
22116		A	Remove extra spine segment	2.32	NA	1.16	0.41	NA	3.89	ZZZ
22210		A	Revision of neck spine	23.78	NA	15.63	4.60	NA	44.01	090
22212		A	Revision of thorax spine	19.39	NA	13.45	3.12	NA	35.96	090
22214		A	Revision of lumbar spine	19.42	NA	13.98	3.10	NA	36.50	090
22216		A	Revise, extra spine segment	6.03	NA	3.12	1.05	NA	10.20	ZZZ
22220		A	Revision of neck spine	21.34	NA	13.87	3.43	NA	38.64	090
22222		A	Revision of thorax spine	21.49	NA	11.74	3.46	NA	36.69	090
22224		A	Revision of lumbar spine	21.49	NA	14.40	3.63	NA	39.52	090
22226		A	Revise, extra spine segment	6.03	NA	3.08	1.05	NA	10.16	ZZZ
22305		A	Treat spine process fracture	2.05	2.31	1.92	0.33	4.69	4.30	090
22310		A	Treat spine fracture	2.61	2.79	2.34	0.42	5.82	5.37	090
22315		A	Treat spine fracture	8.83	9.68	7.32	1.60	20.11	17.75	090
22318		A	Treat odontoid fx w/o graft	21.47	NA	13.56	4.70	NA	39.73	090
22319		A	Treat odontoid fx w/graft	23.96	NA	14.97	5.38	NA	44.31	090
22325		A	Treat spine fracture	18.27	NA	12.26	3.18	NA	33.71	090
22326		A	Treat neck spine fracture	19.56	NA	12.93	3.85	NA	36.34	090
22327		A	Treat thorax spine fracture	19.17	NA	12.55	3.21	NA	34.93	090
22328		A	Treat each add spine fx	4.60	NA	2.26	0.78	NA	7.64	ZZZ
22505		A	Manipulation of spine	1.87	NA	0.94	0.30	NA	3.11	010
22520		A	Percut vertebroplasty thor	8.90	99.93	5.09	1.43	110.26	15.42	010
22521		A	Percut vertebroplasty lumb	8.33	90.95	4.94	1.34	100.62	14.61	010
22522		A	Percut vertebroplasty add-l	4.30	NA	1.67	0.69	NA	6.66	ZZZ
22532		A	Lat thorax spine fusion	23.96	NA	14.84	3.78	NA	42.58	090
22533		A	Lat lumbar spine fusion	23.09	NA	13.60	2.80	NA	39.49	090
22534		A	Lat thor/lumb, add-l seg	5.99	NA	3.03	1.04	NA	10.06	ZZZ
22548		A	Neck spine fusion	25.78	NA	15.79	5.15	NA	46.72	090
22554		A	Neck spine fusion	18.59	NA	12.33	3.73	NA	34.65	090
22556		A	Thorax spine fusion	23.42	NA	14.72	3.78	NA	41.92	090
22558		A	Lumbar spine fusion	22.25	NA	13.28	2.80	NA	38.33	090
22585		A	Additional spinal fusion	5.52	NA	2.79	1.04	NA	9.35	ZZZ
22590		A	Spine & skull spinal fusion	20.48	NA	13.31	4.31	NA	38.10	090
22595		A	Neck spinal fusion	19.36	NA	12.82	3.88	NA	36.06	090
22600		A	Neck spine fusion	16.12	NA	11.18	3.24	NA	30.54	090
22610		A	Thorax spine fusion	16.00	NA	11.40	2.95	NA	30.35	090
22612		A	Lumbar spine fusion	20.97	NA	14.18	3.55	NA	38.70	090
22614		A	Spine fusion, extra segment	6.43	NA	3.35	1.14	NA	10.92	ZZZ
22630		A	Lumbar spine fusion	20.81	NA	13.59	3.86	NA	38.26	090
22632		A	Spine fusion, extra segment	5.22	NA	2.66	0.98	NA	8.86	ZZZ
22800		A	Fusion of spine	18.22	NA	12.74	3.04	NA	34.00	090
22802		A	Fusion of spine	30.83	NA	19.55	5.01	NA	55.39	090
22804		A	Fusion of spine	36.22	NA	22.65	5.68	NA	64.55	090
22808		A	Fusion of spine	26.23	NA	16.28	4.55	NA	47.06	090
22810		A	Fusion of spine	30.22	NA	18.33	4.43	NA	52.98	090
22812		A	Fusion of spine	32.65	NA	20.03	4.55	NA	57.23	090
22818		A	Kyphectomy, 1-2 segments	31.78	NA	18.85	6.00	NA	56.63	090
22819		A	Kyphectomy, 3 or more	36.39	NA	20.03	5.64	NA	62.06	090
22830		A	Exploration of spinal fusion	10.83	NA	7.95	1.89	NA	20.67	090
22840		A	Insert spine fixation device	12.52	NA	6.48	2.19	NA	21.19	ZZZ
22842		A	Insert spine fixation device	12.56	NA	6.49	2.21	NA	21.26	ZZZ
22843		A	Insert spine fixation device	13.44	NA	6.59	2.37	NA	22.40	ZZZ
22844		A	Insert spine fixation device	16.42	NA	8.73	2.63	NA	27.78	ZZZ
22845		A	Insert spine fixation device	11.94	NA	6.06	2.39	NA	20.39	ZZZ
22846		A	Insert spine fixation device	12.40	NA	6.32	2.47	NA	21.19	ZZZ
22847		A	Insert spine fixation device	13.78	NA	7.01	2.37	NA	23.16	ZZZ
22848		A	Insert pelv fixation device	5.99	NA	3.18	0.96	NA	10.13	ZZZ
22849		A	Reinsert spinal fixation	18.48	NA	11.86	3.14	NA	33.48	090
22850		A	Remove spine fixation device	9.51	NA	7.11	1.61	NA	18.23	090
22851		A	Apply spine prosth device	6.70	NA	3.35	1.23	NA	11.28	ZZZ
22852		A	Remove spine fixation device	9.00	NA	6.90	1.52	NA	17.42	090
22855		A	Remove spine fixation device	15.11	NA	9.79	2.90	NA	27.80	090
22900		A	Remove abdominal wall lesion	5.79	NA	3.25	0.74	NA	9.78	090
23000		A	Removal of calcium deposits	4.35	8.62	4.42	0.59	13.56	9.36	090
23020		A	Release shoulder joint	8.92	NA	7.79	1.43	NA	18.14	090
23030		A	Drain shoulder lesion	3.42	7.42	2.90	0.53	11.37	6.85	010
23031		A	Drain shoulder bursa	2.74	7.91	2.72	0.44	11.09	5.90	010
23035		A	Drain shoulder bone lesion	8.60	NA	8.72	1.38	NA	18.70	090
23040		A	Exploratory shoulder surgery	9.19	NA	8.09	1.50	NA	18.78	090
23044		A	Exploratory shoulder surgery	7.11	NA	6.71	1.19	NA	15.01	090
23065		A	Biopsy shoulder tissues	2.27	2.48	1.62	0.24	4.99	4.13	010
23066		A	Biopsy shoulder tissues	4.15	7.70	3.98	0.62	12.47	8.75	090

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[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
23075		A	Removal of shoulder lesion	2.39	3.68	1.78	0.33	6.40	4.50	010
23076		A	Removal of shoulder lesion	7.62	NA	5.86	1.11	NA	14.59	090
23077		A	Remove tumor of shoulder	16.07	NA	10.90	2.27	NA	29.24	090
23100		A	Biopsy of shoulder joint	6.02	NA	5.89	0.96	NA	12.87	090
23101		A	Shoulder joint surgery	5.57	NA	5.58	0.91	NA	12.06	090
23105		A	Remove shoulder joint lining	8.22	NA	7.39	1.32	NA	16.93	090
23106		A	Incision of collarbone joint	5.95	NA	5.94	0.83	NA	12.72	090
23107		A	Explore treat shoulder joint	8.61	NA	7.60	1.40	NA	17.61	090
23120		A	Partial removal, collar bone	7.10	NA	6.69	1.13	NA	14.92	090
23125		A	Removal of collar bone	9.38	NA	7.81	1.45	NA	18.64	090
23130		A	Remove shoulder bone, part	7.54	NA	7.33	1.27	NA	16.14	090
23140		A	Removal of bone lesion	6.88	NA	5.50	0.99	NA	13.37	090
23145		A	Removal of bone lesion	9.08	NA	7.79	1.42	NA	18.29	090
23146		A	Removal of bone lesion	7.82	NA	7.38	1.13	NA	16.33	090
23150		A	Removal of humerus lesion	8.47	NA	7.15	1.24	NA	16.86	090
23155		A	Removal of humerus lesion	10.33	NA	8.68	1.48	NA	20.49	090
23156		A	Removal of humerus lesion	8.67	NA	7.60	1.36	NA	17.63	090
23170		A	Remove collar bone lesion	6.85	NA	6.54	1.10	NA	14.49	090
23172		A	Remove shoulder blade lesion	6.89	NA	6.63	0.95	NA	14.47	090
23174		A	Remove humerus lesion	9.50	NA	8.63	1.56	NA	19.69	090
23180		A	Remove collar bone lesion	8.52	NA	9.43	1.47	NA	19.42	090
23182		A	Remove shoulder blade lesion	8.14	NA	9.09	1.26	NA	18.49	090
23184		A	Remove humerus lesion	9.37	NA	9.78	1.50	NA	20.65	090
23190		A	Partial removal of scapula	7.23	NA	6.38	1.18	NA	14.79	090
23195		A	Removal of head of humerus	9.80	NA	7.95	1.18	NA	18.93	090
23200		A	Removal of collar bone	12.06	NA	9.14	1.69	NA	22.89	090
23210		A	Removal of shoulder blade	12.47	NA	9.49	2.01	NA	23.97	090
23220		A	Partial removal of humerus	14.54	NA	11.12	2.50	NA	28.16	090
23221		A	Partial removal of humerus	17.71	NA	12.01	2.33	NA	32.05	090
23222		A	Partial removal of humerus	23.88	NA	16.10	3.90	NA	43.88	090
23330		A	Remove shoulder foreign body	1.85	3.75	1.88	0.24	5.84	3.97	010
23331		A	Remove shoulder foreign body	7.37	NA	7.01	1.14	NA	15.52	090
23332		A	Remove shoulder foreign body	11.60	NA	9.53	1.85	NA	22.98	090
23350		A	Injection for shoulder x-ray	1.00	3.52	0.33	0.06	4.58	1.39	000
23395		A	Muscle transfer,shoulder/arm	16.82	NA	12.97	2.56	NA	32.35	090
23397		A	Muscle transfers	16.11	NA	11.57	2.62	NA	30.30	090
23400		A	Fixation of shoulder blade	13.52	NA	10.38	2.07	NA	25.97	090
23405		A	Incision of tendon & muscle	8.36	NA	7.15	1.29	NA	16.80	090
23406		A	Incise tendon(s) & muscle(s)	10.77	NA	8.60	1.72	NA	21.09	090
23410		A	Repair rotator cuff, acute	12.43	NA	9.61	1.95	NA	23.99	090
23412		A	Repair rotator cuff, chronic	13.29	NA	10.10	2.08	NA	25.47	090
23415		A	Release of shoulder ligament	9.96	NA	8.15	1.70	NA	19.81	090
23420		A	Repair of shoulder	13.28	NA	11.06	2.10	NA	26.44	090
23430		A	Repair biceps tendon	9.97	NA	8.32	1.57	NA	19.86	090
23440		A	Remove/transplant tendon	10.46	NA	8.49	1.63	NA	20.58	090
23450		A	Repair shoulder capsule	13.38	NA	10.06	2.12	NA	25.56	090
23455		A	Repair shoulder capsule	14.35	NA	10.65	2.26	NA	27.26	090
23460		A	Repair shoulder capsule	15.35	NA	11.58	2.43	NA	29.36	090
23462		A	Repair shoulder capsule	15.28	NA	10.97	2.42	NA	28.67	090
23465		A	Repair shoulder capsule	15.83	NA	11.52	2.51	NA	29.86	090
23466		A	Repair shoulder capsule	14.20	NA	11.53	2.25	NA	27.98	090
23470		A	Reconstruct shoulder joint	17.12	NA	12.23	2.70	NA	32.05	090
23472		A	Reconstruct shoulder joint	21.07	NA	14.38	3.29	NA	38.74	090
23480		A	Revision of collar bone	11.16	NA	8.98	1.89	NA	22.03	090
23485		A	Revision of collar bone	13.41	NA	10.10	2.12	NA	25.63	090
23490		A	Reinforce clavicle	11.84	NA	9.04	1.44	NA	22.32	090
23491		A	Reinforce shoulder bones	14.19	NA	10.91	2.29	NA	27.39	090
23500		A	Treat clavicle fracture	2.08	2.87	2.54	0.29	5.24	4.91	090
23505		A	Treat clavicle fracture	3.68	4.41	3.85	0.58	8.67	8.11	090
23515		A	Treat clavicle fracture	7.40	NA	6.70	1.16	NA	15.26	090
23520		A	Treat clavicle dislocation	2.16	2.86	2.75	0.32	5.34	5.23	090
23525		A	Treat clavicle dislocation	3.59	4.57	3.96	0.42	8.58	7.97	090
23530		A	Treat clavicle dislocation	7.30	NA	6.12	1.21	NA	14.63	090
23532		A	Treat clavicle dislocation	8.00	NA	7.11	1.17	NA	16.28	090
23540		A	Treat clavicle dislocation	2.23	2.87	2.41	0.27	5.37	4.91	090
23545		A	Treat clavicle dislocation	3.25	4.20	3.39	0.42	7.87	7.06	090
23550		A	Treat clavicle dislocation	7.23	NA	6.55	1.14	NA	14.92	090
23552		A	Treat clavicle dislocation	8.44	NA	7.46	1.27	NA	17.17	090
23570		A	Treat shoulder blade fx	2.23	3.01	2.90	0.35	5.59	5.48	090
23575		A	Treat shoulder blade fx	4.05	4.88	4.32	0.66	9.59	9.03	090
23585		A	Treat scapula fracture	8.95	NA	7.80	1.44	NA	18.19	090
23600		A	Treat humerus fracture	2.93	4.54	3.57	0.46	7.93	6.96	090
23605		A	Treat humerus fracture	4.86	6.14	5.11	0.81	11.81	10.78	090
23615		A	Treat humerus fracture	9.34	NA	8.97	1.51	NA	19.82	090
23616		A	Treat humerus fracture	21.24	NA	14.28	3.37	NA	38.89	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
23620		A	Treat humerus fracture	2.40	3.61	3.00	0.38	6.39	5.78	090
23625		A	Treat humerus fracture	3.92	4.93	4.28	0.64	9.49	8.84	090
23630		A	Treat humerus fracture	7.34	NA	6.77	1.18	NA	15.29	090
23650		A	Treat shoulder dislocation	3.38	3.80	2.81	0.30	7.48	6.49	090
23655		A	Treat shoulder dislocation	4.56	NA	4.24	0.62	NA	9.42	090
23660		A	Treat shoulder dislocation	7.48	NA	6.53	1.22	NA	15.23	090
23665		A	Treat dislocation/fracture	4.46	5.33	4.72	0.70	10.49	9.88	090
23670		A	Treat dislocation/fracture	7.89	NA	7.00	1.25	NA	16.14	090
23675		A	Treat dislocation/fracture	6.04	6.83	5.82	0.97	13.84	12.83	090
23680		A	Treat dislocation/fracture	10.04	NA	8.27	1.61	NA	19.92	090
23700		A	Fixation of shoulder	2.52	NA	2.17	0.43	NA	5.12	010
23800		A	Fusion of shoulder joint	14.14	NA	10.68	2.34	NA	27.16	090
23802		A	Fusion of shoulder joint	16.58	NA	10.41	2.45	NA	29.44	090
23900		A	Amputation of arm & girdle	19.69	NA	12.03	3.04	NA	34.76	090
23920		A	Amputation at shoulder joint	14.59	NA	10.26	2.21	NA	27.06	090
23921		A	Amputation follow-up surgery	5.48	NA	5.09	0.90	NA	11.47	090
23930		A	Drainage of arm lesion	2.94	6.36	2.31	0.41	9.71	5.66	010
23931		A	Drainage of arm bursa	1.79	5.93	2.17	0.26	7.98	4.22	010
23935		A	Drain arm/elbow bone lesion	6.08	NA	6.43	0.98	NA	13.49	090
24000		A	Exploratory elbow surgery	5.81	NA	5.50	0.93	NA	12.24	090
24006		A	Release elbow joint	9.30	NA	7.85	1.48	NA	18.63	090
24065		A	Biopsy arm/elbow soft tissue	2.08	3.22	1.75	0.22	5.52	4.05	010
24066		A	Biopsy arm/elbow soft tissue	5.20	8.95	4.14	0.77	14.92	10.11	090
24075		A	Remove arm/elbow lesion	3.91	7.37	3.41	0.54	11.82	7.86	090
24076		A	Remove arm/elbow lesion	6.29	NA	5.17	0.91	NA	12.37	090
24077		A	Remove tumor of arm/elbow	11.74	NA	8.85	1.67	NA	22.26	090
24100		A	Biopsy elbow joint lining	4.92	NA	4.64	0.78	NA	10.34	090
24101		A	Explore/treat elbow joint	6.12	NA	6.02	1.01	NA	13.15	090
24102		A	Remove elbow joint lining	8.02	NA	6.97	1.27	NA	16.26	090
24105		A	Removal of elbow bursa	3.60	NA	4.50	0.60	NA	8.70	090
24110		A	Remove humerus lesion	7.38	NA	6.93	1.21	NA	15.52	090
24115		A	Remove/graft bone lesion	9.62	NA	7.54	1.36	NA	18.52	090
24116		A	Remove/graft bone lesion	11.79	NA	9.31	2.05	NA	23.15	090
24120		A	Remove elbow lesion	6.64	NA	6.02	1.07	NA	13.73	090
24125		A	Remove/graft bone lesion	7.88	NA	6.27	0.73	NA	14.88	090
24126		A	Remove/graft bone lesion	8.30	NA	7.10	1.13	NA	16.53	090
24130		A	Removal of head of radius	6.24	NA	6.11	1.03	NA	13.38	090
24134		A	Removal of arm bone lesion	9.72	NA	9.38	1.52	NA	20.62	090
24136		A	Remove radius bone lesion	7.98	NA	7.41	1.29	NA	16.68	090
24138		A	Remove elbow bone lesion	8.04	NA	7.86	1.29	NA	17.19	090
24140		A	Partial removal of arm bone	9.17	NA	9.76	1.45	NA	20.38	090
24145		A	Partial removal of radius	7.57	NA	8.27	1.22	NA	17.06	090
24147		A	Partial removal of elbow	7.53	NA	8.80	1.26	NA	17.59	090
24149		A	Radical resection of elbow	14.18	NA	11.65	2.23	NA	28.06	090
24150		A	Extensive humerus surgery	13.25	NA	10.35	2.15	NA	25.75	090
24151		A	Extensive humerus surgery	15.56	NA	11.94	1.27	NA	28.77	090
24152		A	Extensive radius surgery	10.04	NA	7.99	1.01	NA	19.04	090
24153		A	Extensive radius surgery	11.52	NA	5.74	0.70	NA	17.96	090
24155		A	Removal of elbow joint	11.71	NA	8.51	1.82	NA	22.04	090
24160		A	Remove elbow joint implant	7.82	NA	6.88	1.26	NA	15.96	090
24164		A	Remove radius head implant	6.22	NA	5.76	1.01	NA	12.99	090
24200		A	Removal of arm foreign body	1.76	3.45	1.63	0.19	5.40	3.58	010
24201		A	Removal of arm foreign body	4.55	9.85	4.23	0.68	15.08	9.46	090
24220		A	Injection for elbow x-ray	1.31	3.71	0.44	0.08	5.10	1.83	000
24300		A	Manipulate elbow w/anesth	3.74	NA	5.62	0.63	NA	9.99	090
24301		A	Muscle/tendon transfer	10.18	NA	8.32	1.64	NA	20.14	090
24305		A	Arm tendon lengthening	7.44	NA	6.83	1.13	NA	15.40	090
24310		A	Revision of arm tendon	5.97	NA	5.91	0.91	NA	12.79	090
24320		A	Repair of arm tendon	10.54	NA	7.93	1.72	NA	20.19	090
24330		A	Revision of arm muscles	9.59	NA	8.02	1.51	NA	19.12	090
24331		A	Revision of arm muscles	10.63	NA	8.75	1.33	NA	20.71	090
24332		A	Tenolysis, triceps	7.44	NA	6.70	1.19	NA	15.33	090
24340		A	Repair of biceps tendon	7.88	NA	7.07	1.27	NA	16.22	090
24341		A	Repair arm tendon/muscle	7.89	NA	7.97	1.26	NA	17.12	090
24342		A	Repair of ruptured tendon	10.60	NA	8.61	1.69	NA	20.90	090
24343		A	Repr elbow lat ligmnt w/tiss	8.64	NA	8.07	1.39	NA	18.10	090
24344		A	Reconstruct elbow lat ligmnt	13.98	NA	11.43	2.25	NA	27.66	090
24345		A	Repr elbw med ligmnt w/tissu	8.64	NA	7.95	1.40	NA	17.99	090
24346		A	Reconstruct elbow med ligmnt	13.98	NA	11.25	2.04	NA	27.27	090
24350		A	Repair of tennis elbow	5.24	NA	5.68	0.86	NA	11.78	090
24351		A	Repair of tennis elbow	5.90	NA	6.02	0.98	NA	12.90	090
24352		A	Repair of tennis elbow	6.42	NA	6.28	1.09	NA	13.79	090
24354		A	Repair of tennis elbow	6.47	NA	6.24	1.11	NA	13.82	090
24356		A	Revision of tennis elbow	6.67	NA	6.42	1.08	NA	14.17	090
24360		A	Reconstruct elbow joint	12.32	NA	9.46	1.92	NA	23.70	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
24361		A	Reconstruct elbow joint	14.06	NA	10.56	2.10	NA	26.72	090
24362		A	Reconstruct elbow joint	14.97	NA	10.04	2.30	NA	27.31	090
24363		A	Replace elbow joint	18.46	NA	13.69	2.84	NA	34.99	090
24365		A	Reconstruct head of radius	8.38	NA	7.19	1.39	NA	16.96	090
24366		A	Reconstruct head of radius	9.12	NA	7.53	1.47	NA	18.12	090
24400		A	Revision of humerus	11.04	NA	9.14	1.82	NA	22.00	090
24410		A	Revision of humerus	14.80	NA	10.60	2.57	NA	27.97	090
24420		A	Revision of humerus	13.42	NA	10.90	2.07	NA	26.39	090
24430		A	Repair of humerus	12.79	NA	9.97	2.04	NA	24.80	090
24435		A	Repair humerus with graft	13.15	NA	11.12	2.10	NA	26.37	090
24470		A	Revision of elbow joint	8.73	NA	7.80	0.77	NA	17.30	090
24495		A	Decompression of forearm	8.11	NA	8.94	1.18	NA	18.23	090
24498		A	Reinforce humerus	11.90	NA	9.50	1.93	NA	23.33	090
24500		A	Treat humerus fracture	3.21	4.86	3.71	0.48	8.55	7.40	090
24505		A	Treat humerus fracture	5.16	6.59	5.39	0.86	12.61	11.41	090
24515		A	Treat humerus fracture	11.63	NA	9.55	1.88	NA	23.06	090
24516		A	Treat humerus fracture	11.63	NA	9.31	1.88	NA	22.82	090
24530		A	Treat humerus fracture	3.49	5.20	4.05	0.55	9.24	8.09	090
24535		A	Treat humerus fracture	6.86	7.83	6.62	1.16	15.85	14.64	090
24538		A	Treat humerus fracture	9.42	NA	8.89	1.51	NA	19.82	090
24545		A	Treat humerus fracture	10.44	NA	8.60	1.70	NA	20.74	090
24546		A	Treat humerus fracture	15.67	NA	11.50	2.52	NA	29.69	090
24560		A	Treat humerus fracture	2.80	4.49	3.22	0.39	7.68	6.41	090
24565		A	Treat humerus fracture	5.55	6.62	5.52	0.94	13.11	12.01	090
24566		A	Treat humerus fracture	7.78	NA	8.34	1.33	NA	17.45	090
24575		A	Treat humerus fracture	10.64	NA	8.44	1.70	NA	20.78	090
24576		A	Treat humerus fracture	2.86	4.77	3.73	0.42	8.05	7.01	090
24577		A	Treat humerus fracture	5.78	6.92	5.83	0.97	13.67	12.58	090
24579		A	Treat humerus fracture	11.58	NA	9.02	1.89	NA	22.49	090
24582		A	Treat humerus fracture	8.54	NA	9.26	1.48	NA	19.28	090
24586		A	Treat elbow fracture	15.19	NA	11.26	2.45	NA	28.90	090
24587		A	Treat elbow fracture	15.14	NA	11.05	2.23	NA	28.42	090
24600		A	Treat elbow dislocation	4.22	4.86	3.53	0.47	9.55	8.22	090
24605		A	Treat elbow dislocation	5.41	NA	5.41	0.87	NA	11.69	090
24615		A	Treat elbow dislocation	9.41	NA	7.87	1.53	NA	18.81	090
24620		A	Treat elbow fracture	6.97	NA	6.27	1.07	NA	14.31	090
24635		A	Treat elbow fracture	13.17	NA	14.21	2.17	NA	29.55	090
24640		A	Treat elbow dislocation	1.20	1.85	0.81	0.13	3.18	2.14	010
24650		A	Treat radius fracture	2.16	3.79	2.78	0.33	6.28	5.27	090
24655		A	Treat radius fracture	4.39	5.95	4.80	0.70	11.04	9.89	090
24665		A	Treat radius fracture	8.13	NA	7.69	1.35	NA	17.17	090
24666		A	Treat radius fracture	9.48	NA	8.25	1.55	NA	19.28	090
24670		A	Treat ulnar fracture	2.54	4.11	3.09	0.38	7.03	6.01	090
24675		A	Treat ulnar fracture	4.71	6.00	4.97	0.77	11.48	10.45	090
24685		A	Treat ulnar fracture	8.79	NA	7.72	1.43	NA	17.94	090
24800		A	Fusion of elbow joint	11.18	NA	8.87	1.63	NA	21.68	090
24802		A	Fusion/graft of elbow joint	13.67	NA	10.49	2.16	NA	26.32	090
24900		A	Amputation of upper arm	9.59	NA	7.49	1.44	NA	18.52	090
24920		A	Amputation of upper arm	9.53	NA	7.71	1.48	NA	18.72	090
24925		A	Amputation follow-up surgery	7.06	NA	6.44	1.12	NA	14.62	090
24930		A	Amputation follow-up surgery	10.23	NA	7.66	1.53	NA	19.42	090
24931		A	Amputate upper arm & implant	12.70	NA	6.10	1.88	NA	20.68	090
24935		A	Revision of amputation	15.54	NA	8.40	2.05	NA	25.99	090
25000		A	Incision of tendon sheath	3.37	NA	6.96	0.53	NA	10.86	090
25001		A	Incise flexor carpi radialis	3.37	NA	4.16	0.52	NA	8.05	090
25020		A	Decompress forearm 1 space	5.91	NA	9.84	0.95	NA	16.70	090
25023		A	Decompress forearm 1 space	12.94	NA	15.33	1.91	NA	30.18	090
25024		A	Decompress forearm 2 spaces	9.49	NA	7.51	1.10	NA	18.10	090
25025		A	Decompress forearm 2 spaces	16.52	NA	9.99	1.79	NA	28.30	090
25028		A	Drainage of forearm lesion	5.24	NA	8.40	0.78	NA	14.42	090
25031		A	Drainage of forearm bursa	4.13	NA	8.21	0.63	NA	12.97	090
25035		A	Treat forearm bone lesion	7.35	NA	13.88	1.21	NA	22.44	090
25040		A	Explore/treat wrist joint	7.17	NA	7.40	1.15	NA	15.72	090
25065		A	Biopsy forearm soft tissues	1.99	3.23	1.90	0.20	5.42	4.09	010
25066		A	Biopsy forearm soft tissues	4.12	NA	7.18	0.62	NA	11.92	090
25075		A	Removel forearm lesion subcu	3.73	NA	6.06	0.52	NA	10.31	090
25076		A	Removel forearm lesion deep	4.91	NA	9.83	0.74	NA	15.48	090
25077		A	Remove tumor, forearm/wrist	9.75	NA	12.53	1.38	NA	23.66	090
25085		A	Incision of wrist capsule	5.49	NA	7.40	0.84	NA	13.73	090
25100		A	Biopsy of wrist joint	3.89	NA	5.49	0.58	NA	9.96	090
25101		A	Explore/treat wrist joint	4.68	NA	6.06	0.51	NA	11.25	090
25105		A	Remove wrist joint lining	5.84	NA	7.58	0.91	NA	14.33	090
25107		A	Remove wrist joint cartilage	6.42	NA	8.54	0.97	NA	15.93	090
25110		A	Remove wrist tendon lesion	3.91	NA	7.20	0.60	NA	11.71	090
25111		A	Remove wrist tendon lesion	3.38	NA	4.89	0.52	NA	8.79	090

[1] CPT codes and descriptions only are copyright 2004 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2004 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
25112		A	Reremove wrist tendon lesion	4.52	NA	5.49	0.70	NA	10.71	090
25115		A	Remove wrist/forearm lesion	8.81	NA	14.32	1.31	NA	24.44	090
25116		A	Remove wrist/forearm lesion	7.10	NA	13.40	1.08	NA	21.58	090
25118		A	Excise wrist tendon sheath	4.36	NA	5.97	0.68	NA	11.01	090
25119		A	Partial removal of ulna	6.03	NA	7.86	0.90	NA	14.79	090
25120		A	Removal of forearm lesion	6.09	NA	12.28	0.99	NA	19.36	090
25125		A	Remove/graft forearm lesion	7.47	NA	13.08	1.14	NA	21.69	090
25126		A	Remove/graft forearm lesion	7.54	NA	13.15	1.16	NA	21.85	090
25130		A	Removal of wrist lesion	5.25	NA	6.61	0.81	NA	12.67	090
25135		A	Remove & graft wrist lesion	6.88	NA	7.64	0.93	NA	15.45	090
25136		A	Remove & graft wrist lesion	5.96	NA	6.77	0.89	NA	13.62	090
25145		A	Remove forearm bone lesion	6.36	NA	12.33	0.91	NA	19.60	090
25150		A	Partial removal of ulna	7.08	NA	8.50	1.11	NA	16.69	090
25151		A	Partial removal of radius	7.38	NA	12.93	1.12	NA	21.43	090
25170		A	Extensive forearm surgery	11.07	NA	15.29	1.69	NA	28.05	090
25210		A	Removal of wrist bone	5.94	NA	7.00	0.87	NA	13.81	090
25215		A	Removal of wrist bones	7.88	NA	9.00	1.20	NA	18.08	090
25230		A	Partial removal of radius	5.22	NA	6.31	0.78	NA	12.31	090
25240		A	Partial removal of ulna	5.16	NA	7.18	0.80	NA	13.14	090
25246		A	Injection for wrist x-ray	1.45	3.48	0.48	0.09	5.02	2.02	000
25248		A	Remove forearm foreign body	5.13	NA	8.64	0.70	NA	14.47	090
25250		A	Removal of wrist prosthesis	6.59	NA	6.09	0.95	NA	13.63	090
25251		A	Removal of wrist prosthesis	9.56	NA	7.91	1.27	NA	18.74	090
25259		A	Manipulate wrist w/anesthes	3.74	NA	5.62	0.62	NA	9.98	090
25260		A	Repair forearm tendon/muscle	7.79	NA	13.77	1.17	NA	22.73	090
25263		A	Repair forearm tendon/muscle	7.81	NA	13.67	1.11	NA	22.59	090
25265		A	Repair forearm tendon/muscle	9.87	NA	14.56	1.36	NA	25.79	090
25270		A	Repair forearm tendon/muscle	5.99	NA	12.45	0.92	NA	19.36	090
25272		A	Repair forearm tendon/muscle	7.03	NA	13.15	1.10	NA	21.28	090
25274		A	Repair forearm tendon/muscle	8.74	NA	13.88	1.28	NA	23.90	090
25275		A	Repair forearm tendon sheath	8.49	NA	7.49	1.19	NA	17.17	090
25280		A	Revise wrist/forearm tendon	7.21	NA	12.88	1.07	NA	21.16	090
25290		A	Incise wrist/forearm tendon	5.28	NA	15.12	0.81	NA	21.21	090
25295		A	Release wrist/forearm tendon	6.54	NA	12.45	0.95	NA	19.94	090
25300		A	Fusion of tendons at wrist	8.79	NA	8.61	1.15	NA	18.55	090
25301		A	Fusion of tendons at wrist	8.39	NA	8.26	1.24	NA	17.89	090
25310		A	Transplant forearm tendon	8.13	NA	13.29	1.17	NA	22.59	090
25312		A	Transplant forearm tendon	9.56	NA	14.17	1.37	NA	25.10	090
25315		A	Revise palsy hand tendon(s)	10.18	NA	14.74	1.52	NA	26.44	090
25316		A	Revise palsy hand tendon(s)	12.31	NA	16.51	2.07	NA	30.89	090
25320		A	Repair/revise wrist joint	10.75	NA	11.40	1.58	NA	23.73	090
25332		A	Revise wrist joint	11.39	NA	9.15	1.72	NA	22.26	090
25335		A	Realignment of hand	12.86	NA	11.80	2.00	NA	26.66	090
25337		A	Reconstruct ulna/radioulnar	10.15	NA	11.24	1.57	NA	22.96	090
25350		A	Revision of radius	8.77	NA	14.12	1.36	NA	24.25	090
25355		A	Revision of radius	10.15	NA	14.74	1.39	NA	26.28	090
25360		A	Revision of ulna	8.42	NA	14.01	1.36	NA	23.79	090
25365		A	Revise radius & ulna	12.38	NA	15.77	2.03	NA	30.18	090
25370		A	Revise radius or ulna	13.34	NA	16.19	2.27	NA	31.80	090
25375		A	Revise radius & ulna	13.02	NA	16.55	2.22	NA	31.79	090
25390		A	Shorten radius or ulna	10.38	NA	14.74	1.55	NA	26.67	090
25391		A	Lengthen radius or ulna	13.63	NA	16.70	2.17	NA	32.50	090
25392		A	Shorten radius & ulna	13.93	NA	16.09	2.15	NA	32.17	090
25393		A	Lengthen radius & ulna	15.85	NA	17.71	2.76	NA	36.32	090
25394		A	Repair carpal bone, shorten	10.38	NA	8.05	1.31	NA	19.74	090
25400		A	Repair radius or ulna	10.90	NA	15.32	1.73	NA	27.95	090
25405		A	Repair/graft radius or ulna	14.36	NA	17.42	2.27	NA	34.05	090
25415		A	Repair radius & ulna	13.33	NA	16.64	2.07	NA	32.04	090
25420		A	Repair/graft radius & ulna	16.31	NA	18.41	2.58	NA	37.30	090
25425		A	Repair/graft radius or ulna	13.19	NA	21.64	1.91	NA	36.74	090
25426		A	Repair/graft radius & ulna	15.80	NA	16.70	1.39	NA	33.89	090
25430		A	Vasc graft into carpal bone	9.24	NA	7.21	1.25	NA	17.70	090
25431		A	Repair nonunion carpal bone	10.42	NA	8.33	1.69	NA	20.44	090
25440		A	Repair/graft wrist bone	10.42	NA	9.51	1.50	NA	21.43	090
25441		A	Reconstruct wrist joint	12.88	NA	9.98	2.06	NA	24.92	090
25442		A	Reconstruct wrist joint	10.83	NA	8.86	1.51	NA	21.20	090
25443		A	Reconstruct wrist joint	10.37	NA	8.75	1.66	NA	20.78	090
25444		A	Reconstruct wrist joint	11.13	NA	9.01	1.53	NA	21.67	090
25445		A	Reconstruct wrist joint	9.68	NA	7.97	1.52	NA	19.17	090
25446		A	Wrist replacement	16.53	NA	11.90	2.43	NA	30.86	090
25447		A	Repair wrist joint(s)	10.35	NA	8.63	1.53	NA	20.51	090
25449		A	Remove wrist joint implant	14.47	NA	10.64	2.08	NA	27.19	090
25450		A	Revision of wrist joint	7.86	NA	10.31	1.22	NA	19.39	090
25455		A	Revision of wrist joint	9.48	NA	11.25	1.21	NA	21.94	090
25490		A	Reinforce radius	9.53	NA	13.89	1.38	NA	24.80	090

[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
25491		A	Reinforce ulna	9.95	NA	14.66	1.52	NA	26.13	090
25492		A	Reinforce radius and ulna	12.31	NA	15.43	2.14	NA	29.88	090
25500		A	Treat fracture of radius	2.45	3.59	2.74	0.33	6.37	5.52	090
25505		A	Treat fracture of radius	5.20	6.54	5.43	0.82	12.56	11.45	090
25515		A	Treat fracture of radius	9.17	NA	7.65	1.47	NA	18.29	090
25520		A	Treat fracture of radius	6.25	6.86	6.06	1.02	14.13	13.33	090
25525		A	Treat fracture of radius	12.22	NA	10.16	1.97	NA	24.35	090
25526		A	Treat fracture of radius	12.96	NA	13.63	2.04	NA	28.63	090
25530		A	Treat fracture of ulna	2.09	3.77	2.88	0.32	6.18	5.29	090
25535		A	Treat fracture of ulna	5.13	6.02	5.29	0.83	11.98	11.25	090
25545		A	Treat fracture of ulna	8.89	NA	7.85	1.43	NA	18.17	090
25560		A	Treat fracture radius & ulna	2.44	3.71	2.64	0.33	6.48	5.41	090
25565		A	Treat fracture radius & ulna	5.62	6.70	5.43	0.90	13.22	11.95	090
25574		A	Treat fracture radius & ulna	7.00	NA	7.37	1.14	NA	15.51	090
25575		A	Treat fracture radius/ulna	10.43	NA	9.66	1.67	NA	21.76	090
25600		A	Treat fracture radius/ulna	2.63	4.09	2.99	0.39	7.11	6.01	090
25605		A	Treat fracture radius/ulna	5.80	7.22	6.21	0.96	13.98	12.97	090
25611		A	Treat fracture radius/ulna	7.76	NA	9.11	1.32	NA	18.19	090
25620		A	Treat fracture radius/ulna	8.54	NA	7.47	1.35	NA	17.36	090
25622		A	Treat wrist bone fracture	2.61	4.27	3.13	0.39	7.27	6.13	090
25624		A	Treat wrist bone fracture	4.52	6.30	5.08	0.72	11.54	10.32	090
25628		A	Treat wrist bone fracture	8.42	NA	8.04	1.30	NA	17.76	090
25630		A	Treat wrist bone fracture	2.88	4.19	2.97	0.43	7.50	6.28	090
25635		A	Treat wrist bone fracture	4.38	5.94	3.93	0.65	10.97	8.96	090
25645		A	Treat wrist bone fracture	7.24	NA	6.99	1.12	NA	15.35	090
25650		A	Treat wrist bone fracture	3.05	4.31	3.21	0.41	7.77	6.67	090
25651		A	Pin ulnar styloid fracture	5.35	NA	5.42	0.73	NA	11.50	090
25652		A	Treat fracture ulnar styloid	7.59	NA	6.94	1.19	NA	15.72	090
25660		A	Treat wrist dislocation	4.75	NA	4.76	0.64	NA	10.15	090
25670		A	Treat wrist dislocation	7.91	NA	7.27	1.23	NA	16.41	090
25671		A	Pin radioulnar dislocation	5.99	NA	6.07	0.93	NA	12.99	090
25675		A	Treat wrist dislocation	4.66	5.67	4.67	0.61	10.94	9.94	090
25676		A	Treat wrist dislocation	8.03	NA	7.53	1.34	NA	16.90	090
25680		A	Treat wrist fracture	5.98	NA	4.85	0.73	NA	11.56	090
25685		A	Treat wrist fracture	9.77	NA	8.05	1.53	NA	19.35	090
25690		A	Treat wrist dislocation	5.49	NA	5.57	0.89	NA	11.95	090
25695		A	Treat wrist dislocation	8.33	NA	7.38	1.32	NA	17.03	090
25800		A	Fusion of wrist joint	9.75	NA	9.20	1.31	NA	20.26	090
25805		A	Fusion/graft of wrist joint	11.26	NA	10.35	1.79	NA	23.40	090
25810		A	Fusion/graft of wrist joint	10.55	NA	10.01	1.60	NA	22.16	090
25820		A	Fusion of hand bones	7.44	NA	7.99	1.11	NA	16.54	090
25825		A	Fuse hand bones with graft	9.26	NA	9.34	1.34	NA	19.94	090
25830		A	Fusion, radioulnar jnt/ulna	10.04	NA	14.57	1.39	NA	26.00	090
25900		A	Amputation of forearm	9.00	NA	12.73	1.36	NA	23.09	090
25905		A	Amputation of forearm	9.11	NA	12.65	1.28	NA	23.04	090
25907		A	Amputation follow-up surgery	7.79	NA	12.07	1.20	NA	21.06	090
25909		A	Amputation follow-up surgery	8.95	NA	12.60	1.21	NA	22.76	090
25915		A	Amputation of forearm	17.05	NA	19.33	1.13	NA	37.51	090
25920		A	Amputate hand at wrist	8.67	NA	8.07	1.33	NA	18.07	090
25922		A	Amputate hand at wrist	7.41	NA	7.30	1.29	NA	16.00	090
25924		A	Amputation follow-up surgery	8.45	NA	8.31	1.47	NA	18.23	090
25927		A	Amputation of hand	8.79	NA	12.00	1.34	NA	22.13	090
25929		A	Amputation follow-up surgery	7.58	NA	6.15	1.27	NA	15.00	090
25931		A	Amputation follow-up surgery	7.80	NA	11.93	1.04	NA	20.77	090
26010		A	Drainage of finger abscess	1.54	5.60	1.64	0.17	7.31	3.35	010
26011		A	Drainage of finger abscess	2.19	8.81	2.32	0.32	11.32	4.83	010
26020		A	Drain hand tendon sheath	4.66	NA	5.73	0.72	NA	11.11	090
26025		A	Drainage of palm bursa	4.81	NA	5.52	0.74	NA	11.07	090
26030		A	Drainage of palm bursa(s)	5.92	NA	6.16	0.92	NA	13.00	090
26034		A	Treat hand bone lesion	6.22	NA	6.34	0.97	NA	13.53	090
26035		A	Decompress fingers/hand	9.50	NA	8.28	1.40	NA	19.18	090
26037		A	Decompress fingers/hand	7.24	NA	6.74	1.09	NA	15.07	090
26040		A	Release palm contracture	3.33	NA	4.04	0.54	NA	7.91	090
26045		A	Release palm contracture	5.55	NA	5.63	0.93	NA	12.11	090
26055		A	Incise finger tendon sheath	2.69	14.17	3.93	0.43	17.29	7.05	090
26060		A	Incision of finger tendon	2.81	NA	3.50	0.44	NA	6.75	090
26070		A	Explore/treat hand joint	3.68	NA	3.38	0.47	NA	7.53	090
26075		A	Explore/treat finger joint	3.78	NA	3.79	0.52	NA	8.09	090
26080		A	Explore/treat finger joint	4.23	NA	4.85	0.65	NA	9.73	090
26100		A	Biopsy hand joint lining	3.66	NA	4.13	0.54	NA	8.33	090
26105		A	Biopsy finger joint lining	3.70	NA	4.22	0.58	NA	8.50	090
26110		A	Biopsy finger joint lining	3.52	NA	4.03	0.53	NA	8.08	090
26115		A	Removel hand lesion subcut	3.85	13.01	4.76	0.59	17.45	9.20	090
26116		A	Removel hand lesion, deep	5.52	NA	5.99	0.82	NA	12.33	090
26117		A	Remove tumor, hand/finger	8.54	NA	7.05	1.24	NA	16.83	090

[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
26121		A	Release palm contracture	7.53	NA	6.95	1.17	NA	15.65	090
26123		A	Release palm contracture	9.28	NA	8.85	1.42	NA	19.55	090
26125		A	Release palm contracture	4.60	NA	2.44	0.70	NA	7.74	ZZZ
26130		A	Remove wrist joint lining	5.41	NA	5.33	0.97	NA	11.71	090
26135		A	Revise finger joint, each	6.95	NA	6.45	1.01	NA	14.41	090
26140		A	Revise finger joint, each	6.16	NA	6.03	0.92	NA	13.11	090
26145		A	Tendon excision, palm/finger	6.31	NA	6.04	0.98	NA	13.33	090
26160		A	Remove tendon sheath lesion	3.15	12.36	4.12	0.48	15.99	7.75	090
26170		A	Removal of palm tendon, each	4.76	NA	4.93	0.71	NA	10.40	090
26180		A	Removal of finger tendon	5.17	NA	5.40	0.81	NA	11.38	090
26185		A	Remove finger bone	5.24	NA	6.02	0.72	NA	11.98	090
26200		A	Remove hand bone lesion	5.50	NA	5.35	0.87	NA	11.72	090
26205		A	Remove/graft bone lesion	7.69	NA	6.88	1.20	NA	15.77	090
26210		A	Removal of finger lesion	5.14	NA	5.41	0.79	NA	11.34	090
26215		A	Remove/graft finger lesion	7.09	NA	6.30	1.10	NA	14.49	090
26230		A	Partial removal of hand bone	6.32	NA	5.90	0.95	NA	13.17	090
26235		A	Partial removal, finger bone	6.18	NA	5.80	0.93	NA	12.91	090
26236		A	Partial removal, finger bone	5.31	NA	5.32	0.80	NA	11.43	090
26250		A	Extensive hand surgery	7.54	NA	6.42	1.21	NA	15.17	090
26255		A	Extensive hand surgery	12.41	NA	9.38	1.47	NA	23.26	090
26260		A	Extensive finger surgery	7.02	NA	6.17	1.05	NA	14.24	090
26261		A	Extensive finger surgery	9.08	NA	6.20	1.29	NA	16.57	090
26262		A	Partial removal of finger	5.66	NA	5.32	0.85	NA	11.83	090
26320		A	Removal of implant from hand	3.97	NA	4.31	0.59	NA	8.87	090
26340		A	Manipulate finger w/anesth	2.50	NA	4.87	0.39	NA	7.76	090
26350		A	Repair finger/hand tendon	5.98	NA	15.28	0.85	NA	22.11	090
26352		A	Repair/graft hand tendon	7.67	NA	15.84	1.19	NA	24.70	090
26356		A	Repair finger/hand tendon	8.06	NA	18.75	1.22	NA	28.03	090
26357		A	Repair finger/hand tendon	8.57	NA	16.30	1.33	NA	26.20	090
26358		A	Repair/graft hand tendon	9.13	NA	17.19	1.34	NA	27.66	090
26370		A	Repair finger/hand tendon	7.10	NA	15.70	1.09	NA	23.89	090
26372		A	Repair/graft hand tendon	8.75	NA	17.07	1.27	NA	27.09	090
26373		A	Repair finger/hand tendon	8.15	NA	16.64	1.30	NA	26.09	090
26390		A	Revise hand/finger tendon	9.18	NA	13.77	1.35	NA	24.30	090
26392		A	Repair/graft hand tendon	10.24	NA	17.43	1.49	NA	29.16	090
26410		A	Repair hand tendon	4.62	NA	12.40	0.72	NA	17.74	090
26412		A	Repair/graft hand tendon	6.30	NA	13.72	0.98	NA	21.00	090
26415		A	Excision, hand/finger tendon	8.33	NA	12.22	1.06	NA	21.61	090
26416		A	Graft hand or finger tendon	9.36	NA	15.03	1.18	NA	25.57	090
26418		A	Repair finger tendon	4.24	NA	12.78	0.65	NA	17.67	090
26420		A	Repair/graft finger tendon	6.76	NA	14.05	1.05	NA	21.86	090
26426		A	Repair finger/hand tendon	6.14	NA	13.57	0.96	NA	20.67	090
26428		A	Repair/graft finger tendon	7.20	NA	14.32	1.10	NA	22.62	090
26432		A	Repair finger tendon	4.01	NA	10.55	0.62	NA	15.18	090
26433		A	Repair finger tendon	4.55	NA	11.22	0.70	NA	16.47	090
26434		A	Repair/graft finger tendon	6.08	NA	11.92	0.88	NA	18.88	090
26437		A	Realignment of tendons	5.81	NA	11.84	0.89	NA	18.54	090
26440		A	Release palm/finger tendon	5.01	NA	13.94	0.76	NA	19.71	090
26442		A	Release palm & finger tendon	8.15	NA	16.43	1.16	NA	25.74	090
26445		A	Release hand/finger tendon	4.30	NA	13.70	0.66	NA	18.66	090
26449		A	Release forearm/hand tendon	6.99	NA	16.21	1.03	NA	24.23	090
26450		A	Incision of palm tendon	3.66	NA	7.53	0.58	NA	11.77	090
26455		A	Incision of finger tendon	3.63	NA	7.46	0.55	NA	11.64	090
26460		A	Incise hand/finger tendon	3.45	NA	7.28	0.51	NA	11.24	090
26471		A	Fusion of finger tendons	5.72	NA	11.52	0.88	NA	18.12	090
26474		A	Fusion of finger tendons	5.31	NA	11.69	0.74	NA	17.74	090
26476		A	Tendon lengthening	5.17	NA	11.23	0.79	NA	17.19	090
26477		A	Tendon shortening	5.14	NA	11.40	0.77	NA	17.31	090
26478		A	Lengthening of hand tendon	5.79	NA	12.09	0.94	NA	18.82	090
26479		A	Shortening of hand tendon	5.73	NA	11.94	0.90	NA	18.57	090
26480		A	Transplant hand tendon	6.68	NA	15.43	1.00	NA	23.11	090
26483		A	Transplant/graft hand tendon	8.28	NA	15.89	1.22	NA	25.39	090
26485		A	Transplant palm tendon	7.69	NA	15.77	1.09	NA	24.55	090
26489		A	Transplant/graft palm tendon	9.54	NA	12.39	1.18	NA	23.11	090
26490		A	Revise thumb tendon	8.40	NA	13.04	1.17	NA	22.61	090
26492		A	Tendon transfer with graft	9.61	NA	13.84	1.39	NA	24.84	090
26494		A	Hand tendon/muscle transfer	8.46	NA	13.47	1.21	NA	23.14	090
26496		A	Revise thumb tendon	9.58	NA	13.47	1.38	NA	24.43	090
26497		A	Finger tendon transfer	9.56	NA	13.82	1.46	NA	24.84	090
26498		A	Finger tendon transfer	13.98	NA	16.40	1.95	NA	32.33	090
26499		A	Revision of finger	8.97	NA	13.40	1.30	NA	23.67	090
26500		A	Hand tendon reconstruction	5.95	NA	11.98	0.89	NA	18.82	090
26502		A	Hand tendon reconstruction	7.13	NA	12.45	1.03	NA	20.61	090
26504		A	Hand tendon reconstruction	7.46	NA	12.85	1.18	NA	21.49	090
26508		A	Release thumb contracture	6.00	NA	11.97	0.94	NA	18.91	090

[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
26510		A	Thumb tendon transfer	5.42	NA	11.65	0.77	NA	17.84	090
26516		A	Fusion of knuckle joint	7.14	NA	12.50	1.04	NA	20.68	090
26517		A	Fusion of knuckle joints	8.82	NA	13.82	1.49	NA	24.13	090
26518		A	Fusion of knuckle joints	9.01	NA	13.63	1.52	NA	24.16	090
26520		A	Release knuckle contracture	5.29	NA	14.38	0.80	NA	20.47	090
26525		A	Release finger contracture	5.32	NA	14.49	0.81	NA	20.62	090
26530		A	Revise knuckle joint	6.68	NA	6.13	1.03	NA	13.84	090
26531		A	Revise knuckle with implant	7.90	NA	7.10	1.15	NA	16.15	090
26535		A	Revise finger joint	5.23	NA	3.74	0.58	NA	9.55	090
26536		A	Revise/implant finger joint	6.36	NA	9.63	0.89	NA	16.88	090
26540		A	Repair hand joint	6.42	NA	12.22	0.97	NA	19.61	090
26541		A	Repair hand joint with graft	8.61	NA	13.69	1.23	NA	23.53	090
26542		A	Repair hand joint with graft	6.77	NA	12.25	0.98	NA	20.00	090
26545		A	Reconstruct finger joint	6.91	NA	12.66	1.01	NA	20.58	090
26546		A	Repair nonunion hand	8.91	NA	15.14	1.33	NA	25.38	090
26548		A	Reconstruct finger joint	8.02	NA	13.25	1.16	NA	22.43	090
26550		A	Construct thumb replacement	21.21	NA	18.11	2.98	NA	42.30	090
26551		A	Great toe-hand transfer	46.51	NA	33.36	5.65	NA	85.52	090
26553		A	Single transfer, toe-hand	46.20	NA	22.83	3.49	NA	72.52	090
26554		A	Double transfer, toe-hand	54.87	NA	37.75	9.36	NA	101.98	090
26555		A	Positional change of finger	16.61	NA	18.47	2.26	NA	37.34	090
26556		A	Toe joint transfer	47.19	NA	33.81	8.04	NA	89.04	090
26560		A	Repair of web finger	5.37	NA	10.18	0.76	NA	16.31	090
26561		A	Repair of web finger	10.90	NA	12.81	1.53	NA	25.24	090
26562		A	Repair of web finger	14.98	NA	17.46	1.18	NA	33.62	090
26565		A	Correct metacarpal flaw	6.73	NA	12.32	0.96	NA	20.01	090
26567		A	Correct finger deformity	6.81	NA	12.25	1.02	NA	20.08	090
26568		A	Lengthen metacarpal/finger	9.07	NA	15.87	1.34	NA	26.28	090
26580		A	Repair hand deformity	18.15	NA	14.01	1.88	NA	34.04	090
26587		A	Reconstruct extra finger	14.03	NA	9.06	1.46	NA	24.55	090
26590		A	Repair finger deformity	17.93	NA	14.31	1.62	NA	33.86	090
26591		A	Repair muscles of hand	3.25	NA	10.31	0.49	NA	14.05	090
26593		A	Release muscles of hand	5.30	NA	11.38	0.77	NA	17.45	090
26596		A	Excision constricting tissue	8.94	NA	9.00	1.38	NA	19.32	090
26600		A	Treat metacarpal fracture	1.96	3.61	2.68	0.29	5.86	4.93	090
26605		A	Treat metacarpal fracture	2.85	4.56	3.65	0.45	7.86	6.95	090
26607		A	Treat metacarpal fracture	5.35	NA	6.38	0.84	NA	12.57	090
26608		A	Treat metacarpal fracture	5.35	NA	6.54	0.88	NA	12.77	090
26615		A	Treat metacarpal fracture	5.32	NA	5.73	0.85	NA	11.90	090
26641		A	Treat thumb dislocation	3.93	4.60	3.58	0.43	8.96	7.94	090
26645		A	Treat thumb fracture	4.40	5.18	4.20	0.62	10.20	9.22	090
26650		A	Treat thumb fracture	5.71	NA	6.95	0.94	NA	13.60	090
26665		A	Treat thumb fracture	7.59	NA	6.99	1.19	NA	15.77	090
26670		A	Treat hand dislocation	3.68	4.29	2.99	0.39	8.36	7.06	090
26675		A	Treat hand dislocation	4.63	5.48	4.48	0.72	10.83	9.83	090
26676		A	Pin hand dislocation	5.51	NA	6.99	0.88	NA	13.38	090
26685		A	Treat hand dislocation	6.97	NA	6.44	1.05	NA	14.46	090
26686		A	Treat hand dislocation	7.93	NA	7.21	1.21	NA	16.35	090
26700		A	Treat knuckle dislocation	3.68	3.79	2.91	0.34	7.81	6.93	090
26705		A	Treat knuckle dislocation	4.18	5.35	4.31	0.61	10.14	9.10	090
26706		A	Pin knuckle dislocation	5.11	NA	5.27	0.77	NA	11.15	090
26715		A	Treat knuckle dislocation	5.73	NA	5.91	0.89	NA	12.53	090
26720		A	Treat finger fracture, each	1.66	2.79	2.09	0.22	4.67	3.97	090
26725		A	Treat finger fracture, each	3.33	4.77	3.51	0.50	8.60	7.34	090
26727		A	Treat finger fracture, each	5.22	NA	6.60	0.84	NA	12.66	090
26735		A	Treat finger fracture, each	5.97	NA	6.06	0.94	NA	12.97	090
26740		A	Treat finger fracture, each	1.94	3.14	2.71	0.30	5.38	4.95	090
26742		A	Treat finger fracture, each	3.84	4.99	3.89	0.56	9.39	8.29	090
26746		A	Treat finger fracture, each	5.80	NA	6.12	0.91	NA	12.83	090
26750		A	Treat finger fracture, each	1.70	2.49	2.05	0.20	4.39	3.95	090
26755		A	Treat finger fracture, each	3.10	4.43	3.02	0.41	7.94	6.53	090
26756		A	Pin finger fracture, each	4.38	NA	6.23	0.69	NA	11.30	090
26765		A	Treat finger fracture, each	4.16	NA	4.96	0.62	NA	9.74	090
26770		A	Treat finger dislocation	3.02	3.46	2.46	0.27	6.75	5.75	090
26775		A	Treat finger dislocation	3.70	5.20	3.84	0.49	9.39	8.03	090
26776		A	Pin finger dislocation	4.79	NA	6.40	0.73	NA	11.92	090
26785		A	Treat finger dislocation	4.20	NA	4.99	0.67	NA	9.86	090
26820		A	Thumb fusion with graft	8.25	NA	13.49	1.36	NA	23.10	090
26841		A	Fusion of thumb	7.12	NA	13.39	1.17	NA	21.68	090
26842		A	Thumb fusion with graft	8.23	NA	13.57	1.24	NA	23.04	090
26843		A	Fusion of hand joint	7.60	NA	12.53	1.21	NA	21.34	090
26844		A	Fusion/graft of hand joint	8.72	NA	13.55	1.29	NA	23.56	090
26850		A	Fusion of knuckle	6.96	NA	12.41	1.05	NA	20.42	090
26852		A	Fusion of knuckle with graft	8.45	NA	13.14	1.23	NA	22.82	090
26860		A	Fusion of finger joint	4.68	NA	11.42	0.73	NA	16.83	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
26861		A	Fusion of finger jnt, add-on	1.74	NA	0.93	0.24	NA	2.91	ZZZ
26862		A	Fusion/graft of finger joint	7.36	NA	12.63	1.05	NA	21.04	090
26863		A	Fuse/graft added joint	3.89	NA	2.10	0.56	NA	6.55	ZZZ
26910		A	Amputate metacarpal bone	7.59	NA	11.57	1.13	NA	20.29	090
26951		A	Amputation of finger/thumb	4.58	NA	10.48	0.70	NA	15.76	090
26952		A	Amputation of finger/thumb	6.30	NA	12.05	0.94	NA	19.29	090
26990		A	Drainage of pelvis lesion	7.47	NA	7.75	1.18	NA	16.40	090
26991		A	Drainage of pelvis bursa	6.67	11.17	5.43	1.07	18.91	13.17	090
26992		A	Drainage of bone lesion	13.00	NA	11.06	2.06	NA	26.12	090
27000		A	Incision of hip tendon	5.61	NA	5.46	0.96	NA	12.03	090
27001		A	Incision of hip tendon	6.93	NA	6.33	1.16	NA	14.42	090
27003		A	Incision of hip tendon	7.33	NA	6.74	1.18	NA	15.25	090
27005		A	Incision of hip tendon	9.65	NA	8.04	1.58	NA	19.27	090
27006		A	Incision of hip tendons	9.67	NA	8.21	1.56	NA	19.44	090
27025		A	Incision of hip/thigh fascia	11.14	NA	8.75	1.75	NA	21.64	090
27030		A	Drainage of hip joint	12.99	NA	9.85	2.10	NA	24.94	090
27033		A	Exploration of hip joint	13.37	NA	10.12	2.20	NA	25.69	090
27035		A	Denervation of hip joint	16.66	NA	12.61	2.43	NA	31.70	090
27036		A	Excision of hip joint/muscle	12.86	NA	10.28	2.11	NA	25.25	090
27040		A	Biopsy of soft tissues	2.87	5.25	2.01	0.30	8.42	5.18	010
27041		A	Biopsy of soft tissues	9.88	NA	6.79	1.30	NA	17.97	090
27047		A	Remove hip/pelvis lesion	7.44	7.14	4.78	1.00	15.58	13.22	090
27048		A	Remove hip/pelvis lesion	6.24	NA	5.12	0.89	NA	12.25	090
27049		A	Remove tumor, hip/pelvis	13.64	NA	8.93	1.95	NA	24.52	090
27050		A	Biopsy of sacroiliac joint	4.35	NA	4.64	0.66	NA	9.65	090
27052		A	Biopsy of hip joint	6.22	NA	6.09	0.98	NA	13.29	090
27054		A	Removal of hip joint lining	8.53	NA	7.59	1.35	NA	17.47	090
27060		A	Removal of ischial bursa	5.42	NA	4.94	0.78	NA	11.14	090
27062		A	Remove femur lesion/bursa	5.36	NA	5.40	0.91	NA	11.67	090
27065		A	Removal of hip bone lesion	5.89	NA	5.71	0.90	NA	12.50	090
27066		A	Removal of hip bone lesion	10.31	NA	8.73	1.60	NA	20.64	090
27067		A	Remove/graft hip bone lesion	13.81	NA	10.92	2.25	NA	26.98	090
27070		A	Partial removal of hip bone	10.70	NA	9.98	1.67	NA	22.35	090
27071		A	Partial removal of hip bone	11.44	NA	10.98	1.82	NA	24.24	090
27075		A	Extensive hip surgery	34.95	NA	19.82	5.16	NA	59.93	090
27076		A	Extensive hip surgery	22.09	NA	15.05	3.43	NA	40.57	090
27077		A	Extensive hip surgery	39.94	NA	23.29	5.61	NA	68.84	090
27078		A	Extensive hip surgery	13.42	NA	10.70	2.12	NA	26.24	090
27079		A	Extensive hip surgery	13.73	NA	10.31	2.00	NA	26.04	090
27080		A	Removal of tail bone	6.38	NA	5.17	0.92	NA	12.47	090
27086		A	Remove hip foreign body	1.87	4.57	1.82	0.22	6.66	3.91	010
27087		A	Remove hip foreign body	8.53	NA	6.85	1.29	NA	16.67	090
27090		A	Removal of hip prosthesis	11.13	NA	8.76	1.81	NA	21.70	090
27091		A	Removal of hip prosthesis	22.11	NA	13.97	3.49	NA	39.57	090
27093		A	Injection for hip x-ray	1.30	4.50	0.48	0.12	5.92	1.90	000
27095		A	Injection for hip x-ray	1.50	5.81	0.52	0.13	7.44	2.15	000
27096		A	Inject sacroiliac joint	1.40	3.95	0.33	0.10	5.45	1.83	000
27097		A	Revision of hip tendon	8.79	NA	6.63	1.49	NA	16.91	090
27098		A	Transfer tendon to pelvis	8.82	NA	7.26	0.91	NA	16.99	090
27100		A	Transfer of abdominal muscle	11.06	NA	8.97	1.76	NA	21.79	090
27105		A	Transfer of spinal muscle	11.75	NA	9.41	1.32	NA	22.48	090
27110		A	Transfer of iliopsoas muscle	13.24	NA	9.48	1.82	NA	24.54	090
27111		A	Transfer of iliopsoas muscle	12.13	NA	9.36	2.11	NA	23.60	090
27120		A	Reconstruction of hip socket	17.98	NA	11.83	2.73	NA	32.54	090
27122		A	Reconstruction of hip socket	14.96	NA	11.02	2.42	NA	28.40	090
27125		A	Partial hip replacement	14.67	NA	10.60	2.32	NA	27.59	090
27130		A	Total hip arthroplasty	20.09	NA	13.28	3.11	NA	36.48	090
27132		A	Total hip arthroplasty	23.27	NA	15.60	3.64	NA	42.51	090
27134		A	Revise hip joint replacement	28.48	NA	17.76	4.44	NA	50.68	090
27137		A	Revise hip joint replacement	21.14	NA	13.90	3.35	NA	38.39	090
27138		A	Revise hip joint replacement	22.14	NA	14.37	3.51	NA	40.02	090
27140		A	Transplant femur ridge	12.22	NA	9.61	1.97	NA	23.80	090
27146		A	Incision of hip bone	17.40	NA	12.49	2.61	NA	32.50	090
27147		A	Revision of hip bone	20.55	NA	13.51	2.80	NA	36.86	090
27151		A	Incision of hip bones	22.48	NA	8.26	3.57	NA	34.31	090
27156		A	Revision of hip bones	24.59	NA	16.32	3.52	NA	44.43	090
27158		A	Revision of pelvis	19.71	NA	11.30	3.14	NA	34.15	090
27161		A	Incision of neck of femur	16.68	NA	12.29	2.77	NA	31.74	090
27165		A	Incision/fixation of femur	17.88	NA	13.07	2.82	NA	33.77	090
27170		A	Repair/graft femur head/neck	16.05	NA	11.49	2.56	NA	30.10	090
27175		A	Treat slipped epiphysis	8.45	NA	6.75	1.47	NA	16.67	090
27176		A	Treat slipped epiphysis	12.03	NA	9.14	2.00	NA	23.17	090
27177		A	Treat slipped epiphysis	15.06	NA	10.99	2.49	NA	28.54	090
27178		A	Treat slipped epiphysis	11.97	NA	8.53	2.08	NA	22.58	090
27179		A	Revise head/neck of femur	12.96	NA	10.09	2.25	NA	25.30	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
27181		A	Treat slipped epiphysis	14.66	NA	10.31	2.28	NA	27.25	090
27185		A	Revision of femur epiphysis	9.17	NA	7.78	1.59	NA	18.54	090
27187		A	Reinforce hip bones	13.52	NA	10.55	2.16	NA	26.23	090
27193		A	Treat pelvic ring fracture	5.55	5.32	5.17	0.93	11.80	11.65	090
27194		A	Treat pelvic ring fracture	9.64	NA	7.64	1.62	NA	18.90	090
27200		A	Treat tail bone fracture	1.84	2.23	2.17	0.26	4.33	4.27	090
27202		A	Treat tail bone fracture	7.03	NA	17.13	0.93	NA	25.09	090
27215		A	Treat pelvic fracture(s)	10.03	NA	7.30	1.78	NA	19.11	090
27216		A	Treat pelvic ring fracture	15.17	NA	9.91	2.49	NA	27.57	090
27217		A	Treat pelvic ring fracture	14.09	NA	10.34	2.23	NA	26.66	090
27218		A	Treat pelvic ring fracture	20.12	NA	11.62	3.23	NA	34.97	090
27220		A	Treat hip socket fracture	6.17	5.71	5.62	1.05	12.93	12.84	090
27222		A	Treat hip socket fracture	12.68	NA	10.04	2.17	NA	24.89	090
27226		A	Treat hip wall fracture	14.89	NA	8.03	2.46	NA	25.38	090
27227		A	Treat hip fracture(s)	23.41	NA	15.53	3.73	NA	42.67	090
27228		A	Treat hip fracture(s)	27.12	NA	17.75	4.44	NA	49.31	090
27230		A	Treat thigh fracture	5.49	5.51	5.11	0.90	11.90	11.50	090
27232		A	Treat thigh fracture	10.66	NA	7.34	1.78	NA	19.78	090
27235		A	Treat thigh fracture	12.14	NA	9.57	2.08	NA	23.79	090
27236		A	Treat thigh fracture	15.58	NA	11.04	2.49	NA	29.11	090
27238		A	Treat thigh fracture	5.51	NA	5.27	0.86	NA	11.64	090
27240		A	Treat thigh fracture	12.48	NA	9.58	2.06	NA	24.12	090
27244		A	Treat thigh fracture	15.92	NA	11.42	2.57	NA	29.91	090
27245		A	Treat thigh fracture	20.28	NA	13.85	3.24	NA	37.37	090
27246		A	Treat thigh fracture	4.70	4.45	4.42	0.80	9.95	9.92	090
27248		A	Treat thigh fracture	10.43	NA	8.35	1.68	NA	20.46	090
27250		A	Treat hip dislocation	6.94	NA	4.75	0.61	NA	12.30	090
27252		A	Treat hip dislocation	10.37	NA	7.53	1.58	NA	19.48	090
27253		A	Treat hip dislocation	12.90	NA	9.89	1.91	NA	24.70	090
27254		A	Treat hip dislocation	18.23	NA	12.17	2.97	NA	33.37	090
27256		A	Treat hip dislocation	4.11	3.52	2.09	0.43	8.06	6.63	010
27257		A	Treat hip dislocation	5.21	NA	2.82	0.67	NA	8.70	010
27258		A	Treat hip dislocation	15.41	NA	11.10	2.51	NA	29.02	090
27259		A	Treat hip dislocation	21.52	NA	14.33	3.35	NA	39.20	090
27265		A	Treat hip dislocation	5.04	NA	4.91	0.64	NA	10.59	090
27266		A	Treat hip dislocation	7.48	NA	6.46	1.26	NA	15.20	090
27275		A	Manipulation of hip joint	2.27	NA	2.10	0.38	NA	4.75	010
27280		A	Fusion of sacroiliac joint	13.37	NA	10.55	2.21	NA	26.13	090
27282		A	Fusion of pubic bones	11.32	NA	8.34	1.26	NA	20.92	090
27284		A	Fusion of hip joint	23.41	NA	15.00	3.26	NA	41.67	090
27286		A	Fusion of hip joint	23.41	NA	16.02	3.54	NA	42.97	090
27290		A	Amputation of leg at hip	23.25	NA	14.33	3.33	NA	40.91	090
27295		A	Amputation of leg at hip	18.62	NA	11.64	2.77	NA	33.03	090
27301		A	Drain thigh/knee lesion	6.48	10.12	5.14	1.00	17.60	12.62	090
27303		A	Drainage of bone lesion	8.27	NA	7.54	1.35	NA	17.16	090
27305		A	Incise thigh tendon & fascia	5.91	NA	5.50	0.92	NA	12.33	090
27306		A	Incision of thigh tendon	4.61	NA	4.97	0.79	NA	10.37	090
27307		A	Incision of thigh tendons	5.79	NA	5.69	1.01	NA	12.49	090
27310		A	Exploration of knee joint	9.26	NA	7.75	1.51	NA	18.52	090
27315		A	Partial removal, thigh nerve	6.96	NA	4.91	1.21	NA	13.08	090
27320		A	Partial removal, thigh nerve	6.29	NA	5.19	0.94	NA	12.42	090
27323		A	Biopsy, thigh soft tissues	2.28	3.52	1.88	0.27	6.07	4.43	010
27324		A	Biopsy, thigh soft tissues	4.89	NA	4.45	0.73	NA	10.07	090
27327		A	Removal of thigh lesion	4.46	6.01	3.73	0.63	11.10	8.82	090
27328		A	Removal of thigh lesion	5.56	NA	4.65	0.83	NA	11.04	090
27329		A	Remove tumor, thigh/knee	14.12	NA	9.68	2.05	NA	25.85	090
27330		A	Biopsy, knee joint lining	4.96	NA	4.72	0.85	NA	10.53	090
27331		A	Explore/treat knee joint	5.87	NA	5.68	0.95	NA	12.50	090
27332		A	Removal of knee cartilage	8.26	NA	7.26	1.38	NA	16.90	090
27333		A	Removal of knee cartilage	7.29	NA	6.81	1.17	NA	15.27	090
27334		A	Remove knee joint lining	8.69	NA	7.58	1.41	NA	17.68	090
27335		A	Remove knee joint lining	9.99	NA	8.39	1.61	NA	19.99	090
27340		A	Removal of kneecap bursa	4.17	NA	4.69	0.71	NA	9.57	090
27345		A	Removal of knee cyst	5.91	NA	5.77	0.95	NA	12.63	090
27347		A	Remove knee cyst	5.77	NA	5.58	0.94	NA	12.29	090
27350		A	Removal of kneecap	8.16	NA	7.38	1.31	NA	16.85	090
27355		A	Remove femur lesion	7.64	NA	7.03	1.20	NA	15.87	090
27356		A	Remove femur lesion/graft	9.47	NA	8.11	1.58	NA	19.16	090
27357		A	Remove femur lesion/graft	10.51	NA	8.94	1.81	NA	21.26	090
27358		A	Remove femur lesion/fixation	4.73	NA	2.52	0.76	NA	8.01	ZZZ
27360		A	Partial removal, leg bone(s)	10.48	NA	10.15	1.68	NA	22.31	090
27365		A	Extensive leg surgery	16.25	NA	11.89	2.70	NA	30.84	090
27370		A	Injection for knee x-ray	0.96	3.76	0.32	0.07	4.79	1.35	000
27372		A	Removal of foreign body	5.06	10.10	4.69	0.77	15.93	10.52	090
27380		A	Repair of kneecap tendon	7.15	NA	7.37	1.16	NA	15.68	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
27381		A	Repair/graft kneecap tendon	10.32	NA	9.17	1.63	NA	21.12	090
27385		A	Repair of thigh muscle	7.75	NA	7.71	1.27	NA	16.73	090
27386		A	Repair/graft of thigh muscle	10.54	NA	9.61	1.69	NA	21.84	090
27390		A	Incision of thigh tendon	5.32	NA	5.43	0.84	NA	11.59	090
27391		A	Incision of thigh tendons	7.19	NA	6.83	1.19	NA	15.21	090
27392		A	Incision of thigh tendons	9.19	NA	7.94	1.52	NA	18.65	090
27393		A	Lengthening of thigh tendon	6.38	NA	6.04	0.98	NA	13.40	090
27394		A	Lengthening of thigh tendons	8.49	NA	7.49	1.37	NA	17.35	090
27395		A	Lengthening of thigh tendons	11.71	NA	9.63	1.80	NA	23.14	090
27396		A	Transplant of thigh tendon	7.85	NA	7.29	1.13	NA	16.27	090
27397		A	Transplants of thigh tendons	11.26	NA	9.27	1.50	NA	22.03	090
27400		A	Revise thigh muscles/tendons	9.01	NA	7.52	1.47	NA	18.00	090
27403		A	Repair of knee cartilage	8.32	NA	7.33	1.34	NA	16.99	090
27405		A	Repair of knee ligament	8.64	NA	7.66	1.41	NA	17.71	090
27407		A	Repair of knee ligament	10.26	NA	8.48	1.65	NA	20.39	090
27409		A	Repair of knee ligaments	12.88	NA	10.10	2.18	NA	25.16	090
27418		A	Repair degenerated kneecap	10.83	NA	9.05	1.70	NA	21.58	090
27420		A	Revision of unstable kneecap	9.82	NA	8.25	1.55	NA	19.62	090
27422		A	Revision of unstable kneecap	9.77	NA	8.25	1.55	NA	19.57	090
27424		A	Revision/removal of kneecap	9.80	NA	8.22	1.54	NA	19.56	090
27425		A	Lat retinacular release open	5.21	NA	5.67	0.89	NA	11.77	090
27427		A	Reconstruction, knee	9.35	NA	7.95	1.47	NA	18.77	090
27428		A	Reconstruction, knee	13.98	NA	11.37	2.30	NA	27.65	090
27429		A	Reconstruction, knee	15.50	NA	12.61	2.61	NA	30.72	090
27430		A	Revision of thigh muscles	9.66	NA	8.15	1.53	NA	19.34	090
27435		A	Incision of knee joint	9.48	NA	8.59	1.45	NA	19.52	090
27437		A	Revise kneecap	8.45	NA	7.23	1.51	NA	17.19	090
27438		A	Revise kneecap with implant	11.21	NA	8.52	1.80	NA	21.53	090
27440		A	Revision of knee joint	10.41	NA	6.01	1.56	NA	17.98	090
27441		A	Revision of knee joint	10.80	NA	6.71	1.66	NA	19.17	090
27442		A	Revision of knee joint	11.87	NA	8.90	1.86	NA	22.63	090
27443		A	Revision of knee joint	10.91	NA	8.70	1.67	NA	21.28	090
27445		A	Revision of knee joint	17.65	NA	12.32	2.80	NA	32.77	090
27446		A	Revision of knee joint	15.82	NA	11.25	2.44	NA	29.51	090
27447		A	Total knee arthroplasty	21.45	NA	14.57	3.35	NA	39.37	090
27448		A	Incision of thigh	11.04	NA	8.86	1.67	NA	21.57	090
27450		A	Incision of thigh	13.96	NA	10.81	2.26	NA	27.03	090
27454		A	Realignment of thigh bone	17.53	NA	12.73	2.84	NA	33.10	090
27455		A	Realignment of knee	12.80	NA	10.02	2.06	NA	24.88	090
27457		A	Realignment of knee	13.43	NA	10.06	2.21	NA	25.70	090
27465		A	Shortening of thigh bone	13.85	NA	10.55	2.31	NA	26.71	090
27466		A	Lengthening of thigh bone	16.31	NA	12.12	2.57	NA	31.00	090
27468		A	Shorten/lengthen thighs	18.94	NA	12.62	2.90	NA	34.46	090
27470		A	Repair of thigh	16.05	NA	12.08	2.57	NA	30.70	090
27472		A	Repair/graft of thigh	17.69	NA	12.96	2.85	NA	33.50	090
27475		A	Surgery to stop leg growth	8.63	NA	7.40	1.50	NA	17.53	090
27477		A	Surgery to stop leg growth	9.84	NA	7.90	1.72	NA	19.46	090
27479		A	Surgery to stop leg growth	12.78	NA	10.03	2.22	NA	25.03	090
27485		A	Surgery to stop leg growth	8.83	NA	7.56	1.71	NA	18.10	090
27486		A	Revise/replace knee joint	19.24	NA	13.46	2.99	NA	35.69	090
27487		A	Revise/replace knee joint	25.23	NA	16.52	3.90	NA	45.65	090
27488		A	Removal of knee prosthesis	15.72	NA	11.68	2.49	NA	29.89	090
27495		A	Reinforce thigh	15.53	NA	11.71	2.52	NA	29.76	090
27496		A	Decompression of thigh/knee	6.10	NA	5.85	0.96	NA	12.91	090
27497		A	Decompression of thigh/knee	7.16	NA	5.77	1.00	NA	13.93	090
27498		A	Decompression of thigh/knee	7.98	NA	6.16	1.27	NA	15.41	090
27499		A	Decompression of thigh/knee	8.99	NA	7.12	1.32	NA	17.43	090
27500		A	Treatment of thigh fracture	5.91	6.11	4.99	0.95	12.97	11.85	090
27501		A	Treatment of thigh fracture	5.91	6.02	5.38	1.01	12.94	12.30	090
27502		A	Treatment of thigh fracture	10.56	NA	8.35	1.73	NA	20.64	090
27503		A	Treatment of thigh fracture	10.56	NA	8.52	1.80	NA	20.88	090
27506		A	Treatment of thigh fracture	17.42	NA	12.93	2.83	NA	33.18	090
27507		A	Treatment of thigh fracture	13.97	NA	10.04	2.24	NA	26.25	090
27508		A	Treatment of thigh fracture	5.82	6.45	5.48	0.95	13.22	12.25	090
27509		A	Treatment of thigh fracture	7.70	NA	8.03	1.30	NA	17.03	090
27510		A	Treatment of thigh fracture	9.12	NA	7.34	1.54	NA	18.00	090
27511		A	Treatment of thigh fracture	13.62	NA	11.29	2.20	NA	27.11	090
27513		A	Treatment of thigh fracture	17.89	NA	13.95	2.91	NA	34.75	090
27514		A	Treatment of thigh fracture	17.27	NA	13.42	2.76	NA	33.45	090
27516		A	Treat thigh fx growth plate	5.36	6.35	5.51	0.89	12.60	11.76	090
27517		A	Treat thigh fx growth plate	8.77	NA	7.44	1.28	NA	17.49	090
27519		A	Treat thigh fx growth plate	15.00	NA	11.71	2.42	NA	29.13	090
27520		A	Treat kneecap fracture	2.86	4.54	3.46	0.44	7.84	6.76	090
27524		A	Treat kneecap fracture	9.99	NA	8.31	1.62	NA	19.92	090
27530		A	Treat knee fracture	3.77	5.31	4.43	0.62	9.70	8.82	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
27532		A	Treat knee fracture	7.29	7.35	6.45	1.25	15.89	14.99	090
27535		A	Treat knee fracture	11.48	NA	10.20	1.78	NA	23.46	090
27536		A	Treat knee fracture	15.63	NA	11.67	2.56	NA	29.86	090
27538		A	Treat knee fracture(s)	4.86	6.13	5.20	0.81	11.80	10.87	090
27540		A	Treat knee fracture	13.08	NA	9.60	2.11	NA	24.79	090
27550		A	Treat knee dislocation	5.75	6.02	4.96	0.73	12.50	11.44	090
27552		A	Treat knee dislocation	7.89	NA	7.08	1.34	NA	16.31	090
27556		A	Treat knee dislocation	14.39	NA	11.79	2.32	NA	28.50	090
27557		A	Treat knee dislocation	16.74	NA	13.25	2.83	NA	32.82	090
27558		A	Treat knee dislocation	17.69	NA	13.18	2.82	NA	33.69	090
27560		A	Treat kneecap dislocation	3.81	4.84	3.24	0.39	9.04	7.44	090
27562		A	Treat kneecap dislocation	5.78	NA	4.88	0.75	NA	11.41	090
27566		A	Treat kneecap dislocation	12.21	NA	9.41	2.03	NA	23.65	090
27570		A	Fixation of knee joint	1.74	NA	1.77	0.30	NA	3.81	010
27580		A	Fusion of knee	19.34	NA	14.85	3.09	NA	37.28	090
27590		A	Amputate leg at thigh	12.01	NA	7.08	1.68	NA	20.77	090
27591		A	Amputate leg at thigh	12.66	NA	9.04	1.95	NA	23.65	090
27592		A	Amputate leg at thigh	10.00	NA	6.61	1.41	NA	18.02	090
27594		A	Amputation follow-up surgery	6.91	NA	5.49	1.02	NA	13.42	090
27596		A	Amputation follow-up surgery	10.58	NA	7.27	1.55	NA	19.40	090
27598		A	Amputate lower leg at knee	10.51	NA	7.40	1.48	NA	19.39	090
27600		A	Decompression of lower leg	5.64	NA	4.76	0.84	NA	11.24	090
27601		A	Decompression of lower leg	5.63	NA	5.09	0.86	NA	11.58	090
27602		A	Decompression of lower leg	7.34	NA	5.32	1.06	NA	13.72	090
27603		A	Drain lower leg lesion	4.93	7.53	4.17	0.71	13.17	9.81	090
27604		A	Drain lower leg bursa	4.46	6.10	3.96	0.67	11.23	9.09	090
27605		A	Incision of achilles tendon	2.87	7.67	2.32	0.36	10.90	5.55	010
27606		A	Incision of achilles tendon	4.13	NA	3.36	0.66	NA	8.15	010
27607		A	Treat lower leg bone lesion	7.96	NA	6.89	1.25	NA	16.10	090
27610		A	Explore/treat ankle joint	8.33	NA	7.28	1.34	NA	16.95	090
27612		A	Exploration of ankle joint	7.32	NA	6.31	0.97	NA	14.60	090
27613		A	Biopsy lower leg soft tissue	2.17	3.24	1.80	0.22	5.63	4.19	010
27614		A	Biopsy lower leg soft tissue	5.65	7.15	4.44	0.75	13.55	10.84	090
27615		A	Remove tumor, lower leg	12.54	NA	10.73	1.75	NA	25.02	090
27618		A	Remove lower leg lesion	5.08	6.03	4.00	0.68	11.79	9.76	090
27619		A	Remove lower leg lesion	8.39	9.53	5.95	1.16	19.08	15.50	090
27620		A	Explore/treat ankle joint	5.97	NA	5.68	0.87	NA	12.52	090
27625		A	Remove ankle joint lining	8.29	NA	6.75	1.14	NA	16.18	090
27626		A	Remove ankle joint lining	8.90	NA	7.21	1.33	NA	17.44	090
27630		A	Removal of tendon lesion	4.79	7.60	4.38	0.67	13.06	9.84	090
27635		A	Remove lower leg bone lesion	7.77	NA	7.09	1.25	NA	16.11	090
27637		A	Remove/graft leg bone lesion	9.84	NA	8.61	1.61	NA	20.06	090
27638		A	Remove/graft leg bone lesion	10.55	NA	8.63	1.70	NA	20.88	090
27640		A	Partial removal of tibia	11.35	NA	11.05	1.78	NA	24.18	090
27641		A	Partial removal of fibula	9.23	NA	9.03	1.39	NA	19.65	090
27645		A	Extensive lower leg surgery	14.15	NA	12.52	2.12	NA	28.79	090
27646		A	Extensive lower leg surgery	12.64	NA	11.52	1.83	NA	25.99	090
27647		A	Extensive ankle/heel surgery	12.22	NA	8.03	1.23	NA	21.48	090
27648		A	Injection for ankle x-ray	0.96	3.57	0.33	0.07	4.60	1.36	000
27650		A	Repair achilles tendon	9.68	NA	7.69	1.44	NA	18.81	090
27652		A	Repair/graft achilles tendon	10.31	NA	8.20	1.51	NA	20.02	090
27654		A	Repair of achilles tendon	10.00	NA	7.43	1.32	NA	18.75	090
27656		A	Repair leg fascia defect	4.56	8.58	3.78	0.62	13.76	8.96	090
27658		A	Repair of leg tendon, each	4.97	NA	4.56	0.70	NA	10.23	090
27659		A	Repair of leg tendon, each	6.80	NA	5.64	0.97	NA	13.41	090
27664		A	Repair of leg tendon, each	4.58	NA	4.55	0.68	NA	9.81	090
27665		A	Repair of leg tendon, each	5.39	NA	4.97	0.82	NA	11.18	090
27675		A	Repair lower leg tendons	7.17	NA	5.97	0.94	NA	14.08	090
27676		A	Repair lower leg tendons	8.41	NA	6.96	0.91	NA	16.28	090
27680		A	Release of lower leg tendon	5.73	NA	5.37	0.87	NA	11.97	090
27681		A	Release of lower leg tendons	6.81	NA	6.15	1.06	NA	14.02	090
27685		A	Revision of lower leg tendon	6.49	7.29	5.46	0.82	14.60	12.77	090
27686		A	Revise lower leg tendons	7.45	NA	6.48	1.21	NA	15.14	090
27687		A	Revision of calf tendon	6.23	NA	5.62	0.89	NA	12.74	090
27690		A	Revise lower leg tendon	8.70	NA	6.65	1.16	NA	16.51	090
27691		A	Revise lower leg tendon	9.95	NA	8.02	1.46	NA	19.43	090
27692		A	Revise additional leg tendon	1.87	NA	0.92	0.28	NA	3.07	ZZZ
27695		A	Repair of ankle ligament	6.50	NA	6.14	1.01	NA	13.65	090
27696		A	Repair of ankle ligaments	8.26	NA	6.71	1.10	NA	16.07	090
27698		A	Repair of ankle ligament	9.35	NA	7.16	1.29	NA	17.80	090
27700		A	Revision of ankle joint	9.28	NA	5.67	1.03	NA	15.98	090
27702		A	Reconstruct ankle joint	13.65	NA	10.44	2.15	NA	26.24	090
27703		A	Reconstruction, ankle joint	15.85	NA	11.21	2.48	NA	29.54	090
27704		A	Removal of ankle implant	7.61	NA	5.59	1.22	NA	14.42	090
27705		A	Incision of tibia	10.36	NA	8.45	1.60	NA	20.41	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
27707		A	Incision of fibula	4.36	NA	5.24	0.74	NA	10.34	090
27709		A	Incision of tibia & fibula	9.94	NA	8.39	1.54	NA	19.87	090
27712		A	Realignment of lower leg	14.23	NA	10.97	2.22	NA	27.42	090
27715		A	Revision of lower leg	14.37	NA	11.09	2.38	NA	27.84	090
27720		A	Repair of tibia	11.77	NA	9.71	1.90	NA	23.38	090
27722		A	Repair/graft of tibia	11.80	NA	9.46	1.94	NA	23.20	090
27724		A	Repair/graft of tibia	18.17	NA	12.68	2.93	NA	33.78	090
27725		A	Repair of lower leg	15.57	NA	12.18	2.53	NA	30.28	090
27727		A	Repair of lower leg	13.99	NA	10.68	2.22	NA	26.89	090
27730		A	Repair of tibia epiphysis	7.40	NA	6.42	1.29	NA	15.11	090
27732		A	Repair of fibula epiphysis	5.31	NA	4.93	0.57	NA	10.81	090
27734		A	Repair lower leg epiphyses	8.47	NA	6.61	0.68	NA	15.76	090
27740		A	Repair of leg epiphyses	9.29	NA	7.98	1.58	NA	18.85	090
27742		A	Repair of leg epiphyses	10.28	3.88	3.88	0.68	14.84	14.84	090
27745		A	Reinforce tibia	10.05	NA	8.44	1.70	NA	20.19	090
27750		A	Treatment of tibia fracture	3.19	4.76	3.86	0.51	8.46	7.56	090
27752		A	Treatment of tibia fracture	5.83	6.64	5.66	0.99	13.46	12.48	090
27756		A	Treatment of tibia fracture	6.77	NA	6.79	1.09	NA	14.65	090
27758		A	Treatment of tibia fracture	11.65	NA	9.41	1.82	NA	22.88	090
27759		A	Treatment of tibia fracture	13.74	NA	10.54	2.23	NA	26.51	090
27760		A	Treatment of ankle fracture	3.01	4.68	3.62	0.44	8.13	7.07	090
27762		A	Treatment of ankle fracture	5.24	6.33	5.27	0.80	12.37	11.31	090
27766		A	Treatment of ankle fracture	8.35	NA	7.36	1.41	NA	17.12	090
27780		A	Treatment of fibula fracture	2.65	4.19	3.24	0.39	7.23	6.28	090
27781		A	Treatment of fibula fracture	4.39	5.49	4.64	0.71	10.59	9.74	090
27784		A	Treatment of fibula fracture	7.10	NA	6.65	1.18	NA	14.93	090
27786		A	Treatment of ankle fracture	2.84	4.46	3.36	0.43	7.73	6.63	090
27788		A	Treatment of ankle fracture	4.44	5.63	4.65	0.71	10.78	9.80	090
27792		A	Treatment of ankle fracture	7.65	NA	7.10	1.28	NA	16.03	090
27808		A	Treatment of ankle fracture	2.83	4.80	3.71	0.44	8.07	6.98	090
27810		A	Treatment of ankle fracture	5.12	6.23	5.15	0.81	12.16	11.08	090
27814		A	Treatment of ankle fracture	10.66	NA	8.75	1.71	NA	21.12	090
27816		A	Treatment of ankle fracture	2.89	4.39	3.43	0.41	7.69	6.73	090
27818		A	Treatment of ankle fracture	5.49	6.37	5.17	0.80	12.66	11.46	090
27822		A	Treatment of ankle fracture	10.98	NA	10.80	1.79	NA	23.57	090
27823		A	Treatment of ankle fracture	12.98	NA	11.64	2.11	NA	26.73	090
27824		A	Treat lower leg fracture	2.89	4.59	3.57	0.44	7.92	6.90	090
27825		A	Treat lower leg fracture	6.18	6.59	5.37	1.00	13.77	12.55	090
27826		A	Treat lower leg fracture	8.53	NA	9.01	1.36	NA	18.90	090
27827		A	Treat lower leg fracture	14.04	NA	12.90	2.31	NA	29.25	090
27828		A	Treat lower leg fracture	16.21	NA	14.06	2.65	NA	32.92	090
27829		A	Treat lower leg joint	5.48	NA	6.92	0.89	NA	13.29	090
27830		A	Treat lower leg dislocation	3.78	4.41	3.87	0.49	8.68	8.14	090
27831		A	Treat lower leg dislocation	4.55	NA	4.58	0.75	NA	9.88	090
27832		A	Treat lower leg dislocation	6.48	NA	6.36	1.07	NA	13.91	090
27840		A	Treat ankle dislocation	4.57	NA	3.91	0.45	NA	8.93	090
27842		A	Treat ankle dislocation	6.20	NA	5.18	0.92	NA	12.30	090
27846		A	Treat ankle dislocation	9.78	NA	8.12	1.61	NA	19.51	090
27848		A	Treat ankle dislocation	11.18	NA	9.84	1.74	NA	22.76	090
27860		A	Fixation of ankle joint	2.34	NA	1.98	0.37	NA	4.69	010
27870		A	Fusion of ankle joint, open	13.89	NA	10.75	2.04	NA	26.68	090
27871		A	Fusion of tibiofibular joint	9.16	NA	7.85	1.47	NA	18.48	090
27880		A	Amputation of lower leg	11.83	NA	7.48	1.67	NA	20.98	090
27881		A	Amputation of lower leg	12.32	NA	9.16	1.89	NA	23.37	090
27882		A	Amputation of lower leg	8.93	NA	6.90	1.26	NA	17.09	090
27884		A	Amputation follow-up surgery	8.20	NA	6.15	1.21	NA	15.56	090
27886		A	Amputation follow-up surgery	9.31	NA	6.89	1.38	NA	17.58	090
27888		A	Amputation of foot at ankle	9.66	NA	7.76	1.43	NA	18.85	090
27889		A	Amputation of foot at ankle	9.97	NA	6.76	1.40	NA	18.13	090
27892		A	Decompression of leg	7.38	NA	5.92	1.01	NA	14.31	090
27893		A	Decompression of leg	7.34	NA	5.83	1.08	NA	14.25	090
27894		A	Decompression of leg	10.47	NA	8.01	1.58	NA	20.06	090
28001		A	Drainage of bursa of foot	2.73	2.98	1.95	0.23	5.94	4.91	010
28002		A	Treatment of foot infection	4.61	4.99	3.76	0.51	10.11	8.88	010
28003		A	Treatment of foot infection	8.40	6.24	5.22	0.93	15.57	14.55	090
28005		A	Treat foot bone lesion	8.67	NA	6.57	0.95	NA	16.19	090
28008		A	Incision of foot fascia	4.44	4.56	3.21	0.43	9.43	8.08	090
28010		A	Incision of toe tendon	2.84	2.38	2.38	0.27	5.49	5.49	090
28011		A	Incision of toe tendons	4.13	NA	3.30	0.47	NA	7.90	090
28020		A	Exploration of foot joint	5.00	6.03	4.13	0.64	11.67	9.77	090
28022		A	Exploration of foot joint	4.66	5.20	3.85	0.49	10.35	9.00	090
28024		A	Exploration of toe joint	4.37	5.22	3.92	0.43	10.02	8.72	090
28030		A	Removal of foot nerve	6.14	NA	3.61	0.55	NA	10.30	090
28035		A	Decompression of tibia nerve	5.08	5.85	4.09	0.57	11.50	9.74	090
28043		A	Excision of foot lesion	3.53	3.82	3.17	0.37	7.72	7.07	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
28045		A	Excision of foot lesion	4.71	5.38	3.60	0.49	10.58	8.80	090
28046		A	Resection of tumor, foot	10.16	8.76	6.47	1.17	20.09	17.80	090
28050		A	Biopsy of foot joint lining	4.24	4.89	3.59	0.55	9.68	8.38	090
28052		A	Biopsy of foot joint lining	3.93	4.92	3.43	0.42	9.27	7.78	090
28054		A	Biopsy of toe joint lining	3.44	4.73	3.22	0.34	8.51	7.00	090
28060		A	Partial removal, foot fascia	5.22	5.47	3.87	0.53	11.22	9.62	090
28062		A	Removal of foot fascia	6.51	6.53	4.01	0.61	13.65	11.13	090
28070		A	Removal of foot joint lining	5.09	5.22	3.81	0.56	10.87	9.46	090
28072		A	Removal of foot joint lining	4.57	5.53	4.29	0.63	10.73	9.49	090
28080		A	Removal of foot lesion	3.57	5.12	3.68	0.35	9.04	7.60	090
28086		A	Excise foot tendon sheath	4.77	7.98	4.68	0.69	13.44	10.14	090
28088		A	Excise foot tendon sheath	3.85	5.76	3.89	0.51	10.12	8.25	090
28090		A	Removal of foot lesion	4.40	5.15	3.44	0.46	10.01	8.30	090
28092		A	Removal of toe lesions	3.63	5.22	3.52	0.40	9.25	7.55	090
28100		A	Removal of ankle/heel lesion	5.65	7.98	4.69	0.70	14.33	11.04	090
28102		A	Remove/graft foot lesion	7.72	NA	6.24	0.88	NA	14.84	090
28103		A	Remove/graft foot lesion	6.49	NA	4.61	0.70	NA	11.80	090
28104		A	Removal of foot lesion	5.11	5.49	3.92	0.56	11.16	9.59	090
28106		A	Remove/graft foot lesion	7.15	NA	4.75	0.64	NA	12.54	090
28107		A	Remove/graft foot lesion	5.55	6.54	4.20	0.54	12.63	10.29	090
28108		A	Removal of toe lesions	4.15	4.59	3.25	0.37	9.11	7.77	090
28110		A	Part removal of metatarsal	4.07	5.22	3.22	0.41	9.70	7.70	090
28111		A	Part removal of metatarsal	5.00	6.28	3.65	0.55	11.83	9.20	090
28112		A	Part removal of metatarsal	4.48	5.80	3.56	0.51	10.79	8.55	090
28113		A	Part removal of metatarsal	4.78	6.07	4.32	0.49	11.34	9.59	090
28114		A	Removal of metatarsal heads	9.78	11.63	8.37	1.23	22.64	19.38	090
28116		A	Revision of foot	7.74	6.80	5.17	0.83	15.37	13.74	090
28118		A	Removal of heel bone	5.95	6.25	4.34	0.69	12.89	10.98	090
28119		A	Removal of heel spur	5.38	5.43	3.72	0.52	11.33	9.62	090
28120		A	Part removal of ankle/heel	5.39	7.30	4.41	0.66	13.35	10.46	090
28122		A	Partial removal of foot bone	7.28	6.84	5.26	0.76	14.88	13.30	090
28124		A	Partial removal of toe	4.80	5.00	3.65	0.42	10.22	8.87	090
28126		A	Partial removal of toe	3.51	4.21	2.99	0.32	8.04	6.82	090
28130		A	Removal of ankle bone	8.10	NA	6.92	1.12	NA	16.14	090
28140		A	Removal of metatarsal	6.90	7.22	4.76	0.79	14.91	12.45	090
28150		A	Removal of toe	4.08	4.84	3.28	0.41	9.33	7.77	090
28153		A	Partial removal of toe	3.65	4.31	2.68	0.34	8.30	6.67	090
28160		A	Partial removal of toe	3.73	4.57	3.33	0.37	8.67	7.43	090
28171		A	Extensive foot surgery	9.59	NA	5.86	0.83	NA	16.28	090
28173		A	Extensive foot surgery	8.79	7.59	5.19	0.85	17.23	14.83	090
28175		A	Extensive foot surgery	6.04	5.70	3.70	0.53	12.27	10.27	090
28190		A	Removal of foot foreign body	1.96	3.40	1.49	0.17	5.53	3.62	010
28192		A	Removal of foot foreign body	4.63	5.49	3.64	0.46	10.58	8.73	090
28193		A	Removal of foot foreign body	5.72	5.61	3.93	0.56	11.89	10.21	090
28200		A	Repair of foot tendon	4.59	5.10	3.55	0.48	10.17	8.62	090
28202		A	Repair/graft of foot tendon	6.83	7.40	4.49	0.64	14.87	11.96	090
28208		A	Repair of foot tendon	4.36	4.82	3.30	0.42	9.60	8.08	090
28210		A	Repair/graft of foot tendon	6.34	6.22	4.02	0.64	13.20	11.00	090
28220		A	Release of foot tendon	4.52	4.67	3.42	0.40	9.59	8.34	090
28222		A	Release of foot tendons	5.61	5.24	4.12	0.49	11.34	10.22	090
28225		A	Release of foot tendon	3.65	4.28	2.90	0.33	8.26	6.88	090
28226		A	Release of foot tendons	4.52	4.80	3.74	0.45	9.77	8.71	090
28230		A	Incision of foot tendon(s)	4.23	4.67	3.66	0.42	9.32	8.31	090
28232		A	Incision of toe tendon	3.38	4.53	3.31	0.34	8.25	7.03	090
28234		A	Incision of foot tendon	3.36	4.68	3.35	0.34	8.38	7.05	090
28238		A	Revision of foot tendon	7.72	7.25	4.93	0.81	15.78	13.46	090
28240		A	Release of big toe	4.35	4.64	3.48	0.45	9.44	8.28	090
28250		A	Revision of foot fascia	5.91	5.63	4.13	0.68	12.22	10.72	090
28260		A	Release of midfoot joint	7.95	6.34	4.99	0.92	15.21	13.86	090
28261		A	Revision of foot tendon	11.71	8.62	7.29	1.12	21.45	20.12	090
28262		A	Revision of foot and ankle	15.81	13.56	10.90	2.43	31.80	29.14	090
28264		A	Release of midfoot joint	10.33	7.74	7.28	1.28	19.35	18.89	090
28270		A	Release of foot contracture	4.75	4.89	3.73	0.46	10.10	8.94	090
28272		A	Release of toe joint, each	3.79	4.18	2.85	0.31	8.28	6.95	090
28280		A	Fusion of toes	5.18	6.25	4.48	0.63	12.06	10.29	090
28285		A	Repair of hammertoe	4.58	4.87	3.42	0.44	9.89	8.44	090
28286		A	Repair of hammertoe	4.55	4.79	3.25	0.41	9.75	8.21	090
28288		A	Partial removal of foot bone	4.73	5.94	4.88	0.53	11.20	10.14	090
28289		A	Repair hallux rigidus	7.03	7.98	5.75	0.87	15.88	13.65	090
28290		A	Correction of bunion	5.65	6.26	4.72	0.69	12.60	11.06	090
28292		A	Correction of bunion	7.03	7.48	5.54	0.67	15.18	13.24	090
28293		A	Correction of bunion	9.14	10.63	6.10	0.79	20.56	16.03	090
28294		A	Correction of bunion	8.55	7.45	4.72	0.81	16.81	14.08	090
28296		A	Correction of bunion	9.17	8.16	5.41	0.88	18.21	15.46	090
28297		A	Correction of bunion	9.17	8.95	6.25	1.08	19.20	16.50	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
28298		A	Correction of bunion	7.93	7.23	5.00	0.80	15.96	13.73	090
28299		A	Correction of bunion	10.56	8.77	6.06	1.01	20.34	17.63	090
28300		A	Incision of heel bone	9.53	NA	7.02	1.36	NA	17.91	090
28302		A	Incision of ankle bone	9.54	NA	6.88	1.59	NA	18.01	090
28304		A	Incision of midfoot bones	9.15	8.37	5.93	1.05	18.57	16.13	090
28305		A	Incise/graft midfoot bones	10.48	4.63	4.63	0.87	15.98	15.98	090
28306		A	Incision of metatarsal	5.85	7.37	4.41	0.69	13.91	10.95	090
28307		A	Incision of metatarsal	6.32	11.75	5.49	0.82	18.89	12.63	090
28308		A	Incision of metatarsal	5.28	6.27	3.90	0.53	12.08	9.71	090
28309		A	Incision of metatarsals	12.76	NA	8.22	1.70	NA	22.68	090
28310		A	Revision of big toe	5.42	6.48	4.13	0.53	12.43	10.08	090
28312		A	Revision of toe	4.54	6.21	4.28	0.51	11.26	9.33	090
28313		A	Repair deformity of toe	5.00	6.67	5.64	0.63	12.30	11.27	090
28315		A	Removal of sesamoid bone	4.85	6.03	3.80	0.46	11.34	9.11	090
28320		A	Repair of foot bones	9.17	NA	6.93	1.27	NA	17.37	090
28322		A	Repair of metatarsals	8.33	10.27	6.50	1.16	19.76	15.99	090
28340		A	Resect enlarged toe tissue	6.97	7.26	4.56	0.58	14.81	12.11	090
28341		A	Resect enlarged toe	8.40	7.45	5.10	0.72	16.57	14.22	090
28344		A	Repair extra toe(s)	4.25	6.93	3.86	0.51	11.69	8.62	090
28345		A	Repair webbed toe(s)	5.91	7.19	4.97	0.54	13.64	11.42	090
28360		A	Reconstruct cleft foot	13.32	NA	10.75	1.90	NA	25.97	090
28400		A	Treatment of heel fracture	2.16	3.63	3.06	0.32	6.11	5.54	090
28405		A	Treatment of heel fracture	4.56	4.83	4.61	0.71	10.10	9.88	090
28406		A	Treatment of heel fracture	6.30	NA	6.98	1.03	NA	14.31	090
28415		A	Treat heel fracture	15.95	NA	13.42	2.44	NA	31.81	090
28420		A	Treat/graft heel fracture	16.62	NA	13.08	2.65	NA	32.35	090
28430		A	Treatment of ankle fracture	2.09	3.39	2.58	0.29	5.77	4.96	090
28435		A	Treatment of ankle fracture	3.39	3.90	3.74	0.48	7.77	7.61	090
28436		A	Treatment of ankle fracture	4.70	NA	6.10	0.76	NA	11.56	090
28445		A	Treat ankle fracture	15.60	NA	11.26	2.40	NA	29.26	090
28450		A	Treat midfoot fracture, each	1.90	3.11	2.50	0.25	5.26	4.65	090
28455		A	Treat midfoot fracture, each	3.09	3.43	3.43	0.41	6.93	6.93	090
28456		A	Treat midfoot fracture	2.68	NA	4.38	0.43	NA	7.49	090
28465		A	Treat midfoot fracture, each	7.00	NA	6.48	0.97	NA	14.45	090
28470		A	Treat metatarsal fracture	1.99	3.12	2.46	0.27	5.38	4.72	090
28475		A	Treat metatarsal fracture	2.97	3.33	3.21	0.38	6.68	6.56	090
28476		A	Treat metatarsal fracture	3.37	NA	5.18	0.51	NA	9.06	090
28485		A	Treat metatarsal fracture	5.70	NA	5.67	0.72	NA	12.09	090
28490		A	Treat big toe fracture	1.09	2.01	1.67	0.12	3.22	2.88	090
28495		A	Treat big toe fracture	1.58	2.18	2.08	0.16	3.92	3.82	090
28496		A	Treat big toe fracture	2.33	9.78	3.77	0.31	12.42	6.41	090
28505		A	Treat big toe fracture	3.80	9.77	4.81	0.49	14.06	9.10	090
28510		A	Treatment of toe fracture	1.09	1.53	1.53	0.11	2.73	2.73	090
28515		A	Treatment of toe fracture	1.46	1.89	1.89	0.14	3.49	3.49	090
28525		A	Treat toe fracture	3.32	9.36	4.36	0.41	13.09	8.09	090
28530		A	Treat sesamoid bone fracture	1.06	1.45	1.45	0.10	2.61	2.61	090
28531		A	Treat sesamoid bone fracture	2.35	8.98	2.61	0.23	11.56	5.19	090
28540		A	Treat foot dislocation	2.04	2.41	2.41	0.19	4.64	4.64	090
28545		A	Treat foot dislocation	2.45	2.35	2.35	0.36	5.16	5.16	090
28546		A	Treat foot dislocation	3.20	8.03	5.00	0.41	11.64	8.61	090
28555		A	Repair foot dislocation	6.29	11.58	6.67	0.90	18.77	13.86	090
28570		A	Treat foot dislocation	1.66	2.42	2.34	0.20	4.28	4.20	090
28575		A	Treat foot dislocation	3.31	3.74	3.74	0.56	7.61	7.61	090
28576		A	Treat foot dislocation	4.16	10.32	5.68	0.59	15.07	10.43	090
28585		A	Repair foot dislocation	7.98	8.27	6.65	1.01	17.26	15.64	090
28600		A	Treat foot dislocation	1.89	2.82	2.69	0.24	4.95	4.82	090
28605		A	Treat foot dislocation	2.71	3.14	3.14	0.39	6.24	6.24	090
28606		A	Treat foot dislocation	4.89	15.93	6.18	0.78	21.60	11.85	090
28615		A	Repair foot dislocation	7.76	NA	8.16	1.21	NA	17.13	090
28630		A	Treat toe dislocation	1.70	1.57	1.01	0.17	3.44	2.88	010
28635		A	Treat toe dislocation	1.91	2.02	1.53	0.19	4.12	3.63	010
28636		A	Treat toe dislocation	2.77	3.87	2.62	0.38	7.02	5.77	010
28645		A	Repair toe dislocation	4.21	5.81	3.59	0.44	10.46	8.24	090
28660		A	Treat toe dislocation	1.23	1.26	0.81	0.12	2.61	2.16	010
28665		A	Treat toe dislocation	1.92	NA	1.43	0.22	NA	3.57	010
28666		A	Treat toe dislocation	2.66	5.90	2.57	0.38	8.94	5.61	010
28675		A	Repair of toe dislocation	2.92	8.85	3.88	0.40	12.17	7.20	090
28705		A	Fusion of foot bones	18.77	NA	12.65	2.77	NA	34.19	090
28715		A	Fusion of foot bones	13.08	NA	9.98	1.93	NA	24.99	090
28725		A	Fusion of foot bones	11.59	NA	8.50	1.66	NA	21.75	090
28730		A	Fusion of foot bones	10.74	NA	8.71	1.44	NA	20.89	090
28735		A	Fusion of foot bones	10.83	NA	8.08	1.44	NA	20.35	090
28737		A	Revision of foot bones	9.63	NA	7.07	1.12	NA	17.82	090
28740		A	Fusion of foot bones	8.01	11.72	6.66	1.03	20.76	15.70	090
28750		A	Fusion of big toe joint	7.29	13.06	6.84	1.04	21.39	15.17	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
28755		A	Fusion of big toe joint	4.73	7.02	4.04	0.52	12.27	9.29	090
28760		A	Fusion of big toe joint	7.74	8.24	5.81	0.81	16.79	14.36	090
28800		A	Amputation of midfoot	8.20	NA	6.12	1.04	NA	15.36	090
28805		A	Amputation thru metatarsal	8.38	NA	5.93	1.10	NA	15.41	090
28810		A	Amputation toe & metatarsal	6.20	NA	4.78	0.81	NA	11.79	090
28820		A	Amputation of toe	4.40	8.56	4.15	0.55	13.51	9.10	090
28825		A	Partial amputation of toe	3.58	8.01	3.87	0.44	12.03	7.89	090
29000		A	Application of body cast	2.25	3.00	1.73	0.47	5.72	4.45	000
29010		A	Application of body cast	2.06	3.29	1.77	0.36	5.71	4.19	000
29015		A	Application of body cast	2.41	2.97	1.60	0.26	5.64	4.27	000
29020		A	Application of body cast	2.11	3.19	1.42	0.21	5.51	3.74	000
29025		A	Application of body cast	2.40	3.19	1.84	0.44	6.03	4.68	000
29035		A	Application of body cast	1.77	3.61	1.58	0.29	5.67	3.64	000
29040		A	Application of body cast	2.22	2.49	1.52	0.18	4.89	3.92	000
29044		A	Application of body cast	2.12	3.97	1.90	0.37	6.46	4.39	000
29046		A	Application of body cast	2.41	3.27	2.08	0.40	6.08	4.89	000
29049		A	Application of figure eight	0.89	1.30	0.53	0.11	2.30	1.53	000
29055		A	Application of shoulder cast	1.78	2.98	1.47	0.28	5.04	3.53	000
29058		A	Application of shoulder cast	1.31	1.56	0.73	0.16	3.03	2.20	000
29065		A	Application of long arm cast	0.87	1.32	0.75	0.14	2.33	1.76	000
29075		A	Application of forearm cast	0.77	1.26	0.68	0.12	2.15	1.57	000
29085		A	Apply hand/wrist cast	0.87	1.28	0.63	0.13	2.28	1.63	000
29086		A	Apply finger cast	0.62	0.96	0.50	0.08	1.66	1.20	000
29105		A	Apply long arm splint	0.87	1.23	0.51	0.12	2.22	1.50	000
29125		A	Apply forearm splint	0.59	1.02	0.39	0.07	1.68	1.05	000
29126		A	Apply forearm splint	0.77	1.21	0.46	0.06	2.04	1.29	000
29130		A	Application of finger splint	0.50	0.47	0.17	0.06	1.03	0.73	000
29131		A	Application of finger splint	0.55	0.74	0.24	0.03	1.32	0.82	000
29200		A	Strapping of chest	0.65	0.73	0.35	0.05	1.43	1.05	000
29220		A	Strapping of low back	0.64	0.73	0.39	0.05	1.42	1.08	000
29240		A	Strapping of shoulder	0.71	0.86	0.37	0.06	1.63	1.14	000
29260		A	Strapping of elbow or wrist	0.55	0.75	0.33	0.05	1.35	0.93	000
29280		A	Strapping of hand or finger	0.51	0.81	0.33	0.03	1.35	0.87	000
29305		A	Application of hip cast	2.03	3.34	1.76	0.33	5.70	4.12	000
29325		A	Application of hip casts	2.32	3.52	1.95	0.39	6.23	4.66	000
29345		A	Application of long leg cast	1.40	1.76	1.06	0.23	3.39	2.69	000
29355		A	Application of long leg cast	1.53	1.71	1.12	0.24	3.48	2.89	000
29358		A	Apply long leg cast brace	1.43	2.06	1.09	0.23	3.72	2.75	000
29365		A	Application of long leg cast	1.18	1.65	0.95	0.20	3.03	2.33	000
29405		A	Apply short leg cast	0.86	1.22	0.71	0.13	2.21	1.70	000
29425		A	Apply short leg cast	1.01	1.23	0.74	0.13	2.37	1.88	000
29435		A	Apply short leg cast	1.18	1.55	0.92	0.19	2.92	2.29	000
29440		A	Addition of walker to cast	0.57	0.69	0.27	0.08	1.34	0.92	000
29445		A	Apply rigid leg cast	1.78	1.80	0.96	0.24	3.82	2.98	000
29450		A	Application of leg cast	2.08	1.47	1.10	0.19	3.74	3.37	000
29505		A	Application, long leg splint	0.69	1.18	0.46	0.07	1.94	1.22	000
29515		A	Application lower leg splint	0.73	0.87	0.47	0.08	1.68	1.28	000
29520		A	Strapping of hip	0.54	0.87	0.47	0.02	1.43	1.03	000
29530		A	Strapping of knee	0.57	0.79	0.33	0.05	1.41	0.95	000
29540		A	Strapping of ankle and/or ft	0.51	0.42	0.31	0.04	0.97	0.86	000
29550		A	Strapping of toes	0.47	0.42	0.28	0.04	0.93	0.79	000
29580		A	Application of paste boot	0.57	0.65	0.36	0.06	1.28	0.99	000
29590		A	Application of foot splint	0.76	0.51	0.29	0.06	1.33	1.11	000
29700		A	Removal/revision of cast	0.57	0.89	0.28	0.07	1.53	0.92	000
29705		A	Removal/revision of cast	0.76	0.82	0.38	0.11	1.69	1.25	000
29710		A	Removal/revision of cast	1.34	1.53	0.70	0.20	3.07	2.24	000
29715		A	Removal/revision of cast	0.94	1.17	0.40	0.13	2.24	1.47	000
29720		A	Repair of body cast	0.68	1.16	0.39	0.11	1.95	1.18	000
29730		A	Windowing of cast	0.75	0.81	0.35	0.11	1.67	1.21	000
29740		A	Wedging of cast	1.12	1.15	0.49	0.16	2.43	1.77	000
29750		A	Wedging of clubfoot cast	1.26	1.06	0.58	0.19	2.51	2.03	000
29800		A	Jaw arthroscopy/surgery	6.42	NA	7.06	0.99	NA	14.47	090
29804		A	Jaw arthroscopy/surgery	8.13	NA	7.84	1.30	NA	17.27	090
29805		A	Shoulder arthroscopy, dx	5.88	NA	5.84	1.01	NA	12.73	090
29806		A	Shoulder arthroscopy/surgery	14.35	NA	11.08	2.42	NA	27.85	090
29807		A	Shoulder arthroscopy/surgery	13.88	NA	10.91	2.35	NA	27.14	090
29819		A	Shoulder arthroscopy/surgery	7.61	NA	6.77	1.26	NA	15.64	090
29820		A	Shoulder arthroscopy/surgery	7.06	NA	6.21	1.17	NA	14.44	090
29821		A	Shoulder arthroscopy/surgery	7.71	NA	6.79	1.24	NA	15.74	090
29822		A	Shoulder arthroscopy/surgery	7.42	NA	6.67	1.20	NA	15.29	090
29823		A	Shoulder arthroscopy/surgery	8.16	NA	7.21	1.30	NA	16.67	090
29824		A	Shoulder arthroscopy/surgery	8.24	NA	7.47	1.30	NA	17.01	090
29825		A	Shoulder arthroscopy/surgery	7.61	NA	6.75	1.12	NA	15.48	090
29826		A	Shoulder arthroscopy/surgery	8.98	NA	7.52	1.42	NA	17.92	090
29827		A	Arthroscop rotator cuff repr	15.34	NA	11.52	2.08	NA	28.94	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
29830		A	Elbow arthroscopy	5.75	NA	5.33	0.87	NA	11.95	090
29834		A	Elbow arthroscopy/surgery	6.27	NA	5.82	1.02	NA	13.11	090
29835		A	Elbow arthroscopy/surgery	6.47	NA	5.87	1.12	NA	13.46	090
29836		A	Elbow arthroscopy/surgery	7.54	NA	6.77	1.08	NA	15.39	090
29837		A	Elbow arthroscopy/surgery	6.86	NA	6.12	1.11	NA	14.09	090
29838		A	Elbow arthroscopy/surgery	7.70	NA	6.87	1.23	NA	15.80	090
29840		A	Wrist arthroscopy	5.53	NA	5.31	0.82	NA	11.66	090
29843		A	Wrist arthroscopy/surgery	6.00	NA	5.62	0.90	NA	12.52	090
29844		A	Wrist arthroscopy/surgery	6.36	NA	5.81	0.99	NA	13.16	090
29845		A	Wrist arthroscopy/surgery	7.51	NA	6.47	0.99	NA	14.97	090
29846		A	Wrist arthroscopy/surgery	6.74	NA	6.04	1.04	NA	13.82	090
29847		A	Wrist arthroscopy/surgery	7.07	NA	6.18	1.07	NA	14.32	090
29848		A	Wrist endoscopy/surgery	5.43	NA	5.59	0.87	NA	11.89	090
29850		A	Knee arthroscopy/surgery	8.18	NA	5.06	0.84	NA	14.08	090
29851		A	Knee arthroscopy/surgery	13.08	NA	9.78	2.04	NA	24.90	090
29855		A	Tibial arthroscopy/surgery	10.60	NA	8.75	1.71	NA	21.06	090
29856		A	Tibial arthroscopy/surgery	14.12	NA	10.65	2.46	NA	27.23	090
29860		A	Hip arthroscopy, dx	8.04	NA	6.94	1.23	NA	16.21	090
29861		A	Hip arthroscopy/surgery	9.14	NA	7.34	1.45	NA	17.93	090
29862		A	Hip arthroscopy/surgery	9.89	NA	8.55	1.62	NA	20.06	090
29863		A	Hip arthroscopy/surgery	9.89	NA	8.49	1.56	NA	19.94	090
29870		A	Knee arthroscopy, dx	5.06	NA	4.88	0.85	NA	10.79	090
29871		A	Knee arthroscopy/drainage	6.54	NA	5.86	1.12	NA	13.52	090
29873		A	Knee arthroscopy/surgery	5.99	NA	6.57	0.89	NA	13.45	090
29874		A	Knee arthroscopy/surgery	7.04	NA	6.06	1.10	NA	14.20	090
29875		A	Knee arthroscopy/surgery	6.30	NA	5.84	1.05	NA	13.19	090
29876		A	Knee arthroscopy/surgery	7.91	NA	7.01	1.36	NA	16.28	090
29877		A	Knee arthroscopy/surgery	7.34	NA	6.73	1.25	NA	15.32	090
29879		A	Knee arthroscopy/surgery	8.03	NA	7.10	1.36	NA	16.49	090
29880		A	Knee arthroscopy/surgery	8.49	NA	7.35	1.43	NA	17.27	090
29881		A	Knee arthroscopy/surgery	7.75	NA	6.95	1.31	NA	16.01	090
29882		A	Knee arthroscopy/surgery	8.64	NA	7.23	1.48	NA	17.35	090
29883		A	Knee arthroscopy/surgery	11.03	NA	9.04	1.88	NA	21.95	090
29884		A	Knee arthroscopy/surgery	7.32	NA	6.68	1.21	NA	15.21	090
29885		A	Knee arthroscopy/surgery	9.08	NA	7.95	1.48	NA	18.51	090
29886		A	Knee arthroscopy/surgery	7.53	NA	6.83	1.29	NA	15.65	090
29887		A	Knee arthroscopy/surgery	9.03	NA	7.92	1.51	NA	18.46	090
29888		A	Knee arthroscopy/surgery	13.88	NA	10.18	2.22	NA	26.28	090
29889		A	Knee arthroscopy/surgery	15.98	NA	12.41	2.67	NA	31.06	090
29891		A	Ankle arthroscopy/surgery	8.39	NA	7.50	1.28	NA	17.17	090
29892		A	Ankle arthroscopy/surgery	8.99	NA	7.72	1.16	NA	17.87	090
29893		A	Scope, plantar fasciotomy	5.21	6.27	3.98	0.45	11.93	9.64	090
29894		A	Ankle arthroscopy/surgery	7.20	NA	5.46	0.99	NA	13.65	090
29895		A	Ankle arthroscopy/surgery	6.98	NA	5.46	0.96	NA	13.40	090
29897		A	Ankle arthroscopy/surgery	7.17	NA	5.87	1.10	NA	14.14	090
29898		A	Ankle arthroscopy/surgery	8.31	NA	6.18	1.11	NA	15.60	090
29899		A	Ankle arthroscopy/surgery	13.89	NA	10.55	2.04	NA	26.48	090
29900		A	Mcp joint arthroscopy, dx	5.41	NA	5.81	0.87	NA	12.09	090
29901		A	Mcp joint arthroscopy, surg	6.12	NA	6.20	0.97	NA	13.29	090
29902		A	Mcp joint arthroscopy, surg	6.69	NA	6.46	0.84	NA	13.99	090
30000		A	Drainage of nose lesion	1.43	4.09	1.40	0.12	5.64	2.95	010
30020		A	Drainage of nose lesion	1.43	3.28	1.47	0.12	4.83	3.02	010
30100		A	Intranasal biopsy	0.94	1.97	0.82	0.08	2.99	1.84	000
30110		A	Removal of nose polyp(s)	1.63	3.24	1.57	0.14	5.01	3.34	010
30115		A	Removal of nose polyp(s)	4.34	NA	5.76	0.42	NA	10.52	090
30117		A	Removal of intranasal lesion	3.16	13.13	4.62	0.26	16.55	8.04	090
30118		A	Removal of intranasal lesion	9.68	NA	9.19	0.82	NA	19.69	090
30120		A	Revision of nose	5.26	6.48	5.99	0.56	12.30	11.81	090
30124		A	Removal of nose lesion	3.10	NA	3.62	0.30	NA	7.02	090
30125		A	Removal of nose lesion	7.15	NA	8.32	0.58	NA	16.05	090
30130		A	Removal of turbinate bones	3.37	NA	5.58	0.32	NA	9.27	090
30140		A	Removal of turbinate bones	3.42	NA	6.19	0.36	NA	9.97	090
30150		A	Partial removal of nose	9.13	NA	10.99	0.91	NA	21.03	090
30160		A	Removal of nose	9.57	NA	10.19	0.87	NA	20.63	090
30200		A	Injection treatment of nose	0.78	1.62	0.74	0.06	2.46	1.58	000
30210		A	Nasal sinus therapy	1.08	2.10	1.31	0.09	3.27	2.48	010
30220		A	Insert nasal septal button	1.54	4.23	1.53	0.12	5.89	3.19	010
30300		A	Remove nasal foreign body	1.04	4.64	1.93	0.08	5.76	3.05	010
30310		A	Remove nasal foreign body	1.96	NA	3.09	0.17	NA	5.22	010
30320		A	Remove nasal foreign body	4.51	NA	7.03	0.37	NA	11.91	090
30400		R	Reconstruction of nose	9.82	NA	15.46	1.02	NA	26.30	090
30410		R	Reconstruction of nose	12.96	NA	18.32	1.47	NA	32.75	090
30420		R	Reconstruction of nose	15.86	NA	17.87	1.48	NA	35.21	090
30430		R	Revision of nose	7.20	NA	15.95	0.79	NA	23.94	090
30435		R	Revision of nose	11.69	NA	19.28	1.33	NA	32.30	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
30450		R	Revision of nose	18.62	NA	21.82	1.89	NA	42.33	090
30460		A	Revision of nose	9.95	NA	9.94	0.91	NA	20.80	090
30462		A	Revision of nose	19.54	NA	20.20	1.90	NA	41.64	090
30465		A	Repair nasal stenosis	11.62	NA	11.99	1.10	NA	24.71	090
30520		A	Repair of nasal septum	5.69	NA	6.65	0.47	NA	12.81	090
30540		A	Repair nasal defect	7.74	NA	9.29	0.64	NA	17.67	090
30545		A	Repair nasal defect	11.36	NA	11.87	0.81	NA	24.04	090
30560		A	Release of nasal adhesions	1.26	4.78	2.13	0.10	6.14	3.49	010
30580		A	Repair upper jaw fistula	6.68	7.76	5.78	0.87	15.31	13.33	090
30600		A	Repair mouth/nose fistula	6.01	7.53	5.02	0.61	14.15	11.64	090
30620		A	Intranasal reconstruction	5.96	NA	8.81	0.56	NA	15.33	090
30630		A	Repair nasal septum defect	7.11	NA	7.94	0.61	NA	15.66	090
30801		A	Cauterization, inner nose	1.09	4.14	1.93	0.09	5.32	3.11	010
30802		A	Cauterization, inner nose	2.03	4.61	2.35	0.17	6.81	4.55	010
30901		A	Control of nosebleed	1.21	1.36	0.32	0.11	2.68	1.64	000
30903		A	Control of nosebleed	1.54	2.71	0.50	0.13	4.38	2.17	000
30905		A	Control of nosebleed	1.97	3.51	0.76	0.17	5.65	2.90	000
30906		A	Repeat control of nosebleed	2.45	3.89	1.20	0.20	6.54	3.85	000
30915		A	Ligation, nasal sinus artery	7.19	NA	6.69	0.60	NA	14.48	090
30920		A	Ligation, upper jaw artery	9.82	NA	8.96	0.80	NA	19.58	090
30930		A	Therapy, fracture of nose	1.26	NA	1.62	0.12	NA	3.00	010
31000		A	Irrigation, maxillary sinus	1.15	2.85	1.40	0.10	4.10	2.65	010
31002		A	Irrigation, sphenoid sinus	1.91	NA	3.26	0.16	NA	5.33	010
31020		A	Exploration, maxillary sinus	2.94	8.54	5.18	0.28	11.76	8.40	090
31030		A	Exploration, maxillary sinus	5.91	11.51	6.66	0.58	18.00	13.15	090
31032		A	Explore sinus, remove polyps	6.56	NA	7.22	0.61	NA	14.39	090
31040		A	Exploration behind upper jaw	9.41	NA	9.85	0.90	NA	20.16	090
31050		A	Exploration, sphenoid sinus	5.27	NA	6.35	0.57	NA	12.19	090
31051		A	Sphenoid sinus surgery	7.10	NA	8.24	0.69	NA	16.03	090
31070		A	Exploration of frontal sinus	4.27	NA	5.93	0.39	NA	10.59	090
31075		A	Exploration of frontal sinus	9.15	NA	9.72	0.80	NA	19.67	090
31080		A	Removal of frontal sinus	11.40	NA	13.54	1.36	NA	26.30	090
31081		A	Removal of frontal sinus	12.73	NA	13.99	2.47	NA	29.19	090
31084		A	Removal of frontal sinus	13.49	NA	13.50	1.23	NA	28.22	090
31085		A	Removal of frontal sinus	14.18	NA	13.94	1.74	NA	29.86	090
31086		A	Removal of frontal sinus	12.84	NA	13.26	1.11	NA	27.21	090
31087		A	Removal of frontal sinus	13.08	NA	12.51	1.28	NA	26.87	090
31090		A	Exploration of sinuses	9.52	NA	12.54	0.94	NA	23.00	090
31200		A	Removal of ethmoid sinus	4.96	NA	9.24	0.31	NA	14.51	090
31201		A	Removal of ethmoid sinus	8.36	NA	9.16	0.82	NA	18.34	090
31205		A	Removal of ethmoid sinus	10.22	NA	11.89	0.73	NA	22.84	090
31225		A	Removal of upper jaw	19.20	NA	17.81	1.69	NA	38.70	090
31230		A	Removal of upper jaw	21.91	NA	19.35	1.89	NA	43.15	090
31231		A	Nasal endoscopy, dx	1.10	3.38	0.88	0.09	4.57	2.07	000
31233		A	Nasal/sinus endoscopy, dx	2.18	4.31	1.47	0.19	6.68	3.84	000
31235		A	Nasal/sinus endoscopy, dx	2.64	4.91	1.72	0.27	7.82	4.63	000
31237		A	Nasal/sinus endoscopy, surg	2.98	5.19	1.88	0.28	8.45	5.14	000
31238		A	Nasal/sinus endoscopy, surg	3.26	5.23	2.08	0.27	8.76	5.61	000
31239		A	Nasal/sinus endoscopy, surg	8.69	NA	8.01	0.62	NA	17.32	010
31240		A	Nasal/sinus endoscopy, surg	2.61	NA	1.73	0.25	NA	4.59	000
31254		A	Revision of ethmoid sinus	4.64	NA	2.84	0.46	NA	7.94	000
31255		A	Removal of ethmoid sinus	6.95	NA	4.10	0.74	NA	11.79	000
31256		A	Exploration maxillary sinus	3.29	NA	2.11	0.34	NA	5.74	000
31267		A	Endoscopy, maxillary sinus	5.45	NA	3.29	0.56	NA	9.30	000
31276		A	Sinus endoscopy, surgical	8.84	NA	5.11	0.92	NA	14.87	000
31287		A	Nasal/sinus endoscopy, surg	3.91	NA	2.45	0.40	NA	6.76	000
31288		A	Nasal/sinus endoscopy, surg	4.57	NA	2.80	0.47	NA	7.84	000
31290		A	Nasal/sinus endoscopy, surg	17.21	NA	12.04	1.41	NA	30.66	010
31291		A	Nasal/sinus endoscopy, surg	18.16	NA	12.46	1.74	NA	32.36	010
31292		A	Nasal/sinus endoscopy, surg	14.74	NA	10.60	1.27	NA	26.61	010
31293		A	Nasal/sinus endoscopy, surg	16.19	NA	11.37	1.17	NA	28.73	010
31294		A	Nasal/sinus endoscopy, surg	19.03	NA	12.86	1.42	NA	33.31	010
31300		A	Removal of larynx lesion	14.27	NA	14.99	1.21	NA	30.47	090
31320		A	Diagnostic incision, larynx	5.25	NA	10.34	0.46	NA	16.05	090
31360		A	Removal of larynx	17.05	NA	16.72	1.44	NA	35.21	090
31365		A	Removal of larynx	24.12	NA	20.35	2.03	NA	46.50	090
31367		A	Partial removal of larynx	21.83	NA	21.88	1.81	NA	45.52	090
31368		A	Partial removal of larynx	27.05	NA	25.47	2.26	NA	54.78	090
31370		A	Partial removal of larynx	21.35	NA	22.26	1.77	NA	45.38	090
31375		A	Partial removal of larynx	20.18	NA	20.41	1.65	NA	42.24	090
31380		A	Partial removal of larynx	20.18	NA	20.60	1.64	NA	42.42	090
31382		A	Partial removal of larynx	20.49	NA	21.61	1.72	NA	43.82	090
31390		A	Removal of larynx & pharynx	27.49	NA	24.37	2.32	NA	54.18	090
31395		A	Reconstruct larynx & pharynx	31.04	NA	28.28	2.61	NA	61.93	090
31400		A	Revision of larynx	10.29	NA	13.80	0.84	NA	24.93	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
31420		A	Removal of epiglottis	10.20	NA	9.54	0.83	NA	20.57	090
31500		A	Insert emergency airway	2.33	NA	0.55	0.18	NA	3.06	000
31502		A	Change of windpipe airway	0.65	0.31	0.28	0.05	1.01	0.98	000
31505		A	Diagnostic laryngoscopy	0.61	1.45	0.62	0.05	2.11	1.28	000
31510		A	Laryngoscopy with biopsy	1.92	3.32	1.25	0.17	5.41	3.34	000
31511		A	Remove foreign body, larynx	2.16	3.12	1.06	0.19	5.47	3.41	000
31512		A	Removal of larynx lesion	2.07	3.20	1.36	0.17	5.44	3.60	000
31513		A	Injection into vocal cord	2.10	NA	1.46	0.17	NA	3.73	000
31515		A	Laryngoscopy for aspiration	1.80	3.63	1.07	0.14	5.57	3.01	000
31520		A	Diagnostic laryngoscopy	2.56	NA	1.56	0.20	NA	4.32	000
31525		A	Diagnostic laryngoscopy	2.63	3.65	1.66	0.22	6.50	4.51	000
31526		A	Diagnostic laryngoscopy	2.57	NA	1.71	0.21	NA	4.49	000
31527		A	Laryngoscopy for treatment	3.27	NA	1.87	0.27	NA	5.41	000
31528		A	Laryngoscopy and dilation	2.37	NA	1.46	0.20	NA	4.03	000
31529		A	Laryngoscopy and dilation	2.68	NA	1.71	0.22	NA	4.61	000
31530		A	Operative laryngoscopy	3.38	NA	1.95	0.29	NA	5.62	000
31531		A	Operative laryngoscopy	3.58	NA	2.27	0.29	NA	6.14	000
31535		A	Operative laryngoscopy	3.16	NA	1.99	0.26	NA	5.41	000
31536		A	Operative laryngoscopy	3.55	NA	2.24	0.29	NA	6.08	000
31540		A	Operative laryngoscopy	4.12	NA	2.54	0.34	NA	7.00	000
31541		A	Operative laryngoscopy	4.52	NA	2.77	0.37	NA	7.66	000
31560		A	Operative laryngoscopy	5.45	NA	3.15	0.44	NA	9.04	000
31561		A	Operative laryngoscopy	5.99	NA	3.36	0.40	NA	9.75	000
31570		A	Laryngoscopy with injection	3.86	5.67	2.38	0.31	9.84	6.55	000
31571		A	Laryngoscopy with injection	4.26	NA	2.59	0.35	NA	7.20	000
31575		A	Diagnostic laryngoscopy	1.10	1.90	0.89	0.09	3.09	2.08	000
31576		A	Laryngoscopy with biopsy	1.97	3.66	1.29	0.15	5.78	3.41	000
31577		A	Remove foreign body, larynx	2.47	3.76	1.53	0.20	6.43	4.20	000
31578		A	Removal of larynx lesion	2.84	4.28	1.52	0.23	7.35	4.59	000
31579		A	Diagnostic laryngoscopy	2.26	3.78	1.48	0.19	6.23	3.93	000
31580		A	Revision of larynx	12.36	NA	15.92	1.00	NA	29.28	090
31582		A	Revision of larynx	21.59	NA	25.84	1.76	NA	49.19	090
31584		A	Treat larynx fracture	19.61	NA	18.15	1.57	NA	39.33	090
31585		A	Treat larynx fracture	4.63	NA	6.70	0.49	NA	11.82	090
31586		A	Treat larynx fracture	8.02	NA	10.86	0.65	NA	19.53	090
31587		A	Revision of larynx	11.97	NA	9.26	0.99	NA	22.22	090
31588		A	Revision of larynx	13.09	NA	13.60	1.05	NA	27.74	090
31590		A	Reinnervate larynx	6.96	NA	15.54	0.85	NA	23.35	090
31595		A	Larynx nerve surgery	8.33	NA	10.58	0.79	NA	19.70	090
31600		A	Incision of windpipe	7.17	NA	3.18	0.80	NA	11.15	000
31601		A	Incision of windpipe	4.44	NA	2.39	0.47	NA	7.30	000
31603		A	Incision of windpipe	4.14	NA	1.71	0.45	NA	6.30	000
31605		A	Incision of windpipe	3.57	NA	1.18	0.39	NA	5.14	000
31610		A	Incision of windpipe	8.75	NA	8.27	0.80	NA	17.82	090
31611		A	Surgery/speech prosthesis	5.63	NA	6.11	0.47	NA	12.21	090
31612		A	Puncture/clear windpipe	0.91	1.10	0.35	0.08	2.09	1.34	000
31613		A	Repair windpipe opening	4.58	NA	5.99	0.45	NA	11.02	090
31614		A	Repair windpipe opening	7.11	NA	8.71	0.62	NA	16.44	090
31615		A	Visualization of windpipe	2.09	2.59	1.20	0.16	4.84	3.45	000
31622		A	Dx bronchoscope/wash	2.78	5.71	1.06	0.19	8.68	4.03	000
31623		A	Dx bronchoscope/brush	2.88	6.51	1.05	0.16	9.55	4.09	000
31624		A	Dx bronchoscope/lavage	2.88	5.85	1.05	0.16	8.89	4.09	000
31625		A	Bronchoscopy w/biopsy(s)	3.36	5.91	1.21	0.20	9.47	4.77	000
31628		A	Bronchoscopy/lung bx, each	3.80	6.13	1.30	0.19	10.12	5.29	000
31629		A	Bronchoscopy/needle bx, each	4.09	13.50	1.40	0.17	17.76	5.66	000
31630		A	Bronchoscopy dilate/fx repr	3.81	NA	1.70	0.35	NA	5.86	000
31631		A	Bronchoscopy, dilate w/stent	4.36	NA	1.74	0.37	NA	6.47	000
31632		A	Bronchoscopy/lung bx, add-l	1.03	0.83	0.31	0.19	2.05	1.53	ZZZ
31633		A	Bronchoscopy/needle bx add-l	1.32	0.93	0.40	0.17	2.42	1.89	ZZZ
31635		A	Bronchoscopy w/fb removal	3.67	6.17	1.43	0.27	10.11	5.37	000
31640		A	Bronchoscopy w/tumor excise	4.93	NA	2.07	0.44	NA	7.44	000
31641		A	Bronchoscopy, treat blockage	5.02	NA	1.88	0.37	NA	7.27	000
31643		A	Diag bronchoscope/catheter	3.49	NA	1.23	0.20	NA	4.92	000
31645		A	Bronchoscopy, clear airways	3.16	5.21	1.13	0.18	8.55	4.47	000
31646		A	Bronchoscopy, reclear airway	2.72	4.93	1.00	0.16	7.81	3.88	000
31656		A	Bronchoscopy, inj for x-ray	2.17	6.44	0.83	0.13	8.74	3.13	000
31700		A	Insertion of airway catheter	1.34	2.17	0.69	0.08	3.59	2.11	000
31708		A	Instill airway contrast dye	1.41	2.12	0.46	0.07	3.60	1.94	000
31710		A	Insertion of airway catheter	1.30	NA	0.41	0.09	NA	1.80	000
31715		A	Injection for bronchus x-ray	1.11	NA	0.34	0.07	NA	1.52	000
31717		A	Bronchial brush biopsy	2.12	8.66	0.79	0.10	10.88	3.01	000
31720		A	Clearance of airways	1.06	0.33	0.33	0.08	1.47	1.47	000
31725		A	Clearance of airways	1.96	0.65	0.58	0.13	2.74	2.67	000
31730		A	Intro, windpipe wire/tube	2.85	2.20	0.99	0.22	5.27	4.06	000
31750		A	Repair of windpipe	13.00	NA	17.58	1.14	NA	31.72	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
31755		A	Repair of windpipe	15.91	NA	24.51	1.41	NA	41.83	090
31760		A	Repair of windpipe	22.32	NA	10.76	3.08	NA	36.16	090
31766		A	Reconstruction of windpipe	30.38	NA	13.67	4.53	NA	48.58	090
31770		A	Repair/graft of bronchus	22.48	NA	10.28	2.76	NA	35.52	090
31775		A	Reconstruct bronchus	23.50	NA	11.82	3.06	NA	38.38	090
31780		A	Reconstruct windpipe	17.69	NA	11.07	1.72	NA	30.48	090
31781		A	Reconstruct windpipe	23.49	NA	12.15	2.51	NA	38.15	090
31785		A	Remove windpipe lesion	17.20	NA	10.20	1.54	NA	28.94	090
31786		A	Remove windpipe lesion	23.94	NA	13.12	3.33	NA	40.39	090
31800		A	Repair of windpipe injury	7.42	NA	9.29	0.76	NA	17.47	090
31805		A	Repair of windpipe injury	13.11	NA	7.25	1.78	NA	22.14	090
31820		A	Closure of windpipe lesion	4.48	5.66	3.65	0.40	10.54	8.53	090
31825		A	Repair of windpipe defect	6.80	7.66	5.37	0.58	15.04	12.75	090
31830		A	Revise windpipe scar	4.49	5.76	3.98	0.43	10.68	8.90	090
32000		A	Drainage of chest	1.54	3.10	0.48	0.09	4.73	2.11	000
32002		A	Treatment of collapsed lung	2.19	3.24	1.06	0.13	5.56	3.38	000
32005		A	Treat lung lining chemically	2.19	6.50	0.70	0.22	8.91	3.11	000
32020		A	Insertion of chest tube	3.97	NA	1.35	0.42	NA	5.74	000
32035		A	Exploration of chest	8.66	NA	5.88	1.18	NA	15.72	090
32036		A	Exploration of chest	9.67	NA	6.46	1.32	NA	17.45	090
32095		A	Biopsy through chest wall	8.35	NA	5.38	1.10	NA	14.83	090
32100		A	Exploration/biopsy of chest	15.22	NA	7.84	2.03	NA	25.09	090
32110		A	Explore/repair chest	22.97	NA	10.74	3.01	NA	36.72	090
32120		A	Re-exploration of chest	11.52	NA	7.10	1.54	NA	20.16	090
32124		A	Explore chest free adhesions	12.70	NA	7.23	1.77	NA	21.70	090
32140		A	Removal of lung lesion(s)	13.91	NA	7.70	1.88	NA	23.49	090
32141		A	Remove/treat lung lesions	13.98	NA	7.57	1.86	NA	23.41	090
32150		A	Removal of lung lesion(s)	14.13	NA	7.63	1.88	NA	23.64	090
32151		A	Remove lung foreign body	14.19	NA	8.03	1.61	NA	23.83	090
32160		A	Open chest heart massage	9.29	NA	5.28	1.20	NA	15.77	090
32200		A	Drain, open, lung lesion	15.27	NA	8.62	1.25	NA	25.14	090
32201		A	Drain, percut, lung lesion	3.99	21.04	1.30	0.24	25.27	5.53	000
32215		A	Treat chest lining	11.31	NA	6.92	1.50	NA	19.73	090
32220		A	Release of lung	23.96	NA	12.96	3.20	NA	40.12	090
32225		A	Partial release of lung	13.94	NA	7.68	1.86	NA	23.48	090
32310		A	Removal of chest lining	13.42	NA	7.41	1.77	NA	22.60	090
32320		A	Free/remove chest lining	23.96	NA	12.16	3.23	NA	39.35	090
32400		A	Needle biopsy chest lining	1.76	2.14	0.55	0.10	4.00	2.41	000
32402		A	Open biopsy chest lining	7.55	NA	5.14	1.00	NA	13.69	090
32405		A	Biopsy, lung or mediastinum	1.93	0.67	0.63	0.12	2.72	2.68	000
32420		A	Puncture/clear lung	2.18	NA	0.68	0.14	NA	3.00	000
32440		A	Removal of lung	24.96	NA	12.89	3.33	NA	41.18	090
32442		A	Sleeve pneumonectomy	26.20	NA	14.75	3.14	NA	44.09	090
32445		A	Removal of lung	25.05	NA	14.06	3.55	NA	42.66	090
32480		A	Partial removal of lung	23.71	NA	12.05	3.16	NA	38.92	090
32482		A	Bilobectomy	24.96	NA	12.90	3.30	NA	41.16	090
32484		A	Segmentectomy	20.66	NA	11.38	2.82	NA	34.86	090
32486		A	Sleeve lobectomy	23.88	NA	13.24	3.36	NA	40.48	090
32488		A	Completion pneumonectomy	25.67	NA	13.78	3.55	NA	43.00	090
32491		R	Lung volume reduction	21.22	NA	12.62	3.11	NA	36.95	090
32500		A	Partial removal of lung	21.97	NA	12.35	2.92	NA	37.24	090
32501		A	Repair bronchus add-on	4.68	NA	1.53	0.64	NA	6.85	ZZZ
32520		A	Remove lung & revise chest	21.65	NA	11.31	2.91	NA	35.87	090
32522		A	Remove lung & revise chest	24.16	NA	12.11	3.29	NA	39.56	090
32525		A	Remove lung & revise chest	26.46	NA	12.79	3.49	NA	42.74	090
32540		A	Removal of lung lesion	14.62	NA	9.63	1.96	NA	26.21	090
32601		A	Thoracoscopy, diagnostic	5.45	NA	2.35	0.73	NA	8.53	000
32602		A	Thoracoscopy, diagnostic	5.95	NA	2.51	0.80	NA	9.26	000
32603		A	Thoracoscopy, diagnostic	7.80	NA	3.03	1.09	NA	11.92	000
32604		A	Thoracoscopy, diagnostic	8.77	NA	3.44	1.12	NA	13.33	000
32605		A	Thoracoscopy, diagnostic	6.92	NA	2.90	0.91	NA	10.73	000
32606		A	Thoracoscopy, diagnostic	8.39	NA	3.33	0.85	NA	12.57	000
32650		A	Thoracoscopy, surgical	10.73	NA	6.76	1.44	NA	18.93	090
32651		A	Thoracoscopy, surgical	12.89	NA	7.23	1.75	NA	21.87	090
32652		A	Thoracoscopy, surgical	18.63	NA	10.14	2.53	NA	31.30	090
32653		A	Thoracoscopy, surgical	12.85	NA	6.97	1.76	NA	21.58	090
32654		A	Thoracoscopy, surgical	12.42	NA	7.53	1.64	NA	21.59	090
32655		A	Thoracoscopy, surgical	13.08	NA	7.24	1.75	NA	22.07	090
32656		A	Thoracoscopy, surgical	12.89	NA	7.93	1.80	NA	22.62	090
32657		A	Thoracoscopy, surgical	13.63	NA	7.68	1.86	NA	23.17	090
32658		A	Thoracoscopy, surgical	11.61	NA	7.35	1.62	NA	20.58	090
32659		A	Thoracoscopy, surgical	11.57	NA	7.45	1.55	NA	20.57	090
32660		A	Thoracoscopy, surgical	17.40	NA	9.47	1.87	NA	28.74	090
32661		A	Thoracoscopy, surgical	13.23	NA	7.79	1.77	NA	22.79	090
32662		A	Thoracoscopy, surgical	16.42	NA	8.81	2.26	NA	27.49	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
32663		A	Thoracoscopy, surgical	18.44	NA	10.75	2.56	NA	31.75	090
32664		A	Thoracoscopy, surgical	14.18	NA	7.63	2.06	NA	23.87	090
32665		A	Thoracoscopy, surgical	15.52	NA	8.13	2.03	NA	25.68	090
32800		A	Repair lung hernia	13.67	NA	7.45	1.91	NA	23.03	090
32810		A	Close chest after drainage	13.03	NA	7.55	1.83	NA	22.41	090
32815		A	Close bronchial fistula	23.12	NA	10.99	3.11	NA	37.22	090
32820		A	Reconstruct injured chest	21.45	NA	12.22	3.02	NA	36.69	090
32851		A	Lung transplant, single	38.57	NA	27.68	5.44	NA	71.69	090
32852		A	Lung transplant with bypass	41.74	NA	33.18	5.79	NA	80.71	090
32853		A	Lung transplant, double	47.74	NA	31.75	6.35	NA	85.84	090
32854		A	Lung transplant with bypass	50.90	NA	34.78	7.07	NA	92.75	090
32900		A	Removal of rib(s)	20.24	NA	9.90	2.79	NA	32.93	090
32905		A	Revise & repair chest wall	20.72	NA	10.14	2.87	NA	33.73	090
32906		A	Revise & repair chest wall	26.73	NA	12.08	3.74	NA	42.55	090
32940		A	Revision of lung	19.40	NA	9.49	2.66	NA	31.55	090
32960		A	Therapeutic pneumothorax	1.84	1.76	0.57	0.19	3.79	2.60	000
32997		A	Total lung lavage	5.99	NA	1.90	0.42	NA	8.31	000
33010		A	Drainage of heart sac	2.24	NA	0.78	0.15	NA	3.17	000
33011		A	Repeat drainage of heart sac	2.24	NA	0.81	0.17	NA	3.22	000
33015		A	Incision of heart sac	6.79	NA	4.95	0.64	NA	12.38	090
33020		A	Incision of heart sac	12.59	NA	6.80	1.62	NA	21.01	090
33025		A	Incision of heart sac	12.07	NA	6.36	1.60	NA	20.03	090
33030		A	Partial removal of heart sac	18.68	NA	9.54	2.53	NA	30.75	090
33031		A	Partial removal of heart sac	21.76	NA	10.05	2.89	NA	34.70	090
33050		A	Removal of heart sac lesion	14.34	NA	7.86	1.83	NA	24.03	090
33120		A	Removal of heart lesion	24.52	NA	11.62	3.25	NA	39.39	090
33130		A	Removal of heart lesion	21.36	NA	10.14	2.80	NA	34.30	090
33140		A	Heart revascularize (tmr)	19.97	NA	10.89	2.66	NA	33.52	090
33141		A	Heart tmr w/other procedure	4.83	NA	1.57	0.62	NA	7.02	ZZZ
33200		A	Insertion of heart pacemaker	12.46	NA	6.94	1.52	NA	20.92	090
33201		A	Insertion of heart pacemaker	10.16	NA	6.69	1.18	NA	18.03	090
33206		A	Insertion of heart pacemaker	6.66	NA	4.54	0.54	NA	11.74	090
33207		A	Insertion of heart pacemaker	8.03	NA	4.73	0.63	NA	13.39	090
33208		A	Insertion of heart pacemaker	8.12	NA	4.84	0.60	NA	13.56	090
33210		A	Insertion of heart electrode	3.30	NA	1.25	0.20	NA	4.75	000
33211		A	Insertion of heart electrode	3.39	NA	1.31	0.23	NA	4.93	000
33212		A	Insertion of pulse generator	5.51	NA	3.40	0.47	NA	9.38	090
33213		A	Insertion of pulse generator	6.36	NA	3.76	0.50	NA	10.62	090
33214		A	Upgrade of pacemaker system	7.74	NA	4.97	0.58	NA	13.29	090
33215		A	Reposition pacing-defib lead	4.75	NA	3.18	0.39	NA	8.32	090
33216		A	Insert lead pace-defib, one	5.77	NA	4.28	0.39	NA	10.44	090
33217		A	Insert lead pace-defib, dual	5.74	NA	4.31	0.43	NA	10.48	090
33218		A	Repair lead pace-defib, one	5.43	NA	4.34	0.43	NA	10.20	090
33220		A	Repair lead pace-defib, dual	5.51	NA	4.31	0.43	NA	10.25	090
33222		A	Revise pocket, pacemaker	4.95	NA	4.34	0.42	NA	9.71	090
33223		A	Revise pocket, pacing-defib	6.45	NA	4.61	0.47	NA	11.53	090
33224		A	Insert pacing lead & connect	9.04	NA	3.99	0.43	NA	13.46	000
33225		A	L ventric pacing lead add-on	8.33	NA	3.25	0.43	NA	12.01	ZZZ
33226		A	Reposition l ventric lead	8.68	NA	3.81	0.43	NA	12.92	000
33233		A	Removal of pacemaker system	3.29	NA	3.28	0.24	NA	6.81	090
33234		A	Removal of pacemaker system	7.81	NA	4.92	0.60	NA	13.33	090
33235		A	Removal pacemaker electrode	9.39	NA	6.82	0.76	NA	16.97	090
33236		A	Remove electrode/thoracotomy	12.58	NA	7.45	1.72	NA	21.75	090
33237		A	Remove electrode/thoracotomy	13.69	NA	7.79	1.63	NA	23.11	090
33238		A	Remove electrode/thoracotomy	15.20	NA	8.22	1.94	NA	25.36	090
33240		A	Insert pulse generator	7.59	NA	4.63	0.50	NA	12.72	090
33241		A	Remove pulse generator	3.24	NA	2.97	0.22	NA	6.43	090
33243		A	Remove eltrd/thoracotomy	22.61	NA	11.45	2.80	NA	36.86	090
33244		A	Remove eltrd, transven	13.74	NA	8.90	1.02	NA	23.66	090
33245		A	Insert epic eltrd pace-defib	14.28	NA	7.99	1.85	NA	24.12	090
33246		A	Insert epic eltrd/generator	20.68	NA	10.35	2.46	NA	33.49	090
33249		A	Eltrd/insert pace-defib	14.21	NA	8.44	0.86	NA	23.51	090
33250		A	Ablate heart dysrhythm focus	21.82	NA	11.05	2.79	NA	35.66	090
33251		A	Ablate heart dysrhythm focus	24.84	NA	11.68	2.87	NA	39.39	090
33253		A	Reconstruct atria	31.01	NA	13.84	4.04	NA	48.89	090
33261		A	Ablate heart dysrhythm focus	24.84	NA	11.79	2.82	NA	39.45	090
33282		A	Implant pat-active ht record	4.16	NA	4.07	0.25	NA	8.48	090
33284		A	Remove pat-active ht record	2.50	NA	3.55	0.16	NA	6.21	090
33300		A	Repair of heart wound	17.89	NA	9.25	2.33	NA	29.47	090
33305		A	Repair of heart wound	21.41	NA	10.64	2.79	NA	34.84	090
33310		A	Exploratory heart surgery	18.48	NA	9.60	2.58	NA	30.66	090
33315		A	Exploratory heart surgery	22.34	NA	10.90	2.87	NA	36.11	090
33320		A	Repair major blood vessel(s)	16.76	NA	8.25	1.83	NA	26.84	090
33321		A	Repair major vessel	20.17	NA	9.81	2.69	NA	32.67	090
33322		A	Repair major blood vessel(s)	20.59	NA	10.38	2.65	NA	33.62	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
33330		A	Insert major vessel graft	21.40	NA	10.28	2.65	NA	34.33	090
33332		A	Insert major vessel graft	23.92	NA	10.53	3.11	NA	37.56	090
33335		A	Insert major vessel graft	29.96	NA	13.35	3.86	NA	47.17	090
33400		A	Repair of aortic valve	28.46	NA	15.65	3.69	NA	47.80	090
33401		A	Valvuloplasty, open	23.87	NA	13.50	1.30	NA	38.67	090
33403		A	Valvuloplasty, w/cp bypass	24.85	NA	14.30	3.53	NA	42.68	090
33404		A	Prepare heart-aorta conduit	28.50	NA	14.53	4.02	NA	47.05	090
33405		A	Replacement of aortic valve	34.95	NA	18.28	4.55	NA	57.78	090
33406		A	Replacement of aortic valve	37.44	NA	19.11	4.93	NA	61.48	090
33410		A	Replacement of aortic valve	32.41	NA	16.58	4.05	NA	53.04	090
33411		A	Replacement of aortic valve	36.20	NA	18.74	4.86	NA	59.80	090
33412		A	Replacement of aortic valve	41.94	NA	20.40	5.61	NA	67.95	090
33413		A	Replacement of aortic valve	43.43	NA	20.80	5.94	NA	70.17	090
33414		A	Repair of aortic valve	30.30	NA	14.15	4.00	NA	48.45	090
33415		A	Revision, subvalvular tissue	27.11	NA	12.05	3.56	NA	42.72	090
33416		A	Revise ventricle muscle	30.30	NA	13.52	4.14	NA	47.96	090
33417		A	Repair of aortic valve	28.49	NA	13.63	3.96	NA	46.08	090
33420		A	Revision of mitral valve	22.67	NA	9.61	1.89	NA	34.17	090
33422		A	Revision of mitral valve	25.90	NA	13.64	3.39	NA	42.93	090
33425		A	Repair of mitral valve	26.96	NA	13.05	3.59	NA	43.60	090
33426		A	Repair of mitral valve	32.95	NA	17.13	4.25	NA	54.33	090
33427		A	Repair of mitral valve	39.94	NA	19.35	5.27	NA	64.56	090
33430		A	Replacement of mitral valve	33.45	NA	17.29	4.36	NA	55.10	090
33460		A	Revision of tricuspid valve	23.56	NA	11.32	3.23	NA	38.11	090
33463		A	Valvuloplasty, tricuspid	25.58	NA	12.92	3.36	NA	41.86	090
33464		A	Valvuloplasty, tricuspid	27.29	NA	13.53	3.52	NA	44.34	090
33465		A	Replace tricuspid valve	28.75	NA	12.98	3.88	NA	45.61	090
33468		A	Revision of tricuspid valve	30.07	NA	13.68	4.35	NA	48.10	090
33470		A	Revision of pulmonary valve	20.78	NA	10.71	2.01	NA	33.50	090
33471		A	Valvotomy, pulmonary valve	22.22	NA	9.77	3.31	NA	35.30	090
33472		A	Revision of pulmonary valve	22.22	NA	11.89	3.11	NA	37.22	090
33474		A	Revision of pulmonary valve	23.01	NA	10.89	2.70	NA	36.60	090
33475		A	Replacement, pulmonary valve	32.95	NA	15.41	4.30	NA	52.66	090
33476		A	Revision of heart chamber	25.73	NA	11.97	2.97	NA	40.67	090
33478		A	Revision of heart chamber	26.70	NA	13.06	3.85	NA	43.61	090
33496		A	Repair, prosth valve clot	27.21	NA	12.76	3.60	NA	43.57	090
33500		A	Repair heart vessel fistula	25.51	NA	11.47	3.33	NA	40.31	090
33501		A	Repair heart vessel fistula	17.75	NA	8.29	2.04	NA	28.08	090
33502		A	Coronary artery correction	21.01	NA	11.10	2.11	NA	34.22	090
33503		A	Coronary artery graft	21.75	NA	9.78	1.84	NA	33.37	090
33504		A	Coronary artery graft	24.62	NA	11.84	3.32	NA	39.78	090
33505		A	Repair artery w/tunnel	26.80	NA	12.93	2.67	NA	42.40	090
33506		A	Repair artery, translocation	35.45	NA	14.59	3.85	NA	53.89	090
33508		A	Endoscopic vein harvest	0.31	NA	0.10	0.88	NA	1.29	ZZZ
33510		A	CABG, vein, single	28.96	NA	16.33	3.75	NA	49.04	090
33511		A	CABG, vein, two	29.96	NA	17.07	3.83	NA	50.86	090
33512		A	CABG, vein, three	31.75	NA	17.60	4.13	NA	53.48	090
33513		A	CABG, vein, four	31.95	NA	17.78	4.16	NA	53.89	090
33514		A	CABG, vein, five	32.70	NA	18.05	4.00	NA	54.75	090
33516		A	Cabg, vein, six or more	34.95	NA	18.79	4.51	NA	58.25	090
33517		A	CABG, artery-vein, single	2.57	NA	0.84	0.33	NA	3.74	ZZZ
33518		A	CABG, artery-vein, two	4.84	NA	1.58	0.63	NA	7.05	ZZZ
33519		A	CABG, artery-vein, three	7.11	NA	2.32	0.92	NA	10.35	ZZZ
33521		A	CABG, artery-vein, four	9.39	NA	3.07	1.20	NA	13.66	ZZZ
33522		A	CABG, artery-vein, five	11.65	NA	3.80	1.49	NA	16.94	ZZZ
33523		A	Cabg, art-vein, six or more	13.93	NA	4.52	1.81	NA	20.26	ZZZ
33530		A	Coronary artery, bypass/reop	5.85	NA	1.90	0.77	NA	8.52	ZZZ
33533		A	CABG, arterial, single	29.96	NA	16.46	3.86	NA	50.28	090
33534		A	CABG, arterial, two	32.15	NA	17.70	4.13	NA	53.98	090
33535		A	CABG, arterial, three	34.45	NA	18.13	4.43	NA	57.01	090
33536		A	Cabg, arterial, four or more	37.44	NA	18.28	4.60	NA	60.32	090
33542		A	Removal of heart lesion	28.81	NA	13.01	3.79	NA	45.61	090
33545		A	Repair of heart damage	36.72	NA	15.64	4.81	NA	57.17	090
33572		A	Open coronary endarterectomy	4.44	NA	1.45	0.58	NA	6.47	ZZZ
33600		A	Closure of valve	29.47	NA	12.55	4.13	NA	46.15	090
33602		A	Closure of valve	28.50	NA	12.46	3.25	NA	44.21	090
33606		A	Anastomosis/artery-aorta	30.69	NA	13.69	4.33	NA	48.71	090
33608		A	Repair anomaly w/conduit	31.04	NA	14.11	4.41	NA	49.56	090
33610		A	Repair by enlargement	30.56	NA	13.66	4.56	NA	48.78	090
33611		A	Repair double ventricle	33.95	NA	14.15	4.11	NA	52.21	090
33612		A	Repair double ventricle	34.95	NA	15.17	5.18	NA	55.30	090
33615		A	Repair, modified fontan	33.95	NA	13.27	2.90	NA	50.12	090
33617		A	Repair single ventricle	36.94	NA	16.02	4.88	NA	57.84	090
33619		A	Repair single ventricle	44.93	NA	20.82	3.60	NA	69.35	090
33641		A	Repair heart septum defect	21.36	NA	9.59	2.73	NA	33.68	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
33645		A	Revision of heart veins	24.78	NA	11.78	3.26	NA	39.82	090
33647		A	Repair heart septum defects	28.69	NA	13.79	3.12	NA	45.60	090
33660		A	Repair of heart defects	29.96	NA	13.50	3.88	NA	47.34	090
33665		A	Repair of heart defects	28.56	NA	13.85	4.21	NA	46.62	090
33670		A	Repair of heart chambers	34.95	NA	13.20	3.47	NA	51.62	090
33681		A	Repair heart septum defect	30.56	NA	14.69	4.03	NA	49.28	090
33684		A	Repair heart septum defect	29.61	NA	13.63	4.08	NA	47.32	090
33688		A	Repair heart septum defect	30.57	NA	10.52	4.39	NA	45.48	090
33690		A	Reinforce pulmonary artery	19.52	NA	10.19	2.66	NA	32.37	090
33692		A	Repair of heart defects	30.70	NA	13.94	4.58	NA	49.22	090
33694		A	Repair of heart defects	33.95	NA	14.23	3.71	NA	51.89	090
33697		A	Repair of heart defects	35.95	NA	14.87	4.32	NA	55.14	090
33702		A	Repair of heart defects	26.50	NA	12.58	4.00	NA	43.08	090
33710		A	Repair of heart defects	29.67	NA	14.00	3.01	NA	46.68	090
33720		A	Repair of heart defect	26.52	NA	12.29	3.60	NA	42.41	090
33722		A	Repair of heart defect	28.37	NA	13.88	4.33	NA	46.58	090
33730		A	Repair heart-vein defect(s)	34.20	NA	14.13	4.32	NA	52.65	090
33732		A	Repair heart-vein defect	28.12	NA	13.41	2.88	NA	44.41	090
33735		A	Revision of heart chamber	21.36	NA	9.06	1.56	NA	31.98	090
33736		A	Revision of heart chamber	23.48	NA	11.87	2.50	NA	37.85	090
33737		A	Revision of heart chamber	21.73	NA	10.95	3.30	NA	35.98	090
33750		A	Major vessel shunt	21.38	NA	10.24	2.56	NA	34.18	090
33755		A	Major vessel shunt	21.76	NA	8.82	3.24	NA	33.82	090
33762		A	Major vessel shunt	21.76	NA	10.17	3.18	NA	35.11	090
33764		A	Major vessel shunt & graft	21.76	NA	10.25	2.15	NA	34.16	090
33766		A	Major vessel shunt	22.73	NA	11.68	3.39	NA	37.80	090
33767		A	Major vessel shunt	24.46	NA	11.75	2.74	NA	38.95	090
33770		A	Repair great vessels defect	36.94	NA	14.69	5.42	NA	57.05	090
33771		A	Repair great vessels defect	34.60	NA	12.42	5.63	NA	52.65	090
33774		A	Repair great vessels defect	30.93	NA	14.75	4.70	NA	50.38	090
33775		A	Repair great vessels defect	32.15	NA	15.02	5.23	NA	52.40	090
33776		A	Repair great vessels defect	33.99	NA	15.80	5.52	NA	55.31	090
33777		A	Repair great vessels defect	33.41	NA	14.87	5.44	NA	53.72	090
33778		A	Repair great vessels defect	39.94	NA	16.89	5.83	NA	62.66	090
33779		A	Repair great vessels defect	36.16	NA	15.39	1.74	NA	53.29	090
33780		A	Repair great vessels defect	41.69	NA	19.06	5.15	NA	65.90	090
33781		A	Repair great vessels defect	36.40	NA	13.48	5.92	NA	55.80	090
33786		A	Repair arterial trunk	38.94	NA	16.70	2.03	NA	57.67	090
33788		A	Revision of pulmonary artery	26.58	NA	11.95	4.02	NA	42.55	090
33800		A	Aortic suspension	16.22	NA	8.16	2.28	NA	26.66	090
33802		A	Repair vessel defect	17.63	NA	9.24	1.66	NA	28.53	090
33803		A	Repair vessel defect	19.57	NA	9.78	3.17	NA	32.52	090
33813		A	Repair septal defect	20.62	NA	10.93	1.13	NA	32.68	090
33814		A	Repair septal defect	25.73	NA	12.66	3.56	NA	41.95	090
33820		A	Revise major vessel	16.27	NA	8.39	2.19	NA	26.85	090
33822		A	Revise major vessel	17.29	NA	8.98	1.92	NA	28.19	090
33824		A	Revise major vessel	19.49	NA	10.01	2.91	NA	32.41	090
33840		A	Remove aorta constriction	20.60	NA	10.31	2.45	NA	33.36	090
33845		A	Remove aorta constriction	22.09	NA	11.36	3.13	NA	36.58	090
33851		A	Remove aorta constriction	21.24	NA	10.71	2.81	NA	34.76	090
33852		A	Repair septal defect	23.67	NA	11.38	2.55	NA	37.60	090
33853		A	Repair septal defect	31.67	NA	14.84	4.13	NA	50.64	090
33860		A	Ascending aortic graft	37.94	NA	16.46	5.05	NA	59.45	090
33861		A	Ascending aortic graft	41.94	NA	17.72	5.45	NA	65.11	090
33863		A	Ascending aortic graft	44.93	NA	18.70	5.46	NA	69.09	090
33870		A	Transverse aortic arch graft	43.93	NA	18.39	5.96	NA	68.28	090
33875		A	Thoracic aortic graft	33.01	NA	14.11	4.43	NA	51.55	090
33877		A	Thoracoabdominal graft	42.54	NA	16.33	5.46	NA	64.33	090
33910		A	Remove lung artery emboli	24.55	NA	11.45	3.32	NA	39.32	090
33915		A	Remove lung artery emboli	20.99	NA	9.64	1.73	NA	32.36	090
33916		A	Surgery of great vessel	25.79	NA	11.37	3.47	NA	40.63	090
33917		A	Repair pulmonary artery	24.46	NA	12.21	3.25	NA	39.92	090
33918		A	Repair pulmonary atresia	26.41	NA	12.13	4.12	NA	42.66	090
33919		A	Repair pulmonary atresia	39.94	NA	17.52	4.45	NA	61.91	090
33920		A	Repair pulmonary atresia	31.90	NA	13.85	3.50	NA	49.25	090
33922		A	Transect pulmonary artery	23.48	NA	10.92	3.25	NA	37.65	090
33924		A	Remove pulmonary shunt	5.49	NA	1.83	0.70	NA	8.02	ZZZ
33935		R	Transplantation, heart/lung	60.87	NA	28.77	9.19	NA	98.83	090
33945		R	Transplantation of heart	42.04	NA	21.38	5.91	NA	69.33	090
33960		A	External circulation assist	19.33	NA	4.90	2.46	NA	26.69	000
33961		A	External circulation assist	10.91	NA	3.61	1.08	NA	15.60	ZZZ
33967		A	Insert ia percut device	4.84	NA	1.83	0.35	NA	7.02	000
33968		A	Remove aortic assist device	0.64	NA	0.23	0.06	NA	0.93	000
33970		A	Aortic circulation assist	6.74	NA	2.28	0.81	NA	9.83	000
33971		A	Aortic circulation assist	9.68	NA	6.03	1.21	NA	16.92	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
33973		A	Insert balloon device	9.75	NA	3.30	1.18	NA	14.23	000
33974		A	Remove intra-aortic balloon	14.39	NA	7.91	1.71	NA	24.01	090
33975		A	Implant ventricular device	20.97	NA	6.27	2.95	NA	30.19	XXX
33976		A	Implant ventricular device	22.97	NA	7.53	2.73	NA	33.23	XXX
33977		A	Remove ventricular device	19.26	NA	11.08	2.68	NA	33.02	090
33978		A	Remove ventricular device	21.70	NA	11.75	3.03	NA	36.48	090
33979		A	Insert intracorporeal device	45.93	NA	14.89	4.80	NA	65.62	XXX
33980		A	Remove intracorporeal device	56.17	NA	25.22	5.55	NA	86.94	090
34001		A	Removal of artery clot	12.89	NA	6.71	1.76	NA	21.36	090
34051		A	Removal of artery clot	15.19	NA	7.77	2.20	NA	25.16	090
34101		A	Removal of artery clot	9.99	NA	5.35	1.36	NA	16.70	090
34111		A	Removal of arm artery clot	9.99	NA	5.35	1.36	NA	16.70	090
34151		A	Removal of artery clot	24.96	NA	10.39	3.34	NA	38.69	090
34201		A	Removal of artery clot	10.01	NA	5.41	1.38	NA	16.80	090
34203		A	Removal of leg artery clot	16.48	NA	8.05	2.25	NA	26.78	090
34401		A	Removal of vein clot	24.96	NA	10.65	3.00	NA	38.61	090
34421		A	Removal of vein clot	11.98	NA	6.28	1.48	NA	19.74	090
34451		A	Removal of vein clot	26.96	NA	11.42	3.65	NA	42.03	090
34471		A	Removal of vein clot	10.16	NA	5.31	0.88	NA	16.35	090
34490		A	Removal of vein clot	9.85	NA	5.43	1.34	NA	16.62	090
34501		A	Repair valve, femoral vein	15.98	NA	8.50	2.31	NA	26.79	090
34502		A	Reconstruct vena cava	26.91	NA	12.28	3.41	NA	42.60	090
34510		A	Transposition of vein valve	18.92	NA	9.43	2.39	NA	30.74	090
34520		A	Cross-over vein graft	17.92	NA	8.48	1.63	NA	28.03	090
34530		A	Leg vein fusion	16.62	NA	8.61	2.16	NA	27.39	090
34800		A	Endovasc abdo repair w/tube	20.72	NA	9.15	2.35	NA	32.22	090
34802		A	Endovasc abdo repr w/device	22.97	NA	9.77	2.34	NA	35.08	090
34804		A	Endovasc abdo repr w/device	22.97	NA	9.79	2.35	NA	35.11	090
34805		A	Endovasc abdo repair w/pros	21.85	NA	9.66	1.99	NA	33.50	090
34808		A	Endovasc abdo occlud device	4.12	NA	1.37	0.50	NA	5.99	ZZZ
34812		A	Xpose for endoprosth, femorl	6.74	NA	2.23	1.09	NA	10.06	000
34813		A	Femoral endovas graft add-on	4.79	NA	1.57	0.65	NA	7.01	ZZZ
34820		A	Xpose for endoprosth, iliac	9.74	NA	3.23	1.35	NA	14.32	000
34825		A	Endovasc extend prosth, init	11.98	NA	6.13	1.29	NA	19.40	090
34826		A	Endovasc exten prosth, add-l	4.12	NA	1.37	0.45	NA	5.94	ZZZ
34830		A	Open aortic tube prosth repr	32.54	NA	13.68	3.75	NA	49.97	090
34831		A	Open aortoiliac prosth repr	35.29	NA	11.73	3.95	NA	50.97	090
34832		A	Open aortofemor prosth repr	35.29	NA	14.60	4.05	NA	53.94	090
34833		A	Xpose for endoprosth, iliac	11.98	NA	4.42	0.84	NA	17.24	000
34834		A	Xpose, endoprosth, brachial	5.34	NA	2.19	0.59	NA	8.12	000
34900		A	Endovasc iliac repr w/graft	16.36	NA	7.59	1.80	NA	25.75	090
35001		A	Repair defect of artery	19.61	NA	9.54	2.64	NA	31.79	090
35002		A	Repair artery rupture, neck	20.97	NA	9.68	2.38	NA	33.03	090
35005		A	Repair defect of artery	18.09	NA	8.83	2.29	NA	29.21	090
35011		A	Repair defect of artery	17.97	NA	7.97	2.42	NA	28.36	090
35013		A	Repair artery rupture, arm	21.97	NA	9.66	2.98	NA	34.61	090
35021		A	Repair defect of artery	19.62	NA	9.41	2.43	NA	31.46	090
35022		A	Repair artery rupture, chest	23.15	NA	9.86	2.32	NA	35.33	090
35045		A	Repair defect of arm artery	17.54	NA	7.53	2.38	NA	27.45	090
35081		A	Repair defect of artery	27.97	NA	11.44	3.66	NA	43.07	090
35082		A	Repair artery rupture, aorta	38.44	NA	15.27	5.10	NA	58.81	090
35091		A	Repair defect of artery	35.35	NA	13.55	4.76	NA	53.66	090
35092		A	Repair artery rupture, aorta	44.93	NA	17.61	5.97	NA	68.51	090
35102		A	Repair defect of artery	30.71	NA	12.34	4.09	NA	47.14	090
35103		A	Repair artery rupture, groin	40.44	NA	15.82	5.49	NA	61.75	090
35111		A	Repair defect of artery	24.96	NA	10.45	3.35	NA	38.76	090
35112		A	Repair artery rupture,spleen	29.96	NA	11.95	3.89	NA	45.80	090
35121		A	Repair defect of artery	29.96	NA	12.35	4.05	NA	46.36	090
35122		A	Repair artery rupture, belly	34.95	NA	13.78	4.48	NA	53.21	090
35131		A	Repair defect of artery	24.96	NA	10.73	3.49	NA	39.18	090
35132		A	Repair artery rupture, groin	29.96	NA	12.36	4.07	NA	46.39	090
35141		A	Repair defect of artery	19.97	NA	8.90	2.72	NA	31.59	090
35142		A	Repair artery rupture, thigh	23.27	NA	10.35	3.11	NA	36.73	090
35151		A	Repair defect of artery	22.61	NA	9.98	3.04	NA	35.63	090
35152		A	Repair artery rupture, knee	25.58	NA	11.36	3.35	NA	40.29	090
35161		A	Repair defect of artery	18.73	NA	9.13	2.48	NA	30.34	090
35162		A	Repair artery rupture	19.75	NA	9.56	2.75	NA	32.06	090
35180		A	Repair blood vessel lesion	13.60	NA	6.94	1.97	NA	22.51	090
35182		A	Repair blood vessel lesion	29.96	NA	12.78	4.09	NA	46.83	090
35184		A	Repair blood vessel lesion	17.97	NA	8.29	2.45	NA	28.71	090
35188		A	Repair blood vessel lesion	14.26	NA	7.62	1.98	NA	23.86	090
35189		A	Repair blood vessel lesion	27.96	NA	11.94	3.68	NA	43.58	090
35190		A	Repair blood vessel lesion	12.73	NA	6.47	1.71	NA	20.91	090
35201		A	Repair blood vessel lesion	16.12	NA	7.98	2.13	NA	26.23	090
35206		A	Repair blood vessel lesion	13.23	NA	6.57	1.83	NA	21.63	090

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[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
35207		A	Repair blood vessel lesion	10.13	NA	7.53	1.46	NA	19.12	090
35211		A	Repair blood vessel lesion	22.09	NA	10.64	2.89	NA	35.62	090
35216		A	Repair blood vessel lesion	18.72	NA	8.99	2.49	NA	30.20	090
35221		A	Repair blood vessel lesion	24.35	NA	9.92	3.20	NA	37.47	090
35226		A	Repair blood vessel lesion	14.48	NA	7.46	1.89	NA	23.83	090
35231		A	Repair blood vessel lesion	19.97	NA	9.75	2.74	NA	32.46	090
35236		A	Repair blood vessel lesion	17.08	NA	7.90	2.35	NA	27.33	090
35241		A	Repair blood vessel lesion	23.09	NA	11.14	3.00	NA	37.23	090
35246		A	Repair blood vessel lesion	26.41	NA	11.43	3.21	NA	41.05	090
35251		A	Repair blood vessel lesion	30.15	NA	11.77	3.99	NA	45.91	090
35256		A	Repair blood vessel lesion	18.33	NA	8.37	2.51	NA	29.21	090
35261		A	Repair blood vessel lesion	17.77	NA	8.00	2.41	NA	28.18	090
35266		A	Repair blood vessel lesion	14.89	NA	7.01	1.98	NA	23.88	090
35271		A	Repair blood vessel lesion	22.09	NA	10.53	2.99	NA	35.61	090
35276		A	Repair blood vessel lesion	24.21	NA	11.22	3.24	NA	38.67	090
35281		A	Repair blood vessel lesion	27.96	NA	11.69	3.73	NA	43.38	090
35286		A	Repair blood vessel lesion	16.14	NA	8.07	2.22	NA	26.43	090
35301		A	Rechanneling of artery	18.67	NA	8.44	2.52	NA	29.63	090
35311		A	Rechanneling of artery	26.96	NA	11.73	3.47	NA	42.16	090
35321		A	Rechanneling of artery	15.98	NA	7.37	2.18	NA	25.53	090
35331		A	Rechanneling of artery	26.16	NA	11.22	3.56	NA	40.94	090
35341		A	Rechanneling of artery	25.07	NA	10.85	3.44	NA	39.36	090
35351		A	Rechanneling of artery	22.97	NA	9.58	3.16	NA	35.71	090
35355		A	Rechanneling of artery	18.47	NA	8.08	2.51	NA	29.06	090
35361		A	Rechanneling of artery	28.16	NA	11.69	3.84	NA	43.69	090
35363		A	Rechanneling of artery	30.15	NA	12.56	4.16	NA	46.87	090
35371		A	Rechanneling of artery	14.70	NA	6.94	2.01	NA	23.65	090
35372		A	Rechanneling of artery	17.97	NA	8.04	2.47	NA	28.48	090
35381		A	Rechanneling of artery	15.79	NA	7.81	2.14	NA	25.74	090
35390		A	Reoperation, carotid add-on	3.19	NA	1.06	0.43	NA	4.68	ZZZ
35400		A	Angioscopy	3.00	NA	1.11	0.42	NA	4.53	ZZZ
35450		A	Repair arterial blockage	10.05	NA	3.55	1.24	NA	14.84	000
35452		A	Repair arterial blockage	6.90	NA	2.60	0.82	NA	10.32	000
35454		A	Repair arterial blockage	6.03	NA	2.31	0.82	NA	9.16	000
35456		A	Repair arterial blockage	7.34	NA	2.76	0.99	NA	11.09	000
35458		A	Repair arterial blockage	9.48	NA	3.46	1.21	NA	14.15	000
35459		A	Repair arterial blockage	8.62	NA	3.16	1.16	NA	12.94	000
35460		A	Repair venous blockage	6.03	NA	2.26	0.82	NA	9.11	000
35470		A	Repair arterial blockage	8.62	90.69	3.34	0.70	100.01	12.66	000
35471		A	Repair arterial blockage	10.05	102.73	3.94	0.69	113.47	14.68	000
35472		A	Repair arterial blockage	6.90	65.72	2.74	0.59	73.21	10.23	000
35473		A	Repair arterial blockage	6.03	61.03	2.42	0.51	67.57	8.96	000
35474		A	Repair arterial blockage	7.35	89.50	2.89	0.56	97.41	10.80	000
35475		R	Repair arterial blockage	9.48	56.75	3.55	0.63	66.86	13.66	000
35476		A	Repair venous blockage	6.03	45.31	2.35	0.39	51.73	8.77	000
35480		A	Atherectomy, open	11.06	NA	4.03	1.27	NA	16.36	000
35481		A	Atherectomy, open	7.60	NA	2.87	0.99	NA	11.46	000
35482		A	Atherectomy, open	6.64	NA	2.56	0.85	NA	10.05	000
35483		A	Atherectomy, open	8.09	NA	3.02	1.05	NA	12.16	000
35484		A	Atherectomy, open	10.42	NA	3.76	1.28	NA	15.46	000
35485		A	Atherectomy, open	9.48	NA	3.53	1.30	NA	14.31	000
35490		A	Atherectomy, percutaneous	11.06	NA	4.69	0.63	NA	16.38	000
35491		A	Atherectomy, percutaneous	7.60	NA	3.28	0.51	NA	11.39	000
35492		A	Atherectomy, percutaneous	6.64	NA	3.19	0.42	NA	10.25	000
35493		A	Atherectomy, percutaneous	8.09	NA	3.80	0.57	NA	12.46	000
35494		A	Atherectomy, percutaneous	10.42	NA	4.45	0.79	NA	15.66	000
35495		A	Atherectomy, percutaneous	9.48	NA	4.38	0.69	NA	14.55	000
35500		A	Harvest vein for bypass	6.44	NA	2.02	0.88	NA	9.34	ZZZ
35501		A	Artery bypass graft	19.16	NA	8.46	2.67	NA	30.29	090
35506		A	Artery bypass graft	19.64	NA	9.45	2.69	NA	31.78	090
35507		A	Artery bypass graft	19.64	NA	9.41	2.66	NA	31.71	090
35508		A	Artery bypass graft	18.62	NA	9.43	2.43	NA	30.48	090
35509		A	Artery bypass graft	18.04	NA	8.75	2.47	NA	29.26	090
35510		A	Artery bypass graft	22.97	NA	10.16	2.10	NA	35.23	090
35511		A	Artery bypass graft	21.17	NA	9.34	2.38	NA	32.89	090
35512		A	Artery bypass graft	22.47	NA	9.99	2.10	NA	34.56	090
35515		A	Artery bypass graft	18.62	NA	9.27	2.50	NA	30.39	090
35516		A	Artery bypass graft	16.30	NA	6.80	2.19	NA	25.29	090
35518		A	Artery bypass graft	21.17	NA	8.96	2.84	NA	32.97	090
35521		A	Artery bypass graft	22.17	NA	9.82	2.98	NA	34.97	090
35522		A	Artery bypass graft	21.73	NA	9.74	2.10	NA	33.57	090
35525		A	Artery bypass graft	20.60	NA	9.36	2.10	NA	32.06	090
35526		A	Artery bypass graft	29.91	NA	12.49	2.43	NA	44.83	090
35531		A	Artery bypass graft	36.15	NA	14.46	5.00	NA	55.61	090
35533		A	Artery bypass graft	27.96	NA	11.71	3.59	NA	43.26	090

[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
35536		A	Artery bypass graft	31.65	NA	12.92	4.36	NA	48.93	090
35541		A	Artery bypass graft	25.76	NA	11.19	3.49	NA	40.44	090
35546		A	Artery bypass graft	25.50	NA	10.85	2.66	NA	39.01	090
35548		A	Artery bypass graft	21.54	NA	9.41	2.84	NA	33.79	090
35549		A	Artery bypass graft	23.31	NA	10.37	3.18	NA	36.86	090
35551		A	Artery bypass graft	26.63	NA	11.48	3.71	NA	41.82	090
35556		A	Artery bypass graft	21.73	NA	9.71	2.86	NA	34.30	090
35558		A	Artery bypass graft	21.17	NA	9.53	2.83	NA	33.53	090
35560		A	Artery bypass graft	31.95	NA	13.29	4.40	NA	49.64	090
35563		A	Artery bypass graft	24.16	NA	10.50	3.39	NA	38.05	090
35565		A	Artery bypass graft	23.17	NA	10.12	3.14	NA	36.43	090
35566		A	Artery bypass graft	26.88	NA	11.37	3.63	NA	41.88	090
35571		A	Artery bypass graft	24.02	NA	10.84	3.26	NA	38.12	090
35572		A	Harvest femoropopliteal vein	6.81	NA	2.23	0.76	NA	9.80	ZZZ
35582		A	Vein bypass graft	27.09	NA	11.55	3.32	NA	41.96	090
35583		A	Vein bypass graft	22.34	NA	10.15	2.97	NA	35.46	090
35585		A	Vein bypass graft	28.35	NA	12.23	3.81	NA	44.39	090
35587		A	Vein bypass graft	24.71	NA	11.44	3.34	NA	39.49	090
35600		A	Harvest artery for cabg	4.94	NA	1.62	0.64	NA	7.20	ZZZ
35601		A	Artery bypass graft	17.47	NA	8.61	2.36	NA	28.44	090
35606		A	Artery bypass graft	18.68	NA	9.00	2.52	NA	30.20	090
35612		A	Artery bypass graft	15.74	NA	7.88	2.10	NA	25.72	090
35616		A	Artery bypass graft	15.68	NA	8.10	2.18	NA	25.96	090
35621		A	Artery bypass graft	19.97	NA	8.67	2.76	NA	31.40	090
35623		A	Bypass graft, not vein	23.96	NA	10.48	3.30	NA	37.74	090
35626		A	Artery bypass graft	27.71	NA	11.96	3.80	NA	43.47	090
35631		A	Artery bypass graft	33.95	NA	13.81	4.64	NA	52.40	090
35636		A	Artery bypass graft	29.46	NA	12.28	3.84	NA	45.58	090
35641		A	Artery bypass graft	24.53	NA	11.05	3.28	NA	38.86	090
35642		A	Artery bypass graft	17.95	NA	8.67	1.88	NA	28.50	090
35645		A	Artery bypass graft	17.44	NA	8.27	2.21	NA	27.92	090
35646		A	Artery bypass graft	30.95	NA	13.08	4.20	NA	48.23	090
35647		A	Artery bypass graft	27.96	NA	11.76	3.78	NA	43.50	090
35650		A	Artery bypass graft	18.97	NA	8.35	2.55	NA	29.87	090
35651		A	Artery bypass graft	25.00	NA	10.73	3.08	NA	38.81	090
35654		A	Artery bypass graft	24.96	NA	10.63	3.40	NA	38.99	090
35656		A	Artery bypass graft	19.50	NA	8.60	2.61	NA	30.71	090
35661		A	Artery bypass graft	18.97	NA	8.91	2.56	NA	30.44	090
35663		A	Artery bypass graft	21.97	NA	9.96	2.99	NA	34.92	090
35665		A	Artery bypass graft	20.97	NA	9.43	2.84	NA	33.24	090
35666		A	Artery bypass graft	22.16	NA	10.64	3.00	NA	35.80	090
35671		A	Artery bypass graft	19.30	NA	9.36	2.62	NA	31.28	090
35681		A	Composite bypass graft	1.60	NA	0.53	0.20	NA	2.33	ZZZ
35682		A	Composite bypass graft	7.19	NA	2.38	0.95	NA	10.52	ZZZ
35683		A	Composite bypass graft	8.49	NA	2.81	1.10	NA	12.40	ZZZ
35685		A	Bypass graft patency/patch	4.04	NA	1.35	0.56	NA	5.95	ZZZ
35686		A	Bypass graft/av fist patency	3.34	NA	1.12	0.47	NA	4.93	ZZZ
35691		A	Arterial transposition	18.02	NA	8.39	2.46	NA	28.87	090
35693		A	Arterial transposition	15.34	NA	7.71	2.07	NA	25.12	090
35694		A	Arterial transposition	19.13	NA	8.59	2.63	NA	30.35	090
35695		A	Arterial transposition	19.13	NA	8.54	2.70	NA	30.37	090
35697		A	Reimplant artery each	3.00	NA	1.02	0.41	NA	4.43	ZZZ
35700		A	Reoperation, bypass graft	3.08	NA	1.02	0.42	NA	4.52	ZZZ
35701		A	Exploration, carotid artery	8.49	NA	5.15	1.16	NA	14.80	090
35721		A	Exploration, femoral artery	7.17	NA	4.45	0.99	NA	12.61	090
35741		A	Exploration popliteal artery	7.99	NA	4.68	1.08	NA	13.75	090
35761		A	Exploration of artery/vein	5.36	NA	4.04	0.73	NA	10.13	090
35800		A	Explore neck vessels	7.01	NA	4.65	0.93	NA	12.59	090
35820		A	Explore chest vessels	12.86	NA	7.18	1.72	NA	21.76	090
35840		A	Explore abdominal vessels	9.76	NA	5.28	1.27	NA	16.31	090
35860		A	Explore limb vessels	5.54	NA	4.03	0.75	NA	10.32	090
35870		A	Repair vessel graft defect	22.14	NA	9.75	2.89	NA	34.78	090
35875		A	Removal of clot in graft	10.11	NA	5.20	1.36	NA	16.67	090
35876		A	Removal of clot in graft	16.97	NA	7.54	2.28	NA	26.79	090
35879		A	Revise graft w/vein	15.98	NA	7.71	2.16	NA	25.85	090
35881		A	Revise graft w/vein	17.97	NA	8.68	2.42	NA	29.07	090
35901		A	Excision, graft, neck	8.18	NA	5.32	1.09	NA	14.59	090
35903		A	Excision, graft, extremity	9.38	NA	6.18	1.27	NA	16.83	090
35905		A	Excision, graft, thorax	31.20	NA	13.18	4.40	NA	48.78	090
35907		A	Excision, graft, abdomen	34.95	NA	14.15	4.76	NA	53.86	090
36000		A	Place needle in vein	0.18	0.60	0.05	0.01	0.79	0.24	XXX
36002		A	Pseudoaneurysm injection trt	1.96	2.87	0.97	0.18	5.01	3.11	000
36005		A	Injection ext venography	0.95	7.89	0.31	0.06	8.90	1.32	000
36010		A	Place catheter in vein	2.43	20.07	0.79	0.20	22.70	3.42	XXX
36011		A	Place catheter in vein	3.14	28.80	1.06	0.24	32.18	4.44	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
36012		A	Place catheter in vein	3.51	19.13	1.19	0.23	22.87	4.93	XXX
36013		A	Place catheter in artery	2.52	22.22	0.69	0.25	24.99	3.46	XXX
36014		A	Place catheter in artery	3.02	20.50	1.03	0.20	23.72	4.25	XXX
36015		A	Place catheter in artery	3.51	24.30	1.19	0.22	28.03	4.92	XXX
36100		A	Establish access to artery	3.02	12.32	1.11	0.28	15.62	4.41	XXX
36120		A	Establish access to artery	2.01	10.85	0.64	0.15	13.01	2.80	XXX
36140		A	Establish access to artery	2.01	13.05	0.64	0.16	15.22	2.81	XXX
36145		A	Artery to vein shunt	2.01	12.75	0.66	0.13	14.89	2.80	XXX
36160		A	Establish access to aorta	2.52	13.81	0.84	0.25	16.58	3.61	XXX
36200		A	Place catheter in aorta	3.02	16.90	1.01	0.23	20.15	4.26	XXX
36215		A	Place catheter in artery	4.67	27.75	1.60	0.31	32.73	6.58	XXX
36216		A	Place catheter in artery	5.27	29.86	1.79	0.36	35.49	7.42	XXX
36217		A	Place catheter in artery	6.29	56.62	2.17	0.44	63.35	8.90	XXX
36218		A	Place catheter in artery	1.01	5.18	0.34	0.07	6.26	1.42	ZZZ
36245		A	Place catheter in artery	4.67	33.09	1.68	0.33	38.09	6.68	XXX
36246		A	Place catheter in artery	5.27	30.97	1.81	0.38	36.62	7.46	XXX
36247		A	Place catheter in artery	6.29	50.83	2.14	0.47	57.59	8.90	XXX
36248		A	Place catheter in artery	1.01	4.12	0.34	0.07	5.20	1.42	ZZZ
36260		A	Insertion of infusion pump	9.70	NA	4.91	1.26	NA	15.87	090
36261		A	Revision of infusion pump	5.44	NA	3.68	0.62	NA	9.74	090
36262		A	Removal of infusion pump	4.01	NA	2.75	0.52	NA	7.28	090
36400		A	Bl draw < 3 yrs fem/jugular	0.38	0.28	0.09	0.03	0.69	0.50	XXX
36405		A	Bl draw < 3 yrs scalp vein	0.31	0.26	0.08	0.02	0.59	0.41	XXX
36406		A	Bl draw < 3 yrs other vein	0.18	0.29	0.05	0.01	0.48	0.24	XXX
36410		A	Non-routine bl draw > 3 yrs	0.18	0.30	0.05	0.01	0.49	0.24	XXX
36420		A	Vein access cutdown < 1 yr	1.01	0.34	0.27	0.06	1.41	1.34	XXX
36425		A	Vein access cutdown > 1 yr	0.76	NA	0.22	0.06	NA	1.04	XXX
36430		A	Blood transfusion service	0.00	1.00	NA	0.06	1.06	NA	XXX
36440		A	Bl push transfuse, 2 yr or <	1.03	NA	0.29	0.07	NA	1.39	XXX
36450		A	Bl exchange/transfuse, nb	2.23	NA	0.70	0.10	NA	3.03	XXX
36455		A	Bl exchange/transfuse non-nb	2.43	NA	1.01	0.14	NA	3.58	XXX
36460		A	Transfusion service, fetal	6.58	NA	2.24	0.88	NA	9.70	XXX
36470		A	Injection therapy of vein	1.09	2.69	0.73	0.13	3.91	1.95	010
36471		A	Injection therapy of veins	1.57	3.08	0.96	0.19	4.84	2.72	010
36481		A	Insertion of catheter, vein	6.98	6.04	2.58	0.48	13.50	10.04	000
36500		A	Insertion of catheter, vein	3.51	NA	1.36	0.24	NA	5.11	000
36510		A	Insertion of catheter, vein	1.09	3.95	0.61	0.08	5.12	1.78	000
36511		A	Apheresis wbc	1.74	NA	0.73	0.08	NA	2.55	000
36512		A	Apheresis rbc	1.74	NA	0.74	0.08	NA	2.56	000
36513		A	Apheresis platelets	1.74	NA	0.73	0.08	NA	2.55	000
36514		A	Apheresis plasma	1.74	17.69	0.71	0.08	19.51	2.53	000
36515		A	Apheresis, adsorp/reinfuse	1.74	65.03	0.65	0.08	66.85	2.47	000
36516		A	Apheresis, selective	1.22	84.13	0.48	0.08	85.43	1.78	000
36522		A	Photopheresis	1.67	30.87	1.13	0.14	32.68	2.94	000
36550		A	Declot vascular device	0.00	0.40	NA	0.37	0.77	NA	XXX
36555		A	Insert non-tunnel cv cath	2.68	5.80	0.80	0.12	8.60	3.60	000
36556		A	Insert non-tunnel cv cath	2.50	5.75	0.74	0.19	8.44	3.43	000
36557		A	Insert tunneled cv cath	5.09	21.23	2.64	0.58	26.90	8.31	010
36558		A	Insert tunneled cv cath	4.79	21.12	2.54	0.58	26.49	7.91	010
36560		A	Insert tunneled cv cath	6.24	29.79	3.03	0.58	36.61	9.85	010
36561		A	Insert tunneled cv cath	5.99	29.70	2.94	0.58	36.27	9.51	010
36563		A	Insert tunneled cv cath	6.19	26.76	2.98	0.83	33.78	10.00	010
36565		A	Insert tunneled cv cath	5.99	24.81	2.94	0.58	31.38	9.51	010
36566		A	Insert tunneled cv cath	6.49	25.60	3.11	0.58	32.67	10.18	010
36568		A	Insert tunneled cv cath	1.92	7.60	0.58	0.12	9.64	2.62	000
36569		A	Insert tunneled cv cath	1.82	7.42	0.57	0.19	9.43	2.58	000
36570		A	Insert tunneled cv cath	5.31	33.30	2.72	0.58	39.19	8.61	010
36571		A	Insert tunneled cv cath	5.29	33.38	2.71	0.58	39.25	8.58	010
36575		A	Repair tunneled cv cath	0.67	4.07	0.26	0.22	4.96	1.15	000
36576		A	Repair tunneled cv cath	3.19	6.98	1.83	0.21	10.38	5.23	010
36578		A	Replace tunneled cv cath	3.49	11.20	2.30	0.21	14.90	6.00	010
36580		A	Replace tunneled cv cath	1.31	7.08	0.41	0.19	8.58	1.91	000
36581		A	Replace tunneled cv cath	3.43	19.63	1.91	0.21	23.27	5.55	010
36582		A	Replace tunneled cv cath	5.19	26.19	2.85	0.21	31.59	8.25	010
36583		A	Replace tunneled cv cath	5.24	26.21	2.87	0.20	31.65	8.31	010
36584		A	Replace tunneled cv cath	1.20	7.11	0.55	0.19	8.50	1.94	000
36585		A	Replace tunneled cv cath	4.79	28.01	2.72	0.21	33.01	7.72	010
36589		A	Removal tunneled cv cath	2.27	2.24	1.39	0.25	4.76	3.91	010
36590		A	Removal tunneled cv cath	3.30	3.38	1.72	0.43	7.11	5.45	010
36595		A	Mech remov tunneled cv cath	3.59	17.42	1.45	0.33	21.34	5.37	000
36596		A	Mech remov tunneled cv cath	0.75	3.71	0.50	0.39	4.85	1.64	000
36597		A	Reposition venous catheter	1.21	2.41	0.44	0.08	3.70	1.73	000
36600		A	Withdrawal of arterial blood	0.32	0.49	0.09	0.02	0.83	0.43	XXX
36620		A	Insertion catheter, artery	1.15	NA	0.23	0.07	NA	1.45	000
36625		A	Insertion catheter, artery	2.11	NA	0.53	0.21	NA	2.85	000

[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
36640		A	Insertion catheter, artery	2.10	NA	1.05	0.22	NA	3.37	000
36660		A	Insertion catheter, artery	1.40	NA	0.44	0.09	NA	1.93	000
36680		A	Insert needle, bone cavity	1.20	NA	0.49	0.13	NA	1.82	000
36800		A	Insertion of cannula	2.43	NA	1.80	0.23	NA	4.46	000
36810		A	Insertion of cannula	3.96	NA	1.68	0.47	NA	6.11	000
36815		A	Insertion of cannula	2.62	NA	1.17	0.33	NA	4.12	000
36819		A	Av fusion/uppr arm vein	13.98	NA	6.36	1.87	NA	22.21	090
36820		A	Av fusion/forearm vein	13.98	NA	6.37	1.88	NA	22.23	090
36821		A	Av fusion direct any site	8.92	NA	4.67	1.18	NA	14.77	090
36822		A	Insertion of cannula(s)	5.41	NA	4.41	0.73	NA	10.55	090
36823		A	Insertion of cannula(s)	20.97	NA	9.38	2.64	NA	32.99	090
36825		A	Artery-vein autograft	9.83	NA	5.07	1.29	NA	16.19	090
36830		A	Artery-vein nonautograft	11.98	NA	5.25	1.60	NA	18.83	090
36831		A	Open thrombect av fistula	7.99	NA	3.94	1.07	NA	13.00	090
36832		A	Av fistula revision, open	10.48	NA	4.74	1.39	NA	16.61	090
36833		A	Av fistula revision	11.93	NA	5.21	1.60	NA	18.74	090
36834		A	Repair A-V aneurysm	9.92	NA	4.79	1.34	NA	16.05	090
36835		A	Artery to vein shunt	7.14	NA	4.34	0.99	NA	12.47	090
36838		A	Dist revas ligation, hemo	20.60	NA	9.37	2.99	NA	32.96	090
36860		A	External cannula declotting	2.01	1.77	0.67	0.13	3.91	2.81	000
36861		A	Cannula declotting	2.52	NA	1.49	0.25	NA	4.26	000
36870		A	Percut thrombect av fistula	5.15	32.39	3.14	0.33	37.87	8.62	090
37140		A	Revision of circulation	23.56	NA	10.46	1.71	NA	35.73	090
37145		A	Revision of circulation	24.57	NA	10.87	2.99	NA	38.43	090
37160		A	Revision of circulation	21.57	NA	9.25	2.79	NA	33.61	090
37180		A	Revision of circulation	24.57	NA	10.29	3.12	NA	37.98	090
37181		A	Splice spleen/kidney veins	26.64	NA	10.99	3.37	NA	41.00	090
37182		A	Insert hepatic shunt (tips)	16.97	NA	6.04	0.59	NA	23.60	000
37183		A	Remove hepatic shunt (tips)	7.99	NA	3.01	0.59	NA	11.59	000
37195		A	Thrombolytic therapy, stroke	0.00	8.04	NA	0.46	8.50	NA	XXX
37200		A	Transcatheter biopsy	4.55	NA	1.49	0.27	NA	6.31	000
37201		A	Transcatheter therapy infuse	4.99	NA	2.54	0.35	NA	7.88	000
37202		A	Transcatheter therapy infuse	5.67	NA	3.02	0.53	NA	9.22	000
37203		A	Transcatheter retrieval	5.02	33.39	2.03	0.33	38.74	7.38	000
37204		A	Transcatheter occlusion	18.11	NA	5.89	1.37	NA	25.37	000
37205		A	Transcatheter stent	8.27	NA	3.75	0.59	NA	12.61	000
37206		A	Transcatheter stent add-on	4.12	NA	1.43	0.31	NA	5.86	ZZZ
37207		A	Transcatheter stent	8.27	NA	3.15	1.10	NA	12.52	000
37208		A	Transcatheter stent add-on	4.12	NA	1.38	0.55	NA	6.05	ZZZ
37209		A	Exchange arterial catheter	2.27	NA	0.74	0.16	NA	3.17	000
37250		A	Iv us first vessel add-on	2.10	NA	0.75	0.20	NA	3.05	ZZZ
37251		A	Iv us each add vessel add-on	1.60	NA	0.55	0.19	NA	2.34	ZZZ
37500		A	Endoscopy ligate perf veins	10.98	NA	6.88	0.48	NA	18.34	090
37565		A	Ligation of neck vein	10.86	NA	5.61	1.31	NA	17.78	090
37600		A	Ligation of neck artery	11.23	NA	6.62	1.30	NA	19.15	090
37605		A	Ligation of neck artery	13.09	NA	6.90	1.93	NA	21.92	090
37606		A	Ligation of neck artery	6.27	NA	4.56	0.94	NA	11.77	090
37607		A	Ligation of a-v fistula	6.15	NA	3.57	0.83	NA	10.55	090
37609		A	Temporal artery procedure	3.00	4.51	1.96	0.36	7.87	5.32	010
37615		A	Ligation of neck artery	5.72	NA	4.10	0.69	NA	10.51	090
37616		A	Ligation of chest artery	16.47	NA	8.10	2.19	NA	26.76	090
37617		A	Ligation of abdomen artery	22.03	NA	9.17	2.85	NA	34.05	090
37618		A	Ligation of extremity artery	4.83	NA	3.62	0.65	NA	9.10	090
37620		A	Revision of major vein	10.54	NA	5.70	0.94	NA	17.18	090
37650		A	Revision of major vein	7.79	NA	4.69	1.05	NA	13.53	090
37660		A	Revision of major vein	20.97	NA	9.05	2.60	NA	32.62	090
37700		A	Revise leg vein	3.72	NA	2.80	0.52	NA	7.04	090
37720		A	Removal of leg vein	5.65	NA	3.71	0.79	NA	10.15	090
37730		A	Removal of leg veins	7.32	NA	4.26	0.97	NA	12.55	090
37735		A	Removal of leg veins/lesion	10.51	NA	5.50	1.48	NA	17.49	090
37760		A	Ligation, leg veins, open	10.45	NA	5.35	1.38	NA	17.18	090
37765		A	Phleb veins - extrem - to 20	7.34	NA	4.61	0.48	NA	12.43	090
37766		A	Phleb veins - extrem 20+	9.29	NA	5.31	0.48	NA	15.08	090
37780		A	Revision of leg vein	3.83	NA	2.86	0.54	NA	7.23	090
37785		A	Ligate/divide/excise vein	3.83	5.22	2.73	0.53	9.58	7.09	090
37788		A	Revascularization, penis	21.98	NA	9.18	1.56	NA	32.72	090
37790		A	Penile venous occlusion	8.33	NA	4.47	0.62	NA	13.42	090
38100		A	Removal of spleen, total	14.48	NA	6.19	1.85	NA	22.52	090
38101		A	Removal of spleen, partial	15.29	NA	6.54	2.01	NA	23.84	090
38102		A	Removal of spleen, total	4.79	NA	1.63	0.61	NA	7.03	ZZZ
38115		A	Repair of ruptured spleen	15.80	NA	6.65	1.97	NA	24.42	090
38120		A	Laparoscopy, splenectomy	16.97	NA	7.38	2.18	NA	26.53	090
38200		A	Injection for spleen x-ray	2.64	NA	0.89	0.17	NA	3.70	000
38205		R	Harvest allogenic stem cells	1.50	NA	0.68	0.06	NA	2.24	000
38206		R	Harvest auto stem cells	1.50	NA	0.67	0.06	NA	2.23	000

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[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
38220		A	Bone marrow aspiration	1.08	3.97	0.52	0.06	5.11	1.66	XXX
38221		A	Bone marrow biopsy	1.37	4.19	0.65	0.07	5.63	2.09	XXX
38230		R	Bone marrow collection	4.53	NA	3.27	0.33	NA	8.13	010
38240		R	Bone marrow/stem transplant	2.24	NA	1.03	0.11	NA	3.38	XXX
38241		R	Bone marrow/stem transplant	2.24	NA	1.04	0.11	NA	3.39	XXX
38242		A	Lymphocyte infuse transplant	1.71	NA	0.78	0.07	NA	2.56	000
38300		A	Drainage, lymph node lesion	1.99	4.36	2.06	0.22	6.57	4.27	010
38305		A	Drainage, lymph node lesion	5.99	NA	4.47	0.60	NA	11.06	090
38308		A	Incision of lymph channels	6.44	NA	3.76	0.85	NA	11.05	090
38380		A	Thoracic duct procedure	7.45	NA	5.68	0.80	NA	13.93	090
38381		A	Thoracic duct procedure	12.86	NA	6.90	1.81	NA	21.57	090
38382		A	Thoracic duct procedure	10.06	NA	5.79	1.40	NA	17.25	090
38500		A	Biopsy/removal, lymph nodes	3.74	3.71	2.08	0.48	7.93	6.30	010
38505		A	Needle biopsy, lymph nodes	1.14	2.06	0.79	0.10	3.30	2.03	000
38510		A	Biopsy/removal, lymph nodes	6.42	5.54	3.48	0.74	12.70	10.64	010
38520		A	Biopsy/removal, lymph nodes	6.66	NA	4.06	0.84	NA	11.56	090
38525		A	Biopsy/removal, lymph nodes	6.06	NA	3.33	0.79	NA	10.18	090
38530		A	Biopsy/removal, lymph nodes	7.97	NA	4.43	1.06	NA	13.46	090
38542		A	Explore deep node(s), neck	5.90	NA	4.48	0.63	NA	11.01	090
38550		A	Removal, neck/armpit lesion	6.91	NA	3.96	0.87	NA	11.74	090
38555		A	Removal, neck/armpit lesion	14.12	NA	8.57	1.67	NA	24.36	090
38562		A	Removal, pelvic lymph nodes	10.47	NA	5.79	1.21	NA	17.47	090
38564		A	Removal, abdomen lymph nodes	10.81	NA	5.27	1.31	NA	17.39	090
38570		A	Laparoscopy, lymph node biop	9.24	NA	3.97	1.12	NA	14.33	010
38571		A	Laparoscopy, lymphadenectomy	14.66	NA	5.64	1.20	NA	21.50	010
38572		A	Laparoscopy, lymphadenectomy	16.57	NA	7.07	1.89	NA	25.53	010
38700		A	Removal of lymph nodes, neck	8.23	NA	6.22	0.76	NA	15.21	090
38720		A	Removal of lymph nodes, neck	13.59	NA	9.35	1.24	NA	24.18	090
38724		A	Removal of lymph nodes, neck	14.52	NA	9.82	1.32	NA	25.66	090
38740		A	Remove armpit lymph nodes	10.01	NA	4.98	1.30	NA	16.29	090
38745		A	Remove armpit lymph nodes	13.08	NA	6.14	1.68	NA	20.90	090
38746		A	Remove thoracic lymph nodes	4.88	NA	1.61	0.67	NA	7.16	ZZZ
38747		A	Remove abdominal lymph nodes	4.88	NA	1.66	0.62	NA	7.16	ZZZ
38760		A	Remove groin lymph nodes	12.93	NA	6.16	1.65	NA	20.74	090
38765		A	Remove groin lymph nodes	19.95	NA	8.85	2.44	NA	31.24	090
38770		A	Remove pelvis lymph nodes	13.21	NA	5.76	1.37	NA	20.34	090
38780		A	Remove abdomen lymph nodes	16.57	NA	8.22	1.88	NA	26.67	090
38790		A	Inject for lymphatic x-ray	1.29	7.42	0.76	0.13	8.84	2.18	000
38792		A	Identify sentinel node	0.52	NA	0.44	0.06	NA	1.02	000
38794		A	Access thoracic lymph duct	4.44	NA	3.43	0.21	NA	8.08	090
39000		A	Exploration of chest	6.09	NA	4.68	0.83	NA	11.60	090
39010		A	Exploration of chest	11.77	NA	6.64	1.59	NA	20.00	090
39200		A	Removal chest lesion	13.60	NA	6.78	1.82	NA	22.20	090
39220		A	Removal chest lesion	17.39	NA	8.50	2.23	NA	28.12	090
39400		A	Visualization of chest	5.60	NA	4.85	0.79	NA	11.24	010
39501		A	Repair diaphragm laceration	13.17	NA	6.48	1.68	NA	21.33	090
39502		A	Repair paraesophageal hernia	16.31	NA	7.16	2.10	NA	25.57	090
39503		A	Repair of diaphragm hernia	94.86	NA	33.37	11.59	NA	139.82	090
39520		A	Repair of diaphragm hernia	16.08	NA	8.06	2.10	NA	26.24	090
39530		A	Repair of diaphragm hernia	15.39	NA	7.15	1.97	NA	24.51	090
39531		A	Repair of diaphragm hernia	16.40	NA	7.40	2.10	NA	25.90	090
39540		A	Repair of diaphragm hernia	13.30	NA	6.25	1.67	NA	21.22	090
39541		A	Repair of diaphragm hernia	14.39	NA	6.60	1.86	NA	22.85	090
39545		A	Revision of diaphragm	13.35	NA	7.57	1.81	NA	22.73	090
39560		A	Resect diaphragm, simple	11.98	NA	6.31	1.55	NA	19.84	090
39561		A	Resect diaphragm, complex	17.47	NA	9.35	2.27	NA	29.09	090
40490		A	Biopsy of lip	1.22	1.63	0.61	0.11	2.96	1.94	000
40500		A	Partial excision of lip	4.27	6.90	4.33	0.45	11.62	9.05	090
40510		A	Partial excision of lip	4.69	6.61	4.01	0.51	11.81	9.21	090
40520		A	Partial excision of lip	4.66	7.53	4.10	0.55	12.74	9.31	090
40525		A	Reconstruct lip with flap	7.54	NA	6.29	0.88	NA	14.71	090
40527		A	Reconstruct lip with flap	9.12	NA	7.33	1.01	NA	17.46	090
40530		A	Partial removal of lip	5.39	7.81	4.57	0.60	13.80	10.56	090
40650		A	Repair lip	3.63	6.79	3.32	0.39	10.81	7.34	090
40652		A	Repair lip	4.25	7.74	4.27	0.53	12.52	9.05	090
40654		A	Repair lip	5.30	8.59	4.93	0.67	14.56	10.90	090
40700		A	Repair cleft lip/nasal	12.77	NA	9.06	1.08	NA	22.91	090
40701		A	Repair cleft lip/nasal	15.83	NA	11.30	2.36	NA	29.49	090
40702		A	Repair cleft lip/nasal	13.02	NA	8.27	0.92	NA	22.21	090
40720		A	Repair cleft lip/nasal	13.53	NA	9.86	1.74	NA	25.13	090
40761		A	Repair cleft lip/nasal	14.70	NA	10.24	1.70	NA	26.64	090
40800		A	Drainage of mouth lesion	1.17	2.97	1.77	0.12	4.26	3.06	010
40801		A	Drainage of mouth lesion	2.53	4.01	2.74	0.32	6.86	5.59	010
40804		A	Removal, foreign body, mouth	1.24	3.41	1.87	0.12	4.77	3.23	010
40805		A	Removal, foreign body, mouth	2.69	4.48	2.81	0.29	7.46	5.79	010

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
40806		A	Incision of lip fold	0.31	1.83	0.50	0.03	2.17	0.84	000
40808		A	Biopsy of mouth lesion	0.96	2.65	1.48	0.10	3.71	2.54	010
40810		A	Excision of mouth lesion	1.31	2.88	1.66	0.13	4.32	3.10	010
40812		A	Excise/repair mouth lesion	2.31	3.71	2.40	0.28	6.30	4.99	010
40814		A	Excise/repair mouth lesion	3.41	4.94	3.89	0.40	8.75	7.70	090
40816		A	Excision of mouth lesion	3.66	5.17	3.99	0.39	9.22	8.04	090
40818		A	Excise oral mucosa for graft	2.41	5.17	3.97	0.21	7.79	6.59	090
40819		A	Excise lip or cheek fold	2.41	4.08	3.09	0.27	6.76	5.77	090
40820		A	Treatment of mouth lesion	1.28	3.93	2.44	0.12	5.33	3.84	010
40830		A	Repair mouth laceration	1.76	3.73	2.11	0.17	5.66	4.04	010
40831		A	Repair mouth laceration	2.46	4.65	3.05	0.28	7.39	5.79	010
40840		R	Reconstruction of mouth	8.72	9.77	6.96	0.98	19.47	16.66	090
40842		R	Reconstruction of mouth	8.72	10.04	6.78	0.94	19.70	16.44	090
40843		R	Reconstruction of mouth	12.08	11.93	7.80	1.39	25.40	21.27	090
40844		R	Reconstruction of mouth	15.99	15.74	11.55	2.12	33.85	29.66	090
40845		R	Reconstruction of mouth	18.55	17.03	13.19	2.02	37.60	33.76	090
41000		A	Drainage of mouth lesion	1.30	2.32	1.41	0.12	3.74	2.83	010
41005		A	Drainage of mouth lesion	1.26	3.33	1.73	0.15	4.74	3.14	010
41006		A	Drainage of mouth lesion	3.24	4.79	3.16	0.34	8.37	6.74	090
41007		A	Drainage of mouth lesion	3.10	5.11	3.02	0.34	8.55	6.46	090
41008		A	Drainage of mouth lesion	3.36	4.67	3.20	0.44	8.47	7.00	090
41009		A	Drainage of mouth lesion	3.58	4.96	3.56	0.45	8.99	7.59	090
41010		A	Incision of tongue fold	1.06	3.44	1.60	0.09	4.59	2.75	010
41015		A	Drainage of mouth lesion	3.95	5.39	4.14	0.49	9.83	8.58	090
41016		A	Drainage of mouth lesion	4.06	5.60	4.22	0.51	10.17	8.79	090
41017		A	Drainage of mouth lesion	4.06	5.62	4.30	0.53	10.21	8.89	090
41018		A	Drainage of mouth lesion	5.09	6.13	4.58	0.65	11.87	10.32	090
41100		A	Biopsy of tongue	1.63	2.42	1.42	0.15	4.20	3.20	010
41105		A	Biopsy of tongue	1.42	2.30	1.32	0.13	3.85	2.87	010
41108		A	Biopsy of floor of mouth	1.05	2.07	1.13	0.10	3.22	2.28	010
41110		A	Excision of tongue lesion	1.51	2.99	1.64	0.13	4.63	3.28	010
41112		A	Excision of tongue lesion	2.73	4.46	3.22	0.28	7.47	6.23	090
41113		A	Excision of tongue lesion	3.19	4.73	3.46	0.35	8.27	7.00	090
41114		A	Excision of tongue lesion	8.46	NA	7.18	0.84	NA	16.48	090
41115		A	Excision of tongue fold	1.74	3.28	1.85	0.19	5.21	3.78	010
41116		A	Excision of mouth lesion	2.44	4.35	2.80	0.23	7.02	5.47	090
41120		A	Partial removal of tongue	9.76	NA	15.31	0.84	NA	25.91	090
41130		A	Partial removal of tongue	11.13	NA	16.19	0.96	NA	28.28	090
41135		A	Tongue and neck surgery	23.06	NA	23.23	2.01	NA	48.30	090
41140		A	Removal of tongue	25.46	NA	26.66	2.50	NA	54.62	090
41145		A	Tongue removal, neck surgery	30.01	NA	30.53	2.59	NA	63.13	090
41150		A	Tongue, mouth, jaw surgery	23.01	NA	24.70	2.05	NA	49.76	090
41153		A	Tongue, mouth, neck surgery	23.73	NA	25.01	2.10	NA	50.84	090
41155		A	Tongue, jaw, & neck surgery	27.68	NA	26.79	2.44	NA	56.91	090
41250		A	Repair tongue laceration	1.91	2.76	1.19	0.18	4.85	3.28	010
41251		A	Repair tongue laceration	2.27	3.27	1.56	0.22	5.76	4.05	010
41252		A	Repair tongue laceration	2.97	3.89	2.26	0.31	7.17	5.54	010
41500		A	Fixation of tongue	3.70	NA	7.45	0.32	NA	11.47	090
41510		A	Tongue to lip surgery	3.41	NA	7.99	0.38	NA	11.78	090
41520		A	Reconstruction, tongue fold	2.73	4.62	3.61	0.27	7.62	6.61	090
41800		A	Drainage of gum lesion	1.17	2.59	1.29	0.12	3.88	2.58	010
41805		A	Removal foreign body, gum	1.24	2.67	2.22	0.15	4.06	3.61	010
41806		A	Removal foreign body,jawbone	2.69	3.58	3.03	0.35	6.62	6.07	010
41822		R	Excision of gum lesion	2.31	3.88	1.86	0.34	6.53	4.51	010
41823		R	Excision of gum lesion	3.30	5.56	4.00	0.44	9.30	7.74	090
41825		A	Excision of gum lesion	1.31	3.06	2.24	0.15	4.52	3.70	010
41826		A	Excision of gum lesion	2.31	2.43	2.10	0.30	5.04	4.71	010
41827		A	Excision of gum lesion	3.41	5.51	3.66	0.37	9.29	7.44	090
41828		R	Excision of gum lesion	3.09	3.80	2.96	0.44	7.33	6.49	010
41830		R	Removal of gum tissue	3.34	4.95	3.62	0.45	8.74	7.41	010
41872		R	Repair gum	2.59	5.01	3.45	0.22	7.82	6.26	090
41874		R	Repair tooth socket	3.09	4.83	3.17	0.45	8.37	6.71	090
42000		A	Drainage mouth roof lesion	1.23	2.57	1.26	0.11	3.91	2.60	010
42100		A	Biopsy roof of mouth	1.31	2.08	1.36	0.13	3.52	2.80	010
42104		A	Excision lesion, mouth roof	1.64	2.53	1.55	0.16	4.33	3.35	010
42106		A	Excision lesion, mouth roof	2.10	3.22	2.44	0.25	5.57	4.79	010
42107		A	Excision lesion, mouth roof	4.43	5.70	3.94	0.46	10.59	8.83	090
42120		A	Remove palate/lesion	6.16	NA	11.77	0.53	NA	18.46	090
42140		A	Excision of uvula	1.62	3.72	2.09	0.13	5.47	3.84	090
42145		A	Repair palate, pharynx/uvula	8.04	NA	7.49	0.66	NA	16.19	090
42160		A	Treatment mouth roof lesion	1.80	4.25	2.29	0.16	6.21	4.25	010
42180		A	Repair palate	2.50	3.07	2.10	0.21	5.78	4.81	010
42182		A	Repair palate	3.82	3.87	3.02	0.40	8.09	7.24	010
42200		A	Reconstruct cleft palate	11.98	NA	10.20	1.22	NA	23.40	090
42205		A	Reconstruct cleft palate	13.27	NA	10.06	1.44	NA	24.77	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
42210		A	Reconstruct cleft palate	14.48	NA	11.44	2.00	NA	27.92	090
42215		A	Reconstruct cleft palate	8.81	NA	9.05	1.31	NA	19.17	090
42220		A	Reconstruct cleft palate	7.01	NA	6.77	0.49	NA	14.27	090
42225		A	Reconstruct cleft palate	9.53	NA	16.94	0.97	NA	27.44	090
42226		A	Lengthening of palate	9.99	NA	14.63	0.89	NA	25.51	090
42227		A	Lengthening of palate	9.51	NA	15.40	1.02	NA	25.93	090
42235		A	Repair palate	7.86	NA	11.86	0.82	NA	20.54	090
42260		A	Repair nose to lip fistula	9.79	10.17	7.06	0.98	20.94	17.83	090
42280		A	Preparation, palate mold	1.54	1.95	1.14	0.21	3.70	2.89	010
42281		A	Insertion, palate prosthesis	1.93	2.62	1.87	0.16	4.71	3.96	010
42300		A	Drainage of salivary gland	1.93	2.82	1.81	0.17	4.92	3.91	010
42305		A	Drainage of salivary gland	6.06	NA	4.72	0.53	NA	11.31	090
42310		A	Drainage of salivary gland	1.56	2.26	1.54	0.15	3.97	3.25	010
42320		A	Drainage of salivary gland	2.35	3.26	2.09	0.23	5.84	4.67	010
42325		A	Create salivary cyst drain	2.75	4.61	2.31	0.22	7.58	5.28	090
42326		A	Create salivary cyst drain	3.77	5.89	3.16	0.23	9.89	7.16	090
42330		A	Removal of salivary stone	2.21	3.14	1.84	0.19	5.54	4.24	010
42335		A	Removal of salivary stone	3.31	4.90	3.14	0.30	8.51	6.75	090
42340		A	Removal of salivary stone	4.59	6.04	3.93	0.41	11.04	8.93	090
42400		A	Biopsy of salivary gland	0.78	1.65	0.72	0.06	2.49	1.56	000
42405		A	Biopsy of salivary gland	3.29	4.02	2.45	0.29	7.60	6.03	010
42408		A	Excision of salivary cyst	4.53	5.90	3.61	0.42	10.85	8.56	090
42409		A	Drainage of salivary cyst	2.81	4.52	2.76	0.23	7.56	5.80	090
42410		A	Excise parotid gland/lesion	9.33	NA	6.21	0.93	NA	16.47	090
42415		A	Excise parotid gland/lesion	16.86	NA	10.84	1.49	NA	29.19	090
42420		A	Excise parotid gland/lesion	19.56	NA	12.35	1.72	NA	33.63	090
42425		A	Excise parotid gland/lesion	13.00	NA	8.60	1.14	NA	22.74	090
42426		A	Excise parotid gland/lesion	21.23	NA	12.99	1.86	NA	36.08	090
42440		A	Excise submaxillary gland	6.96	NA	4.79	0.61	NA	12.36	090
42450		A	Excise sublingual gland	4.61	5.89	4.24	0.42	10.92	9.27	090
42500		A	Repair salivary duct	4.29	5.67	4.18	0.41	10.37	8.88	090
42505		A	Repair salivary duct	6.17	7.12	5.35	0.56	13.85	12.08	090
42507		A	Parotid duct diversion	6.10	NA	6.53	0.49	NA	13.12	090
42508		A	Parotid duct diversion	9.09	NA	8.34	0.74	NA	18.17	090
42509		A	Parotid duct diversion	11.52	NA	10.17	1.50	NA	23.19	090
42510		A	Parotid duct diversion	8.14	NA	7.78	0.66	NA	16.58	090
42550		A	Injection for salivary x-ray	1.25	3.25	0.41	0.08	4.58	1.74	000
42600		A	Closure of salivary fistula	4.81	6.57	4.12	0.40	11.78	9.33	090
42650		A	Dilation of salivary duct	0.77	1.10	0.71	0.07	1.94	1.55	000
42660		A	Dilation of salivary duct	1.13	1.35	0.85	0.09	2.57	2.07	000
42665		A	Ligation of salivary duct	2.53	4.16	2.59	0.21	6.90	5.33	090
42700		A	Drainage of tonsil abscess	1.62	2.65	1.71	0.13	4.40	3.46	010
42720		A	Drainage of throat abscess	5.41	4.82	3.78	0.48	10.71	9.67	010
42725		A	Drainage of throat abscess	10.70	NA	8.21	0.96	NA	19.87	090
42800		A	Biopsy of throat	1.39	2.18	1.40	0.12	3.69	2.91	010
42802		A	Biopsy of throat	1.54	4.77	2.06	0.13	6.44	3.73	010
42804		A	Biopsy of upper nose/throat	1.24	3.74	1.73	0.10	5.08	3.07	010
42806		A	Biopsy of upper nose/throat	1.58	4.08	1.93	0.13	5.79	3.64	010
42808		A	Excise pharynx lesion	2.30	3.09	1.93	0.19	5.58	4.42	010
42809		A	Remove pharynx foreign body	1.81	2.33	1.35	0.16	4.30	3.32	010
42810		A	Excision of neck cyst	3.25	5.71	3.54	0.31	9.27	7.10	090
42815		A	Excision of neck cyst	7.06	NA	6.40	0.63	NA	14.09	090
42820		A	Remove tonsils and adenoids	3.90	NA	3.29	0.33	NA	7.52	090
42821		A	Remove tonsils and adenoids	4.28	NA	3.50	0.35	NA	8.13	090
42825		A	Removal of tonsils	3.41	NA	3.17	0.28	NA	6.86	090
42826		A	Removal of tonsils	3.37	NA	3.03	0.28	NA	6.68	090
42830		A	Removal of adenoids	2.57	NA	2.56	0.21	NA	5.34	090
42831		A	Removal of adenoids	2.71	NA	2.84	0.22	NA	5.77	090
42835		A	Removal of adenoids	2.30	NA	2.46	0.21	NA	4.97	090
42836		A	Removal of adenoids	3.18	NA	2.95	0.26	NA	6.39	090
42842		A	Extensive surgery of throat	8.75	NA	10.99	0.72	NA	20.46	090
42844		A	Extensive surgery of throat	14.29	NA	16.23	1.24	NA	31.76	090
42845		A	Extensive surgery of throat	24.25	NA	23.17	2.07	NA	49.49	090
42860		A	Excision of tonsil tags	2.22	NA	2.40	0.19	NA	4.81	090
42870		A	Excision of lingual tonsil	5.39	NA	8.57	0.45	NA	14.41	090
42890		A	Partial removal of pharynx	12.92	NA	14.15	1.10	NA	28.17	090
42892		A	Revision of pharyngeal walls	15.81	NA	17.17	1.33	NA	34.31	090
42894		A	Revision of pharyngeal walls	22.85	NA	22.01	1.91	NA	46.77	090
42900		A	Repair throat wound	5.24	NA	3.66	0.55	NA	9.45	010
42950		A	Reconstruction of throat	8.09	NA	11.85	0.72	NA	20.66	090
42953		A	Repair throat, esophagus	8.95	NA	17.22	0.88	NA	27.05	090
42955		A	Surgical opening of throat	7.38	NA	10.69	0.70	NA	18.77	090
42960		A	Control throat bleeding	2.33	NA	1.95	0.18	NA	4.46	010
42961		A	Control throat bleeding	5.58	NA	4.96	0.46	NA	11.00	090
42962		A	Control throat bleeding	7.13	NA	5.91	0.62	NA	13.66	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
42970		A	Control nose/throat bleeding	5.42	NA	4.22	0.40	NA	10.04	090
42971		A	Control nose/throat bleeding	6.20	NA	5.12	0.54	NA	11.86	090
42972		A	Control nose/throat bleeding	7.19	NA	5.69	0.59	NA	13.47	090
43020		A	Incision of esophagus	8.08	NA	5.41	0.92	NA	14.41	090
43030		A	Throat muscle surgery	7.68	NA	5.48	0.70	NA	13.86	090
43045		A	Incision of esophagus	20.09	NA	10.71	2.22	NA	33.02	090
43100		A	Excision of esophagus lesion	9.18	NA	6.23	0.98	NA	16.39	090
43101		A	Excision of esophagus lesion	16.22	NA	7.89	2.09	NA	26.20	090
43107		A	Removal of esophagus	39.94	NA	17.05	5.03	NA	62.02	090
43108		A	Removal of esophagus	34.14	NA	14.21	4.27	NA	52.62	090
43112		A	Removal of esophagus	43.43	NA	18.14	5.61	NA	67.18	090
43113		A	Removal of esophagus	35.22	NA	15.11	4.43	NA	54.76	090
43116		A	Partial removal of esophagus	31.17	NA	16.69	3.02	NA	50.88	090
43117		A	Partial removal of esophagus	39.94	NA	16.29	4.98	NA	61.21	090
43118		A	Partial removal of esophagus	33.15	NA	13.79	4.27	NA	51.21	090
43121		A	Partial removal of esophagus	29.15	NA	12.68	4.06	NA	45.89	090
43122		A	Partial removal of esophagus	39.94	NA	16.40	5.11	NA	61.45	090
43123		A	Partial removal of esophagus	33.15	NA	14.10	4.49	NA	51.74	090
43124		A	Removal of esophagus	27.28	NA	13.09	3.28	NA	43.65	090
43130		A	Removal of esophagus pouch	11.73	NA	7.57	1.22	NA	20.52	090
43135		A	Removal of esophagus pouch	16.08	NA	8.11	2.16	NA	26.35	090
43200		A	Esophagus endoscopy	1.59	4.15	1.07	0.13	5.87	2.79	000
43201		A	Esoph scope w/submucous inj	2.09	4.61	1.10	0.13	6.83	3.32	000
43202		A	Esophagus endoscopy, biopsy	1.89	5.59	0.94	0.16	7.64	2.99	000
43204		A	Esoph scope w/sclerosis inj	3.76	NA	1.52	0.30	NA	5.58	000
43205		A	Esophagus endoscopy/ligation	3.78	NA	1.52	0.29	NA	5.59	000
43215		A	Esophagus endoscopy	2.60	NA	1.20	0.23	NA	4.03	000
43216		A	Esophagus endoscopy/lesion	2.40	NA	1.19	0.20	NA	3.79	000
43217		A	Esophagus endoscopy	2.90	7.02	1.19	0.25	10.17	4.34	000
43219		A	Esophagus endoscopy	2.80	NA	1.35	0.23	NA	4.38	000
43220		A	Esoph endoscopy, dilation	2.10	NA	0.97	0.17	NA	3.24	000
43226		A	Esoph endoscopy, dilation	2.34	NA	1.03	0.19	NA	3.56	000
43227		A	Esoph endoscopy, repair	3.59	NA	1.45	0.28	NA	5.32	000
43228		A	Esoph endoscopy, ablation	3.76	NA	1.55	0.35	NA	5.66	000
43231		A	Esoph endoscopy w/us exam	3.19	NA	1.31	0.23	NA	4.73	000
43232		A	Esoph endoscopy w/us fn bx	4.47	NA	1.81	0.31	NA	6.59	000
43234		A	Upper GI endoscopy, exam	2.01	5.37	0.87	0.17	7.55	3.05	000
43235		A	Uppr gi endoscopy, diagnosis	2.39	5.22	1.02	0.19	7.80	3.60	000
43236		A	Uppr gi scope w/submuc inj	2.92	6.45	1.22	0.19	9.56	4.33	000
43237		A	Endoscopic us exam, esoph	3.98	NA	1.59	0.43	NA	6.00	000
43238		A	Uppr gi endoscopy w/us fn bx	5.02	NA	1.96	0.43	NA	7.41	000
43239		A	Upper GI endoscopy, biopsy	2.87	5.77	1.19	0.23	8.87	4.29	000
43240		A	Esoph endoscope w/drain cyst	6.85	NA	2.60	0.54	NA	9.99	000
43241		A	Upper GI endoscopy with tube	2.59	NA	1.10	0.21	NA	3.90	000
43242		A	Uppr gi endoscopy w/us fn bx	7.30	NA	2.73	0.53	NA	10.56	000
43243		A	Upper gi endoscopy & inject	4.56	NA	1.79	0.34	NA	6.69	000
43244		A	Upper GI endoscopy/ligation	5.04	NA	1.96	0.37	NA	7.37	000
43245		A	Uppr gi scope dilate strictr	3.18	NA	1.30	0.28	NA	4.76	000
43246		A	Place gastrostomy tube	4.32	NA	1.69	0.34	NA	6.35	000
43247		A	Operative upper GI endoscopy	3.38	NA	1.37	0.27	NA	5.02	000
43248		A	Uppr gi endoscopy/guide wire	3.15	NA	1.31	0.24	NA	4.70	000
43249		A	Esoph endoscopy, dilation	2.90	NA	1.21	0.22	NA	4.33	000
43250		A	Upper GI endoscopy/tumor	3.20	NA	1.31	0.26	NA	4.77	000
43251		A	Operative upper GI endoscopy	3.69	NA	1.48	0.29	NA	5.46	000
43255		A	Operative upper GI endoscopy	4.81	NA	1.88	0.36	NA	7.05	000
43256		A	Uppr gi endoscopy w stent	4.34	NA	1.71	0.37	NA	6.42	000
43258		A	Operative upper GI endoscopy	4.54	NA	1.78	0.35	NA	6.67	000
43259		A	Endoscopic ultrasound exam	5.19	NA	1.99	0.36	NA	7.54	000
43260		A	Endo cholangiopancreatograph	5.95	NA	2.28	0.44	NA	8.67	000
43261		A	Endo cholangiopancreatograph	6.26	NA	2.39	0.46	NA	9.11	000
43262		A	Endo cholangiopancreatograph	7.38	NA	2.78	0.55	NA	10.71	000
43263		A	Endo cholangiopancreatograph	7.28	NA	2.76	0.55	NA	10.59	000
43264		A	Endo cholangiopancreatograph	8.89	NA	3.31	0.66	NA	12.86	000
43265		A	Endo cholangiopancreatograph	10.00	NA	3.69	0.74	NA	14.43	000
43267		A	Endo cholangiopancreatograph	7.38	NA	2.78	0.56	NA	10.72	000
43268		A	Endo cholangiopancreatograph	7.38	NA	2.88	0.55	NA	10.81	000
43269		A	Endo cholangiopancreatograph	8.20	NA	3.07	0.61	NA	11.88	000
43271		A	Endo cholangiopancreatograph	7.38	NA	2.77	0.54	NA	10.69	000
43272		A	Endo cholangiopancreatograph	7.38	NA	2.78	0.55	NA	10.71	000
43280		A	Laparoscopy, fundoplasty	17.22	NA	7.28	2.20	NA	26.70	090
43300		A	Repair of esophagus	9.13	NA	6.45	1.01	NA	16.59	090
43305		A	Repair esophagus and fistula	17.36	NA	10.72	1.53	NA	29.61	090
43310		A	Repair of esophagus	25.35	NA	11.08	3.44	NA	39.87	090
43312		A	Repair esophagus and fistula	28.38	NA	11.93	3.43	NA	43.74	090
43313		A	Esophagoplasty congenital	45.21	NA	18.82	6.55	NA	70.58	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
43314		A	Tracheo-esophagoplasty cong	50.19	NA	19.15	6.67	NA	76.01	090
43320		A	Fuse esophagus & stomach	19.90	NA	9.21	2.41	NA	31.52	090
43324		A	Revise esophagus & stomach	20.54	NA	8.77	2.59	NA	31.90	090
43325		A	Revise esophagus & stomach	20.03	NA	8.79	2.54	NA	31.36	090
43326		A	Revise esophagus & stomach	19.71	NA	9.29	2.63	NA	31.63	090
43330		A	Repair of esophagus	19.74	NA	8.54	2.51	NA	30.79	090
43331		A	Repair of esophagus	20.10	NA	9.79	2.65	NA	32.54	090
43340		A	Fuse esophagus & intestine	19.58	NA	8.97	2.49	NA	31.04	090
43341		A	Fuse esophagus & intestine	20.82	NA	10.03	2.89	NA	33.74	090
43350		A	Surgical opening, esophagus	15.76	NA	8.46	1.78	NA	26.00	090
43351		A	Surgical opening, esophagus	18.32	NA	9.79	2.46	NA	30.57	090
43352		A	Surgical opening, esophagus	15.24	NA	8.39	1.85	NA	25.48	090
43360		A	Gastrointestinal repair	35.65	NA	15.07	4.26	NA	54.98	090
43361		A	Gastrointestinal repair	40.44	NA	16.88	4.52	NA	61.84	090
43400		A	Ligate esophagus veins	21.17	NA	9.45	2.04	NA	32.66	090
43401		A	Esophagus surgery for veins	22.06	NA	9.49	2.61	NA	34.16	090
43405		A	Ligate/staple esophagus	19.98	NA	9.57	2.56	NA	32.11	090
43410		A	Repair esophagus wound	13.45	NA	7.64	1.63	NA	22.72	090
43415		A	Repair esophagus wound	24.96	NA	11.73	3.34	NA	40.03	090
43420		A	Repair esophagus opening	14.33	NA	7.45	1.38	NA	23.16	090
43425		A	Repair esophagus opening	21.00	NA	9.97	2.62	NA	33.59	090
43450		A	Dilate esophagus	1.38	2.67	0.69	0.11	4.16	2.18	000
43453		A	Dilate esophagus	1.51	6.11	0.73	0.11	7.73	2.35	000
43456		A	Dilate esophagus	2.57	13.83	1.10	0.20	16.60	3.87	000
43458		A	Dilate esophagus	3.06	6.69	1.28	0.25	10.00	4.59	000
43460		A	Pressure treatment esophagus	3.79	NA	1.48	0.31	NA	5.58	000
43500		A	Surgical opening of stomach	11.03	NA	4.98	1.39	NA	17.40	090
43501		A	Surgical repair of stomach	20.01	NA	8.31	2.57	NA	30.89	090
43502		A	Surgical repair of stomach	23.10	NA	9.45	2.75	NA	35.30	090
43510		A	Surgical opening of stomach	13.06	NA	6.61	1.54	NA	21.21	090
43520		A	Incision of pyloric muscle	9.98	NA	5.27	1.30	NA	16.55	090
43600		A	Biopsy of stomach	1.91	NA	0.66	0.15	NA	2.72	000
43605		A	Biopsy of stomach	11.96	NA	5.28	1.54	NA	18.78	090
43610		A	Excision of stomach lesion	14.58	NA	6.16	1.88	NA	22.62	090
43611		A	Excision of stomach lesion	17.81	NA	7.56	2.30	NA	27.67	090
43620		A	Removal of stomach	29.99	NA	11.80	3.85	NA	45.64	090
43621		A	Removal of stomach	30.68	NA	11.98	3.94	NA	46.60	090
43622		A	Removal of stomach	32.48	NA	12.58	4.17	NA	49.23	090
43631		A	Removal of stomach, partial	22.56	NA	9.15	2.90	NA	34.61	090
43632		A	Removal of stomach, partial	22.56	NA	9.15	2.90	NA	34.61	090
43633		A	Removal of stomach, partial	23.07	NA	9.32	2.96	NA	35.35	090
43634		A	Removal of stomach, partial	25.08	NA	10.08	3.13	NA	38.29	090
43635		A	Removal of stomach, partial	2.06	NA	0.70	0.27	NA	3.03	ZZZ
43638		A	Removal of stomach, partial	28.96	NA	11.87	3.72	NA	44.55	090
43639		A	Removal of stomach, partial	29.61	NA	11.68	3.78	NA	45.07	090
43640		A	Vagotomy & pylorus repair	16.99	NA	7.26	2.19	NA	26.44	090
43641		A	Vagotomy & pylorus repair	17.24	NA	7.37	2.16	NA	26.77	090
43651		A	Laparoscopy, vagus nerve	10.13	NA	4.76	1.32	NA	16.21	090
43652		A	Laparoscopy, vagus nerve	12.13	NA	5.75	1.51	NA	19.39	090
43653		A	Laparoscopy, gastrostomy	7.72	NA	4.19	0.98	NA	12.89	090
43750		A	Place gastrostomy tube	4.48	NA	2.19	0.43	NA	7.10	010
43752		A	Nasal/orogastric w/stent	0.68	0.23	0.22	0.02	0.93	0.92	000
43760		A	Change gastrostomy tube	1.10	2.10	0.45	0.09	3.29	1.64	000
43761		A	Reposition gastrostomy tube	2.01	1.19	0.66	0.14	3.34	2.81	000
43800		A	Reconstruction of pylorus	13.67	NA	5.91	1.76	NA	21.34	090
43810		A	Fusion of stomach and bowel	14.63	NA	6.19	1.91	NA	22.73	090
43820		A	Fusion of stomach and bowel	15.35	NA	6.42	1.96	NA	23.73	090
43825		A	Fusion of stomach and bowel	19.19	NA	8.01	2.45	NA	29.65	090
43830		A	Place gastrostomy tube	9.52	NA	4.85	1.18	NA	15.55	090
43831		A	Place gastrostomy tube	7.83	NA	4.52	1.00	NA	13.35	090
43832		A	Place gastrostomy tube	15.58	NA	6.86	1.94	NA	24.38	090
43840		A	Repair of stomach lesion	15.54	NA	6.77	2.00	NA	24.31	090
43842		A	Gastroplasty for obesity	18.44	NA	7.95	2.40	NA	28.79	090
43843		A	Gastroplasty for obesity	18.62	NA	7.91	2.45	NA	28.98	090
43846		A	Gastric bypass for obesity	24.01	NA	10.17	3.09	NA	37.27	090
43847		A	Gastric bypass for obesity	26.88	NA	11.07	3.49	NA	41.44	090
43848		A	Revision gastroplasty	29.35	NA	11.99	3.80	NA	45.14	090
43850		A	Revise stomach-bowel fusion	24.68	NA	9.81	3.17	NA	37.66	090
43855		A	Revise stomach-bowel fusion	26.12	NA	10.32	3.43	NA	39.87	090
43860		A	Revise stomach-bowel fusion	24.96	NA	9.97	3.19	NA	38.12	090
43865		A	Revise stomach-bowel fusion	26.48	NA	10.50	3.46	NA	40.44	090
43870		A	Repair stomach opening	9.68	NA	4.53	1.21	NA	15.42	090
43880		A	Repair stomach-bowel fistula	24.61	NA	9.90	3.11	NA	37.62	090
44005		A	Freeing of bowel adhesion	16.21	NA	6.73	2.06	NA	25.00	090
44010		A	Incision of small bowel	12.50	NA	5.46	1.60	NA	19.56	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
44015		A	Insert needle cath bowel	2.62	NA	0.88	0.33	NA	3.83	ZZZ
44020		A	Explore small intestine	13.97	NA	5.94	1.77	NA	21.68	090
44021		A	Decompress small bowel	14.06	NA	5.98	1.78	NA	21.82	090
44025		A	Incision of large bowel	14.26	NA	6.03	1.81	NA	22.10	090
44050		A	Reduce bowel obstruction	14.01	NA	5.96	1.79	NA	21.76	090
44055		A	Correct malrotation of bowel	21.97	NA	8.73	2.81	NA	33.51	090
44100		A	Biopsy of bowel	2.01	NA	0.71	0.17	NA	2.89	000
44110		A	Excise intestine lesion(s)	11.79	NA	5.24	1.48	NA	18.51	090
44111		A	Excision of bowel lesion(s)	14.27	NA	6.12	1.80	NA	22.19	090
44120		A	Removal of small intestine	16.97	NA	7.08	2.13	NA	26.18	090
44121		A	Removal of small intestine	4.44	NA	1.52	0.55	NA	6.51	ZZZ
44125		A	Removal of small intestine	17.51	NA	7.26	2.19	NA	26.96	090
44126		A	Enterectomy w/o taper, cong	35.45	NA	14.10	4.60	NA	54.15	090
44127		A	Enterectomy w/taper, cong	40.94	NA	15.69	5.41	NA	62.04	090
44128		A	Enterectomy cong, add-on	4.44	NA	1.53	0.59	NA	6.56	ZZZ
44130		A	Bowel to bowel fusion	14.47	NA	6.22	1.80	NA	22.49	090
44139		A	Mobilization of colon	2.23	NA	0.76	0.28	NA	3.27	ZZZ
44140		A	Partial removal of colon	20.97	NA	8.64	2.62	NA	32.23	090
44141		A	Partial removal of colon	19.48	NA	10.04	2.42	NA	31.94	090
44143		A	Partial removal of colon	22.96	NA	10.69	2.91	NA	36.56	090
44144		A	Partial removal of colon	21.50	NA	9.62	2.71	NA	33.83	090
44145		A	Partial removal of colon	26.38	NA	10.80	3.22	NA	40.40	090
44146		A	Partial removal of colon	27.50	NA	12.85	3.35	NA	43.70	090
44147		A	Partial removal of colon	20.68	NA	8.68	2.48	NA	31.84	090
44150		A	Removal of colon	23.91	NA	12.03	2.98	NA	38.92	090
44151		A	Removal of colon/ileostomy	26.84	NA	13.39	3.39	NA	43.62	090
44152		A	Removal of colon/ileostomy	27.79	NA	11.59	3.40	NA	42.78	090
44153		A	Removal of colon/ileostomy	30.54	NA	14.38	3.30	NA	48.22	090
44155		A	Removal of colon/ileostomy	27.82	NA	13.30	3.25	NA	44.37	090
44156		A	Removal of colon/ileostomy	30.74	NA	15.03	3.95	NA	49.72	090
44160		A	Removal of colon	18.59	NA	7.74	2.31	NA	28.64	090
44200		A	Laparoscopy, enterolysis	14.42	NA	6.19	1.75	NA	22.36	090
44201		A	Laparoscopy, jejunostomy	9.77	NA	4.66	1.25	NA	15.68	090
44202		A	Lap resect s/intestine singl	22.01	NA	8.92	2.71	NA	33.64	090
44203		A	Lap resect s/intestine, addl	4.44	NA	1.49	0.56	NA	6.49	ZZZ
44204		A	Laparo partial colectomy	25.04	NA	9.94	3.05	NA	38.03	090
44205		A	Lap colectomy part w/ileum	22.20	NA	8.83	2.69	NA	33.72	090
44206		A	Lap part colectomy w/stoma	26.96	NA	11.22	2.91	NA	41.09	090
44207		A	L colectomy/coloproctostomy	29.96	NA	11.46	3.22	NA	44.64	090
44208		A	L colectomy/coloproctostomy	31.95	NA	13.09	3.35	NA	48.39	090
44210		A	Laparo total proctocolectomy	27.96	NA	11.83	2.98	NA	42.77	090
44211		A	Laparo total proctocolectomy	34.95	NA	14.61	3.35	NA	52.91	090
44212		A	Laparo total proctocolectomy	32.45	NA	13.59	3.25	NA	49.29	090
44300		A	Open bowel to skin	12.09	NA	5.49	1.55	NA	19.13	090
44310		A	Ileostomy/jejunostomy	15.93	NA	6.69	1.94	NA	24.56	090
44312		A	Revision of ileostomy	8.01	NA	3.99	0.90	NA	12.90	090
44314		A	Revision of ileostomy	15.03	NA	6.55	1.73	NA	23.31	090
44316		A	Devise bowel pouch	21.06	NA	8.54	2.41	NA	32.01	090
44320		A	Colostomy	17.61	NA	7.65	2.21	NA	27.47	090
44322		A	Colostomy with biopsies	11.96	NA	8.59	1.51	NA	22.06	090
44340		A	Revision of colostomy	7.71	NA	4.27	0.97	NA	12.95	090
44345		A	Revision of colostomy	15.41	NA	6.88	1.92	NA	24.21	090
44346		A	Revision of colostomy	16.96	NA	7.38	2.07	NA	26.41	090
44360		A	Small bowel endoscopy	2.59	NA	1.10	0.19	NA	3.88	000
44361		A	Small bowel endoscopy/biopsy	2.87	NA	1.20	0.21	NA	4.28	000
44363		A	Small bowel endoscopy	3.49	NA	1.38	0.26	NA	5.13	000
44364		A	Small bowel endoscopy	3.73	NA	1.49	0.28	NA	5.50	000
44365		A	Small bowel endoscopy	3.31	NA	1.36	0.25	NA	4.92	000
44366		A	Small bowel endoscopy	4.40	NA	1.73	0.32	NA	6.45	000
44369		A	Small bowel endoscopy	4.51	NA	1.73	0.34	NA	6.58	000
44370		A	Small bowel endoscopy/stent	4.79	NA	1.97	0.36	NA	7.12	000
44372		A	Small bowel endoscopy	4.40	NA	1.72	0.35	NA	6.47	000
44373		A	Small bowel endoscopy	3.49	NA	1.42	0.26	NA	5.17	000
44376		A	Small bowel endoscopy	5.25	NA	2.02	0.41	NA	7.68	000
44377		A	Small bowel endoscopy/biopsy	5.52	NA	2.13	0.40	NA	8.05	000
44378		A	Small bowel endoscopy	7.12	NA	2.69	0.53	NA	10.34	000
44379		A	S bowel endoscope w/stent	7.46	NA	2.91	0.55	NA	10.92	000
44380		A	Small bowel endoscopy	1.05	NA	0.55	0.08	NA	1.68	000
44382		A	Small bowel endoscopy	1.27	NA	0.63	0.12	NA	2.02	000
44383		A	Ileoscopy w/stent	2.94	NA	1.27	0.24	NA	4.45	000
44385		A	Endoscopy of bowel pouch	1.82	3.35	0.75	0.15	5.32	2.72	000
44386		A	Endoscopy, bowel pouch/biop	2.12	6.68	0.88	0.19	8.99	3.19	000
44388		A	Colonoscopy	2.82	5.14	1.15	0.26	8.22	4.23	000
44389		A	Colonoscopy with biopsy	3.13	6.70	1.27	0.27	10.10	4.67	000
44390		A	Colonoscopy for foreign body	3.82	7.19	1.49	0.30	11.31	5.61	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
44391		A	Colonoscopy for bleeding	4.31	8.84	1.69	0.34	13.49	6.34	000
44392		A	Colonoscopy & polypectomy	3.81	6.66	1.49	0.34	10.81	5.64	000
44393		A	Colonoscopy, lesion removal	4.83	6.99	1.86	0.41	12.23	7.10	000
44394		A	Colonoscopy w/snare	4.42	7.90	1.72	0.39	12.71	6.53	000
44397		A	Colonoscopy w/stent	4.70	NA	1.78	0.42	NA	6.90	000
44500		A	Intro, gastrointestinal tube	0.49	NA	0.16	0.03	NA	0.68	000
44602		A	Suture, small intestine	16.01	NA	6.38	2.00	NA	24.39	090
44603		A	Suture, small intestine	18.63	NA	7.26	2.37	NA	28.26	090
44604		A	Suture, large intestine	16.01	NA	6.45	2.02	NA	24.48	090
44605		A	Repair of bowel lesion	19.50	NA	8.38	2.46	NA	30.34	090
44615		A	Intestinal stricturoplasty	15.91	NA	6.67	1.99	NA	24.57	090
44620		A	Repair bowel opening	12.18	NA	5.32	1.47	NA	18.97	090
44625		A	Repair bowel opening	15.03	NA	6.30	1.82	NA	23.15	090
44626		A	Repair bowel opening	25.32	NA	9.80	3.19	NA	38.31	090
44640		A	Repair bowel-skin fistula	21.62	NA	8.57	2.71	NA	32.90	090
44650		A	Repair bowel fistula	22.54	NA	8.87	2.79	NA	34.20	090
44660		A	Repair bowel-bladder fistula	21.33	NA	8.33	2.21	NA	31.87	090
44661		A	Repair bowel-bladder fistula	24.77	NA	9.54	2.80	NA	37.11	090
44680		A	Surgical revision, intestine	15.38	NA	6.44	1.95	NA	23.77	090
44700		A	Suspend bowel w/prosthesis	16.09	NA	6.65	1.79	NA	24.53	090
44701		A	Intraop colon lavage add-on	3.10	NA	1.05	0.28	NA	4.43	ZZZ
44800		A	Excision of bowel pouch	11.21	NA	5.39	1.40	NA	18.00	090
44820		A	Excision of mesentery lesion	12.07	NA	5.48	1.53	NA	19.08	090
44850		A	Repair of mesentery	10.72	NA	5.00	1.35	NA	17.07	090
44900		A	Drain app abscess, open	10.12	NA	4.70	1.29	NA	16.11	090
44901		A	Drain app abscess, percut	3.37	28.20	1.11	0.22	31.79	4.70	000
44950		A	Appendectomy	9.99	NA	4.31	1.27	NA	15.57	090
44955		A	Appendectomy add-on	1.53	NA	0.54	0.19	NA	2.26	ZZZ
44960		A	Appendectomy	12.32	NA	5.34	1.59	NA	19.25	090
44970		A	Laparoscopy, appendectomy	8.69	NA	4.21	1.12	NA	14.02	090
45000		A	Drainage of pelvic abscess	4.51	NA	2.96	0.50	NA	7.97	090
45005		A	Drainage of rectal abscess	1.99	4.08	1.59	0.24	6.31	3.82	010
45020		A	Drainage of rectal abscess	4.71	NA	3.28	0.53	NA	8.52	090
45100		A	Biopsy of rectum	3.67	NA	2.37	0.41	NA	6.45	090
45108		A	Removal of anorectal lesion	4.75	NA	2.78	0.59	NA	8.12	090
45110		A	Removal of rectum	27.96	NA	12.39	3.35	NA	43.70	090
45111		A	Partial removal of rectum	16.46	NA	7.17	2.00	NA	25.63	090
45112		A	Removal of rectum	30.49	NA	11.75	3.51	NA	45.75	090
45113		A	Partial proctectomy	30.53	NA	12.59	3.53	NA	46.65	090
45114		A	Partial removal of rectum	27.28	NA	10.85	3.32	NA	41.45	090
45116		A	Partial removal of rectum	24.54	NA	10.01	2.90	NA	37.45	090
45119		A	Remove rectum w/reservoir	30.79	NA	12.44	3.30	NA	46.53	090
45120		A	Removal of rectum	24.56	NA	10.12	3.04	NA	37.72	090
45121		A	Removal of rectum and colon	27.00	NA	11.10	3.37	NA	41.47	090
45123		A	Partial proctectomy	16.68	NA	6.85	1.85	NA	25.38	090
45126		A	Pelvic exenteration	45.09	NA	19.20	4.86	NA	69.15	090
45130		A	Excision of rectal prolapse	16.42	NA	6.76	1.75	NA	24.93	090
45135		A	Excision of rectal prolapse	19.25	NA	8.42	2.33	NA	30.00	090
45136		A	Excise ileoanal reservior	27.26	NA	12.45	2.93	NA	42.64	090
45150		A	Excision of rectal stricture	5.66	NA	2.97	0.58	NA	9.21	090
45160		A	Excision of rectal lesion	15.30	NA	6.64	1.64	NA	23.58	090
45170		A	Excision of rectal lesion	11.47	NA	5.24	1.35	NA	18.06	090
45190		A	Destruction, rectal tumor	9.73	NA	4.66	1.13	NA	15.52	090
45300		A	Proctosigmoidoscopy dx	0.38	1.55	0.29	0.04	1.97	0.71	000
45303		A	Proctosigmoidoscopy dilate	0.44	18.84	0.33	0.04	19.32	0.81	000
45305		A	Proctosigmoidoscopy w/bx	1.01	2.65	0.50	0.11	3.77	1.62	000
45307		A	Proctosigmoidoscopy fb	0.94	3.07	0.48	0.10	4.11	1.52	000
45308		A	Proctosigmoidoscopy removal	0.83	2.00	0.44	0.09	2.92	1.36	000
45309		A	Proctosigmoidoscopy removal	2.01	2.83	0.84	0.22	5.06	3.07	000
45315		A	Proctosigmoidoscopy removal	1.40	2.89	0.64	0.16	4.45	2.20	000
45317		A	Proctosigmoidoscopy bleed	1.50	2.44	0.66	0.15	4.09	2.31	000
45320		A	Proctosigmoidoscopy ablate	1.58	2.93	0.71	0.15	4.66	2.44	000
45321		A	Proctosigmoidoscopy volvul	1.17	NA	0.56	0.13	NA	1.86	000
45327		A	Proctosigmoidoscopy w/stent	1.65	NA	0.69	0.16	NA	2.50	000
45330		A	Diagnostic sigmoidoscopy	0.96	2.30	0.50	0.08	3.34	1.54	000
45331		A	Sigmoidoscopy and biopsy	1.15	3.11	0.59	0.09	4.35	1.83	000
45332		A	Sigmoidoscopy w/fb removal	1.79	5.05	0.80	0.15	6.99	2.74	000
45333		A	Sigmoidoscopy & polypectomy	1.79	4.91	0.80	0.15	6.85	2.74	000
45334		A	Sigmoidoscopy for bleeding	2.73	NA	1.14	0.21	NA	4.08	000
45335		A	Sigmoidoscopy w/submuc inj	1.46	3.22	0.69	0.04	4.72	2.19	000
45337		A	Sigmoidoscopy & decompress	2.36	NA	1.00	0.22	NA	3.58	000
45338		A	Sigmoidoscopy w/tumr remove	2.34	5.24	1.00	0.20	7.78	3.54	000
45339		A	Sigmoidoscopy w/ablate tumr	3.14	3.47	1.28	0.26	6.87	4.68	000
45340		A	Sig w/balloon dilation	1.89	6.18	0.83	0.04	8.11	2.76	000
45341		A	Sigmoidoscopy w/ultrasound	2.60	NA	1.07	0.20	NA	3.87	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
45342		A	Sigmoidoscopy w/us guide bx	4.05	NA	1.55	0.30	NA	5.90	000
45345		A	Sigmoidoscopy w/stent	2.92	NA	1.16	0.24	NA	4.32	000
45355		A	Surgical colonoscopy	3.51	NA	1.38	0.35	NA	5.24	000
45378		A	Diagnostic colonoscopy	3.69	6.20	1.47	0.24	10.13	5.40	000
45378	53	A	Diagnostic colonoscopy	0.96	2.30	0.50	0.08	3.34	1.54	000
45379		A	Colonoscopy w/fb removal	4.68	7.75	1.81	0.38	12.81	6.87	000
45380		A	Colonoscopy and biopsy	4.43	7.26	1.73	0.35	12.04	6.51	000
45381		A	Colonoscopy, submucous inj	4.19	7.17	1.65	0.31	11.67	6.15	000
45382		A	Colonoscopy/control bleeding	5.68	10.01	2.18	0.43	16.12	8.29	000
45383		A	Lesion removal colonoscopy	5.86	7.99	2.22	0.48	14.33	8.56	000
45384		A	Lesion remove colonoscopy	4.69	6.85	1.82	0.38	11.92	6.89	000
45385		A	Lesion removal colonoscopy	5.30	7.86	2.03	0.42	13.58	7.75	000
45386		A	Colonoscopy dilate stricture	4.57	12.46	1.77	0.31	17.34	6.65	000
45387		A	Colonoscopy w/stent	5.90	NA	2.33	0.49	NA	8.72	000
45500		A	Repair of rectum	7.28	NA	3.58	0.73	NA	11.59	090
45505		A	Repair of rectum	7.57	NA	3.86	0.83	NA	12.26	090
45520		A	Treatment of rectal prolapse	0.55	1.65	0.37	0.05	2.25	0.97	000
45540		A	Correct rectal prolapse	16.25	NA	6.82	1.84	NA	24.91	090
45541		A	Correct rectal prolapse	13.38	NA	5.96	1.53	NA	20.87	090
45550		A	Repair rectum/remove sigmoid	22.97	NA	9.23	2.61	NA	34.81	090
45560		A	Repair of rectocele	10.56	NA	5.09	1.14	NA	16.79	090
45562		A	Exploration/repair of rectum	15.36	NA	7.00	1.81	NA	24.17	090
45563		A	Exploration/repair of rectum	23.43	NA	10.52	2.95	NA	36.90	090
45800		A	Repair rect/bladder fistula	17.74	NA	7.45	1.89	NA	27.08	090
45805		A	Repair fistula w/colostomy	20.75	NA	9.52	2.32	NA	32.59	090
45820		A	Repair rectourethral fistula	18.45	NA	7.64	1.66	NA	27.75	090
45825		A	Repair fistula w/colostomy	21.22	NA	9.83	2.15	NA	33.20	090
45900		A	Reduction of rectal prolapse	2.61	NA	1.51	0.29	NA	4.41	010
45905		A	Dilation of anal sphincter	2.30	NA	1.43	0.27	NA	4.00	010
45910		A	Dilation of rectal narrowing	2.80	NA	1.67	0.28	NA	4.75	010
45915		A	Remove rectal obstruction	3.14	4.36	2.10	0.30	7.80	5.54	010
46020		A	Placement of seton	2.90	2.35	1.86	0.35	5.60	5.11	010
46030		A	Removal of rectal marker	1.23	1.35	0.71	0.14	2.72	2.08	010
46040		A	Incision of rectal abscess	4.95	5.52	3.61	0.60	11.07	9.16	090
46045		A	Incision of rectal abscess	4.31	NA	2.91	0.53	NA	7.75	090
46050		A	Incision of anal abscess	1.19	2.56	0.85	0.14	3.89	2.18	010
46060		A	Incision of rectal abscess	5.68	NA	3.28	0.67	NA	9.63	090
46070		A	Incision of anal septum	2.71	NA	1.86	0.20	NA	4.77	090
46080		A	Incision of anal sphincter	2.49	2.38	1.13	0.30	5.17	3.92	010
46083		A	Incise external hemorrhoid	1.40	2.55	0.94	0.15	4.10	2.49	010
46200		A	Removal of anal fissure	3.41	3.87	2.88	0.39	7.67	6.68	090
46210		A	Removal of anal crypt	2.67	5.16	2.64	0.31	8.14	5.62	090
46211		A	Removal of anal crypts	4.24	5.44	3.52	0.52	10.20	8.28	090
46220		A	Removal of anal tag	1.56	2.22	0.93	0.18	3.96	2.67	010
46221		A	Ligation of hemorrhoid(s)	2.04	2.65	1.75	0.22	4.91	4.01	010
46230		A	Removal of anal tags	2.57	3.00	1.27	0.29	5.86	4.13	010
46250		A	Hemorrhoidectomy	3.88	5.34	2.62	0.46	9.68	6.96	090
46255		A	Hemorrhoidectomy	4.59	5.87	2.84	0.57	11.03	8.00	090
46257		A	Remove hemorrhoids & fissure	5.39	NA	2.89	0.64	NA	8.92	090
46258		A	Remove hemorrhoids & fistula	5.72	NA	3.29	0.68	NA	9.69	090
46260		A	Hemorrhoidectomy	6.36	NA	3.23	0.75	NA	10.34	090
46261		A	Remove hemorrhoids & fissure	7.07	NA	3.64	0.81	NA	11.52	090
46262		A	Remove hemorrhoids & fistula	7.49	NA	3.77	0.85	NA	12.11	090
46270		A	Removal of anal fistula	3.71	5.02	2.85	0.46	9.19	7.02	090
46275		A	Removal of anal fistula	4.55	4.65	2.98	0.51	9.71	8.04	090
46280		A	Removal of anal fistula	5.97	NA	3.29	0.66	NA	9.92	090
46285		A	Removal of anal fistula	4.08	3.76	2.75	0.45	8.29	7.28	090
46288		A	Repair anal fistula	7.12	NA	3.71	0.79	NA	11.62	090
46320		A	Removal of hemorrhoid clot	1.61	2.14	0.86	0.17	3.92	2.64	010
46500		A	Injection into hemorrhoid(s)	1.61	2.12	1.16	0.16	3.89	2.93	010
46600		A	Diagnostic anoscopy	0.50	1.57	0.35	0.05	2.12	0.90	000
46604		A	Anoscopy and dilation	1.31	9.16	0.62	0.13	10.60	2.06	000
46606		A	Anoscopy and biopsy	0.81	3.81	0.43	0.09	4.71	1.33	000
46608		A	Anoscopy, remove for body	1.51	4.44	0.65	0.16	6.11	2.32	000
46610		A	Anoscopy, remove lesion	1.32	4.05	0.61	0.15	5.52	2.08	000
46611		A	Anoscopy	1.81	3.36	0.78	0.19	5.36	2.78	000
46612		A	Anoscopy, remove lesions	2.34	5.21	0.98	0.28	7.83	3.60	000
46614		A	Anoscopy, control bleeding	2.01	2.33	0.84	0.20	4.54	3.05	000
46615		A	Anoscopy	2.68	2.50	1.07	0.32	5.50	4.07	000
46700		A	Repair of anal stricture	9.12	NA	4.23	0.93	NA	14.28	090
46705		A	Repair of anal stricture	6.89	NA	3.72	0.91	NA	11.52	090
46706		A	Repr of anal fistula w/glue	2.39	NA	1.25	0.51	NA	4.15	010
46715		A	Repair of anovaginal fistula	7.19	NA	3.61	0.92	NA	11.72	090
46716		A	Repair of anovaginal fistula	15.05	NA	7.95	1.57	NA	24.57	090
46730		A	Construction of absent anus	26.71	NA	11.99	1.71	NA	40.41	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
46735		A	Construction of absent anus	32.12	NA	13.51	3.18	NA	48.81	090
46740		A	Construction of absent anus	29.96	NA	13.16	2.89	NA	46.01	090
46742		A	Repair of imperforated anus	35.75	NA	17.47	4.73	NA	57.95	090
46744		A	Repair of cloacal anomaly	52.55	NA	21.07	3.83	NA	77.45	090
46746		A	Repair of cloacal anomaly	58.13	NA	25.05	3.03	NA	86.21	090
46748		A	Repair of cloacal anomaly	64.11	NA	23.66	3.34	NA	91.11	090
46750		A	Repair of anal sphincter	10.23	NA	5.08	1.13	NA	16.44	090
46751		A	Repair of anal sphincter	8.76	NA	5.50	0.94	NA	15.20	090
46753		A	Reconstruction of anus	8.28	NA	3.86	0.97	NA	13.11	090
46754		A	Removal of suture from anus	2.20	3.66	1.68	0.19	6.05	4.07	010
46760		A	Repair of anal sphincter	14.41	NA	7.09	1.57	NA	23.07	090
46761		A	Repair of anal sphincter	13.82	NA	6.04	1.48	NA	21.34	090
46762		A	Implant artificial sphincter	12.69	NA	5.53	1.24	NA	19.46	090
46900		A	Destruction, anal lesion(s)	1.91	2.59	1.28	0.18	4.68	3.37	010
46910		A	Destruction, anal lesion(s)	1.86	2.92	1.06	0.19	4.97	3.11	010
46916		A	Cryosurgery, anal lesion(s)	1.86	3.17	1.40	0.16	5.19	3.42	010
46917		A	Laser surgery, anal lesions	1.86	9.19	1.12	0.21	11.26	3.19	010
46922		A	Excision of anal lesion(s)	1.86	3.29	1.08	0.21	5.36	3.15	010
46924		A	Destruction, anal lesion(s)	2.76	8.72	1.36	0.27	11.75	4.39	010
46934		A	Destruction of hemorrhoids	3.50	5.10	2.97	0.31	8.91	6.78	090
46935		A	Destruction of hemorrhoids	2.43	3.49	1.21	0.22	6.14	3.86	010
46936		A	Destruction of hemorrhoids	3.68	4.89	2.50	0.36	8.93	6.54	090
46937		A	Cryotherapy of rectal lesion	2.69	2.77	1.23	0.28	5.74	4.20	010
46938		A	Cryotherapy of rectal lesion	4.65	4.00	3.06	0.58	9.23	8.29	090
46940		A	Treatment of anal fissure	2.32	1.99	1.09	0.22	4.53	3.63	010
46942		A	Treatment of anal fissure	2.04	1.83	1.02	0.19	4.06	3.25	010
46945		A	Ligation of hemorrhoids	1.84	3.36	2.49	0.19	5.39	4.52	090
46946		A	Ligation of hemorrhoids	2.58	3.79	2.40	0.26	6.63	5.24	090
47000		A	Needle biopsy of liver	1.90	3.07	0.63	0.12	5.09	2.65	000
47001		A	Needle biopsy, liver add-on	1.90	NA	0.65	0.24	NA	2.79	ZZZ
47010		A	Open drainage, liver lesion	15.99	NA	8.40	1.74	NA	26.13	090
47011		A	Percut drain, liver lesion	3.69	NA	1.20	0.23	NA	5.12	000
47015		A	Inject/aspirate liver cyst	15.09	NA	7.49	1.78	NA	24.36	090
47100		A	Wedge biopsy of liver	11.65	NA	6.04	1.48	NA	19.17	090
47120		A	Partial removal of liver	35.45	NA	15.15	4.53	NA	55.13	090
47122		A	Extensive removal of liver	55.05	NA	21.45	6.99	NA	83.49	090
47125		A	Partial removal of liver	49.12	NA	19.51	6.23	NA	74.86	090
47130		A	Partial removal of liver	53.27	NA	20.97	6.80	NA	81.04	090
47135		R	Transplantation of liver	81.40	NA	31.49	9.89	NA	122.78	090
47136		R	Transplantation of liver	68.50	NA	26.99	8.36	NA	103.85	090
47140		A	Partial removal, donor liver	54.92	NA	22.25	4.87	NA	82.04	090
47141		A	Partial removal, donor liver	67.40	NA	26.87	4.87	NA	99.14	090
47142		A	Partial removal, donor liver	74.89	NA	29.43	4.87	NA	109.19	090
47300		A	Surgery for liver lesion	15.06	NA	7.23	1.91	NA	24.20	090
47350		A	Repair liver wound	19.53	NA	8.86	2.48	NA	30.87	090
47360		A	Repair liver wound	26.88	NA	11.59	3.35	NA	41.82	090
47361		A	Repair liver wound	47.05	NA	18.51	5.77	NA	71.33	090
47362		A	Repair liver wound	18.48	NA	8.73	2.31	NA	29.52	090
47370		A	Laparo ablate liver tumor rf	19.66	NA	8.13	2.27	NA	30.06	090
47371		A	Laparo ablate liver cryosurg	19.66	NA	8.14	2.11	NA	29.91	090
47380		A	Open ablate liver tumor rf	22.97	NA	9.34	2.69	NA	35.00	090
47381		A	Open ablate liver tumor cryo	23.24	NA	9.58	2.39	NA	35.21	090
47382		A	Percut ablate liver rf	15.17	NA	6.06	0.80	NA	22.03	010
47400		A	Incision of liver duct	32.44	NA	13.43	3.46	NA	49.33	090
47420		A	Incision of bile duct	19.85	NA	8.75	2.54	NA	31.14	090
47425		A	Incision of bile duct	19.80	NA	8.81	2.46	NA	31.07	090
47460		A	Incise bile duct sphincter	18.01	NA	8.38	2.00	NA	28.39	090
47480		A	Incision of gallbladder	10.80	NA	5.92	1.38	NA	18.10	090
47490		A	Incision of gallbladder	7.22	NA	5.58	0.44	NA	13.24	090
47500		A	Injection for liver x-rays	1.96	NA	0.64	0.12	NA	2.72	000
47505		A	Injection for liver x-rays	0.76	NA	0.25	0.05	NA	1.06	000
47510		A	Insert catheter, bile duct	7.82	NA	5.00	0.50	NA	13.32	090
47511		A	Insert bile duct drain	10.48	NA	5.07	0.64	NA	16.19	090
47525		A	Change bile duct catheter	5.54	12.22	2.80	0.33	18.09	8.67	010
47530		A	Revise/reinsert bile tube	5.84	25.23	3.70	0.38	31.45	9.92	090
47550		A	Bile duct endoscopy add-on	3.02	NA	1.02	0.39	NA	4.43	ZZZ
47552		A	Biliary endoscopy thru skin	6.03	NA	2.40	0.44	NA	8.87	000
47553		A	Biliary endoscopy thru skin	6.34	NA	2.06	0.41	NA	8.81	000
47554		A	Biliary endoscopy thru skin	9.05	NA	3.38	0.96	NA	13.39	000
47555		A	Biliary endoscopy thru skin	7.55	NA	2.45	0.46	NA	10.46	000
47556		A	Biliary endoscopy thru skin	8.55	NA	2.77	0.51	NA	11.83	000
47560		A	Laparoscopy w/cholangio	4.88	NA	1.66	0.59	NA	7.13	000
47561		A	Laparo w/cholangio/biopsy	5.17	NA	1.91	0.65	NA	7.73	000
47562		A	Laparoscopic cholecystectomy	11.07	NA	4.98	1.42	NA	17.47	090
47563		A	Laparo cholecystectomy/graph	11.92	NA	5.29	1.52	NA	18.73	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
47564		A	Laparo cholecystectomy/explr	14.21	NA	5.94	1.82	NA	21.97	090
47570		A	Laparo cholecystoenterostomy	12.56	NA	5.36	1.60	NA	19.52	090
47600		A	Removal of gallbladder	13.56	NA	6.15	1.73	NA	21.44	090
47605		A	Removal of gallbladder	14.67	NA	6.50	1.88	NA	23.05	090
47610		A	Removal of gallbladder	18.79	NA	7.94	2.41	NA	29.14	090
47612		A	Removal of gallbladder	18.75	NA	7.88	2.40	NA	29.03	090
47620		A	Removal of gallbladder	20.61	NA	8.52	2.68	NA	31.81	090
47630		A	Remove bile duct stone	9.10	NA	4.86	0.69	NA	14.65	090
47700		A	Exploration of bile ducts	15.60	NA	7.43	1.89	NA	24.92	090
47701		A	Bile duct revision	27.77	NA	11.49	3.55	NA	42.81	090
47711		A	Excision of bile duct tumor	23.00	NA	9.92	2.93	NA	35.85	090
47712		A	Excision of bile duct tumor	30.19	NA	12.41	3.93	NA	46.53	090
47715		A	Excision of bile duct cyst	18.77	NA	8.42	2.38	NA	29.57	090
47716		A	Fusion of bile duct cyst	16.42	NA	7.83	2.08	NA	26.33	090
47720		A	Fuse gallbladder & bowel	15.89	NA	7.48	2.03	NA	25.40	090
47721		A	Fuse upper gi structures	19.09	NA	8.57	2.46	NA	30.12	090
47740		A	Fuse gallbladder & bowel	18.45	NA	8.38	2.43	NA	29.26	090
47741		A	Fuse gallbladder & bowel	21.31	NA	9.28	2.63	NA	33.22	090
47760		A	Fuse bile ducts and bowel	25.81	NA	10.84	3.32	NA	39.97	090
47765		A	Fuse liver ducts & bowel	24.84	NA	10.80	3.21	NA	38.85	090
47780		A	Fuse bile ducts and bowel	26.46	NA	11.20	3.43	NA	41.09	090
47785		A	Fuse bile ducts and bowel	31.13	NA	12.91	4.04	NA	48.08	090
47800		A	Reconstruction of bile ducts	23.27	NA	10.06	2.94	NA	36.27	090
47801		A	Placement, bile duct support	15.15	NA	8.15	1.24	NA	24.54	090
47802		A	Fuse liver duct & intestine	21.52	NA	9.68	2.73	NA	33.93	090
47900		A	Suture bile duct injury	19.87	NA	8.87	2.57	NA	31.31	090
48000		A	Drainage of abdomen	28.03	NA	11.49	3.40	NA	42.92	090
48001		A	Placement of drain, pancreas	35.40	NA	13.87	4.47	NA	53.74	090
48005		A	Resect/debride pancreas	42.11	NA	16.53	5.41	NA	64.05	090
48020		A	Removal of pancreatic stone	15.68	NA	7.29	2.12	NA	25.09	090
48100		A	Biopsy of pancreas, open	12.21	NA	5.61	1.54	NA	19.36	090
48102		A	Needle biopsy, pancreas	4.67	7.95	1.94	0.29	12.91	6.90	010
48120		A	Removal of pancreas lesion	15.83	NA	6.86	1.98	NA	24.67	090
48140		A	Partial removal of pancreas	22.91	NA	9.53	2.91	NA	35.35	090
48145		A	Partial removal of pancreas	23.98	NA	9.84	3.09	NA	36.91	090
48146		A	Pancreatectomy	26.36	NA	11.98	3.40	NA	41.74	090
48148		A	Removal of pancreatic duct	17.31	NA	7.62	2.20	NA	27.13	090
48150		A	Partial removal of pancreas	47.93	NA	19.49	6.18	NA	73.60	090
48152		A	Pancreatectomy	43.68	NA	18.20	5.68	NA	67.56	090
48153		A	Pancreatectomy	47.82	NA	19.54	6.19	NA	73.55	090
48154		A	Pancreatectomy	44.03	NA	18.23	5.74	NA	68.00	090
48155		A	Removal of pancreas	24.60	NA	11.69	3.14	NA	39.43	090
48180		A	Fuse pancreas and bowel	24.68	NA	10.16	3.22	NA	38.06	090
48400		A	Injection, intraop add-on	1.95	NA	0.64	0.16	NA	2.75	ZZZ
48500		A	Surgery of pancreatic cyst	15.26	NA	7.34	2.04	NA	24.64	090
48510		A	Drain pancreatic pseudocyst	14.29	NA	7.43	1.80	NA	23.52	090
48511		A	Drain pancreatic pseudocyst	3.99	21.20	1.30	0.25	25.44	5.54	000
48520		A	Fuse pancreas cyst and bowel	15.57	NA	6.70	1.99	NA	24.26	090
48540		A	Fuse pancreas cyst and bowel	19.69	NA	8.11	2.50	NA	30.30	090
48545		A	Pancreatorrhaphy	18.15	NA	7.99	2.30	NA	28.44	090
48547		A	Duodenal exclusion	25.79	NA	10.48	3.28	NA	39.55	090
48554		R	Transpl allograft pancreas	34.12	NA	18.29	4.19	NA	56.60	090
48556		A	Removal, allograft pancreas	15.69	NA	8.07	1.96	NA	25.72	090
49000		A	Exploration of abdomen	11.66	NA	5.38	1.44	NA	18.48	090
49002		A	Reopening of abdomen	10.47	NA	5.04	1.33	NA	16.84	090
49010		A	Exploration behind abdomen	12.26	NA	5.91	1.49	NA	19.66	090
49020		A	Drain abdominal abscess	22.81	NA	10.19	2.71	NA	35.71	090
49021		A	Drain abdominal abscess	3.37	21.58	1.11	0.21	25.16	4.69	000
49040		A	Drain, open, abdom abscess	13.50	NA	6.44	1.65	NA	21.59	090
49041		A	Drain, percut, abdom abscess	3.99	19.76	1.31	0.25	24.00	5.55	000
49060		A	Drain, open, retrop abscess	15.84	NA	7.44	1.64	NA	24.92	090
49061		A	Drain, percut, retroper absc	3.69	19.95	1.21	0.22	23.86	5.12	000
49062		A	Drain to peritoneal cavity	11.34	NA	5.46	1.40	NA	18.20	090
49080		A	Puncture, peritoneal cavity	1.35	4.15	0.45	0.09	5.59	1.89	000
49081		A	Removal of abdominal fluid	1.26	2.66	0.43	0.09	4.01	1.78	000
49085		A	Remove abdomen foreign body	12.12	NA	5.51	1.43	NA	19.06	090
49180		A	Biopsy, abdominal mass	1.73	3.14	0.56	0.11	4.98	2.40	000
49200		A	Removal of abdominal lesion	10.23	NA	5.05	1.14	NA	16.42	090
49201		A	Remove abdom lesion, complex	14.82	NA	7.06	1.77	NA	23.65	090
49215		A	Excise sacral spine tumor	33.45	NA	14.04	4.29	NA	51.78	090
49220		A	Multiple surgery, abdomen	14.86	NA	6.65	1.83	NA	23.34	090
49250		A	Excision of umbilicus	8.34	NA	4.30	1.05	NA	13.69	090
49255		A	Removal of omentum	11.12	NA	5.63	1.39	NA	18.14	090
49320		A	Diag laparo separate proc	5.09	NA	2.63	0.63	NA	8.35	010
49321		A	Laparoscopy, biopsy	5.39	NA	2.64	0.68	NA	8.71	010

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
49322		A	Laparoscopy, aspiration	5.69	NA	2.99	0.70	NA	9.38	010
49323		A	Laparo drain lymphocele	9.47	NA	4.49	1.12	NA	15.08	090
49400		A	Air injection into abdomen	1.88	3.16	0.62	0.16	5.20	2.66	000
49419		A	Insrt abdom cath for chemotx	6.64	NA	3.55	0.70	NA	10.89	090
49420		A	Insert abdom drain, temp	2.22	NA	1.09	0.21	NA	3.52	000
49421		A	Insert abdom drain, perm	5.53	NA	3.17	0.70	NA	9.40	090
49422		A	Remove perm cannula/catheter	6.24	NA	2.89	0.80	NA	9.93	010
49423		A	Exchange drainage catheter	1.46	14.40	0.52	0.09	15.95	2.07	000
49424		A	Assess cyst, contrast inject	0.76	3.92	0.29	0.05	4.73	1.10	000
49425		A	Insert abdomen-venous drain	11.35	NA	5.62	1.52	NA	18.49	090
49426		A	Revise abdomen-venous shunt	9.62	NA	4.78	1.23	NA	15.63	090
49427		A	Injection, abdominal shunt	0.89	NA	0.30	0.06	NA	1.25	000
49428		A	Ligation of shunt	6.05	NA	3.92	0.84	NA	10.81	010
49429		A	Removal of shunt	7.39	NA	3.42	0.99	NA	11.80	010
49491		A	Rpr hern preemie reduc	11.11	NA	5.04	1.47	NA	17.62	090
49492		A	Rpr ing hern premie, blocked	14.01	NA	6.10	1.64	NA	21.75	090
49495		A	Rpr ing hernia baby, reduc	5.88	NA	2.97	0.78	NA	9.63	090
49496		A	Rpr ing hernia baby, blocked	8.78	NA	4.33	1.10	NA	14.21	090
49500		A	Rpr ing hernia, init, reduce	5.47	NA	3.13	0.62	NA	9.22	090
49501		A	Rpr ing hernia, init blocked	8.87	NA	4.21	1.13	NA	14.21	090
49505		A	Prp i/hern init reduc>5 yr	7.59	NA	3.75	0.99	NA	12.33	090
49507		A	Prp i/hern init block>5 yr	9.56	NA	4.50	1.24	NA	15.30	090
49520		A	Rerepair ing hernia, reduce	9.62	NA	4.46	1.24	NA	15.32	090
49521		A	Rerepair ing hernia, blocked	11.95	NA	5.25	1.56	NA	18.76	090
49525		A	Repair ing hernia, sliding	8.56	NA	4.10	1.09	NA	13.75	090
49540		A	Repair lumbar hernia	10.37	NA	4.77	1.34	NA	16.48	090
49550		A	Rpr rem hernia, init, reduce	8.62	NA	4.14	1.12	NA	13.88	090
49553		A	Rpr fem hernia, init blocked	9.43	NA	4.43	1.22	NA	15.08	090
49555		A	Rerepair fem hernia, reduce	9.02	NA	4.29	1.17	NA	14.48	090
49557		A	Rerepair fem hernia, blocked	11.13	NA	5.00	1.44	NA	17.57	090
49560		A	Rpr ventral hern init, reduc	11.55	NA	5.17	1.48	NA	18.20	090
49561		A	Rpr ventral hern init, block	14.23	NA	6.07	1.83	NA	22.13	090
49565		A	Rerepair ventrl hern, reduce	11.55	NA	5.24	1.48	NA	18.27	090
49566		A	Rerepair ventrl hern, block	14.38	NA	6.14	1.85	NA	22.37	090
49568		A	Hernia repair w/mesh	4.88	NA	1.67	0.63	NA	7.18	ZZZ
49570		A	Rpr epigastric hern, reduce	5.68	NA	3.18	0.73	NA	9.59	090
49572		A	Rpr epigastric hern, blocked	6.72	NA	3.48	0.86	NA	11.06	090
49580		A	Rpr umbil hern, reduc < 5 yr	4.10	NA	2.62	0.52	NA	7.24	090
49582		A	Rpr umbil hern, block < 5 yr	6.64	NA	3.51	0.86	NA	11.01	090
49585		A	Rpr umbil hern, reduc > 5 yr	6.22	NA	3.32	0.79	NA	10.33	090
49587		A	Rpr umbil hern, block > 5 yr	7.55	NA	3.75	0.97	NA	12.27	090
49590		A	Repair spigilian hernia	8.53	NA	4.11	1.09	NA	13.73	090
49600		A	Repair umbilical lesion	10.94	NA	5.35	1.31	NA	17.60	090
49605		A	Repair umbilical lesion	75.89	NA	28.48	9.95	NA	114.32	090
49606		A	Repair umbilical lesion	18.57	NA	7.72	2.43	NA	28.72	090
49610		A	Repair umbilical lesion	10.48	NA	5.24	0.57	NA	16.29	090
49611		A	Repair umbilical lesion	8.91	NA	7.31	0.78	NA	17.00	090
49650		A	Laparo hernia repair initial	6.26	NA	3.20	0.90	NA	10.36	090
49651		A	Laparo hernia repair recur	8.23	NA	4.06	1.10	NA	13.39	090
49900		A	Repair of abdominal wall	12.26	NA	6.23	1.55	NA	20.04	090
49904		A	Omental flap, extra-abdom	19.97	NA	15.17	2.52	NA	37.66	090
49905		A	Omental flap, intra-abdom	6.54	NA	2.29	0.79	NA	9.62	ZZZ
50010		A	Exploration of kidney	10.96	NA	5.21	0.93	NA	17.10	090
50020		A	Renal abscess, open drain	14.64	NA	7.73	1.27	NA	23.64	090
50021		A	Renal abscess, percut drain	3.37	21.89	1.10	0.20	25.46	4.67	000
50040		A	Drainage of kidney	14.92	NA	6.80	1.03	NA	22.75	090
50045		A	Exploration of kidney	15.44	NA	6.59	1.24	NA	23.27	090
50060		A	Removal of kidney stone	19.27	NA	7.81	1.46	NA	28.54	090
50065		A	Incision of kidney	20.76	NA	6.09	1.48	NA	28.33	090
50070		A	Incision of kidney	20.29	NA	8.20	1.48	NA	29.97	090
50075		A	Removal of kidney stone	25.30	NA	9.88	1.93	NA	37.11	090
50080		A	Removal of kidney stone	14.69	NA	6.27	1.04	NA	22.00	090
50081		A	Removal of kidney stone	21.77	NA	8.74	1.57	NA	32.08	090
50100		A	Revise kidney blood vessels	16.07	NA	7.77	1.78	NA	25.62	090
50120		A	Exploration of kidney	15.89	NA	6.75	1.19	NA	23.83	090
50125		A	Explore and drain kidney	16.50	NA	6.96	1.34	NA	24.80	090
50130		A	Removal of kidney stone	17.26	NA	7.16	1.30	NA	25.72	090
50135		A	Exploration of kidney	19.15	NA	7.76	1.43	NA	28.34	090
50200		A	Biopsy of kidney	2.63	NA	1.29	0.16	NA	4.08	000
50205		A	Biopsy of kidney	11.29	NA	5.01	1.28	NA	17.58	090
50220		A	Remove kidney, open	17.12	NA	7.22	1.44	NA	25.78	090
50225		A	Removal kidney open, complex	20.20	NA	8.13	1.58	NA	29.91	090
50230		A	Removal kidney open, radical	22.04	NA	8.56	1.70	NA	32.30	090
50234		A	Removal of kidney & ureter	22.37	NA	8.81	1.67	NA	32.85	090
50236		A	Removal of kidney & ureter	24.82	NA	10.23	1.88	NA	36.93	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
50240		A	Partial removal of kidney	21.97	NA	8.99	1.66	NA	32.62	090
50280		A	Removal of kidney lesion	15.65	NA	6.67	1.29	NA	23.61	090
50290		A	Removal of kidney lesion	14.71	NA	6.45	1.22	NA	22.38	090
50320		A	Removal of donor kidney	22.18	NA	10.66	2.33	NA	35.17	090
50340		A	Removal of kidney	12.13	NA	6.49	1.66	NA	20.28	090
50360		A	Transplantation of kidney	31.48	NA	15.48	3.73	NA	50.69	090
50365		A	Transplantation of kidney	36.75	NA	18.26	4.25	NA	59.26	090
50370		A	Remove transplanted kidney	13.70	NA	7.15	1.55	NA	22.40	090
50380		A	Reimplantation of kidney	20.73	NA	12.06	2.53	NA	35.32	090
50390		A	Drainage of kidney lesion	1.96	NA	0.64	0.12	NA	2.72	000
50392		A	Insert kidney drain	3.37	NA	1.52	0.21	NA	5.10	000
50393		A	Insert ureteral tube	4.15	NA	1.77	0.26	NA	6.18	000
50394		A	Injection for kidney x-ray	0.76	3.04	0.66	0.05	3.85	1.47	000
50395		A	Create passage to kidney	3.37	NA	1.50	0.21	NA	5.08	000
50396		A	Measure kidney pressure	2.09	NA	1.08	0.13	NA	3.30	000
50398		A	Change kidney tube	1.46	16.30	0.52	0.09	17.85	2.07	000
50400		A	Revision of kidney/ureter	19.47	NA	7.86	1.49	NA	28.82	090
50405		A	Revision of kidney/ureter	23.89	NA	9.01	1.79	NA	34.69	090
50500		A	Repair of kidney wound	19.54	NA	8.39	1.96	NA	29.89	090
50520		A	Close kidney-skin fistula	17.20	NA	7.41	1.55	NA	26.16	090
50525		A	Repair renal-abdomen fistula	22.24	NA	8.99	2.30	NA	33.53	090
50526		A	Repair renal-abdomen fistula	23.98	NA	9.84	4.17	NA	37.99	090
50540		A	Revision of horseshoe kidney	19.90	NA	8.32	1.76	NA	29.98	090
50541		A	Laparo ablate renal cyst	15.98	NA	6.47	1.22	NA	23.67	090
50542		A	Laparo ablate renal mass	19.97	NA	8.11	1.66	NA	29.74	090
50543		A	Laparo partial nephrectomy	25.46	NA	10.17	1.66	NA	37.29	090
50544		A	Laparoscopy, pyeloplasty	22.37	NA	8.51	1.69	NA	32.57	090
50545		A	Laparo radical nephrectomy	23.96	NA	9.17	1.82	NA	34.95	090
50546		A	Laparoscopic nephrectomy	20.45	NA	8.35	1.60	NA	30.40	090
50547		A	Laparo removal donor kidney	25.46	NA	11.10	2.80	NA	39.36	090
50548		A	Laparo remove w/ ureter	24.36	NA	9.15	1.84	NA	35.35	090
50551		A	Kidney endoscopy	5.59	4.14	1.96	0.40	10.13	7.95	000
50553		A	Kidney endoscopy	5.98	4.35	2.16	0.39	10.72	8.53	000
50555		A	Kidney endoscopy & biopsy	6.52	4.82	2.33	0.49	11.83	9.34	000
50557		A	Kidney endoscopy & treatment	6.61	4.57	2.29	0.48	11.66	9.38	000
50559		A	Renal endoscopy/radiotracer	6.77	5.30	2.78	0.41	12.48	9.96	000
50561		A	Kidney endoscopy & treatment	7.58	5.08	2.64	0.55	13.21	10.77	000
50562		A	Renal scope w/tumor resect	10.90	NA	4.27	0.48	NA	15.65	090
50570		A	Kidney endoscopy	9.53	NA	3.20	0.66	NA	13.39	000
50572		A	Kidney endoscopy	10.33	NA	3.49	0.87	NA	14.69	000
50574		A	Kidney endoscopy & biopsy	11.00	NA	3.74	0.74	NA	15.48	000
50575		A	Kidney endoscopy	13.96	NA	4.62	1.00	NA	19.58	000
50576		A	Kidney endoscopy & treatment	10.97	NA	3.65	0.76	NA	15.38	000
50578		A	Renal endoscopy/radiotracer	11.33	NA	3.79	0.81	NA	15.93	000
50580		A	Kidney endoscopy & treatment	11.84	NA	3.95	0.84	NA	16.63	000
50590		A	Fragmenting of kidney stone	9.08	12.49	4.11	0.66	22.23	13.85	090
50600		A	Exploration of ureter	15.82	NA	6.66	1.34	NA	23.82	090
50605		A	Insert ureteral support	15.44	NA	6.73	1.44	NA	23.61	090
50610		A	Removal of ureter stone	15.90	NA	6.96	1.28	NA	24.14	090
50620		A	Removal of ureter stone	15.14	NA	6.32	1.12	NA	22.58	090
50630		A	Removal of ureter stone	14.92	NA	6.27	1.14	NA	22.33	090
50650		A	Removal of ureter	17.38	NA	7.21	1.26	NA	25.85	090
50660		A	Removal of ureter	19.52	NA	7.94	1.55	NA	29.01	090
50684		A	Injection for ureter x-ray	0.76	5.00	0.47	0.05	5.81	1.28	000
50686		A	Measure ureter pressure	1.51	3.43	0.82	0.11	5.05	2.44	000
50688		A	Change of ureter tube	1.17	NA	1.06	0.07	NA	2.30	010
50690		A	Injection for ureter x-ray	1.16	1.80	0.72	0.08	3.04	1.96	000
50700		A	Revision of ureter	15.19	NA	7.10	1.25	NA	23.54	090
50715		A	Release of ureter	18.87	NA	8.73	2.06	NA	29.66	090
50722		A	Release of ureter	16.33	NA	7.80	1.88	NA	26.01	090
50725		A	Release/revise ureter	18.46	NA	8.04	1.58	NA	28.08	090
50727		A	Revise ureter	8.17	NA	4.27	0.65	NA	13.09	090
50728		A	Revise ureter	12.00	NA	5.55	1.05	NA	18.60	090
50740		A	Fusion of ureter & kidney	18.39	NA	7.73	1.88	NA	28.00	090
50750		A	Fusion of ureter & kidney	19.48	NA	7.97	1.54	NA	28.99	090
50760		A	Fusion of ureters	18.39	NA	7.67	1.53	NA	27.59	090
50770		A	Splicing of ureters	19.48	NA	7.96	1.61	NA	29.05	090
50780		A	Reimplant ureter in bladder	18.33	NA	7.58	1.59	NA	27.50	090
50782		A	Reimplant ureter in bladder	19.51	NA	8.80	1.61	NA	29.92	090
50783		A	Reimplant ureter in bladder	20.52	NA	8.20	1.64	NA	30.36	090
50785		A	Reimplant ureter in bladder	20.49	NA	8.28	1.63	NA	30.40	090
50800		A	Implant ureter in bowel	14.50	NA	6.46	1.23	NA	22.19	090
50810		A	Fusion of ureter & bowel	20.02	NA	9.08	2.16	NA	31.26	090
50815		A	Urine shunt to intestine	19.90	NA	8.43	1.62	NA	29.95	090
50820		A	Construct bowel bladder	21.86	NA	8.62	1.83	NA	32.31	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
50825		A	Construct bowel bladder	28.14	NA	11.10	2.14	NA	41.38	090
50830		A	Revise urine flow	31.23	NA	12.15	2.58	NA	45.96	090
50840		A	Replace ureter by bowel	19.97	NA	8.42	1.56	NA	29.95	090
50845		A	Appendico-vesicostomy	20.86	NA	8.89	1.53	NA	31.28	090
50860		A	Transplant ureter to skin	15.34	NA	6.61	1.21	NA	23.16	090
50900		A	Repair of ureter	13.60	NA	6.13	1.26	NA	20.99	090
50920		A	Closure ureter/skin fistula	14.31	NA	6.56	1.13	NA	22.00	090
50930		A	Closure ureter/bowel fistula	18.69	NA	7.96	1.28	NA	27.93	090
50940		A	Release of ureter	14.49	NA	6.39	1.40	NA	22.28	090
50945		A	Laparoscopy ureterolithotomy	16.97	NA	7.02	1.18	NA	25.17	090
50947		A	Laparo new ureter/bladder	24.46	NA	9.66	1.97	NA	36.09	090
50948		A	Laparo new ureter/bladder	22.47	NA	8.67	1.60	NA	32.74	090
50951		A	Endoscopy of ureter	5.83	4.28	2.05	0.42	10.53	8.30	000
50953		A	Endoscopy of ureter	6.23	4.40	2.36	0.44	11.07	9.03	000
50955		A	Ureter endoscopy & biopsy	6.74	6.66	2.68	0.46	13.86	9.88	000
50957		A	Ureter endoscopy & treatment	6.78	4.56	2.37	0.48	11.82	9.63	000
50959		A	Ureter endoscopy & tracer	4.39	NA	1.88	0.25	NA	6.52	000
50961		A	Ureter endoscopy & treatment	6.04	4.36	2.18	0.42	10.82	8.64	000
50970		A	Ureter endoscopy	7.13	NA	2.45	0.50	NA	10.08	000
50972		A	Ureter endoscopy & catheter	6.88	NA	2.46	0.50	NA	9.84	000
50974		A	Ureter endoscopy & biopsy	9.16	NA	3.10	0.63	NA	12.89	000
50976		A	Ureter endoscopy & treatment	9.03	NA	3.06	0.64	NA	12.73	000
50978		A	Ureter endoscopy & tracer	5.09	NA	1.83	0.36	NA	7.28	000
50980		A	Ureter endoscopy & treatment	6.84	NA	2.36	0.51	NA	9.71	000
51000		A	Drainage of bladder	0.78	1.97	0.24	0.06	2.81	1.08	000
51005		A	Drainage of bladder	1.02	4.75	0.34	0.09	5.86	1.45	000
51010		A	Drainage of bladder	3.52	5.59	1.87	0.28	9.39	5.67	010
51020		A	Incise & treat bladder	6.70	NA	3.91	0.53	NA	11.14	090
51030		A	Incise & treat bladder	6.76	NA	4.04	0.56	NA	11.36	090
51040		A	Incise & drain bladder	4.39	NA	2.82	0.33	NA	7.54	090
51045		A	Incise bladder/drain ureter	6.76	NA	4.00	0.58	NA	11.34	090
51050		A	Removal of bladder stone	6.91	NA	3.69	0.50	NA	11.10	090
51060		A	Removal of ureter stone	8.84	NA	4.56	0.68	NA	14.08	090
51065		A	Remove ureter calculus	8.84	NA	4.40	0.67	NA	13.91	090
51080		A	Drainage of bladder abscess	5.95	NA	3.61	0.47	NA	10.03	090
51500		A	Removal of bladder cyst	10.12	NA	5.03	1.10	NA	16.25	090
51520		A	Removal of bladder lesion	9.28	NA	4.72	0.72	NA	14.72	090
51525		A	Removal of bladder lesion	13.95	NA	6.17	1.05	NA	21.17	090
51530		A	Removal of bladder lesion	12.36	NA	5.80	1.12	NA	19.28	090
51535		A	Repair of ureter lesion	12.55	NA	6.16	1.20	NA	19.91	090
51550		A	Partial removal of bladder	15.64	NA	6.78	1.37	NA	23.79	090
51555		A	Partial removal of bladder	21.20	NA	8.71	1.80	NA	31.71	090
51565		A	Revise bladder & ureter(s)	21.59	NA	9.01	1.69	NA	32.29	090
51570		A	Removal of bladder	24.20	NA	9.81	1.89	NA	35.90	090
51575		A	Removal of bladder & nodes	30.40	NA	12.10	2.27	NA	44.77	090
51580		A	Remove bladder/revise tract	31.03	NA	12.58	2.29	NA	45.90	090
51585		A	Removal of bladder & nodes	35.18	NA	13.77	2.80	NA	51.75	090
51590		A	Remove bladder/revise tract	32.61	NA	12.69	2.43	NA	47.73	090
51595		A	Remove bladder/revise tract	37.08	NA	14.19	2.74	NA	54.01	090
51596		A	Remove bladder/create pouch	39.46	NA	15.30	2.88	NA	57.64	090
51597		A	Removal of pelvic structures	38.29	NA	14.91	2.97	NA	56.17	090
51600		A	Injection for bladder x-ray	0.88	5.08	0.29	0.06	6.02	1.23	000
51605		A	Preparation for bladder xray	0.64	6.03	0.35	0.04	6.71	1.03	000
51610		A	Injection for bladder x-ray	1.05	2.33	0.60	0.07	3.45	1.72	000
51700		A	Irrigation of bladder	0.88	1.60	0.28	0.06	2.54	1.22	000
51701		A	Insert bladder catheter	0.50	1.57	0.19	0.04	2.11	0.73	000
51702		A	Insert temp bladder cath	0.50	2.08	0.24	0.04	2.62	0.78	000
51703		A	Insert bladder cath, complex	1.47	2.72	0.56	0.08	4.27	2.11	000
51705		A	Change of bladder tube	1.02	2.27	0.62	0.07	3.36	1.71	010
51710		A	Change of bladder tube	1.49	3.32	0.77	0.11	4.92	2.37	010
51715		A	Endoscopic injection/implant	3.73	3.88	1.35	0.29	7.90	5.37	000
51720		A	Treatment of bladder lesion	1.96	1.74	0.69	0.14	3.84	2.79	000
51725		A	Simple cystometrogram	1.51	5.58	NA	0.16	7.25	NA	000
51725	26	A	Simple cystometrogram	1.51	0.49	0.49	0.12	2.12	2.12	000
51725	TC	A	Simple cystometrogram	0.00	5.09	NA	0.04	5.13	NA	000
51726		A	Complex cystometrogram	1.71	7.48	NA	0.18	9.37	NA	000
51726	26	A	Complex cystometrogram	1.71	0.56	0.56	0.13	2.40	2.40	000
51726	TC	A	Complex cystometrogram	0.00	6.92	NA	0.05	6.97	NA	000
51736		A	Urine flow measurement	0.61	0.58	NA	0.06	1.25	NA	000
51736	26	A	Urine flow measurement	0.61	0.20	0.20	0.05	0.86	0.86	000
51736	TC	A	Urine flow measurement	0.00	0.38	NA	0.01	0.39	NA	000
51741		A	Electro-uroflowmetry, first	1.14	0.80	NA	0.11	2.05	NA	000
51741	26	A	Electro-uroflowmetry, first	1.14	0.37	0.37	0.09	1.60	1.60	000
51741	TC	A	Electro-uroflowmetry, first	0.00	0.43	NA	0.02	0.45	NA	000
51772		A	Urethra pressure profile	1.61	5.58	NA	0.19	7.38	NA	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
51772	26	A	Urethra pressure profile	1.61	0.55	0.55	0.14	2.30	2.30	000
51772	TC	A	Urethra pressure profile	0.00	5.03	NA	0.05	5.08	NA	000
51784		A	Anal/urinary muscle study	1.53	3.99	NA	0.16	5.68	NA	000
51784	26	A	Anal/urinary muscle study	1.53	0.50	0.50	0.12	2.15	2.15	000
51784	TC	A	Anal/urinary muscle study	0.00	3.48	NA	0.04	3.52	NA	000
51785		A	Anal/urinary muscle study	1.53	4.44	NA	0.15	6.12	NA	000
51785	26	A	Anal/urinary muscle study	1.53	0.50	0.50	0.11	2.14	2.14	000
51785	TC	A	Anal/urinary muscle study	0.00	3.94	NA	0.04	3.98	NA	000
51792		A	Urinary reflex study	1.10	5.99	NA	0.20	7.29	NA	000
51792	26	A	Urinary reflex study	1.10	0.41	0.41	0.07	1.58	1.58	000
51792	TC	A	Urinary reflex study	0.00	5.57	NA	0.13	5.70	NA	000
51795		A	Urine voiding pressure study	1.53	7.28	NA	0.22	9.03	NA	000
51795	26	A	Urine voiding pressure study	1.53	0.50	0.50	0.12	2.15	2.15	000
51795	TC	A	Urine voiding pressure study	0.00	6.78	NA	0.10	6.88	NA	000
51797		A	Intraabdominal pressure test	1.60	5.76	NA	0.17	7.53	NA	000
51797	26	A	Intraabdominal pressure test	1.60	0.52	0.52	0.12	2.24	2.24	000
51797	TC	A	Intraabdominal pressure test	0.00	5.23	NA	0.05	5.28	NA	000
51798		A	Us urine capacity measure	0.00	0.34	NA	0.08	0.42	NA	XXX
51800		A	Revision of bladder/urethra	17.39	NA	7.60	1.38	NA	26.37	090
51820		A	Revision of urinary tract	17.86	NA	8.38	1.90	NA	28.14	090
51840		A	Attach bladder/urethra	10.69	NA	5.56	1.10	NA	17.35	090
51841		A	Attach bladder/urethra	13.01	NA	6.37	1.30	NA	20.68	090
51845		A	Repair bladder neck	9.72	NA	4.80	0.81	NA	15.33	090
51860		A	Repair of bladder wound	12.00	NA	5.83	1.20	NA	19.03	090
51865		A	Repair of bladder wound	15.02	NA	6.74	1.33	NA	23.09	090
51880		A	Repair of bladder opening	7.65	NA	4.02	0.70	NA	12.37	090
51900		A	Repair bladder/vagina lesion	12.95	NA	6.13	1.15	NA	20.23	090
51920		A	Close bladder-uterus fistula	11.79	NA	5.68	0.90	NA	18.37	090
51925		A	Hysterectomy/bladder repair	15.56	NA	8.75	1.38	NA	25.69	090
51940		A	Correction of bladder defect	28.39	NA	12.23	2.39	NA	43.01	090
51960		A	Revision of bladder & bowel	22.98	NA	9.74	1.73	NA	34.45	090
51980		A	Construct bladder opening	11.34	NA	5.42	0.88	NA	17.64	090
51990		A	Laparo urethral suspension	12.48	NA	6.13	1.41	NA	20.02	090
51992		A	Laparo sling operation	13.99	NA	6.19	1.36	NA	21.54	090
52000		A	Cystoscopy	2.01	3.29	0.76	0.15	5.45	2.92	000
52001		A	Cystoscopy, removal of clots	5.44	5.06	1.86	0.17	10.67	7.47	000
52005		A	Cystoscopy & ureter catheter	2.37	5.54	0.89	0.17	8.08	3.43	000
52007		A	Cystoscopy and biopsy	3.02	16.43	1.15	0.22	19.67	4.39	000
52010		A	Cystoscopy & duct catheter	3.02	10.81	1.15	0.22	14.05	4.39	000
52204		A	Cystoscopy	2.37	14.45	0.90	0.17	16.99	3.44	000
52214		A	Cystoscopy and treatment	3.70	37.93	1.33	0.27	41.90	5.30	000
52224		A	Cystoscopy and treatment	3.14	36.30	1.15	0.22	39.66	4.51	000
52234		A	Cystoscopy and treatment	4.62	NA	1.65	0.33	NA	6.60	000
52235		A	Cystoscopy and treatment	5.44	NA	1.93	0.39	NA	7.76	000
52240		A	Cystoscopy and treatment	9.71	NA	3.29	0.69	NA	13.69	000
52250		A	Cystoscopy and radiotracer	4.49	NA	1.65	0.33	NA	6.47	000
52260		A	Cystoscopy and treatment	3.91	NA	1.42	0.29	NA	5.62	000
52265		A	Cystoscopy and treatment	2.94	13.28	1.11	0.22	16.44	4.27	000
52270		A	Cystoscopy & revise urethra	3.36	10.99	1.24	0.24	14.59	4.84	000
52275		A	Cystoscopy & revise urethra	4.69	15.48	1.66	0.34	20.51	6.69	000
52276		A	Cystoscopy and treatment	4.99	NA	1.78	0.36	NA	7.13	000
52277		A	Cystoscopy and treatment	6.16	NA	2.22	0.45	NA	8.83	000
52281		A	Cystoscopy and treatment	2.80	7.07	1.08	0.20	10.07	4.08	000
52282		A	Cystoscopy, implant stent	6.39	NA	2.23	0.46	NA	9.08	000
52283		A	Cystoscopy and treatment	3.73	3.94	1.38	0.27	7.94	5.38	000
52285		A	Cystoscopy and treatment	3.60	4.00	1.33	0.27	7.87	5.20	000
52290		A	Cystoscopy and treatment	4.58	NA	1.65	0.33	NA	6.56	000
52300		A	Cystoscopy and treatment	5.30	NA	1.90	0.38	NA	7.58	000
52301		A	Cystoscopy and treatment	5.50	NA	1.99	0.48	NA	7.97	000
52305		A	Cystoscopy and treatment	5.30	NA	1.85	0.39	NA	7.54	000
52310		A	Cystoscopy and treatment	2.81	4.68	1.03	0.20	7.69	4.04	000
52315		A	Cystoscopy and treatment	5.20	8.68	1.83	0.37	14.25	7.40	000
52317		A	Remove bladder stone	6.71	28.82	2.27	0.48	36.01	9.46	000
52318		A	Remove bladder stone	9.18	NA	3.09	0.66	NA	12.93	000
52320		A	Cystoscopy and treatment	4.69	NA	1.63	0.34	NA	6.66	000
52325		A	Cystoscopy, stone removal	6.15	NA	2.10	0.44	NA	8.69	000
52327		A	Cystoscopy, inject material	5.18	31.67	1.81	0.39	37.24	7.38	000
52330		A	Cystoscopy and treatment	5.03	38.66	1.74	0.36	44.05	7.13	000
52332		A	Cystoscopy and treatment	2.83	5.73	1.05	0.21	8.77	4.09	000
52334		A	Create passage to kidney	4.82	NA	1.73	0.34	NA	6.89	000
52341		A	Cysto w/ureter stricture tx	5.99	NA	2.21	0.43	NA	8.63	000
52342		A	Cysto w/up stricture tx	6.49	NA	2.34	0.47	NA	9.30	000
52343		A	Cysto w/renal stricture tx	7.19	NA	2.57	0.51	NA	10.27	000
52344		A	Cysto/uretero, stone remove	7.69	NA	2.79	0.56	NA	11.04	000
52345		A	Cysto/uretero w/up stricture	8.19	NA	2.95	0.58	NA	11.72	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
52346		A	Cystouretero w/renal strict	9.22	NA	3.27	0.67	NA	13.16	000
52347		A	Cystoscopy, resect ducts	5.27	NA	1.70	0.38	NA	7.35	000
52351		A	Cystouretero & or pyeloscope	5.85	NA	2.14	0.42	NA	8.41	000
52352		A	Cystouretero w/stone remove	6.87	NA	2.50	0.49	NA	9.86	000
52353		A	Cystouretero w/lithotripsy	7.96	NA	2.85	0.57	NA	11.38	000
52354		A	Cystouretero w/biopsy	7.33	NA	2.66	0.53	NA	10.52	000
52355		A	Cystouretero w/excise tumor	8.81	NA	3.13	0.63	NA	12.57	000
52400		A	Cystouretero w/congen repr	9.67	NA	3.75	0.69	NA	14.11	090
52450		A	Incision of prostate	7.63	NA	3.68	0.55	NA	11.86	090
52500		A	Revision of bladder neck	8.46	NA	3.92	0.60	NA	12.98	090
52510		A	Dilation prostatic urethra	6.71	NA	3.12	0.49	NA	10.32	090
52601		A	Prostatectomy (TURP)	12.35	NA	5.11	0.88	NA	18.34	090
52606		A	Control postop bleeding	8.12	NA	3.55	0.58	NA	12.25	090
52612		A	Prostatectomy, first stage	7.97	NA	3.74	0.57	NA	12.28	090
52614		A	Prostatectomy, second stage	6.83	NA	3.35	0.49	NA	10.67	090
52620		A	Remove residual prostate	6.60	NA	2.98	0.47	NA	10.05	090
52630		A	Remove prostate regrowth	7.25	NA	3.19	0.52	NA	10.96	090
52640		A	Relieve bladder contracture	6.61	NA	2.96	0.47	NA	10.04	090
52647		A	Laser surgery of prostate	10.34	73.74	4.53	0.74	84.82	15.61	090
52648		A	Laser surgery of prostate	11.19	NA	4.79	0.80	NA	16.78	090
52700		A	Drainage of prostate abscess	6.79	NA	3.18	0.49	NA	10.46	090
53000		A	Incision of urethra	2.28	NA	1.55	0.16	NA	3.99	010
53010		A	Incision of urethra	3.63	NA	2.97	0.26	NA	6.86	090
53020		A	Incision of urethra	1.77	2.99	0.67	0.13	4.89	2.57	000
53025		A	Incision of urethra	1.13	3.71	0.51	0.09	4.93	1.73	000
53040		A	Drainage of urethra abscess	6.39	NA	3.43	0.47	NA	10.29	090
53060		A	Drainage of urethra abscess	2.63	2.09	1.37	0.27	4.99	4.27	010
53080		A	Drainage of urinary leakage	6.28	NA	6.06	0.55	NA	12.89	090
53085		A	Drainage of urinary leakage	10.25	NA	7.45	0.92	NA	18.62	090
53200		A	Biopsy of urethra	2.59	1.32	0.98	0.20	4.11	3.77	000
53210		A	Removal of urethra	12.55	NA	5.91	1.00	NA	19.46	090
53215		A	Removal of urethra	15.56	NA	6.69	1.13	NA	23.38	090
53220		A	Treatment of urethra lesion	6.99	NA	3.79	0.54	NA	11.32	090
53230		A	Removal of urethra lesion	9.57	NA	4.76	0.72	NA	15.05	090
53235		A	Removal of urethra lesion	10.12	NA	4.96	0.79	NA	15.87	090
53240		A	Surgery for urethra pouch	6.44	NA	3.59	0.54	NA	10.57	090
53250		A	Removal of urethra gland	5.88	NA	3.35	0.50	NA	9.73	090
53260		A	Treatment of urethra lesion	2.98	2.25	1.42	0.26	5.49	4.66	010
53265		A	Treatment of urethra lesion	3.12	2.71	1.42	0.24	6.07	4.78	010
53270		A	Removal of urethra gland	3.09	2.20	1.54	0.32	5.61	4.95	010
53275		A	Repair of urethra defect	4.52	NA	2.24	0.33	NA	7.09	010
53400		A	Revise urethra, stage 1	12.75	NA	6.02	1.04	NA	19.81	090
53405		A	Revise urethra, stage 2	14.46	NA	6.37	1.22	NA	22.05	090
53410		A	Reconstruction of urethra	16.42	NA	7.12	1.21	NA	24.75	090
53415		A	Reconstruction of urethra	19.38	NA	7.40	1.46	NA	28.24	090
53420		A	Reconstruct urethra, stage 1	14.06	NA	6.43	0.98	NA	21.47	090
53425		A	Reconstruct urethra, stage 2	15.96	NA	6.96	1.16	NA	24.08	090
53430		A	Reconstruction of urethra	16.32	NA	7.05	1.27	NA	24.64	090
53431		A	Reconstruct urethra/bladder	19.86	NA	8.09	1.44	NA	29.39	090
53440		A	Male sling procedure	13.60	NA	5.97	0.89	NA	20.46	090
53442		A	Remove/revise male sling	11.55	NA	5.45	0.61	NA	17.61	090
53444		A	Insert tandem cuff	13.38	NA	5.87	0.99	NA	20.24	090
53445		A	Insert uro/ves nck sphincter	14.04	NA	7.14	1.03	NA	22.21	090
53446		A	Remove uro sphincter	10.21	NA	5.21	0.74	NA	16.16	090
53447		A	Remove/replace ur sphincter	13.47	NA	6.41	0.98	NA	20.86	090
53448		A	Remov/replc ur sphinctr comp	21.12	NA	9.03	1.51	NA	31.66	090
53449		A	Repair uro sphincter	9.69	NA	4.77	0.65	NA	15.11	090
53450		A	Revision of urethra	6.13	NA	3.35	0.44	NA	9.92	090
53460		A	Revision of urethra	7.11	NA	3.75	0.53	NA	11.39	090
53500		A	Urethrlys, transvag w/ scope	12.19	NA	6.19	0.91	NA	19.29	090
53502		A	Repair of urethra injury	7.62	NA	4.06	0.63	NA	12.31	090
53505		A	Repair of urethra injury	7.62	NA	3.92	0.55	NA	12.09	090
53510		A	Repair of urethra injury	10.09	NA	5.23	0.74	NA	16.06	090
53515		A	Repair of urethra injury	13.29	NA	5.98	0.95	NA	20.22	090
53520		A	Repair of urethra defect	8.67	NA	4.53	0.64	NA	13.84	090
53600		A	Dilate urethra stricture	1.21	1.14	0.42	0.09	2.44	1.72	000
53601		A	Dilate urethra stricture	0.98	1.26	0.37	0.07	2.31	1.42	000
53605		A	Dilate urethra stricture	1.28	NA	0.41	0.09	NA	1.78	000
53620		A	Dilate urethra stricture	1.62	1.99	0.59	0.12	3.73	2.33	000
53621		A	Dilate urethra stricture	1.35	2.06	0.49	0.10	3.51	1.94	000
53660		A	Dilation of urethra	0.71	1.31	0.31	0.05	2.07	1.07	000
53661		A	Dilation of urethra	0.72	1.30	0.29	0.05	2.07	1.06	000
53665		A	Dilation of urethra	0.76	NA	0.25	0.06	NA	1.07	000
53850		A	Prostatic microwave thermotx	9.44	94.10	3.94	0.67	104.21	14.05	090
53852		A	Prostatic rf thermotx	9.87	88.49	4.37	0.70	99.06	14.94	090

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[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
53853		A	Prostatic water thermother	5.23	55.09	2.85	0.29	60.61	8.37	090
54000		A	Slitting of prepuce	1.54	2.91	0.93	0.11	4.56	2.58	010
54001		A	Slitting of prepuce	2.19	3.18	1.11	0.16	5.53	3.46	010
54015		A	Drain penis lesion	5.31	NA	2.55	0.40	NA	8.26	010
54050		A	Destruction, penis lesion(s)	1.24	1.67	1.04	0.10	3.01	2.38	010
54055		A	Destruction, penis lesion(s)	1.22	1.57	0.80	0.09	2.88	2.11	010
54056		A	Cryosurgery, penis lesion(s)	1.24	1.70	1.14	0.10	3.04	2.48	010
54057		A	Laser surg, penis lesion(s)	1.24	2.22	0.83	0.09	3.55	2.16	010
54060		A	Excision of penis lesion(s)	1.93	3.09	1.06	0.15	5.17	3.14	010
54065		A	Destruction, penis lesion(s)	2.42	2.63	1.23	0.19	5.24	3.84	010
54100		A	Biopsy of penis	1.90	2.82	0.82	0.15	4.87	2.87	000
54105		A	Biopsy of penis	3.49	4.28	1.93	0.25	8.02	5.67	010
54110		A	Treatment of penis lesion	10.11	NA	4.75	0.74	NA	15.60	090
54111		A	Treat penis lesion, graft	13.55	NA	5.75	0.96	NA	20.26	090
54112		A	Treat penis lesion, graft	15.84	NA	6.78	1.13	NA	23.75	090
54115		A	Treatment of penis lesion	6.14	4.37	3.45	0.44	10.95	10.03	090
54120		A	Partial removal of penis	9.96	NA	4.67	0.72	NA	15.35	090
54125		A	Removal of penis	13.51	NA	5.82	0.99	NA	20.32	090
54130		A	Remove penis & nodes	20.11	NA	8.16	1.43	NA	29.70	090
54135		A	Remove penis & nodes	26.32	NA	10.15	1.87	NA	38.34	090
54150		A	Circumcision	1.81	4.53	0.97	0.19	6.53	2.97	010
54152		A	Circumcision	2.31	NA	1.20	0.19	NA	3.70	010
54160		A	Circumcision	2.48	4.13	1.09	0.19	6.80	3.76	010
54161		A	Circumcision	3.27	NA	1.56	0.24	NA	5.07	010
54162		A	Lysis penil circumic lesion	3.00	4.63	1.44	0.22	7.85	4.66	010
54163		A	Repair of circumcision	3.00	NA	2.00	0.22	NA	5.22	010
54164		A	Frenulotomy of penis	2.50	NA	1.83	0.18	NA	4.51	010
54200		A	Treatment of penis lesion	1.06	1.79	0.98	0.08	2.93	2.12	010
54205		A	Treatment of penis lesion	7.92	NA	4.73	0.56	NA	13.21	090
54220		A	Treatment of penis lesion	2.42	3.83	0.95	0.18	6.43	3.55	000
54230		A	Prepare penis study	1.34	1.08	0.63	0.10	2.52	2.07	000
54231		A	Dynamic cavernosometry	2.04	1.38	0.87	0.15	3.57	3.06	000
54235		A	Penile injection	1.19	0.96	0.58	0.09	2.24	1.86	000
54240		A	Penis study	1.31	1.01	NA	0.17	2.49	NA	000
54240	26	A	Penis study	1.31	0.43	0.43	0.11	1.85	1.85	000
54240	TC	A	Penis study	0.00	0.59	NA	0.06	0.65	NA	000
54250		A	Penis study	2.22	0.92	NA	0.19	3.33	NA	000
54250	26	A	Penis study	2.22	0.71	0.71	0.17	3.10	3.10	000
54250	TC	A	Penis study	0.00	0.21	NA	0.02	0.23	NA	000
54300		A	Revision of penis	10.39	NA	5.65	0.74	NA	16.78	090
54304		A	Revision of penis	12.47	NA	6.43	0.92	NA	19.82	090
54308		A	Reconstruction of urethra	11.81	NA	6.05	0.84	NA	18.70	090
54312		A	Reconstruction of urethra	13.55	NA	7.07	0.96	NA	21.58	090
54316		A	Reconstruction of urethra	16.79	NA	8.05	1.21	NA	26.05	090
54318		A	Reconstruction of urethra	11.23	NA	5.88	0.80	NA	17.91	090
54322		A	Reconstruction of urethra	12.99	NA	6.53	0.99	NA	20.51	090
54324		A	Reconstruction of urethra	16.29	NA	8.10	1.48	NA	25.87	090
54326		A	Reconstruction of urethra	15.70	NA	7.89	1.12	NA	24.71	090
54328		A	Revise penis/urethra	15.63	NA	7.33	1.11	NA	24.07	090
54332		A	Revise penis/urethra	17.05	NA	7.82	1.21	NA	26.08	090
54336		A	Revise penis/urethra	20.01	NA	10.59	1.42	NA	32.02	090
54340		A	Secondary urethral surgery	8.90	NA	5.16	0.59	NA	14.65	090
54344		A	Secondary urethral surgery	15.92	NA	7.86	1.13	NA	24.91	090
54348		A	Secondary urethral surgery	17.12	NA	8.48	1.18	NA	26.78	090
54352		A	Reconstruct urethra/penis	24.70	NA	11.36	1.81	NA	37.87	090
54360		A	Penis plastic surgery	11.91	NA	6.08	0.86	NA	18.85	090
54380		A	Repair penis	13.16	NA	6.78	1.00	NA	20.94	090
54385		A	Repair penis	15.37	NA	8.57	1.20	NA	25.14	090
54390		A	Repair penis and bladder	21.58	NA	9.47	1.28	NA	32.33	090
54400		A	Insert semi-rigid prosthesis	8.98	NA	4.40	0.65	NA	14.03	090
54401		A	Insert self-contd prosthesis	10.26	NA	5.75	0.73	NA	16.74	090
54405		A	Insert multi-comp penis pros	13.41	NA	5.98	0.99	NA	20.38	090
54406		A	Remove muti-comp penis pros	12.08	NA	5.41	0.88	NA	18.37	090
54408		A	Repair multi-comp penis pros	12.73	NA	5.72	0.92	NA	19.37	090
54410		A	Remove/replace penis prosth	15.48	NA	6.61	1.13	NA	23.22	090
54411		A	Remov/replc penis pros, comp	15.98	NA	7.02	1.17	NA	24.17	090
54415		A	Remove self-contd penis pros	8.19	NA	4.18	0.59	NA	12.96	090
54416		A	Remv/repl penis contain pros	10.85	NA	5.36	0.79	NA	17.00	090
54417		A	Remv/replc penis pros, compl	14.17	NA	6.15	1.01	NA	21.33	090
54420		A	Revision of penis	11.40	NA	5.63	0.91	NA	17.94	090
54430		A	Revision of penis	10.13	NA	5.16	0.73	NA	16.02	090
54435		A	Revision of penis	6.11	NA	3.66	0.47	NA	10.24	090
54450		A	Preputial stretching	1.12	0.95	0.44	0.08	2.15	1.64	000
54500		A	Biopsy of testis	1.31	0.60	0.56	0.11	2.02	1.98	000
54505		A	Biopsy of testis	3.45	NA	1.91	0.28	NA	5.64	010

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
54512		A	Excise lesion testis	8.57	NA	4.12	0.65	NA	13.34	090
54520		A	Removal of testis	5.22	NA	2.81	0.50	NA	8.53	090
54522		A	Orchiectomy, partial	9.49	NA	4.85	0.91	NA	15.25	090
54530		A	Removal of testis	8.57	NA	4.26	0.68	NA	13.51	090
54535		A	Extensive testis surgery	12.14	NA	5.59	1.09	NA	18.82	090
54550		A	Exploration for testis	7.77	NA	3.84	0.63	NA	12.24	090
54560		A	Exploration for testis	11.11	NA	5.20	0.96	NA	17.27	090
54600		A	Reduce testis torsion	7.00	NA	3.57	0.53	NA	11.10	090
54620		A	Suspension of testis	4.89	NA	2.43	0.42	NA	7.74	010
54640		A	Suspension of testis	6.89	NA	3.76	0.63	NA	11.28	090
54650		A	Orchiopexy (Fowler-Stephens)	11.43	NA	5.45	1.41	NA	18.29	090
54660		A	Revision of testis	5.10	NA	3.01	0.40	NA	8.51	090
54670		A	Repair testis injury	6.40	NA	3.56	0.50	NA	10.46	090
54680		A	Relocation of testis(es)	12.63	NA	6.22	1.23	NA	20.08	090
54690		A	Laparoscopy, orchiectomy	10.94	NA	4.99	1.23	NA	17.16	090
54692		A	Laparoscopy, orchiopexy	12.86	NA	5.40	1.05	NA	19.31	090
54700		A	Drainage of scrotum	3.42	NA	1.93	0.28	NA	5.63	010
54800		A	Biopsy of epididymis	2.33	0.94	0.89	0.22	3.49	3.44	000
54820		A	Exploration of epididymis	5.13	NA	2.96	0.39	NA	8.48	090
54830		A	Remove epididymis lesion	5.37	NA	3.04	0.42	NA	8.83	090
54840		A	Remove epididymis lesion	5.19	NA	2.80	0.37	NA	8.36	090
54860		A	Removal of epididymis	6.31	NA	3.33	0.46	NA	10.10	090
54861		A	Removal of epididymis	8.89	NA	4.33	0.64	NA	13.86	090
54900		A	Fusion of spermatic ducts	13.18	NA	5.80	1.62	NA	20.60	090
54901		A	Fusion of spermatic ducts	17.91	NA	7.55	1.28	NA	26.74	090
55000		A	Drainage of hydrocele	1.43	2.06	0.65	0.12	3.61	2.20	000
55040		A	Removal of hydrocele	5.35	NA	2.92	0.44	NA	8.71	090
55041		A	Removal of hydroceles	7.73	NA	3.98	0.60	NA	12.31	090
55060		A	Repair of hydrocele	5.51	NA	3.09	0.46	NA	9.06	090
55100		A	Drainage of scrotum abscess	2.13	3.67	1.56	0.17	5.97	3.86	010
55110		A	Explore scrotum	5.69	NA	3.12	0.45	NA	9.26	090
55120		A	Removal of scrotum lesion	5.08	NA	2.94	0.39	NA	8.41	090
55150		A	Removal of scrotum	7.21	NA	3.83	0.58	NA	11.62	090
55175		A	Revision of scrotum	5.23	NA	3.00	0.40	NA	8.63	090
55180		A	Revision of scrotum	10.70	NA	5.34	0.85	NA	16.89	090
55200		A	Incision of sperm duct	4.23	12.26	2.37	0.30	16.79	6.90	090
55250		A	Removal of sperm duct(s)	3.29	11.44	2.21	0.26	14.99	5.76	090
55300		A	Prepare, sperm duct x-ray	3.50	NA	1.31	0.26	NA	5.07	000
55400		A	Repair of sperm duct	8.48	NA	4.05	0.74	NA	13.27	090
55450		A	Ligation of sperm duct	4.11	6.96	1.86	0.29	11.36	6.26	010
55500		A	Removal of hydrocele	5.58	NA	3.11	0.55	NA	9.24	090
55520		A	Removal of sperm cord lesion	6.02	NA	3.28	0.73	NA	10.03	090
55530		A	Revise spermatic cord veins	5.65	NA	3.03	0.46	NA	9.14	090
55535		A	Revise spermatic cord veins	6.55	NA	3.41	0.53	NA	10.49	090
55540		A	Revise hernia & sperm veins	7.66	NA	3.83	0.94	NA	12.43	090
55550		A	Laparo ligate spermatic vein	6.56	NA	3.29	0.66	NA	10.51	090
55600		A	Incise sperm duct pouch	6.37	NA	3.35	0.59	NA	10.31	090
55605		A	Incise sperm duct pouch	7.95	NA	4.32	0.97	NA	13.24	090
55650		A	Remove sperm duct pouch	11.78	NA	5.29	0.95	NA	18.02	090
55680		A	Remove sperm pouch lesion	5.18	NA	2.98	0.47	NA	8.63	090
55700		A	Biopsy of prostate	1.57	4.18	0.64	0.11	5.86	2.32	000
55705		A	Biopsy of prostate	4.56	NA	2.29	0.33	NA	7.18	010
55720		A	Drainage of prostate abscess	7.63	NA	3.88	0.55	NA	12.06	090
55725		A	Drainage of prostate abscess	8.67	NA	4.55	0.74	NA	13.96	090
55801		A	Removal of prostate	17.77	NA	7.65	1.37	NA	26.79	090
55810		A	Extensive prostate surgery	22.55	NA	8.99	1.66	NA	33.20	090
55812		A	Extensive prostate surgery	27.47	NA	11.03	2.22	NA	40.72	090
55815		A	Extensive prostate surgery	30.41	NA	11.94	2.39	NA	44.74	090
55821		A	Removal of prostate	14.23	NA	6.24	1.05	NA	21.52	090
55831		A	Removal of prostate	15.60	NA	6.69	1.16	NA	23.45	090
55840		A	Extensive prostate surgery	22.66	NA	9.33	1.68	NA	33.67	090
55842		A	Extensive prostate surgery	24.34	NA	9.89	1.82	NA	36.05	090
55845		A	Extensive prostate surgery	28.51	NA	10.99	2.13	NA	41.63	090
55859		A	Percut/needle insert, pros	12.50	NA	5.87	0.88	NA	19.25	090
55860		A	Surgical exposure, prostate	14.43	NA	6.45	0.99	NA	21.87	090
55862		A	Extensive prostate surgery	18.36	NA	7.88	1.31	NA	27.55	090
55865		A	Extensive prostate surgery	22.84	NA	9.29	1.73	NA	33.86	090
55866		A	Laparo radical prostatectomy	30.69	NA	11.68	1.68	NA	44.05	090
55870		A	Electroejaculation	2.58	1.53	1.08	0.17	4.28	3.83	000
55873		A	Cryoablate prostate	19.44	NA	8.92	1.39	NA	29.75	090
56405		A	I & D of vulva/perineum	1.44	1.33	1.14	0.17	2.94	2.75	010
56420		A	Drainage of gland abscess	1.39	2.28	1.05	0.15	3.82	2.59	010
56440		A	Surgery for vulva lesion	2.84	NA	1.71	0.34	NA	4.89	010
56441		A	Lysis of labial lesion(s)	1.97	1.81	1.42	0.19	3.97	3.58	010
56501		A	Destroy, vulva lesions, sim	1.53	1.78	1.25	0.18	3.49	2.96	010

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
56515		A	Destroy vulva lesion/s compl	2.76	2.55	1.81	0.32	5.63	4.89	010
56605		A	Biopsy of vulva/perineum	1.10	1.08	0.46	0.13	2.31	1.69	000
56606		A	Biopsy of vulva/perineum	0.55	0.49	0.22	0.07	1.11	0.84	ZZZ
56620		A	Partial removal of vulva	7.46	NA	4.83	0.89	NA	13.18	090
56625		A	Complete removal of vulva	8.39	NA	5.39	1.00	NA	14.78	090
56630		A	Extensive vulva surgery	12.34	NA	6.96	1.45	NA	20.75	090
56631		A	Extensive vulva surgery	16.18	NA	8.98	1.92	NA	27.08	090
56632		A	Extensive vulva surgery	20.26	NA	9.64	2.35	NA	32.25	090
56633		A	Extensive vulva surgery	16.45	NA	8.71	1.93	NA	27.09	090
56634		A	Extensive vulva surgery	17.85	NA	9.60	2.09	NA	29.54	090
56637		A	Extensive vulva surgery	21.94	NA	11.24	2.56	NA	35.74	090
56640		A	Extensive vulva surgery	22.14	NA	10.78	2.61	NA	35.53	090
56700		A	Partial removal of hymen	2.52	NA	1.83	0.29	NA	4.64	010
56720		A	Incision of hymen	0.68	NA	0.51	0.08	NA	1.27	000
56740		A	Remove vagina gland lesion	4.56	NA	2.56	0.55	NA	7.67	010
56800		A	Repair of vagina	3.88	NA	2.18	0.44	NA	6.50	010
56805		A	Repair clitoris	18.83	NA	9.38	2.08	NA	30.29	090
56810		A	Repair of perineum	4.12	NA	2.29	0.48	NA	6.89	010
56820		A	Exam of vulva w/scope	1.50	1.32	0.65	0.11	2.93	2.26	000
56821		A	Exam/biopsy of vulva w/scope	2.05	1.76	0.91	0.15	3.96	3.11	000
57000		A	Exploration of vagina	2.97	NA	1.72	0.30	NA	4.99	010
57010		A	Drainage of pelvic abscess	6.02	NA	3.83	0.69	NA	10.54	090
57020		A	Drainage of pelvic fluid	1.50	0.95	0.59	0.18	2.63	2.27	000
57022		A	I & d vaginal hematoma, pp	2.56	NA	1.50	0.27	NA	4.33	010
57023		A	I & d vag hematoma, non-ob	4.74	NA	2.57	0.55	NA	7.86	010
57061		A	Destroy vag lesions, simple	1.25	1.66	1.12	0.15	3.06	2.52	010
57065		A	Destroy vag lesions, complex	2.61	2.30	1.68	0.31	5.22	4.60	010
57100		A	Biopsy of vagina	1.20	1.09	0.48	0.14	2.43	1.82	000
57105		A	Biopsy of vagina	1.69	1.79	1.43	0.20	3.68	3.32	010
57106		A	Remove vagina wall, partial	6.35	NA	4.19	0.73	NA	11.27	090
57107		A	Remove vagina tissue, part	22.97	NA	10.45	2.67	NA	36.09	090
57109		A	Vaginectomy partial w/nodes	26.96	NA	11.28	3.10	NA	41.34	090
57110		A	Remove vagina wall, complete	14.27	NA	7.28	1.67	NA	23.22	090
57111		A	Remove vagina tissue, compl	26.96	NA	12.58	2.95	NA	42.49	090
57112		A	Vaginectomy w/nodes, compl	28.96	NA	12.12	2.61	NA	43.69	090
57120		A	Closure of vagina	7.40	NA	4.62	0.87	NA	12.89	090
57130		A	Remove vagina lesion	2.43	2.16	1.54	0.27	4.86	4.24	010
57135		A	Remove vagina lesion	2.67	2.27	1.65	0.31	5.25	4.63	010
57150		A	Treat vagina infection	0.55	1.10	0.21	0.07	1.72	0.83	000
57155		A	Insert uteri tandems/ovoids	6.26	NA	4.61	0.45	NA	11.32	090
57160		A	Insert pessary/other device	0.89	1.01	0.34	0.10	2.00	1.33	000
57170		A	Fitting of diaphragm/cap	0.91	1.49	0.33	0.11	2.51	1.35	000
57180		A	Treat vaginal bleeding	1.58	2.17	1.27	0.18	3.93	3.03	010
57200		A	Repair of vagina	3.93	NA	2.89	0.45	NA	7.27	090
57210		A	Repair vagina/perineum	5.16	NA	3.43	0.61	NA	9.20	090
57220		A	Revision of urethra	4.30	NA	3.10	0.50	NA	7.90	090
57230		A	Repair of urethral lesion	5.63	NA	3.40	0.57	NA	9.60	090
57240		A	Repair bladder & vagina	6.06	NA	3.81	0.62	NA	10.49	090
57250		A	Repair rectum & vagina	5.52	NA	3.57	0.64	NA	9.73	090
57260		A	Repair of vagina	8.26	NA	4.83	0.96	NA	14.05	090
57265		A	Extensive repair of vagina	11.32	NA	6.03	1.32	NA	18.67	090
57268		A	Repair of bowel bulge	6.75	NA	4.19	0.78	NA	11.72	090
57270		A	Repair of bowel pouch	12.09	NA	6.24	1.39	NA	19.72	090
57280		A	Suspension of vagina	15.02	NA	7.35	1.65	NA	24.02	090
57282		A	Repair of vaginal prolapse	8.85	NA	5.29	1.02	NA	15.16	090
57284		A	Repair paravaginal defect	12.68	NA	7.13	1.44	NA	21.25	090
57287		A	Revise/remove sling repair	10.69	NA	5.46	0.91	NA	17.06	090
57288		A	Repair bladder defect	13.00	NA	5.90	1.14	NA	20.04	090
57289		A	Repair bladder & vagina	11.56	NA	6.03	1.17	NA	18.76	090
57291		A	Construction of vagina	7.94	NA	4.92	0.94	NA	13.80	090
57292		A	Construct vagina with graft	13.07	NA	6.93	1.57	NA	21.57	090
57300		A	Repair rectum-vagina fistula	7.60	NA	4.29	0.88	NA	12.77	090
57305		A	Repair rectum-vagina fistula	13.75	NA	6.26	1.67	NA	21.68	090
57307		A	Fistula repair & colostomy	15.91	NA	7.02	1.96	NA	24.89	090
57308		A	Fistula repair, transperine	9.93	NA	5.13	1.12	NA	16.18	090
57310		A	Repair urethrovaginal lesion	6.77	NA	3.86	0.57	NA	11.20	090
57311		A	Repair urethrovaginal lesion	7.97	NA	4.14	0.68	NA	12.79	090
57320		A	Repair bladder-vagina lesion	8.00	NA	4.39	0.65	NA	13.04	090
57330		A	Repair bladder-vagina lesion	12.33	NA	5.73	1.07	NA	19.13	090
57335		A	Repair vagina	18.70	NA	9.03	1.84	NA	29.57	090
57400		A	Dilation of vagina	2.27	NA	1.11	0.26	NA	3.64	000
57410		A	Pelvic examination	1.75	2.02	0.89	0.17	3.94	2.81	000
57415		A	Remove vaginal foreign body	2.17	NA	1.43	0.23	NA	3.83	010
57420		A	Exam of vagina w/scope	1.60	1.36	0.67	0.11	3.07	2.38	000
57421		A	Exam/biopsy of vag w/scope	2.20	1.85	0.96	0.15	4.20	3.31	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
57425		A	Laparoscopy, surg, colpopexy	15.73	NA	6.63	1.74	NA	24.10	090
57452		A	Exam of cervix w/scope	1.50	1.29	0.77	0.11	2.90	2.38	000
57454		A	Bx/curett of cervix w/scope	2.33	1.64	1.15	0.15	4.12	3.63	000
57455		A	Biopsy of cervix w/scope	1.99	1.72	0.87	0.15	3.86	3.01	000
57456		A	Endocerv curettage w/scope	1.85	1.65	0.82	0.15	3.65	2.82	000
57460		A	Bx of cervix w/scope, leep	2.83	5.85	1.37	0.33	9.01	4.53	000
57461		A	Conz of cervix w/scope, leep	3.43	6.11	1.47	0.33	9.87	5.23	000
57500		A	Biopsy of cervix	0.97	2.55	0.63	0.11	3.63	1.71	000
57505		A	Endocervical curettage	1.14	1.47	1.10	0.13	2.74	2.37	010
57510		A	Cauterization of cervix	1.90	1.57	1.04	0.22	3.69	3.16	010
57511		A	Cryocautery of cervix	1.90	1.83	1.38	0.22	3.95	3.50	010
57513		A	Laser surgery of cervix	1.90	1.73	1.41	0.23	3.86	3.54	010
57520		A	Conization of cervix	4.03	3.93	2.88	0.48	8.44	7.39	090
57522		A	Conization of cervix	3.35	3.15	2.46	0.40	6.90	6.21	090
57530		A	Removal of cervix	4.78	NA	3.42	0.56	NA	8.76	090
57531		A	Removal of cervix, radical	27.96	NA	13.18	3.29	NA	44.43	090
57540		A	Removal of residual cervix	12.20	NA	6.24	1.39	NA	19.83	090
57545		A	Remove cervix/repair pelvis	13.01	NA	6.67	1.57	NA	21.25	090
57550		A	Removal of residual cervix	5.52	NA	3.85	0.67	NA	10.04	090
57555		A	Remove cervix/repair vagina	8.94	NA	5.11	1.08	NA	15.13	090
57556		A	Remove cervix, repair bowel	8.36	NA	4.87	0.95	NA	14.18	090
57700		A	Revision of cervix	3.54	NA	3.08	0.40	NA	7.02	090
57720		A	Revision of cervix	4.12	NA	3.14	0.49	NA	7.75	090
57800		A	Dilation of cervical canal	0.77	0.76	0.47	0.09	1.62	1.33	000
57820		A	D & c of residual cervix	1.67	1.48	1.14	0.20	3.35	3.01	010
58100		A	Biopsy of uterus lining	1.53	1.32	0.72	0.18	3.03	2.43	000
58120		A	Dilation and curettage	3.27	2.30	1.87	0.39	5.96	5.53	010
58140		A	Myomectomy abdom method	14.58	NA	7.10	1.77	NA	23.45	090
58145		A	Myomectomy vag method	8.03	NA	4.82	0.96	NA	13.81	090
58146		A	Myomectomy abdom complex	18.97	NA	8.90	1.77	NA	29.64	090
58150		A	Total hysterectomy	15.22	NA	7.48	1.81	NA	24.51	090
58152		A	Total hysterectomy	20.57	NA	9.83	2.39	NA	32.79	090
58180		A	Partial hysterectomy	15.27	NA	7.44	1.83	NA	24.54	090
58200		A	Extensive hysterectomy	21.56	NA	10.00	2.52	NA	34.08	090
58210		A	Extensive hysterectomy	28.81	NA	13.20	3.31	NA	45.32	090
58240		A	Removal of pelvis contents	38.33	NA	17.63	4.33	NA	60.29	090
58260		A	Vaginal hysterectomy	12.96	NA	6.68	1.54	NA	21.18	090
58262		A	Vag hyst including t/o	14.75	NA	7.36	1.75	NA	23.86	090
58263		A	Vag hyst w/t/o & vag repair	16.04	NA	7.86	1.90	NA	25.80	090
58267		A	Vag hyst w/urinary repair	17.01	NA	8.36	2.01	NA	27.38	090
58270		A	Vag hyst w/enterocele repair	14.24	NA	7.05	1.69	NA	22.98	090
58275		A	Hysterectomy/revise vagina	15.74	NA	7.75	1.86	NA	25.35	090
58280		A	Hysterectomy/revise vagina	16.98	NA	8.23	1.99	NA	27.20	090
58285		A	Extensive hysterectomy	22.23	NA	9.97	2.65	NA	34.85	090
58290		A	Vag hyst complex	18.97	NA	9.10	1.48	NA	29.55	090
58291		A	Vag hyst incl t/o, complex	20.76	NA	9.86	1.75	NA	32.37	090
58292		A	Vag hyst t/o & repair, compl	22.05	NA	10.34	1.90	NA	34.29	090
58293		A	Vag hyst w/uro repair, compl	23.03	NA	10.66	2.01	NA	35.70	090
58294		A	Vag hyst w/enterocele, compl	20.25	NA	9.54	1.69	NA	31.48	090
58301		A	Remove intrauterine device	1.27	1.32	0.48	0.14	2.73	1.89	000
58321		A	Artificial insemination	0.92	1.15	0.37	0.11	2.18	1.40	000
58322		A	Artificial insemination	1.10	1.21	0.42	0.13	2.44	1.65	000
58323		A	Sperm washing	0.23	0.53	0.09	0.03	0.79	0.35	000
58340		A	Catheter for hysterography	0.88	3.16	0.65	0.09	4.13	1.62	000
58345		A	Reopen fallopian tube	4.65	NA	2.43	0.33	NA	7.41	010
58346		A	Insert heyman uteri capsule	6.74	NA	3.93	0.79	NA	11.46	090
58350		A	Reopen fallopian tube	1.01	1.49	0.93	0.12	2.62	2.06	010
58353		A	Endometr ablate, thermal	3.55	35.73	2.04	0.42	39.70	6.01	010
58400		A	Suspension of uterus	6.35	NA	3.96	0.75	NA	11.06	090
58410		A	Suspension of uterus	12.71	NA	6.46	1.37	NA	20.54	090
58520		A	Repair of ruptured uterus	11.90	NA	6.04	1.32	NA	19.26	090
58540		A	Revision of uterus	14.62	NA	6.95	1.76	NA	23.33	090
58545		A	Laparoscopic myomectomy	14.58	NA	7.21	1.71	NA	23.50	090
58546		A	Laparo-myomectomy, complex	18.97	NA	9.05	1.71	NA	29.73	090
58550		A	Laparo-asst vag hysterectomy	14.17	NA	7.28	1.70	NA	23.15	090
58552		A	Laparo-vag hyst incl t/o	15.98	NA	8.00	1.70	NA	25.68	090
58553		A	Laparo-vag hyst, complex	18.97	NA	8.93	1.54	NA	29.44	090
58554		A	Laparo-vag hyst w/t/o, compl	21.97	NA	10.41	1.54	NA	33.92	090
58555		A	Hysteroscopy, dx, sep proc	3.33	2.19	1.55	0.40	5.92	5.28	000
58558		A	Hysteroscopy, biopsy	4.74	NA	2.17	0.57	NA	7.48	000
58559		A	Hysteroscopy, lysis	6.16	NA	2.72	0.73	NA	9.61	000
58560		A	Hysteroscopy, resect septum	6.99	NA	3.07	0.84	NA	10.90	000
58561		A	Hysteroscopy, remove myoma	9.99	NA	4.27	1.18	NA	15.44	000
58562		A	Hysteroscopy, remove fb	5.20	NA	2.34	0.62	NA	8.16	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
58563		A	Hysteroscopy, ablation	6.16	56.02	2.74	0.74	62.92	9.64	000
58600		A	Division of fallopian tube	5.59	NA	3.35	0.67	NA	9.61	090
58605		A	Division of fallopian tube	4.99	NA	3.14	0.59	NA	8.72	090
58611		A	Ligate oviduct(s) add-on	1.45	NA	0.57	0.17	NA	2.19	ZZZ
58615		A	Occlude fallopian tube(s)	3.89	NA	2.71	0.48	NA	7.08	010
58660		A	Laparoscopy, lysis	11.27	NA	5.25	1.38	NA	17.90	090
58661		A	Laparoscopy, remove adnexa	11.03	NA	5.11	1.31	NA	17.45	010
58662		A	Laparoscopy, excise lesions	11.77	NA	5.78	1.42	NA	18.97	090
58670		A	Laparoscopy, tubal cautery	5.59	NA	3.27	0.66	NA	9.52	090
58671		A	Laparoscopy, tubal block	5.59	NA	3.28	0.67	NA	9.54	090
58672		A	Laparoscopy, fimbrioplasty	12.86	NA	6.21	1.49	NA	20.56	090
58673		A	Laparoscopy, salpingostomy	13.72	NA	6.59	1.68	NA	21.99	090
58700		A	Removal of fallopian tube	12.03	NA	5.99	1.47	NA	19.49	090
58720		A	Removal of ovary/tube(s)	11.34	NA	5.79	1.36	NA	18.49	090
58740		A	Revise fallopian tube(s)	13.98	NA	7.13	1.68	NA	22.79	090
58750		A	Repair oviduct	14.82	NA	7.37	1.72	NA	23.91	090
58752		A	Revise ovarian tube(s)	14.82	NA	6.96	1.82	NA	23.60	090
58760		A	Remove tubal obstruction	13.11	NA	6.71	1.53	NA	21.35	090
58770		A	Create new tubal opening	13.95	NA	6.91	1.52	NA	22.38	090
58800		A	Drainage of ovarian cyst(s)	4.13	3.64	2.90	0.47	8.24	7.50	090
58805		A	Drainage of ovarian cyst(s)	5.87	NA	3.53	0.66	NA	10.06	090
58820		A	Drain ovary abscess, open	4.21	NA	3.32	0.41	NA	7.94	090
58822		A	Drain ovary abscess, percut	10.11	NA	5.22	1.23	NA	16.56	090
58823		A	Drain pelvic abscess, percut	3.37	21.77	1.12	0.25	25.39	4.74	000
58825		A	Transposition, ovary(s)	10.96	NA	5.80	1.33	NA	18.09	090
58900		A	Biopsy of ovary(s)	5.98	NA	3.59	0.70	NA	10.27	090
58920		A	Partial removal of ovary(s)	11.34	NA	5.60	1.37	NA	18.31	090
58925		A	Removal of ovarian cyst(s)	11.34	NA	5.69	1.39	NA	18.42	090
58940		A	Removal of ovary(s)	7.28	NA	4.12	0.88	NA	12.28	090
58943		A	Removal of ovary(s)	18.40	NA	8.73	2.19	NA	29.32	090
58950		A	Resect ovarian malignancy	16.90	NA	8.48	2.01	NA	27.39	090
58951		A	Resect ovarian malignancy	22.35	NA	10.52	2.62	NA	35.49	090
58952		A	Resect ovarian malignancy	24.97	NA	11.83	2.96	NA	39.76	090
58953		A	Tah, rad dissect for debulk	31.95	NA	14.54	3.77	NA	50.26	090
58954		A	Tah rad debulk/lymph remove	34.95	NA	15.68	4.14	NA	54.77	090
58960		A	Exploration of abdomen	14.63	NA	7.44	1.74	NA	23.81	090
58970		A	Retrieval of oocyte	3.52	2.31	1.49	0.29	6.12	5.30	000
58976		A	Transfer of embryo	3.82	2.65	1.82	0.47	6.94	6.11	000
59000		A	Amniocentesis, diagnostic	1.30	2.08	0.67	0.31	3.69	2.28	000
59001		A	Amniocentesis, therapeutic	3.00	NA	1.40	0.71	NA	5.11	000
59012		A	Fetal cord puncture,prenatal	3.44	NA	1.53	0.82	NA	5.79	000
59015		A	Chorion biopsy	2.20	1.56	1.04	0.52	4.28	3.76	000
59020		A	Fetal contract stress test	0.66	0.78	NA	0.26	1.70	NA	000
59020	26	A	Fetal contract stress test	0.66	0.26	0.26	0.16	1.08	1.08	000
59020	TC	A	Fetal contract stress test	0.00	0.52	NA	0.10	0.62	NA	000
59025		A	Fetal non-stress test	0.53	0.44	NA	0.15	1.12	NA	000
59025	26	A	Fetal non-stress test	0.53	0.21	0.21	0.13	0.87	0.87	000
59025	TC	A	Fetal non-stress test	0.00	0.23	NA	0.02	0.25	NA	000
59030		A	Fetal scalp blood sample	1.99	NA	0.77	0.47	NA	3.23	000
59050		A	Fetal monitor w/report	0.89	NA	0.35	0.21	NA	1.45	XXX
59051		A	Fetal monitor/interpret only	0.74	NA	0.29	0.18	NA	1.21	XXX
59070		A	Transabdom amnioinfus w/ us	5.24	5.06	2.29	0.28	10.58	7.81	000
59072		A	Umbilical cord occlud w/ us	8.99	NA	3.11	0.16	NA	12.26	000
59074		A	Fetal fluid drainage w/ us	5.24	4.47	2.29	0.28	9.99	7.81	000
59076		A	Fetal shunt placement, w/ us	8.99	NA	3.11	0.16	NA	12.26	000
59100		A	Remove uterus lesion	12.33	NA	6.46	2.93	NA	21.72	090
59120		A	Treat ectopic pregnancy	11.47	NA	6.24	2.73	NA	20.44	090
59121		A	Treat ectopic pregnancy	11.65	NA	6.32	2.77	NA	20.74	090
59130		A	Treat ectopic pregnancy	14.20	NA	4.86	1.96	NA	21.02	090
59135		A	Treat ectopic pregnancy	13.86	NA	7.22	3.00	NA	24.08	090
59136		A	Treat ectopic pregnancy	13.16	NA	6.61	2.85	NA	22.62	090
59140		A	Treat ectopic pregnancy	5.45	2.20	2.20	1.30	8.95	8.95	090
59150		A	Treat ectopic pregnancy	11.65	NA	6.02	2.77	NA	20.44	090
59151		A	Treat ectopic pregnancy	11.47	NA	6.06	2.73	NA	20.26	090
59160		A	D & c after delivery	2.71	3.29	2.13	0.64	6.64	5.48	010
59200		A	Insert cervical dilator	0.79	1.19	0.30	0.19	2.17	1.28	000
59300		A	Episiotomy or vaginal repair	2.41	2.20	0.95	0.57	5.18	3.93	000
59320		A	Revision of cervix	2.48	NA	1.24	0.59	NA	4.31	000
59325		A	Revision of cervix	4.06	NA	1.89	0.88	NA	6.83	000
59350		A	Repair of uterus	4.94	NA	1.86	1.18	NA	7.98	000
59400		A	Obstetrical care	23.03	NA	15.35	5.48	NA	43.86	MMM
59409		A	Obstetrical care	13.48	NA	5.29	3.21	NA	21.98	MMM
59410		A	Obstetrical care	14.76	NA	6.29	3.51	NA	24.56	MMM
59412		A	Antepartum manipulation	1.71	NA	0.81	0.41	NA	2.93	MMM
59414		A	Deliver placenta	1.61	NA	0.64	0.38	NA	2.63	MMM

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
59425		A	Antepartum care only	4.80	4.22	1.85	1.14	10.16	7.79	MMM
59426		A	Antepartum care only	8.27	7.58	3.21	1.97	17.82	13.45	MMM
59430		A	Care after delivery	2.13	1.23	0.93	0.51	3.87	3.57	MMM
59510		A	Cesarean delivery	26.18	NA	17.26	6.23	NA	49.67	MMM
59514		A	Cesarean delivery only	15.95	NA	6.19	3.79	NA	25.93	MMM
59515		A	Cesarean delivery	17.34	NA	7.81	4.13	NA	29.28	MMM
59525		A	Remove uterus after cesarean	8.53	NA	3.29	2.03	NA	13.85	ZZZ
59610		A	Vbac delivery	24.58	NA	15.89	5.85	NA	46.32	MMM
59612		A	Vbac delivery only	15.04	NA	6.03	3.58	NA	24.65	MMM
59614		A	Vbac care after delivery	16.32	NA	6.91	3.88	NA	27.11	MMM
59618		A	Attempted vbac delivery	27.74	NA	18.29	6.60	NA	52.63	MMM
59620		A	Attempted vbac delivery only	17.50	NA	6.74	4.17	NA	28.41	MMM
59622		A	Attempted vbac after care	18.90	NA	8.61	4.50	NA	32.01	MMM
59812		A	Treatment of miscarriage	4.00	NA	2.54	0.95	NA	7.49	090
59820		A	Care of miscarriage	4.00	4.43	3.56	0.95	9.38	8.51	090
59821		A	Treatment of miscarriage	4.46	4.26	3.40	1.06	9.78	8.92	090
59830		A	Treat uterus infection	6.10	NA	3.99	1.45	NA	11.54	090
59840		R	Abortion	3.01	NA	2.12	0.72	NA	5.85	010
59841		R	Abortion	5.23	2.56	2.56	1.25	9.04	9.04	010
59850		R	Abortion	5.90	NA	3.25	1.28	NA	10.43	090
59851		R	Abortion	5.92	NA	3.73	1.41	NA	11.06	090
59852		R	Abortion	8.23	NA	5.05	1.79	NA	15.07	090
59855		R	Abortion	6.11	NA	3.55	1.45	NA	11.11	090
59856		R	Abortion	7.47	NA	4.05	1.62	NA	13.14	090
59857		R	Abortion	9.28	NA	4.59	2.00	NA	15.87	090
59866		R	Abortion (mpr)	3.99	NA	1.82	0.87	NA	6.68	000
59870		A	Evacuate mole of uterus	6.00	NA	4.42	1.43	NA	11.85	090
59871		A	Remove cerclage suture	2.13	1.74	1.13	0.51	4.38	3.77	000
60000		A	Drain thyroid/tongue cyst	1.76	1.94	1.73	0.14	3.84	3.63	010
60001		A	Aspirate/inject thyriod cyst	0.97	1.43	0.33	0.08	2.48	1.38	000
60100		A	Biopsy of thyroid	1.56	1.40	0.53	0.10	3.06	2.19	000
60200		A	Remove thyroid lesion	9.54	NA	6.08	1.01	NA	16.63	090
60210		A	Partial thyroid excision	10.86	NA	5.72	1.24	NA	17.82	090
60212		A	Partial thyroid excision	16.01	NA	7.75	1.59	NA	25.35	090
60220		A	Partial removal of thyroid	11.88	NA	6.24	1.34	NA	19.46	090
60225		A	Partial removal of thyroid	14.17	NA	7.48	1.65	NA	23.30	090
60240		A	Removal of thyroid	16.04	NA	7.68	1.84	NA	25.56	090
60252		A	Removal of thyroid	20.54	NA	10.20	2.28	NA	33.02	090
60254		A	Extensive thyroid surgery	26.95	NA	14.28	2.75	NA	43.98	090
60260		A	Repeat thyroid surgery	17.44	NA	8.77	1.94	NA	28.15	090
60270		A	Removal of thyroid	20.24	NA	10.56	2.27	NA	33.07	090
60271		A	Removal of thyroid	16.80	NA	8.70	1.83	NA	27.33	090
60280		A	Remove thyroid duct lesion	5.86	NA	4.78	0.53	NA	11.17	090
60281		A	Remove thyroid duct lesion	8.52	NA	5.94	0.80	NA	15.26	090
60500		A	Explore parathyroid glands	16.21	NA	7.47	1.98	NA	25.66	090
60502		A	Re-explore parathyroids	20.32	NA	9.41	2.50	NA	32.23	090
60505		A	Explore parathyroid glands	21.46	NA	11.03	2.65	NA	35.14	090
60512		A	Autotransplant parathyroid	4.44	NA	1.62	0.54	NA	6.60	ZZZ
60520		A	Removal of thymus gland	16.78	NA	8.31	2.16	NA	27.25	090
60521		A	Removal of thymus gland	18.84	NA	9.57	1.92	NA	30.33	090
60522		A	Removal of thymus gland	23.06	NA	11.28	3.13	NA	37.47	090
60540		A	Explore adrenal gland	17.00	NA	7.58	1.75	NA	26.33	090
60545		A	Explore adrenal gland	19.85	NA	8.54	2.05	NA	30.44	090
60600		A	Remove carotid body lesion	17.90	NA	10.76	2.15	NA	30.81	090
60605		A	Remove carotid body lesion	20.21	NA	12.59	2.45	NA	35.25	090
60650		A	Laparoscopy adrenalectomy	19.97	NA	7.95	2.32	NA	30.24	090
61000		A	Remove cranial cavity fluid	1.58	NA	0.96	0.17	NA	2.71	000
61001		A	Remove cranial cavity fluid	1.49	NA	1.07	0.18	NA	2.74	000
61020		A	Remove brain cavity fluid	1.51	NA	1.35	0.30	NA	3.16	000
61026		A	Injection into brain canal	1.69	NA	1.40	0.25	NA	3.34	000
61050		A	Remove brain canal fluid	1.51	NA	1.27	0.12	NA	2.90	000
61055		A	Injection into brain canal	2.10	NA	1.43	0.16	NA	3.69	000
61070		A	Brain canal shunt procedure	0.89	NA	1.03	0.14	NA	2.06	000
61105		A	Twist drill hole	5.13	NA	3.93	1.26	NA	10.32	090
61107		A	Drill skull for implantation	4.99	NA	2.52	1.24	NA	8.75	000
61108		A	Drill skull for drainage	10.17	NA	7.13	2.53	NA	19.83	090
61120		A	Burr hole for puncture	8.75	NA	5.99	2.04	NA	16.78	090
61140		A	Pierce skull for biopsy	15.88	NA	9.87	3.63	NA	29.38	090
61150		A	Pierce skull for drainage	17.54	NA	10.36	3.95	NA	31.85	090
61151		A	Pierce skull for drainage	12.40	NA	7.81	2.97	NA	23.18	090
61154		A	Pierce skull & remove clot	14.97	NA	9.47	3.76	NA	28.20	090
61156		A	Pierce skull for drainage	16.30	NA	9.82	4.03	NA	30.15	090
61210		A	Pierce skull, implant device	5.83	NA	2.91	1.45	NA	10.19	000
61215		A	Insert brain-fluid device	4.88	NA	4.00	1.21	NA	10.09	090
61250		A	Pierce skull & explore	10.40	NA	6.84	2.15	NA	19.39	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
61253		A	Pierce skull & explore	12.34	NA	7.72	2.01	NA	22.07	090
61304		A	Open skull for exploration	21.93	NA	12.83	4.96	NA	39.72	090
61305		A	Open skull for exploration	26.57	NA	15.30	6.08	NA	47.95	090
61312		A	Open skull for drainage	24.53	NA	15.03	5.60	NA	45.16	090
61313		A	Open skull for drainage	24.89	NA	14.79	5.79	NA	45.47	090
61314		A	Open skull for drainage	24.19	NA	13.03	5.53	NA	42.75	090
61315		A	Open skull for drainage	27.64	NA	16.00	6.33	NA	49.97	090
61316		A	Implt cran bone flap to abdo	1.39	NA	0.60	0.52	NA	2.51	ZZZ
61320		A	Open skull for drainage	25.58	NA	14.74	5.81	NA	46.13	090
61321		A	Open skull for drainage	28.46	NA	16.11	6.55	NA	51.12	090
61322		A	Decompressive craniotomy	29.46	NA	15.68	6.02	NA	51.16	090
61323		A	Decompressive lobectomy	30.95	NA	16.13	6.02	NA	53.10	090
61330		A	Decompress eye socket	23.29	NA	13.70	3.67	NA	40.66	090
61332		A	Explore/biopsy eye socket	27.24	NA	15.57	4.76	NA	47.57	090
61333		A	Explore orbit/remove lesion	27.91	NA	15.55	3.55	NA	47.01	090
61334		A	Explore orbit/remove object	18.24	NA	10.62	3.15	NA	32.01	090
61340		A	Subtemporal decompression	18.63	NA	11.12	4.26	NA	34.01	090
61343		A	Incise skull (press relief)	29.73	NA	16.81	6.70	NA	53.24	090
61345		A	Relieve cranial pressure	27.16	NA	15.40	5.70	NA	48.26	090
61440		A	Incise skull for surgery	26.59	NA	14.21	6.88	NA	47.68	090
61450		A	Incise skull for surgery	25.91	NA	14.28	5.43	NA	45.62	090
61458		A	Incise skull for brain wound	27.25	NA	15.50	6.24	NA	48.99	090
61460		A	Incise skull for surgery	28.35	NA	16.40	5.35	NA	50.10	090
61470		A	Incise skull for surgery	26.02	NA	13.85	6.74	NA	46.61	090
61480		A	Incise skull for surgery	26.45	NA	15.27	6.10	NA	47.82	090
61490		A	Incise skull for surgery	25.62	NA	14.32	6.26	NA	46.20	090
61500		A	Removal of skull lesion	17.89	NA	10.80	3.71	NA	32.40	090
61501		A	Remove infected skull bone	14.82	NA	9.21	3.00	NA	27.03	090
61510		A	Removal of brain lesion	28.41	NA	16.68	6.49	NA	51.58	090
61512		A	Remove brain lining lesion	35.04	NA	19.66	8.06	NA	62.76	090
61514		A	Removal of brain abscess	25.22	NA	14.42	6.01	NA	45.65	090
61516		A	Removal of brain lesion	24.57	NA	14.27	5.43	NA	44.27	090
61517		A	Implt brain chemotx add-on	1.38	NA	0.64	0.10	NA	2.12	ZZZ
61518		A	Removal of brain lesion	37.26	NA	21.09	8.46	NA	66.81	090
61519		A	Remove brain lining lesion	41.33	NA	22.64	9.61	NA	73.58	090
61520		A	Removal of brain lesion	54.76	NA	30.31	10.02	NA	95.09	090
61521		A	Removal of brain lesion	44.41	NA	24.21	9.76	NA	78.38	090
61522		A	Removal of brain abscess	29.41	NA	16.42	6.78	NA	52.61	090
61524		A	Removal of brain lesion	27.82	NA	15.67	6.02	NA	49.51	090
61526		A	Removal of brain lesion	52.09	NA	29.46	7.10	NA	88.65	090
61530		A	Removal of brain lesion	43.79	NA	25.06	5.67	NA	74.52	090
61531		A	Implant brain electrodes	14.61	NA	9.13	3.60	NA	27.34	090
61533		A	Implant brain electrodes	19.68	NA	11.54	4.43	NA	35.65	090
61534		A	Removal of brain lesion	20.94	NA	12.10	5.32	NA	38.36	090
61535		A	Remove brain electrodes	11.61	NA	7.43	2.81	NA	21.85	090
61536		A	Removal of brain lesion	35.47	NA	19.78	7.56	NA	62.81	090
61537		A	Removal of brain tissue	24.96	NA	14.72	6.05	NA	45.73	090
61538		A	Removal of brain tissue	26.77	NA	15.31	6.05	NA	48.13	090
61539		A	Removal of brain tissue	32.03	NA	17.77	7.41	NA	57.21	090
61540		A	Removal of brain tissue	29.96	NA	17.23	7.41	NA	54.60	090
61541		A	Incision of brain tissue	28.81	NA	16.20	6.10	NA	51.11	090
61542		A	Removal of brain tissue	30.97	NA	17.82	7.83	NA	56.62	090
61543		A	Removal of brain tissue	29.18	NA	16.39	6.58	NA	52.15	090
61544		A	Remove & treat brain lesion	25.46	NA	13.84	5.73	NA	45.03	090
61545		A	Excision of brain tumor	43.73	NA	24.21	10.03	NA	77.97	090
61546		A	Removal of pituitary gland	31.25	NA	17.49	7.15	NA	55.89	090
61548		A	Removal of pituitary gland	21.50	NA	12.79	3.31	NA	37.60	090
61550		A	Release of skull seams	14.63	NA	6.98	1.37	NA	22.98	090
61552		A	Release of skull seams	19.53	NA	9.14	5.06	NA	33.73	090
61556		A	Incise skull/sutures	22.23	NA	11.37	5.12	NA	38.72	090
61557		A	Incise skull/sutures	22.35	NA	13.62	5.79	NA	41.76	090
61558		A	Excision of skull/sutures	25.54	NA	14.18	3.15	NA	42.87	090
61559		A	Excision of skull/sutures	32.74	NA	19.30	2.01	NA	54.05	090
61563		A	Excision of skull tumor	26.79	NA	15.25	5.75	NA	47.79	090
61564		A	Excision of skull tumor	33.78	NA	18.27	8.28	NA	60.33	090
61566		A	Removal of brain tissue	30.95	NA	17.75	6.05	NA	54.75	090
61567		A	Incision of brain tissue	35.45	NA	20.66	6.49	NA	62.60	090
61570		A	Remove foreign body, brain	24.56	NA	13.90	5.07	NA	43.53	090
61571		A	Incise skull for brain wound	26.35	NA	15.13	5.77	NA	47.25	090
61575		A	Skull base/brainstem surgery	34.31	NA	19.64	5.42	NA	59.37	090
61576		A	Skull base/brainstem surgery	52.35	NA	34.69	5.80	NA	92.84	090
61580		A	Craniofacial approach, skull	30.30	NA	25.50	3.37	NA	59.17	090
61581		A	Craniofacial approach, skull	34.55	NA	23.42	3.30	NA	61.27	090
61582		A	Craniofacial approach, skull	31.61	NA	27.28	6.96	NA	65.85	090
61583		A	Craniofacial approach, skull	36.16	NA	25.08	8.12	NA	69.36	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
61584		A	Orbitocranial approach/skull	34.60	NA	24.48	7.51	NA	66.59	090
61585		A	Orbitocranial approach/skull	38.55	NA	26.44	7.50	NA	72.49	090
61586		A	Resect nasopharynx, skull	25.06	NA	22.52	4.95	NA	52.53	090
61590		A	Infratemporal approach/skull	41.72	NA	28.54	5.11	NA	75.37	090
61591		A	Infratemporal approach/skull	43.61	NA	29.45	5.64	NA	78.70	090
61592		A	Orbitocranial approach/skull	39.58	NA	26.46	8.93	NA	74.97	090
61595		A	Transtemporal approach/skull	29.53	NA	22.27	3.81	NA	55.61	090
61596		A	Transcochlear approach/skull	35.58	NA	24.37	4.83	NA	64.78	090
61597		A	Transcondylar approach/skull	37.90	NA	22.96	8.56	NA	69.42	090
61598		A	Transpetrosal approach/skull	33.36	NA	23.18	5.50	NA	62.04	090
61600		A	Resect/excise cranial lesion	25.81	NA	19.72	3.60	NA	49.13	090
61601		A	Resect/excise cranial lesion	27.85	NA	20.46	6.16	NA	54.47	090
61605		A	Resect/excise cranial lesion	29.29	NA	21.89	2.90	NA	54.08	090
61606		A	Resect/excise cranial lesion	38.77	NA	25.10	8.22	NA	72.09	090
61607		A	Resect/excise cranial lesion	36.22	NA	23.74	6.58	NA	66.54	090
61608		A	Resect/excise cranial lesion	42.04	NA	26.54	9.67	NA	78.25	090
61609		A	Transect artery, sinus	9.88	NA	4.85	1.57	NA	16.30	ZZZ
61610		A	Transect artery, sinus	29.63	NA	13.11	4.25	NA	46.99	ZZZ
61611		A	Transect artery, sinus	7.41	NA	3.81	1.87	NA	13.09	ZZZ
61612		A	Transect artery, sinus	27.84	NA	13.29	2.08	NA	43.21	ZZZ
61613		A	Remove aneurysm, sinus	40.80	NA	26.22	8.76	NA	75.78	090
61615		A	Resect/excise lesion, skull	32.02	NA	22.66	5.07	NA	59.75	090
61616		A	Resect/excise lesion, skull	43.27	NA	28.59	8.13	NA	79.99	090
61618		A	Repair dura	16.96	NA	10.46	3.42	NA	30.84	090
61619		A	Repair dura	20.68	NA	12.25	3.41	NA	36.34	090
61623		A	Endovasc tempory vessel occl	9.95	NA	4.07	0.60	NA	14.62	000
61624		A	Transcath occlusion, cns	20.12	NA	6.88	1.84	NA	28.84	000
61626		A	Transcath occlusion, non-cns	16.60	NA	5.50	1.17	NA	23.27	000
61680		A	Intracranial vessel surgery	30.66	NA	17.44	7.03	NA	55.13	090
61682		A	Intracranial vessel surgery	61.48	NA	32.20	14.22	NA	107.90	090
61684		A	Intracranial vessel surgery	39.75	NA	21.99	9.24	NA	70.98	090
61686		A	Intracranial vessel surgery	64.39	NA	34.70	14.04	NA	113.13	090
61690		A	Intracranial vessel surgery	29.27	NA	16.72	7.58	NA	53.57	090
61692		A	Intracranial vessel surgery	51.79	NA	27.47	11.64	NA	90.90	090
61697		A	Brain aneurysm repr, complx	50.44	NA	27.98	12.05	NA	90.47	090
61698		A	Brain aneurysm repr, complx	48.34	NA	26.67	11.01	NA	86.02	090
61700		A	Brain aneurysm repr, simple	50.44	NA	27.78	11.94	NA	90.16	090
61702		A	Inner skull vessel surgery	48.34	NA	26.02	11.56	NA	85.92	090
61703		A	Clamp neck artery	17.44	NA	10.48	3.72	NA	31.64	090
61705		A	Revise circulation to head	36.15	NA	19.24	8.11	NA	63.50	090
61708		A	Revise circulation to head	35.25	NA	15.14	2.67	NA	53.06	090
61710		A	Revise circulation to head	29.63	NA	13.63	3.78	NA	47.04	090
61711		A	Fusion of skull arteries	36.28	NA	19.80	8.36	NA	64.44	090
61720		A	Incise skull/brain surgery	16.74	NA	9.98	3.55	NA	30.27	090
61735		A	Incise skull/brain surgery	20.40	NA	12.16	3.83	NA	36.39	090
61750		A	Incise skull/brain biopsy	18.17	NA	10.61	4.48	NA	33.26	090
61751		A	Brain biopsy w/ct/mr guide	17.59	NA	10.82	4.34	NA	32.75	090
61760		A	Implant brain electrodes	22.24	NA	8.73	5.49	NA	36.46	090
61770		A	Incise skull for treatment	21.41	NA	12.26	4.44	NA	38.11	090
61790		A	Treat trigeminal nerve	10.84	NA	5.92	2.66	NA	19.42	090
61791		A	Treat trigeminal tract	14.59	NA	8.92	3.51	NA	27.02	090
61793		A	Focus radiation beam	17.21	NA	10.13	4.22	NA	31.56	090
61795		A	Brain surgery using computer	4.03	NA	2.03	0.80	NA	6.86	ZZZ
61850		A	Implant neuroelectrodes	12.37	NA	7.68	1.98	NA	22.03	090
61860		A	Implant neuroelectrodes	20.84	NA	12.07	4.87	NA	37.78	090
61863		A	Implant neuroelectrode	18.97	NA	11.76	4.66	NA	35.39	090
61864		A	Implant neuroelectrde, add-l	4.49	NA	2.27	4.66	NA	11.42	ZZZ
61867		A	Implant neuroelectrode	31.29	NA	18.00	4.66	NA	53.95	090
61868		A	Implant neuroelectrde, add-l	7.91	NA	4.01	4.66	NA	16.58	ZZZ
61870		A	Implant neuroelectrodes	14.92	NA	9.73	2.05	NA	26.70	090
61875		A	Implant neuroelectrodes	15.04	NA	8.57	2.39	NA	26.00	090
61880		A	Revise/remove neuroelectrode	6.28	NA	4.59	1.50	NA	12.37	090
61885		A	Implant neurostim one array	5.84	NA	5.31	1.35	NA	12.50	090
61886		A	Implant neurostim arrays	7.99	NA	6.36	1.78	NA	16.13	090
61888		A	Revise/remove neuroreceiver	5.06	NA	3.67	1.22	NA	9.95	010
62000		A	Treat skull fracture	12.51	NA	5.50	1.28	NA	19.29	090
62005		A	Treat skull fracture	16.15	NA	8.79	3.26	NA	28.20	090
62010		A	Treatment of head injury	19.78	NA	11.70	4.64	NA	36.12	090
62100		A	Repair brain fluid leakage	22.00	NA	12.80	4.71	NA	39.51	090
62115		A	Reduction of skull defect	21.63	NA	11.64	5.46	NA	38.73	090
62116		A	Reduction of skull defect	23.55	NA	13.36	1.92	NA	38.83	090
62117		A	Reduction of skull defect	26.56	NA	15.37	6.88	NA	48.81	090
62120		A	Repair skull cavity lesion	23.31	NA	18.61	2.64	NA	44.56	090
62121		A	Incise skull repair	21.55	NA	15.41	3.49	NA	40.45	090
62140		A	Repair of skull defect	13.49	NA	8.33	3.02	NA	24.84	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
62141		A	Repair of skull defect	14.89	NA	9.06	3.26	NA	27.21	090
62142		A	Remove skull plate/flap	10.77	NA	7.00	2.41	NA	20.18	090
62143		A	Replace skull plate/flap	13.03	NA	8.05	3.02	NA	24.10	090
62145		A	Repair of skull & brain	18.79	NA	10.90	3.77	NA	33.46	090
62146		A	Repair of skull with graft	16.10	NA	9.64	3.20	NA	28.94	090
62147		A	Repair of skull with graft	19.31	NA	11.32	4.35	NA	34.98	090
62148		A	Retr bone flap to fix skull	2.00	NA	0.86	0.52	NA	3.38	ZZZ
62160		A	Neuroendoscopy add-on	3.00	NA	1.53	0.63	NA	5.16	ZZZ
62161		A	Dissect brain w/scope	19.97	NA	12.08	4.46	NA	36.51	090
62162		A	Remove colloid cyst w/scope	25.21	NA	15.07	6.96	NA	47.24	090
62163		A	Neuroendoscopy w/fb removal	15.48	NA	9.91	4.46	NA	29.85	090
62164		A	Remove brain tumor w/scope	27.46	NA	14.95	6.96	NA	49.37	090
62165		A	Remove pituit tumor w/scope	21.97	NA	13.34	4.38	NA	39.69	090
62180		A	Establish brain cavity shunt	21.03	NA	12.29	4.55	NA	37.87	090
62190		A	Establish brain cavity shunt	11.05	NA	7.09	2.67	NA	20.81	090
62192		A	Establish brain cavity shunt	12.23	NA	7.63	2.79	NA	22.65	090
62194		A	Replace/irrigate catheter	5.02	NA	2.44	0.62	NA	8.08	010
62200		A	Establish brain cavity shunt	18.29	NA	10.85	4.45	NA	33.59	090
62201		A	Brain cavity shunt w/scope	14.84	NA	9.45	2.88	NA	27.17	090
62220		A	Establish brain cavity shunt	12.98	NA	8.00	2.85	NA	23.83	090
62223		A	Establish brain cavity shunt	12.85	NA	8.25	2.83	NA	23.93	090
62225		A	Replace/irrigate catheter	5.40	NA	4.10	1.32	NA	10.82	090
62230		A	Replace/revise brain shunt	10.52	NA	6.49	2.40	NA	19.41	090
62252		A	Csf shunt reprogram	0.74	1.47	NA	0.20	2.41	NA	XXX
62252	26	A	Csf shunt reprogram	0.74	0.37	0.37	0.18	1.29	1.29	XXX
62252	TC	A	Csf shunt reprogram	0.00	1.10	NA	0.02	1.12	NA	XXX
62256		A	Remove brain cavity shunt	6.59	NA	4.71	1.57	NA	12.87	090
62258		A	Replace brain cavity shunt	14.52	NA	8.71	3.27	NA	26.50	090
62263		A	Epidural lysis mult sessions	6.13	12.79	3.22	0.40	19.32	9.75	010
62264		A	Epidural lysis on single day	4.42	7.75	1.42	0.40	12.57	6.24	010
62268		A	Drain spinal cord cyst	4.73	11.63	2.14	0.31	16.67	7.18	000
62269		A	Needle biopsy, spinal cord	5.01	15.11	1.97	0.39	20.51	7.37	000
62270		A	Spinal fluid tap, diagnostic	1.13	2.98	0.56	0.08	4.19	1.77	000
62272		A	Drain cerebro spinal fluid	1.35	3.60	0.71	0.17	5.12	2.23	000
62273		A	Treat epidural spine lesion	2.15	2.73	0.72	0.14	5.02	3.01	000
62280		A	Treat spinal cord lesion	2.63	6.99	1.01	0.23	9.85	3.87	010
62281		A	Treat spinal cord lesion	2.66	5.70	0.90	0.18	8.54	3.74	010
62282		A	Treat spinal canal lesion	2.33	8.43	0.92	0.17	10.93	3.42	010
62284		A	Injection for myelogram	1.54	5.02	0.68	0.13	6.69	2.35	000
62287		A	Percutaneous diskectomy	8.07	NA	5.55	0.69	NA	14.31	090
62290		A	Inject for spine disk x-ray	3.00	7.19	1.38	0.26	10.45	4.64	000
62291		A	Inject for spine disk x-ray	2.91	5.99	1.23	0.28	9.18	4.42	000
62292		A	Injection into disk lesion	7.85	NA	4.49	0.84	NA	13.18	090
62294		A	Injection into spinal artery	11.81	NA	5.59	1.38	NA	18.78	090
62310		A	Inject spine c/t	1.91	4.85	0.65	0.12	6.88	2.68	000
62311		A	Inject spine l/s (cd)	1.54	4.94	0.60	0.10	6.58	2.24	000
62318		A	Inject spine w/cath, c/t	2.04	5.76	0.65	0.13	7.93	2.82	000
62319		A	Inject spine w/cath l/s (cd)	1.87	5.03	0.61	0.12	7.02	2.60	000
62350		A	Implant spinal canal cath	6.86	NA	3.97	0.86	NA	11.69	090
62351		A	Implant spinal canal cath	9.99	NA	7.12	1.88	NA	18.99	090
62355		A	Remove spinal canal catheter	5.44	NA	3.18	0.69	NA	9.31	090
62360		A	Insert spine infusion device	2.62	NA	2.71	0.33	NA	5.66	090
62361		A	Implant spine infusion pump	5.41	NA	3.94	0.69	NA	10.04	090
62362		A	Implant spine infusion pump	7.03	NA	4.37	1.08	NA	12.48	090
62365		A	Remove spine infusion device	5.41	NA	3.59	0.77	NA	9.77	090
62367	26	A	Analyze spine infusion pump	0.48	0.13	0.13	0.03	0.64	0.64	XXX
62368	26	A	Analyze spine infusion pump	0.75	0.19	0.19	0.06	1.00	1.00	XXX
63001		A	Removal of spinal lamina	15.80	NA	9.50	3.30	NA	28.60	090
63003		A	Removal of spinal lamina	15.93	NA	9.85	3.41	NA	29.19	090
63005		A	Removal of spinal lamina	14.90	NA	9.96	2.77	NA	27.63	090
63011		A	Removal of spinal lamina	14.50	NA	8.27	3.17	NA	25.94	090
63012		A	Removal of spinal lamina	15.38	NA	10.11	3.04	NA	28.53	090
63015		A	Removal of spinal lamina	19.32	NA	11.86	4.14	NA	35.32	090
63016		A	Removal of spinal lamina	19.17	NA	11.77	4.03	NA	34.97	090
63017		A	Removal of spinal lamina	15.92	NA	10.38	3.20	NA	29.50	090
63020		A	Neck spine disk surgery	14.79	NA	9.66	3.29	NA	27.74	090
63030		A	Low back disk surgery	11.98	NA	8.41	2.43	NA	22.82	090
63035		A	Spinal disk surgery add-on	3.15	NA	1.59	0.67	NA	5.41	ZZZ
63040		A	Laminotomy, single cervical	18.78	NA	11.49	4.07	NA	34.34	090
63042		A	Laminotomy, single lumbar	17.44	NA	11.32	3.58	NA	32.34	090
63045		A	Removal of spinal lamina	16.48	NA	10.34	3.47	NA	30.29	090
63046		A	Removal of spinal lamina	15.78	NA	10.17	3.17	NA	29.12	090
63047		A	Removal of spinal lamina	14.59	NA	9.88	2.77	NA	27.24	090
63048		A	Remove spinal lamina add-on	3.26	NA	1.66	0.63	NA	5.55	ZZZ
63055		A	Decompress spinal cord	21.96	NA	13.12	4.73	NA	39.81	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
63056		A	Decompress spinal cord	20.33	NA	12.54	4.07	NA	36.94	090
63057		A	Decompress spine cord add-on	5.25	NA	2.63	1.11	NA	8.99	ZZZ
63064		A	Decompress spinal cord	24.57	NA	14.41	5.05	NA	44.03	090
63066		A	Decompress spine cord add-on	3.26	NA	1.66	0.66	NA	5.58	ZZZ
63075		A	Neck spine disk surgery	19.38	NA	12.07	3.95	NA	35.40	090
63076		A	Neck spine disk surgery	4.04	NA	2.05	0.82	NA	6.91	ZZZ
63077		A	Spine disk surgery, thorax	21.41	NA	12.77	3.41	NA	37.59	090
63078		A	Spine disk surgery, thorax	3.28	NA	1.63	0.53	NA	5.44	ZZZ
63081		A	Removal of vertebral body	23.69	NA	14.30	4.86	NA	42.85	090
63082		A	Remove vertebral body add-on	4.36	NA	2.22	0.91	NA	7.49	ZZZ
63085		A	Removal of vertebral body	26.88	NA	15.45	4.23	NA	46.56	090
63086		A	Remove vertebral body add-on	3.19	NA	1.59	0.57	NA	5.35	ZZZ
63087		A	Removal of vertebral body	35.52	NA	19.43	5.70	NA	60.65	090
63088		A	Remove vertebral body add-on	4.32	NA	2.17	0.72	NA	7.21	ZZZ
63090		A	Removal of vertebral body	28.12	NA	16.01	4.09	NA	48.22	090
63091		A	Remove vertebral body add-on	3.03	NA	1.45	0.47	NA	4.95	ZZZ
63101		A	Removal of vertebral body	31.95	NA	19.28	5.05	NA	56.28	090
63102		A	Removal of vertebral body	31.95	NA	19.28	5.05	NA	56.28	090
63103		A	Remove vertebral body add-on	3.89	NA	2.03	0.66	NA	6.58	ZZZ
63170		A	Incise spinal cord tract(s)	19.80	NA	12.08	4.48	NA	36.36	090
63172		A	Drainage of spinal cyst	17.63	NA	10.90	4.06	NA	32.59	090
63173		A	Drainage of spinal cyst	21.96	NA	13.06	4.95	NA	39.97	090
63180		A	Revise spinal cord ligaments	18.24	NA	11.24	2.46	NA	31.94	090
63182		A	Revise spinal cord ligaments	20.47	NA	11.18	3.47	NA	35.12	090
63185		A	Incise spinal column/nerves	15.02	NA	8.29	2.22	NA	25.53	090
63190		A	Incise spinal column/nerves	17.42	NA	10.34	3.35	NA	31.11	090
63191		A	Incise spinal column/nerves	17.51	NA	10.71	4.53	NA	32.75	090
63194		A	Incise spinal column & cord	19.16	NA	11.93	3.82	NA	34.91	090
63195		A	Incise spinal column & cord	18.81	NA	11.26	4.37	NA	34.44	090
63196		A	Incise spinal column & cord	22.27	NA	13.60	5.62	NA	41.49	090
63197		A	Incise spinal column & cord	21.08	NA	12.41	4.20	NA	37.69	090
63198		A	Incise spinal column & cord	25.34	NA	8.58	6.40	NA	40.32	090
63199		A	Incise spinal column & cord	26.85	NA	15.23	6.78	NA	48.86	090
63200		A	Release of spinal cord	19.15	NA	11.50	4.31	NA	34.96	090
63250		A	Revise spinal cord vessels	40.70	NA	19.92	8.81	NA	69.43	090
63251		A	Revise spinal cord vessels	41.14	NA	22.57	9.46	NA	73.17	090
63252		A	Revise spinal cord vessels	41.13	NA	22.22	9.52	NA	72.87	090
63265		A	Excise intraspinal lesion	21.53	NA	12.76	4.85	NA	39.14	090
63266		A	Excise intraspinal lesion	22.27	NA	13.18	4.89	NA	40.34	090
63267		A	Excise intraspinal lesion	17.92	NA	11.07	3.79	NA	32.78	090
63268		A	Excise intraspinal lesion	18.49	NA	10.38	3.01	NA	31.88	090
63270		A	Excise intraspinal lesion	26.76	NA	15.46	5.94	NA	48.16	090
63271		A	Excise intraspinal lesion	26.88	NA	15.56	6.38	NA	48.82	090
63272		A	Excise intraspinal lesion	25.28	NA	14.68	5.41	NA	45.37	090
63273		A	Excise intraspinal lesion	24.25	NA	14.33	6.05	NA	44.63	090
63275		A	Biopsy/excise spinal tumor	23.64	NA	13.77	5.20	NA	42.61	090
63276		A	Biopsy/excise spinal tumor	23.41	NA	13.67	5.16	NA	42.24	090
63277		A	Biopsy/excise spinal tumor	20.80	NA	12.51	4.32	NA	37.63	090
63278		A	Biopsy/excise spinal tumor	20.53	NA	12.38	4.07	NA	36.98	090
63280		A	Biopsy/excise spinal tumor	28.31	NA	16.30	6.47	NA	51.08	090
63281		A	Biopsy/excise spinal tumor	28.01	NA	16.16	6.41	NA	50.58	090
63282		A	Biopsy/excise spinal tumor	26.35	NA	15.32	6.03	NA	47.70	090
63283		A	Biopsy/excise spinal tumor	24.96	NA	14.65	5.64	NA	45.25	090
63285		A	Biopsy/excise spinal tumor	35.95	NA	19.92	9.19	NA	65.06	090
63286		A	Biopsy/excise spinal tumor	35.58	NA	19.88	8.10	NA	63.56	090
63287		A	Biopsy/excise spinal tumor	36.64	NA	20.41	8.00	NA	65.05	090
63290		A	Biopsy/excise spinal tumor	37.32	NA	20.57	9.00	NA	66.89	090
63300		A	Removal of vertebral body	24.39	NA	14.29	4.92	NA	43.60	090
63301		A	Removal of vertebral body	27.56	NA	15.54	5.21	NA	48.31	090
63302		A	Removal of vertebral body	27.77	NA	15.83	5.11	NA	48.71	090
63303		A	Removal of vertebral body	30.45	NA	16.89	4.99	NA	52.33	090
63304		A	Removal of vertebral body	30.28	NA	17.26	6.03	NA	53.57	090
63305		A	Removal of vertebral body	31.98	NA	18.03	5.92	NA	55.93	090
63306		A	Removal of vertebral body	32.17	NA	17.78	6.13	NA	56.08	090
63307		A	Removal of vertebral body	31.58	NA	16.79	4.80	NA	53.17	090
63308		A	Remove vertebral body add-on	5.24	NA	2.60	1.15	NA	8.99	ZZZ
63600		A	Remove spinal cord lesion	14.00	NA	5.41	1.29	NA	20.70	090
63610		A	Stimulation of spinal cord	8.72	59.95	2.25	0.55	69.22	11.52	000
63615		A	Remove lesion of spinal cord	16.26	NA	9.30	1.89	NA	27.45	090
63650		A	Implant neuroelectrodes	6.73	NA	3.19	0.54	NA	10.46	090
63655		A	Implant neuroelectrodes	10.27	NA	6.90	2.07	NA	19.24	090
63660		A	Revise/remove neuroelectrode	6.15	NA	3.63	0.80	NA	10.58	090
63685		A	Implant neuroreceiver	7.03	NA	4.16	0.99	NA	12.18	090
63688		A	Revise/remove neuroreceiver	5.38	NA	3.57	0.85	NA	9.80	090
63700		A	Repair of spinal herniation	16.51	NA	10.29	3.14	NA	29.94	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
63702		A	Repair of spinal herniation	18.45	NA	11.05	3.43	NA	32.93	090
63704		A	Repair of spinal herniation	21.15	NA	12.90	4.54	NA	38.59	090
63706		A	Repair of spinal herniation	24.07	NA	13.58	5.45	NA	43.10	090
63707		A	Repair spinal fluid leakage	11.24	NA	7.70	2.18	NA	21.12	090
63709		A	Repair spinal fluid leakage	14.30	NA	9.39	2.77	NA	26.46	090
63710		A	Graft repair of spine defect	14.05	NA	9.04	3.02	NA	26.11	090
63740		A	Install spinal shunt	11.34	NA	7.35	2.44	NA	21.13	090
63741		A	Install spinal shunt	8.24	NA	4.76	1.69	NA	14.69	090
63744		A	Revision of spinal shunt	8.09	NA	5.26	1.54	NA	14.89	090
63746		A	Removal of spinal shunt	6.42	NA	3.79	1.60	NA	11.81	090
64400		A	N block inj, trigeminal	1.11	1.89	0.43	0.09	3.09	1.63	000
64402		A	N block inj, facial	1.25	1.62	0.60	0.08	2.95	1.93	000
64405		A	N block inj, occipital	1.32	1.46	0.46	0.09	2.87	1.87	000
64408		A	N block inj, vagus	1.41	1.58	0.85	0.09	3.08	2.35	000
64410		A	N block inj, phrenic	1.43	2.52	0.47	0.09	4.04	1.99	000
64412		A	N block inj, spinal accessor	1.18	2.66	0.43	0.08	3.92	1.69	000
64413		A	N block inj, cervical plexus	1.40	1.85	0.50	0.10	3.35	2.00	000
64415		A	N block inj, brachial plexus	1.48	2.81	0.46	0.10	4.39	2.04	000
64416		A	N block cont infuse, b plex	3.49	NA	0.79	0.10	NA	4.38	010
64417		A	N block inj, axillary	1.44	3.04	0.49	0.12	4.60	2.05	000
64418		A	N block inj, suprascapular	1.32	2.63	0.44	0.08	4.03	1.84	000
64420		A	N block inj, intercost, sng	1.18	3.98	0.42	0.08	5.24	1.68	000
64421		A	N block inj, intercost, mlt	1.68	6.19	0.52	0.12	7.99	2.32	000
64425		A	N block inj ilio-ing/hypogi	1.75	1.65	0.54	0.14	3.54	2.43	000
64430		A	N block inj, pudendal	1.46	2.51	0.55	0.11	4.08	2.12	000
64435		A	N block inj, paracervical	1.45	2.52	0.69	0.17	4.14	2.31	000
64445		A	N block inj, sciatic, sng	1.48	2.68	0.50	0.10	4.26	2.08	000
64446		A	N blk inj, sciatic, cont inf	3.25	NA	1.01	0.10	NA	4.36	010
64447		A	N block inj fem, single	1.50	NA	0.43	0.10	NA	2.03	000
64448		A	N block inj fem, cont inf	3.00	NA	0.81	0.10	NA	3.91	010
64449		A	N block inj, lumbar plexus	3.00	NA	0.96	0.10	NA	4.06	010
64450		A	N block, other peripheral	1.27	1.24	0.48	0.10	2.61	1.85	000
64470		A	Inj paravertebral c/t	1.85	7.29	0.72	0.14	9.28	2.71	000
64472		A	Inj paravertebral c/t add-on	1.29	2.35	0.34	0.09	3.73	1.72	ZZZ
64475		A	Inj paravertebral l/s	1.41	6.93	0.63	0.11	8.45	2.15	000
64476		A	Inj paravertebral l/s add-on	0.98	2.14	0.24	0.08	3.20	1.30	ZZZ
64479		A	Inj foramen epidural c/t	2.20	7.56	0.89	0.16	9.92	3.25	000
64480		A	Inj foramen epidural add-on	1.54	2.87	0.47	0.12	4.53	2.13	ZZZ
64483		A	Inj foramen epidural l/s	1.90	7.95	0.83	0.12	9.97	2.85	000
64484		A	Inj foramen epidural add-on	1.33	3.31	0.37	0.09	4.73	1.79	ZZZ
64505		A	N block, spenopalatine gangl	1.36	1.25	0.66	0.09	2.70	2.11	000
64508		A	N block, carotid sinus s/p	1.12	3.39	0.74	0.09	4.60	1.95	000
64510		A	N block, stellate ganglion	1.22	3.51	0.51	0.08	4.81	1.81	000
64517		A	N block inj, hypogas plxs	2.20	2.73	0.87	0.11	5.04	3.18	000
64520		A	N block, lumbar/thoracic	1.35	5.21	0.55	0.09	6.65	1.99	000
64530		A	N block inj, celiac pelus	1.58	4.49	0.66	0.10	6.17	2.34	000
64550		A	Apply neurostimulator	0.18	0.28	0.05	0.01	0.47	0.24	000
64553		A	Implant neuroelectrodes	2.31	2.83	1.85	0.23	5.37	4.39	010
64555		A	Implant neuroelectrodes	2.27	3.11	1.20	0.23	5.61	3.70	010
64560		A	Implant neuroelectrodes	2.36	2.66	1.30	0.24	5.26	3.90	010
64561		A	Implant neuroelectrodes	6.73	30.03	2.82	0.51	37.27	10.06	010
64565		A	Implant neuroelectrodes	1.76	3.30	1.26	0.10	5.16	3.12	010
64573		A	Implant neuroelectrodes	7.49	NA	5.25	1.48	NA	14.22	090
64575		A	Implant neuroelectrodes	4.34	NA	2.69	0.45	NA	7.48	090
64577		A	Implant neuroelectrodes	4.61	NA	3.30	0.61	NA	8.52	090
64580		A	Implant neuroelectrodes	4.11	NA	3.57	0.23	NA	7.91	090
64581		A	Implant neuroelectrodes	13.48	NA	5.36	1.05	NA	19.89	090
64585		A	Revise/remove neuroelectrode	2.06	11.26	2.14	0.22	13.54	4.42	010
64590		A	Implant neuroreceiver	2.40	7.15	2.28	0.23	9.78	4.91	010
64595		A	Revise/remove neuroreceiver	1.73	10.42	1.93	0.22	12.37	3.88	010
64600		A	Injection treatment of nerve	3.44	9.36	1.66	0.33	13.13	5.43	010
64605		A	Injection treatment of nerve	5.60	9.58	2.19	0.92	16.10	8.71	010
64610		A	Injection treatment of nerve	7.15	8.92	3.71	1.35	17.42	12.21	010
64612		A	Destroy nerve, face muscle	1.96	2.48	1.32	0.12	4.56	3.40	010
64613		A	Destroy nerve, spine muscle	1.96	2.90	1.22	0.12	4.98	3.30	010
64614		A	Destroy nerve, extrem musc	2.20	3.21	1.31	0.12	5.53	3.63	010
64620		A	Injection treatment of nerve	2.84	5.13	1.34	0.20	8.17	4.38	010
64622		A	Destr paravertebrl nerve l/s	3.00	7.82	1.38	0.21	11.03	4.59	010
64623		A	Destr paravertebral n add-on	0.99	2.98	0.22	0.07	4.04	1.28	ZZZ
64626		A	Destr paravertebrl nerve c/t	3.28	7.84	1.98	0.22	11.34	5.48	010
64627		A	Destr paravertebral n add-on	1.16	4.58	0.27	0.08	5.82	1.51	ZZZ
64630		A	Injection treatment of nerve	3.00	2.73	1.42	0.23	5.96	4.65	010
64640		A	Injection treatment of nerve	2.76	4.19	1.85	0.19	7.14	4.80	010
64680		A	Injection treatment of nerve	2.62	6.75	1.44	0.18	9.55	4.24	010
64681		A	Injection treatment of nerve	3.54	9.36	2.06	0.19	13.09	5.79	010

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
64702		A	Revise finger/toe nerve	4.22	NA	3.86	0.60	NA	8.68	090
64704		A	Revise hand/foot nerve	4.56	NA	3.31	0.47	NA	8.34	090
64708		A	Revise arm/leg nerve	6.11	NA	4.87	0.92	NA	11.90	090
64712		A	Revision of sciatic nerve	7.74	NA	4.98	0.98	NA	13.70	090
64713		A	Revision of arm nerve(s)	10.98	NA	5.88	1.68	NA	18.54	090
64714		A	Revise low back nerve(s)	10.31	NA	4.23	1.04	NA	15.58	090
64716		A	Revision of cranial nerve	6.30	NA	5.96	0.64	NA	12.90	090
64718		A	Revise ulnar nerve at elbow	5.98	NA	5.98	1.03	NA	12.99	090
64719		A	Revise ulnar nerve at wrist	4.84	NA	4.53	0.78	NA	10.15	090
64721		A	Carpal tunnel surgery	4.28	NA	5.35	0.72	NA	10.35	090
64722		A	Relieve pressure on nerve(s)	4.69	NA	3.06	0.45	NA	8.20	090
64726		A	Release foot/toe nerve	4.17	NA	2.80	0.40	NA	7.37	090
64727		A	Internal nerve revision	3.10	NA	1.50	0.49	NA	5.09	ZZZ
64732		A	Incision of brow nerve	4.40	NA	3.52	0.81	NA	8.73	090
64734		A	Incision of cheek nerve	4.91	NA	4.05	0.95	NA	9.91	090
64736		A	Incision of chin nerve	4.59	NA	4.03	0.64	NA	9.26	090
64738		A	Incision of jaw nerve	5.72	NA	4.61	1.24	NA	11.57	090
64740		A	Incision of tongue nerve	5.58	NA	5.11	0.57	NA	11.26	090
64742		A	Incision of facial nerve	6.21	NA	4.70	0.57	NA	11.48	090
64744		A	Incise nerve, back of head	5.23	NA	3.78	1.03	NA	10.04	090
64746		A	Incise diaphragm nerve	5.92	NA	4.51	0.82	NA	11.25	090
64752		A	Incision of vagus nerve	7.05	NA	4.30	0.89	NA	12.24	090
64755		A	Incision of stomach nerves	13.50	NA	5.65	1.63	NA	20.78	090
64760		A	Incision of vagus nerve	6.95	NA	3.48	0.79	NA	11.22	090
64761		A	Incision of pelvis nerve	6.40	NA	3.54	0.45	NA	10.39	090
64763		A	Incise hip/thigh nerve	6.92	NA	5.23	0.98	NA	13.13	090
64766		A	Incise hip/thigh nerve	8.66	NA	5.26	1.11	NA	15.03	090
64771		A	Sever cranial nerve	7.34	NA	5.56	1.04	NA	13.94	090
64772		A	Incision of spinal nerve	7.20	NA	4.93	1.25	NA	13.38	090
64774		A	Remove skin nerve lesion	5.16	NA	3.83	0.63	NA	9.62	090
64776		A	Remove digit nerve lesion	5.11	NA	3.70	0.66	NA	9.47	090
64778		A	Digit nerve surgery add-on	3.11	NA	1.50	0.46	NA	5.07	ZZZ
64782		A	Remove limb nerve lesion	6.22	NA	3.77	0.71	NA	10.70	090
64783		A	Limb nerve surgery add-on	3.71	NA	1.83	0.52	NA	6.06	ZZZ
64784		A	Remove nerve lesion	9.81	NA	6.60	1.39	NA	17.80	090
64786		A	Remove sciatic nerve lesion	15.44	NA	9.84	2.52	NA	27.80	090
64787		A	Implant nerve end	4.29	NA	2.11	0.56	NA	6.96	ZZZ
64788		A	Remove skin nerve lesion	4.60	NA	3.48	0.64	NA	8.72	090
64790		A	Removal of nerve lesion	11.29	NA	7.20	1.76	NA	20.25	090
64792		A	Removal of nerve lesion	14.90	NA	8.82	2.29	NA	26.01	090
64795		A	Biopsy of nerve	3.01	NA	1.58	0.50	NA	5.09	000
64802		A	Remove sympathetic nerves	9.14	NA	5.15	1.17	NA	15.46	090
64804		A	Remove sympathetic nerves	14.62	NA	7.17	1.99	NA	23.78	090
64809		A	Remove sympathetic nerves	13.65	NA	5.77	1.79	NA	21.21	090
64818		A	Remove sympathetic nerves	10.28	NA	5.29	1.32	NA	16.89	090
64820		A	Remove sympathetic nerves	10.35	NA	7.14	1.54	NA	19.03	090
64821		A	Remove sympathetic nerves	8.74	NA	7.33	1.38	NA	17.45	090
64822		A	Remove sympathetic nerves	8.74	NA	7.22	1.33	NA	17.29	090
64823		A	Remove sympathetic nerves	10.35	NA	8.13	1.58	NA	20.06	090
64831		A	Repair of digit nerve	9.43	NA	7.08	1.40	NA	17.91	090
64832		A	Repair nerve add-on	5.65	NA	2.93	0.83	NA	9.41	ZZZ
64834		A	Repair of hand or foot nerve	10.17	NA	7.09	1.57	NA	18.83	090
64835		A	Repair of hand or foot nerve	10.92	NA	7.70	1.61	NA	20.23	090
64836		A	Repair of hand or foot nerve	10.92	NA	7.67	1.63	NA	20.22	090
64837		A	Repair nerve add-on	6.25	NA	3.22	0.95	NA	10.42	ZZZ
64840		A	Repair of leg nerve	13.00	NA	8.25	1.44	NA	22.69	090
64856		A	Repair/transpose nerve	13.78	NA	9.18	2.06	NA	25.02	090
64857		A	Repair arm/leg nerve	14.47	NA	9.63	2.22	NA	26.32	090
64858		A	Repair sciatic nerve	16.47	NA	10.77	2.98	NA	30.22	090
64859		A	Nerve surgery	4.25	NA	2.19	0.59	NA	7.03	ZZZ
64861		A	Repair of arm nerves	19.21	NA	11.78	4.24	NA	35.23	090
64862		A	Repair of low back nerves	19.41	NA	11.93	2.98	NA	34.32	090
64864		A	Repair of facial nerve	12.53	NA	8.75	1.35	NA	22.63	090
64865		A	Repair of facial nerve	15.22	NA	13.44	1.82	NA	30.48	090
64866		A	Fusion of facial/other nerve	15.72	NA	13.10	1.63	NA	30.45	090
64868		A	Fusion of facial/other nerve	14.02	NA	11.39	1.64	NA	27.05	090
64870		A	Fusion of facial/other nerve	15.97	NA	8.72	0.80	NA	25.49	090
64872		A	Subsequent repair of nerve	1.99	NA	1.08	0.28	NA	3.35	ZZZ
64874		A	Repair & revise nerve add-on	2.98	NA	1.53	0.41	NA	4.92	ZZZ
64876		A	Repair nerve/shorten bone	3.37	NA	1.27	0.47	NA	5.11	ZZZ
64885		A	Nerve graft, head or neck	17.50	NA	11.59	1.69	NA	30.78	090
64886		A	Nerve graft, head or neck	20.72	NA	13.52	2.06	NA	36.30	090
64890		A	Nerve graft, hand or foot	15.13	NA	9.99	2.24	NA	27.36	090
64891		A	Nerve graft, hand or foot	16.12	NA	7.60	1.38	NA	25.10	090
64892		A	Nerve graft, arm or leg	14.63	NA	8.87	1.97	NA	25.47	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
64893		A	Nerve graft, arm or leg	15.58	NA	9.87	2.28	NA	27.73	090
64895		A	Nerve graft, hand or foot	19.22	NA	9.65	2.43	NA	31.30	090
64896		A	Nerve graft, hand or foot	20.46	NA	11.00	1.97	NA	33.43	090
64897		A	Nerve graft, arm or leg	18.21	NA	10.69	2.61	NA	31.51	090
64898		A	Nerve graft, arm or leg	19.47	NA	11.79	2.14	NA	33.40	090
64901		A	Nerve graft add-on	10.20	NA	5.25	1.22	NA	16.67	ZZZ
64902		A	Nerve graft add-on	11.81	NA	5.95	1.43	NA	19.19	ZZZ
64905		A	Nerve pedicle transfer	14.00	NA	8.50	1.53	NA	24.03	090
64907		A	Nerve pedicle transfer	18.80	NA	12.50	2.16	NA	33.46	090
65091		A	Revise eye	6.45	NA	8.37	0.34	NA	15.16	090
65093		A	Revise eye with implant	6.86	NA	8.73	0.36	NA	15.95	090
65101		A	Removal of eye	7.02	NA	9.55	0.37	NA	16.94	090
65103		A	Remove eye/insert implant	7.56	NA	9.75	0.39	NA	17.70	090
65105		A	Remove eye/attach implant	8.48	NA	10.48	0.44	NA	19.40	090
65110		A	Removal of eye	13.93	NA	13.66	0.86	NA	28.45	090
65112		A	Remove eye/revise socket	16.36	NA	16.08	0.98	NA	33.42	090
65114		A	Remove eye/revise socket	17.50	NA	16.31	1.07	NA	34.88	090
65125		A	Revise ocular implant	3.12	8.84	3.59	0.18	12.14	6.89	090
65130		A	Insert ocular implant	7.14	NA	9.18	0.38	NA	16.70	090
65135		A	Insert ocular implant	7.32	NA	9.32	0.38	NA	17.02	090
65140		A	Attach ocular implant	8.01	NA	9.88	0.43	NA	18.32	090
65150		A	Revise ocular implant	6.25	NA	7.99	0.35	NA	14.59	090
65155		A	Reinsert ocular implant	8.65	NA	10.48	0.50	NA	19.63	090
65175		A	Removal of ocular implant	6.27	NA	8.49	0.34	NA	15.10	090
65205		A	Remove foreign body from eye	0.71	0.64	0.30	0.04	1.39	1.05	000
65210		A	Remove foreign body from eye	0.84	0.81	0.38	0.04	1.69	1.26	000
65220		A	Remove foreign body from eye	0.71	0.65	0.29	0.05	1.41	1.05	000
65222		A	Remove foreign body from eye	0.93	0.89	0.38	0.05	1.87	1.36	000
65235		A	Remove foreign body from eye	7.56	NA	6.74	0.38	NA	14.68	090
65260		A	Remove foreign body from eye	10.94	NA	9.65	0.56	NA	21.15	090
65265		A	Remove foreign body from eye	12.57	NA	10.63	0.66	NA	23.86	090
65270		A	Repair of eye wound	1.90	5.24	1.39	0.10	7.24	3.39	010
65272		A	Repair of eye wound	3.81	7.73	3.29	0.20	11.74	7.30	090
65273		A	Repair of eye wound	4.35	NA	3.57	0.25	NA	8.17	090
65275		A	Repair of eye wound	5.33	6.33	3.95	0.30	11.96	9.58	090
65280		A	Repair of eye wound	7.65	NA	6.23	0.39	NA	14.27	090
65285		A	Repair of eye wound	12.88	NA	9.20	0.65	NA	22.73	090
65286		A	Repair of eye wound	5.50	11.17	4.62	0.28	16.95	10.40	090
65290		A	Repair of eye socket wound	5.40	NA	4.73	0.36	NA	10.49	090
65400		A	Removal of eye lesion	6.05	8.33	6.12	0.30	14.68	12.47	090
65410		A	Biopsy of cornea	1.47	2.11	0.97	0.07	3.65	2.51	000
65420		A	Removal of eye lesion	4.16	8.86	4.44	0.21	13.23	8.81	090
65426		A	Removal of eye lesion	5.24	10.19	4.92	0.26	15.69	10.42	090
65430		A	Corneal smear	1.47	1.29	0.98	0.07	2.83	2.52	000
65435		A	Curette/treat cornea	0.92	1.00	0.71	0.05	1.97	1.68	000
65436		A	Curette/treat cornea	4.18	4.10	3.67	0.21	8.49	8.06	090
65450		A	Treatment of corneal lesion	3.27	4.03	3.86	0.17	7.47	7.30	090
65600		A	Revision of cornea	3.39	5.49	3.03	0.17	9.05	6.59	090
65710		A	Corneal transplant	12.33	NA	11.43	0.62	NA	24.38	090
65730		A	Corneal transplant	14.23	NA	11.83	0.71	NA	26.77	090
65750		A	Corneal transplant	14.98	NA	12.29	0.75	NA	28.02	090
65755		A	Corneal transplant	14.87	NA	12.22	0.74	NA	27.83	090
65770		A	Revise cornea with implant	17.53	NA	13.20	0.87	NA	31.60	090
65772		A	Correction of astigmatism	4.28	5.53	4.13	0.21	10.02	8.62	090
65775		A	Correction of astigmatism	5.78	NA	6.25	0.29	NA	12.32	090
65780		A	Ocular reconst, transplant	10.23	NA	10.30	0.45	NA	20.98	090
65781		A	Ocular reconst, transplant	17.64	NA	13.67	0.45	NA	31.76	090
65782		A	Ocular reconst, transplant	14.98	NA	11.99	0.45	NA	27.42	090
65800		A	Drainage of eye	1.91	1.79	1.18	0.10	3.80	3.19	000
65805		A	Drainage of eye	1.91	2.17	1.18	0.10	4.18	3.19	000
65810		A	Drainage of eye	4.86	NA	4.70	0.25	NA	9.81	090
65815		A	Drainage of eye	5.04	10.02	4.81	0.26	15.32	10.11	090
65820		A	Relieve inner eye pressure	8.12	NA	9.06	0.42	NA	17.60	090
65850		A	Incision of eye	10.50	NA	8.44	0.52	NA	19.46	090
65855		A	Laser surgery of eye	3.84	4.32	3.10	0.19	8.35	7.13	010
65860		A	Incise inner eye adhesions	3.54	4.05	2.50	0.18	7.77	6.22	090
65865		A	Incise inner eye adhesions	5.59	NA	5.63	0.28	NA	11.50	090
65870		A	Incise inner eye adhesions	6.26	NA	6.41	0.31	NA	12.98	090
65875		A	Incise inner eye adhesions	6.53	NA	6.80	0.33	NA	13.66	090
65880		A	Incise inner eye adhesions	7.08	NA	7.04	0.35	NA	14.47	090
65900		A	Remove eye lesion	10.91	NA	10.42	0.56	NA	21.89	090
65920		A	Remove implant of eye	8.39	NA	8.17	0.42	NA	16.98	090
65930		A	Remove blood clot from eye	7.43	NA	6.84	0.37	NA	14.64	090
66020		A	Injection treatment of eye	1.59	3.13	1.43	0.08	4.80	3.10	010
66030		A	Injection treatment of eye	1.25	2.97	1.28	0.06	4.28	2.59	010

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
66130		A	Remove eye lesion	7.68	9.64	5.60	0.39	17.71	13.67	090
66150		A	Glaucoma surgery	8.29	NA	9.41	0.44	NA	18.14	090
66155		A	Glaucoma surgery	8.28	NA	9.37	0.43	NA	18.08	090
66160		A	Glaucoma surgery	10.15	NA	10.20	0.52	NA	20.87	090
66165		A	Glaucoma surgery	8.00	NA	9.24	0.42	NA	17.66	090
66170		A	Glaucoma surgery	12.14	NA	12.23	0.61	NA	24.98	090
66172		A	Incision of eye	15.02	NA	15.21	0.75	NA	30.98	090
66180		A	Implant eye shunt	14.53	NA	10.76	0.73	NA	26.02	090
66185		A	Revise eye shunt	8.13	NA	7.38	0.41	NA	15.92	090
66220		A	Repair eye lesion	7.76	NA	7.11	0.41	NA	15.28	090
66225		A	Repair/graft eye lesion	11.03	NA	8.73	0.55	NA	20.31	090
66250		A	Follow-up surgery of eye	5.97	11.71	5.48	0.30	17.98	11.75	090
66500		A	Incision of iris	3.70	NA	4.65	0.19	NA	8.54	090
66505		A	Incision of iris	4.07	NA	4.99	0.20	NA	9.26	090
66600		A	Remove iris and lesion	8.67	NA	8.23	0.44	NA	17.34	090
66605		A	Removal of iris	12.77	NA	10.02	0.79	NA	23.58	090
66625		A	Removal of iris	5.12	NA	4.73	0.27	NA	10.12	090
66630		A	Removal of iris	6.15	NA	5.70	0.31	NA	12.16	090
66635		A	Removal of iris	6.24	NA	5.74	0.32	NA	12.30	090
66680		A	Repair iris & ciliary body	5.43	NA	5.27	0.27	NA	10.97	090
66682		A	Repair iris & ciliary body	6.20	NA	6.61	0.31	NA	13.12	090
66700		A	Destruction, ciliary body	4.77	5.25	3.93	0.25	10.27	8.95	090
66710		A	Destruction, ciliary body	4.77	5.17	3.84	0.24	10.18	8.85	090
66720		A	Destruction, ciliary body	4.77	5.82	4.71	0.26	10.85	9.74	090
66740		A	Destruction, ciliary body	4.77	5.09	3.97	0.24	10.10	8.98	090
66761		A	Revision of iris	4.06	5.59	4.31	0.21	9.86	8.58	090
66762		A	Revision of iris	4.57	5.66	4.28	0.23	10.46	9.08	090
66770		A	Removal of inner eye lesion	5.17	6.09	4.80	0.26	11.52	10.23	090
66820		A	Incision, secondary cataract	3.88	NA	5.83	0.19	NA	9.90	090
66821		A	After cataract laser surgery	2.35	3.81	3.63	0.11	6.27	6.09	090
66825		A	Reposition intraocular lens	8.22	NA	9.07	0.40	NA	17.69	090
66830		A	Removal of lens lesion	8.19	NA	6.95	0.40	NA	15.54	090
66840		A	Removal of lens material	7.90	NA	6.86	0.39	NA	15.15	090
66850		A	Removal of lens material	9.10	NA	7.64	0.45	NA	17.19	090
66852		A	Removal of lens material	9.96	NA	8.10	0.50	NA	18.56	090
66920		A	Extraction of lens	8.85	NA	7.30	0.44	NA	16.59	090
66930		A	Extraction of lens	10.16	NA	8.14	0.51	NA	18.81	090
66940		A	Extraction of lens	8.92	NA	7.67	0.44	NA	17.03	090
66982		A	Cataract surgery, complex	13.48	NA	9.86	0.63	NA	23.97	090
66983		A	Cataract surg w/iol, 1 stage	8.98	NA	6.11	0.21	NA	15.30	090
66984		A	Cataract surg w/iol, 1 stage	10.21	NA	7.41	0.42	NA	18.04	090
66985		A	Insert lens prosthesis	8.38	NA	7.45	0.39	NA	16.22	090
66986		A	Exchange lens prosthesis	12.26	NA	9.17	0.60	NA	22.03	090
66990		A	Ophthalmic endoscope add-on	1.51	NA	0.69	0.07	NA	2.27	ZZZ
67005		A	Partial removal of eye fluid	5.69	NA	4.37	0.29	NA	10.35	090
67010		A	Partial removal of eye fluid	6.86	NA	4.91	0.34	NA	12.11	090
67015		A	Release of eye fluid	6.91	NA	6.46	0.35	NA	13.72	090
67025		A	Replace eye fluid	6.83	9.24	6.22	0.34	16.41	13.39	090
67027		A	Implant eye drug system	10.83	NA	8.00	0.55	NA	19.38	090
67028		A	Injection eye drug	2.52	2.70	1.45	0.13	5.35	4.10	000
67030		A	Incise inner eye strands	4.83	NA	5.85	0.25	NA	10.93	090
67031		A	Laser surgery, eye strands	3.66	4.61	3.64	0.18	8.45	7.48	090
67036		A	Removal of inner eye fluid	11.87	NA	9.12	0.60	NA	21.59	090
67038		A	Strip retinal membrane	21.21	NA	15.49	1.07	NA	37.77	090
67039		A	Laser treatment of retina	14.50	NA	12.18	0.73	NA	27.41	090
67040		A	Laser treatment of retina	17.20	NA	13.68	0.87	NA	31.75	090
67101		A	Repair detached retina	7.52	9.13	6.53	0.38	17.03	14.43	090
67105		A	Repair detached retina	7.40	8.09	6.15	0.37	15.86	13.92	090
67107		A	Repair detached retina	14.82	NA	11.30	0.74	NA	26.86	090
67108		A	Repair detached retina	20.79	NA	14.41	1.05	NA	36.25	090
67110		A	Repair detached retina	8.80	10.24	7.39	0.44	19.48	16.63	090
67112		A	Rerepair detached retina	16.83	NA	11.81	0.85	NA	29.49	090
67115		A	Release encircling material	4.98	NA	5.08	0.25	NA	10.31	090
67120		A	Remove eye implant material	5.97	8.59	5.52	0.30	14.86	11.79	090
67121		A	Remove eye implant material	10.65	NA	8.53	0.53	NA	19.71	090
67141		A	Treatment of retina	5.19	5.85	4.86	0.26	11.30	10.31	090
67145		A	Treatment of retina	5.36	5.72	4.93	0.27	11.35	10.56	090
67208		A	Treatment of retinal lesion	6.69	6.12	5.51	0.34	13.15	12.54	090
67210		A	Treatment of retinal lesion	8.81	6.58	5.87	0.44	15.83	15.12	090
67218		A	Treatment of retinal lesion	18.50	NA	12.15	0.93	NA	31.58	090
67220		A	Treatment of choroid lesion	13.11	10.43	9.01	0.66	24.20	22.78	090
67221		R	Ocular photodynamic ther	4.00	4.34	1.80	0.20	8.54	6.00	000
67225		A	Eye photodynamic ther add-on	0.47	0.25	0.21	0.02	0.74	0.70	ZZZ
67227		A	Treatment of retinal lesion	6.57	6.58	5.52	0.33	13.48	12.42	090
67228		A	Treatment of retinal lesion	12.72	11.49	8.54	0.64	24.85	21.90	090

[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
67250		A	Reinforce eye wall	8.65	NA	9.18	0.43	NA	18.26	090
67255		A	Reinforce/graft eye wall	8.89	NA	9.91	0.45	NA	19.25	090
67311		A	Revise eye muscle	6.64	NA	6.02	0.37	NA	13.03	090
67312		A	Revise two eye muscles	8.53	NA	6.75	0.44	NA	15.72	090
67314		A	Revise eye muscle	7.51	NA	6.55	0.40	NA	14.46	090
67316		A	Revise two eye muscles	9.65	NA	7.50	0.51	NA	17.66	090
67318		A	Revise eye muscle(s)	7.84	NA	6.93	0.41	NA	15.18	090
67320		A	Revise eye muscle(s) add-on	4.32	NA	1.95	0.23	NA	6.50	ZZZ
67331		A	Eye surgery follow-up add-on	4.05	NA	1.82	0.21	NA	6.08	ZZZ
67332		A	Rerevise eye muscles add-on	4.48	NA	2.02	0.24	NA	6.74	ZZZ
67334		A	Revise eye muscle w/suture	3.97	NA	1.79	0.20	NA	5.96	ZZZ
67335		A	Eye suture during surgery	2.49	NA	1.12	0.13	NA	3.74	ZZZ
67340		A	Revise eye muscle add-on	4.92	NA	2.20	0.26	NA	7.38	ZZZ
67343		A	Release eye tissue	7.34	NA	6.50	0.42	NA	14.26	090
67345		A	Destroy nerve of eye muscle	2.96	2.58	2.01	0.18	5.72	5.15	010
67350		A	Biopsy eye muscle	2.87	NA	1.86	0.15	NA	4.88	000
67400		A	Explore/biopsy eye socket	9.75	NA	11.27	0.58	NA	21.60	090
67405		A	Explore/drain eye socket	7.92	NA	9.78	0.49	NA	18.19	090
67412		A	Explore/treat eye socket	9.49	NA	10.95	0.53	NA	20.97	090
67413		A	Explore/treat eye socket	9.99	NA	10.78	0.56	NA	21.33	090
67414		A	Explr/decompress eye socket	11.11	NA	12.06	0.66	NA	23.83	090
67415		A	Aspiration, orbital contents	1.76	NA	0.76	0.09	NA	2.61	000
67420		A	Explore/treat eye socket	20.03	NA	17.39	1.21	NA	38.63	090
67430		A	Explore/treat eye socket	13.37	NA	15.08	0.84	NA	29.29	090
67440		A	Explore/drain eye socket	13.07	NA	14.27	0.76	NA	28.10	090
67445		A	Explr/decompress eye socket	14.40	NA	13.93	0.92	NA	29.25	090
67450		A	Explore/biopsy eye socket	13.49	NA	14.71	0.75	NA	28.95	090
67500		A	Inject/treat eye socket	0.79	0.67	0.29	0.05	1.51	1.13	000
67505		A	Inject/treat eye socket	0.82	0.69	0.31	0.05	1.56	1.18	000
67515		A	Inject/treat eye socket	0.61	0.59	0.38	0.03	1.23	1.02	000
67550		A	Insert eye socket implant	10.17	NA	11.29	0.66	NA	22.12	090
67560		A	Revise eye socket implant	10.58	NA	11.37	0.70	NA	22.65	090
67570		A	Decompress optic nerve	13.56	NA	13.60	0.82	NA	27.98	090
67700		A	Drainage of eyelid abscess	1.35	6.05	1.27	0.07	7.47	2.69	010
67710		A	Incision of eyelid	1.02	5.40	1.20	0.05	6.47	2.27	010
67715		A	Incision of eyelid fold	1.22	5.39	1.29	0.06	6.67	2.57	010
67800		A	Remove eyelid lesion	1.38	1.62	1.03	0.07	3.07	2.48	010
67801		A	Remove eyelid lesions	1.88	1.96	1.26	0.10	3.94	3.24	010
67805		A	Remove eyelid lesions	2.22	2.52	1.64	0.12	4.86	3.98	010
67808		A	Remove eyelid lesion(s)	3.79	NA	3.77	0.21	NA	7.77	090
67810		A	Biopsy of eyelid	1.48	3.34	0.67	0.11	4.93	2.26	000
67820		A	Revise eyelashes	0.89	0.60	0.56	0.04	1.53	1.49	000
67825		A	Revise eyelashes	1.38	1.73	1.41	0.07	3.18	2.86	010
67830		A	Revise eyelashes	1.70	5.55	1.50	0.09	7.34	3.29	010
67835		A	Revise eyelashes	5.55	NA	4.61	0.29	NA	10.45	090
67840		A	Remove eyelid lesion	2.04	5.49	1.65	0.11	7.64	3.80	010
67850		A	Treat eyelid lesion	1.69	3.37	1.46	0.11	5.17	3.26	010
67875		A	Closure of eyelid by suture	1.35	3.31	0.94	0.08	4.74	2.37	000
67880		A	Revision of eyelid	3.79	6.63	3.79	0.20	10.62	7.78	090
67882		A	Revision of eyelid	5.06	7.65	4.80	0.27	12.98	10.13	090
67900		A	Repair brow defect	6.13	9.05	5.23	0.39	15.57	11.75	090
67901		A	Repair eyelid defect	6.96	NA	5.38	0.53	NA	12.87	090
67902		A	Repair eyelid defect	7.02	NA	5.44	0.46	NA	12.92	090
67903		A	Repair eyelid defect	6.36	9.58	5.47	0.44	16.38	12.27	090
67904		A	Repair eyelid defect	6.25	9.69	5.22	0.41	16.35	11.88	090
67906		A	Repair eyelid defect	6.78	5.39	5.02	0.44	12.61	12.24	090
67908		A	Repair eyelid defect	5.12	7.04	5.24	0.30	12.46	10.66	090
67909		A	Revise eyelid defect	5.39	8.03	4.93	0.32	13.74	10.64	090
67911		A	Revise eyelid defect	5.26	NA	4.77	0.31	NA	10.34	090
67912		A	Correction eyelid w/ implant	5.67	18.69	5.46	0.28	24.64	11.41	090
67914		A	Repair eyelid defect	3.67	6.35	3.04	0.21	10.23	6.92	090
67915		A	Repair eyelid defect	3.18	6.00	2.80	0.17	9.35	6.15	090
67916		A	Repair eyelid defect	5.30	8.06	4.76	0.30	13.66	10.36	090
67917		A	Repair eyelid defect	6.01	8.47	5.07	0.37	14.85	11.45	090
67921		A	Repair eyelid defect	3.39	6.21	2.89	0.18	9.78	6.46	090
67922		A	Repair eyelid defect	3.06	5.93	2.75	0.16	9.15	5.97	090
67923		A	Repair eyelid defect	5.87	8.14	4.97	0.32	14.33	11.16	090
67924		A	Repair eyelid defect	5.78	8.94	4.68	0.32	15.04	10.78	090
67930		A	Repair eyelid wound	3.60	5.74	2.17	0.20	9.54	5.97	010
67935		A	Repair eyelid wound	6.21	8.53	4.40	0.39	15.13	11.00	090
67938		A	Remove eyelid foreign body	1.33	5.40	1.27	0.07	6.80	2.67	010
67950		A	Revision of eyelid	5.81	8.63	5.19	0.36	14.80	11.36	090
67961		A	Revision of eyelid	5.68	8.68	5.01	0.33	14.69	11.02	090
67966		A	Revision of eyelid	6.56	9.13	5.53	0.39	16.08	12.48	090
67971		A	Reconstruction of eyelid	9.78	NA	7.27	0.54	NA	17.59	090

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[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
67973		A	Reconstruction of eyelid	12.85	NA	9.29	0.73	NA	22.87	090
67974		A	Reconstruction of eyelid	12.82	NA	9.21	0.70	NA	22.73	090
67975		A	Reconstruction of eyelid	9.12	NA	6.94	0.49	NA	16.55	090
68020		A	Incise/drain eyelid lining	1.37	1.41	1.21	0.07	2.85	2.65	010
68040		A	Treatment of eyelid lesions	0.85	0.71	0.43	0.04	1.60	1.32	000
68100		A	Biopsy of eyelid lining	1.35	3.25	0.95	0.07	4.67	2.37	000
68110		A	Remove eyelid lining lesion	1.77	4.10	1.64	0.09	5.96	3.50	010
68115		A	Remove eyelid lining lesion	2.36	5.97	1.91	0.12	8.45	4.39	010
68130		A	Remove eyelid lining lesion	4.92	8.72	4.59	0.25	13.89	9.76	090
68135		A	Remove eyelid lining lesion	1.84	1.81	1.65	0.09	3.74	3.58	010
68200		A	Treat eyelid by injection	0.49	0.54	0.33	0.02	1.05	0.84	000
68320		A	Revise/graft eyelid lining	5.36	11.29	5.52	0.29	16.94	11.17	090
68325		A	Revise/graft eyelid lining	7.35	NA	6.53	0.41	NA	14.29	090
68326		A	Revise/graft eyelid lining	7.14	NA	6.40	0.38	NA	13.92	090
68328		A	Revise/graft eyelid lining	8.17	NA	7.26	0.55	NA	15.98	090
68330		A	Revise eyelid lining	4.82	9.41	4.71	0.25	14.48	9.78	090
68335		A	Revise/graft eyelid lining	7.18	NA	6.37	0.36	NA	13.91	090
68340		A	Separate eyelid adhesions	4.16	8.89	4.10	0.21	13.26	8.47	090
68360		A	Revise eyelid lining	4.36	8.05	4.18	0.22	12.63	8.76	090
68362		A	Revise eyelid lining	7.33	NA	6.40	0.37	NA	14.10	090
68371		A	Harvest eye tissue, alograft	4.89	NA	4.73	0.45	NA	10.07	010
68400		A	Incise/drain tear gland	1.69	5.92	1.83	0.09	7.70	3.61	010
68420		A	Incise/drain tear sac	2.30	6.22	2.11	0.12	8.64	4.53	010
68440		A	Incise tear duct opening	0.94	2.09	1.27	0.05	3.08	2.26	010
68500		A	Removal of tear gland	11.00	NA	9.73	0.63	NA	21.36	090
68505		A	Partial removal, tear gland	10.92	NA	10.59	0.61	NA	22.12	090
68510		A	Biopsy of tear gland	4.60	7.35	2.09	0.24	12.19	6.93	000
68520		A	Removal of tear sac	7.50	NA	7.41	0.39	NA	15.30	090
68525		A	Biopsy of tear sac	4.42	NA	2.01	0.24	NA	6.67	000
68530		A	Clearance of tear duct	3.65	8.19	2.64	0.20	12.04	6.49	010
68540		A	Remove tear gland lesion	10.58	NA	9.38	0.53	NA	20.49	090
68550		A	Remove tear gland lesion	13.24	NA	11.33	0.66	NA	25.23	090
68700		A	Repair tear ducts	6.59	NA	5.97	0.35	NA	12.91	090
68705		A	Revise tear duct opening	2.06	4.19	1.78	0.10	6.35	3.94	010
68720		A	Create tear sac drain	8.95	NA	7.86	0.50	NA	17.31	090
68745		A	Create tear duct drain	8.62	NA	7.86	0.43	NA	16.91	090
68750		A	Create tear duct drain	8.65	NA	8.27	0.46	NA	17.38	090
68760		A	Close tear duct opening	1.73	3.55	1.63	0.09	5.37	3.45	010
68761		A	Close tear duct opening	1.36	2.27	1.32	0.07	3.70	2.75	010
68770		A	Close tear system fistula	7.01	3.17	3.17	0.36	10.54	10.54	090
68801		A	Dilate tear duct opening	0.94	1.95	1.48	0.05	2.94	2.47	010
68810		A	Probe nasolacrimal duct	1.90	3.66	2.67	0.11	5.67	4.68	010
68811		A	Probe nasolacrimal duct	2.35	NA	2.40	0.14	NA	4.89	010
68815		A	Probe nasolacrimal duct	3.20	8.27	2.81	0.18	11.65	6.19	010
68840		A	Explore/irrigate tear ducts	1.25	1.61	1.12	0.06	2.92	2.43	010
68850		A	Injection for tear sac x-ray	0.80	0.88	0.67	0.04	1.72	1.51	000
69000		A	Drain external ear lesion	1.45	2.89	1.38	0.12	4.46	2.95	010
69005		A	Drain external ear lesion	2.11	2.93	1.83	0.18	5.22	4.12	010
69020		A	Drain outer ear canal lesion	1.48	3.97	2.07	0.12	5.57	3.67	010
69100		A	Biopsy of external ear	0.81	1.71	0.39	0.07	2.59	1.27	000
69105		A	Biopsy of external ear canal	0.85	2.32	0.77	0.07	3.24	1.69	000
69110		A	Remove external ear, partial	3.43	6.73	4.46	0.34	10.50	8.23	090
69120		A	Removal of external ear	4.04	NA	6.16	0.39	NA	10.59	090
69140		A	Remove ear canal lesion(s)	7.96	NA	13.21	0.67	NA	21.84	090
69145		A	Remove ear canal lesion(s)	2.62	5.73	3.28	0.22	8.57	6.12	090
69150		A	Extensive ear canal surgery	13.41	NA	13.32	1.27	NA	28.00	090
69155		A	Extensive ear/neck surgery	20.77	NA	19.43	1.84	NA	42.04	090
69200		A	Clear outer ear canal	0.77	2.38	0.56	0.06	3.21	1.39	000
69205		A	Clear outer ear canal	1.20	NA	1.35	0.10	NA	2.65	010
69210		A	Remove impacted ear wax	0.61	0.63	0.23	0.05	1.29	0.89	000
69220		A	Clean out mastoid cavity	0.83	2.35	0.74	0.07	3.25	1.64	000
69222		A	Clean out mastoid cavity	1.40	3.82	2.05	0.12	5.34	3.57	010
69300		R	Revise external ear	6.35	NA	4.21	0.75	NA	11.31	YYY
69310		A	Rebuild outer ear canal	10.77	NA	16.18	0.89	NA	27.84	090
69320		A	Rebuild outer ear canal	16.93	NA	21.71	1.45	NA	40.09	090
69400		A	Inflate middle ear canal	0.83	2.16	0.67	0.07	3.06	1.57	000
69401		A	Inflate middle ear canal	0.63	1.24	0.65	0.05	1.92	1.33	000
69405		A	Catheterize middle ear canal	2.63	3.46	2.29	0.21	6.30	5.13	010
69410		A	Inset middle ear (baffle)	0.33	2.12	0.48	0.03	2.48	0.84	000
69420		A	Incision of eardrum	1.33	3.12	1.58	0.11	4.56	3.02	010
69421		A	Incision of eardrum	1.73	NA	2.15	0.16	NA	4.04	010
69424		A	Remove ventilating tube	0.85	2.17	0.68	0.07	3.09	1.60	000
69433		A	Create eardrum opening	1.52	3.09	1.64	0.13	4.74	3.29	010
69436		A	Create eardrum opening	1.96	NA	2.27	0.19	NA	4.42	010
69440		A	Exploration of middle ear	7.56	NA	8.71	0.62	NA	16.89	090

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
69450		A	Eardrum revision	5.56	NA	6.99	0.45	NA	13.00	090
69501		A	Mastoidectomy	9.06	NA	8.96	0.76	NA	18.78	090
69502		A	Mastoidectomy	12.36	NA	11.54	1.03	NA	24.93	090
69505		A	Remove mastoid structures	12.97	NA	17.11	1.08	NA	31.16	090
69511		A	Extensive mastoid surgery	13.50	NA	17.39	1.09	NA	31.98	090
69530		A	Extensive mastoid surgery	19.16	NA	21.52	1.44	NA	42.12	090
69535		A	Remove part of temporal bone	36.09	NA	31.85	2.98	NA	70.92	090
69540		A	Remove ear lesion	1.20	3.71	1.95	0.10	5.01	3.25	010
69550		A	Remove ear lesion	10.97	NA	14.79	0.90	NA	26.66	090
69552		A	Remove ear lesion	19.43	NA	20.60	1.55	NA	41.58	090
69554		A	Remove ear lesion	33.11	NA	30.18	2.94	NA	66.23	090
69601		A	Mastoid surgery revision	13.22	NA	12.60	1.07	NA	26.89	090
69602		A	Mastoid surgery revision	13.56	NA	13.16	1.05	NA	27.77	090
69603		A	Mastoid surgery revision	14.00	NA	18.26	1.14	NA	33.40	090
69604		A	Mastoid surgery revision	14.00	NA	13.63	0.92	NA	28.55	090
69605		A	Mastoid surgery revision	18.46	NA	20.85	1.51	NA	40.82	090
69610		A	Repair of eardrum	4.42	5.50	3.26	0.36	10.28	8.04	010
69620		A	Repair of eardrum	5.88	11.03	6.25	0.48	17.39	12.61	090
69631		A	Repair eardrum structures	9.85	NA	11.13	0.81	NA	21.79	090
69632		A	Rebuild eardrum structures	12.73	NA	13.39	1.04	NA	27.16	090
69633		A	Rebuild eardrum structures	12.08	NA	12.97	0.99	NA	26.04	090
69635		A	Repair eardrum structures	13.31	NA	16.66	1.08	NA	31.05	090
69636		A	Rebuild eardrum structures	15.20	NA	19.18	1.23	NA	35.61	090
69637		A	Rebuild eardrum structures	15.09	NA	19.11	1.25	NA	35.45	090
69641		A	Revise middle ear & mastoid	12.69	NA	12.70	1.04	NA	26.43	090
69642		A	Revise middle ear & mastoid	16.81	NA	16.19	1.37	NA	34.37	090
69643		A	Revise middle ear & mastoid	15.30	NA	14.73	1.26	NA	31.29	090
69644		A	Revise middle ear & mastoid	16.94	NA	20.30	1.38	NA	38.62	090
69645		A	Revise middle ear & mastoid	16.36	NA	19.92	1.35	NA	37.63	090
69646		A	Revise middle ear & mastoid	17.96	NA	20.65	1.48	NA	40.09	090
69650		A	Release middle ear bone	9.65	NA	9.85	0.78	NA	20.28	090
69660		A	Revise middle ear bone	11.88	NA	11.13	0.95	NA	23.96	090
69661		A	Revise middle ear bone	15.72	NA	14.62	1.29	NA	31.63	090
69662		A	Revise middle ear bone	15.42	NA	13.68	1.26	NA	30.36	090
69666		A	Repair middle ear structures	9.74	NA	9.91	0.79	NA	20.44	090
69667		A	Repair middle ear structures	9.75	NA	9.92	0.79	NA	20.46	090
69670		A	Remove mastoid air cells	11.49	NA	11.65	0.96	NA	24.10	090
69676		A	Remove middle ear nerve	9.51	NA	10.67	0.84	NA	21.02	090
69700		A	Close mastoid fistula	8.22	NA	9.20	0.66	NA	18.08	090
69711		A	Remove/repair hearing aid	10.42	NA	10.74	0.85	NA	22.01	090
69714		A	Implant temple bone w/stimul	13.98	NA	12.61	1.21	NA	27.80	090
69715		A	Temple bne implnt w/stimulat	18.22	NA	14.96	1.49	NA	34.67	090
69717		A	Temple bone implant revision	14.96	NA	14.46	1.35	NA	30.77	090
69718		A	Revise temple bone implant	18.47	NA	15.26	1.62	NA	35.35	090
69720		A	Release facial nerve	14.36	NA	14.43	1.24	NA	30.03	090
69725		A	Release facial nerve	25.34	NA	20.02	2.29	NA	47.65	090
69740		A	Repair facial nerve	15.94	NA	13.37	1.58	NA	30.89	090
69745		A	Repair facial nerve	16.66	NA	14.91	1.36	NA	32.93	090
69801		A	Incise inner ear	8.55	NA	9.41	0.70	NA	18.66	090
69802		A	Incise inner ear	13.08	NA	12.25	1.07	NA	26.40	090
69805		A	Explore inner ear	13.80	NA	11.82	1.16	NA	26.78	090
69806		A	Explore inner ear	12.33	NA	10.99	1.04	NA	24.36	090
69820		A	Establish inner ear window	10.32	NA	11.19	0.82	NA	22.33	090
69840		A	Revise inner ear window	10.24	NA	13.15	0.74	NA	24.13	090
69905		A	Remove inner ear	11.08	NA	11.29	0.90	NA	23.27	090
69910		A	Remove inner ear & mastoid	13.61	NA	11.88	1.10	NA	26.59	090
69915		A	Incise inner ear nerve	21.20	NA	16.39	1.70	NA	39.29	090
69930		A	Implant cochlear device	16.78	NA	14.68	1.38	NA	32.84	090
69950		A	Incise inner ear nerve	25.60	NA	18.82	3.07	NA	47.49	090
69955		A	Release facial nerve	27.00	NA	21.29	2.77	NA	51.06	090
69960		A	Release inner ear canal	27.00	NA	19.98	2.69	NA	49.67	090
69970		A	Remove inner ear lesion	29.99	NA	23.17	2.73	NA	55.89	090
69990		R	Microsurgery add-on	3.46	NA	1.78	0.81	NA	6.05	ZZZ
70010		A	Contrast x-ray of brain	1.19	4.72	NA	0.28	6.19	NA	XXX
70010	26	A	Contrast x-ray of brain	1.19	0.39	0.39	0.06	1.64	1.64	XXX
70010	TC	A	Contrast x-ray of brain	0.00	4.32	NA	0.22	4.54	NA	XXX
70015		A	Contrast x-ray of brain	1.19	1.74	NA	0.14	3.07	NA	XXX
70015	26	A	Contrast x-ray of brain	1.19	0.39	0.39	0.06	1.64	1.64	XXX
70015	TC	A	Contrast x-ray of brain	0.00	1.35	NA	0.08	1.43	NA	XXX
70030		A	X-ray eye for foreign body	0.17	0.47	NA	0.03	0.67	NA	XXX
70030	26	A	X-ray eye for foreign body	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70030	TC	A	X-ray eye for foreign body	0.00	0.42	NA	0.02	0.44	NA	XXX
70100		A	X-ray exam of jaw	0.18	0.58	NA	0.03	0.79	NA	XXX
70100	26	A	X-ray exam of jaw	0.18	0.06	0.06	0.01	0.25	0.25	XXX
70100	TC	A	X-ray exam of jaw	0.00	0.52	NA	0.02	0.54	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
70110		A	X-ray exam of jaw	0.25	0.70	NA	0.05	1.00	NA	XXX
70110	26	A	X-ray exam of jaw	0.25	0.08	0.08	0.01	0.34	0.34	XXX
70110	TC	A	X-ray exam of jaw	0.00	0.62	NA	0.04	0.66	NA	XXX
70120		A	X-ray exam of mastoids	0.18	0.68	NA	0.05	0.91	NA	XXX
70120	26	A	X-ray exam of mastoids	0.18	0.06	0.06	0.01	0.25	0.25	XXX
70120	TC	A	X-ray exam of mastoids	0.00	0.62	NA	0.04	0.66	NA	XXX
70130		A	X-ray exam of mastoids	0.34	0.89	NA	0.07	1.30	NA	XXX
70130	26	A	X-ray exam of mastoids	0.34	0.11	0.11	0.02	0.47	0.47	XXX
70130	TC	A	X-ray exam of mastoids	0.00	0.78	NA	0.05	0.83	NA	XXX
70134		A	X-ray exam of middle ear	0.34	0.85	NA	0.07	1.26	NA	XXX
70134	26	A	X-ray exam of middle ear	0.34	0.11	0.11	0.02	0.47	0.47	XXX
70134	TC	A	X-ray exam of middle ear	0.00	0.73	NA	0.05	0.78	NA	XXX
70140		A	X-ray exam of facial bones	0.19	0.68	NA	0.05	0.92	NA	XXX
70140	26	A	X-ray exam of facial bones	0.19	0.06	0.06	0.01	0.26	0.26	XXX
70140	TC	A	X-ray exam of facial bones	0.00	0.62	NA	0.04	0.66	NA	XXX
70150		A	X-ray exam of facial bones	0.26	0.87	NA	0.06	1.19	NA	XXX
70150	26	A	X-ray exam of facial bones	0.26	0.08	0.08	0.01	0.35	0.35	XXX
70150	TC	A	X-ray exam of facial bones	0.00	0.78	NA	0.05	0.83	NA	XXX
70160		A	X-ray exam of nasal bones	0.17	0.58	NA	0.03	0.78	NA	XXX
70160	26	A	X-ray exam of nasal bones	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70160	TC	A	X-ray exam of nasal bones	0.00	0.52	NA	0.02	0.54	NA	XXX
70170		A	X-ray exam of tear duct	0.30	1.04	NA	0.07	1.41	NA	XXX
70170	26	A	X-ray exam of tear duct	0.30	0.10	0.10	0.01	0.41	0.41	XXX
70170	TC	A	X-ray exam of tear duct	0.00	0.95	NA	0.06	1.01	NA	XXX
70190		A	X-ray exam of eye sockets	0.21	0.69	NA	0.05	0.95	NA	XXX
70190	26	A	X-ray exam of eye sockets	0.21	0.07	0.07	0.01	0.29	0.29	XXX
70190	TC	A	X-ray exam of eye sockets	0.00	0.62	NA	0.04	0.66	NA	XXX
70200		A	X-ray exam of eye sockets	0.28	0.87	NA	0.06	1.21	NA	XXX
70200	26	A	X-ray exam of eye sockets	0.28	0.09	0.09	0.01	0.38	0.38	XXX
70200	TC	A	X-ray exam of eye sockets	0.00	0.78	NA	0.05	0.83	NA	XXX
70210		A	X-ray exam of sinuses	0.17	0.67	NA	0.05	0.89	NA	XXX
70210	26	A	X-ray exam of sinuses	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70210	TC	A	X-ray exam of sinuses	0.00	0.62	NA	0.04	0.66	NA	XXX
70220		A	X-ray exam of sinuses	0.25	0.86	NA	0.06	1.17	NA	XXX
70220	26	A	X-ray exam of sinuses	0.25	0.08	0.08	0.01	0.34	0.34	XXX
70220	TC	A	X-ray exam of sinuses	0.00	0.78	NA	0.05	0.83	NA	XXX
70240		A	X-ray exam, pituitary saddle	0.19	0.48	NA	0.03	0.70	NA	XXX
70240	26	A	X-ray exam, pituitary saddle	0.19	0.06	0.06	0.01	0.26	0.26	XXX
70240	TC	A	X-ray exam, pituitary saddle	0.00	0.42	NA	0.02	0.44	NA	XXX
70250		A	X-ray exam of skull	0.24	0.70	NA	0.05	0.99	NA	XXX
70250	26	A	X-ray exam of skull	0.24	0.08	0.08	0.01	0.33	0.33	XXX
70250	TC	A	X-ray exam of skull	0.00	0.62	NA	0.04	0.66	NA	XXX
70260		A	X-ray exam of skull	0.34	1.00	NA	0.08	1.42	NA	XXX
70260	26	A	X-ray exam of skull	0.34	0.11	0.11	0.02	0.47	0.47	XXX
70260	TC	A	X-ray exam of skull	0.00	0.89	NA	0.06	0.95	NA	XXX
70300		A	X-ray exam of teeth	0.10	0.31	NA	0.03	0.44	NA	XXX
70300	26	A	X-ray exam of teeth	0.10	0.05	0.05	0.01	0.16	0.16	XXX
70300	TC	A	X-ray exam of teeth	0.00	0.26	NA	0.02	0.28	NA	XXX
70310		A	X-ray exam of teeth	0.16	0.49	NA	0.03	0.68	NA	XXX
70310	26	A	X-ray exam of teeth	0.16	0.08	0.08	0.01	0.25	0.25	XXX
70310	TC	A	X-ray exam of teeth	0.00	0.42	NA	0.02	0.44	NA	XXX
70320		A	Full mouth x-ray of teeth	0.22	0.86	NA	0.06	1.14	NA	XXX
70320	26	A	Full mouth x-ray of teeth	0.22	0.08	0.08	0.01	0.31	0.31	XXX
70320	TC	A	Full mouth x-ray of teeth	0.00	0.78	NA	0.05	0.83	NA	XXX
70328		A	X-ray exam of jaw joint	0.18	0.55	NA	0.03	0.76	NA	XXX
70328	26	A	X-ray exam of jaw joint	0.18	0.06	0.06	0.01	0.25	0.25	XXX
70328	TC	A	X-ray exam of jaw joint	0.00	0.49	NA	0.02	0.51	NA	XXX
70330		A	X-ray exam of jaw joints	0.24	0.92	NA	0.06	1.22	NA	XXX
70330	26	A	X-ray exam of jaw joints	0.24	0.08	0.08	0.01	0.33	0.33	XXX
70330	TC	A	X-ray exam of jaw joints	0.00	0.84	NA	0.05	0.89	NA	XXX
70332		A	X-ray exam of jaw joint	0.54	2.29	NA	0.15	2.98	NA	XXX
70332	26	A	X-ray exam of jaw joint	0.54	0.20	0.20	0.03	0.77	0.77	XXX
70332	TC	A	X-ray exam of jaw joint	0.00	2.09	NA	0.12	2.21	NA	XXX
70336		A	Magnetic image, jaw joint	1.48	11.67	NA	0.66	13.81	NA	XXX
70336	26	A	Magnetic image, jaw joint	1.48	0.49	0.49	0.07	2.04	2.04	XXX
70336	TC	A	Magnetic image, jaw joint	0.00	11.19	NA	0.59	11.78	NA	XXX
70350		A	X-ray head for orthodontia	0.17	0.45	NA	0.03	0.65	NA	XXX
70350	26	A	X-ray head for orthodontia	0.17	0.07	0.07	0.01	0.25	0.25	XXX
70350	TC	A	X-ray head for orthodontia	0.00	0.38	NA	0.02	0.40	NA	XXX
70355		A	Panoramic x-ray of jaws	0.20	0.64	NA	0.05	0.89	NA	XXX
70355	26	A	Panoramic x-ray of jaws	0.20	0.07	0.07	0.01	0.28	0.28	XXX
70355	TC	A	Panoramic x-ray of jaws	0.00	0.57	NA	0.04	0.61	NA	XXX
70360		A	X-ray exam of neck	0.17	0.47	NA	0.03	0.67	NA	XXX
70360	26	A	X-ray exam of neck	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70360	TC	A	X-ray exam of neck	0.00	0.42	NA	0.02	0.44	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
70370		A	Throat x-ray & fluoroscopy	0.32	1.41	NA	0.08	1.81	NA	XXX
70370	26	A	Throat x-ray & fluoroscopy	0.32	0.10	0.10	0.01	0.43	0.43	XXX
70370	TC	A	Throat x-ray & fluoroscopy	0.00	1.30	NA	0.07	1.37	NA	XXX
70371		A	Speech evaluation, complex	0.84	2.37	NA	0.16	3.37	NA	XXX
70371	26	A	Speech evaluation, complex	0.84	0.27	0.27	0.04	1.15	1.15	XXX
70371	TC	A	Speech evaluation, complex	0.00	2.09	NA	0.12	2.21	NA	XXX
70373		A	Contrast x-ray of larynx	0.44	1.92	NA	0.13	2.49	NA	XXX
70373	26	A	Contrast x-ray of larynx	0.44	0.14	0.14	0.02	0.60	0.60	XXX
70373	TC	A	Contrast x-ray of larynx	0.00	1.78	NA	0.11	1.89	NA	XXX
70380		A	X-ray exam of salivary gland	0.17	0.72	NA	0.05	0.94	NA	XXX
70380	26	A	X-ray exam of salivary gland	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70380	TC	A	X-ray exam of salivary gland	0.00	0.67	NA	0.04	0.71	NA	XXX
70390		A	X-ray exam of salivary duct	0.38	1.90	NA	0.13	2.41	NA	XXX
70390	26	A	X-ray exam of salivary duct	0.38	0.12	0.12	0.02	0.52	0.52	XXX
70390	TC	A	X-ray exam of salivary duct	0.00	1.78	NA	0.11	1.89	NA	XXX
70450		A	Ct head/brain w/o dye	0.85	4.99	NA	0.29	6.13	NA	XXX
70450	26	A	Ct head/brain w/o dye	0.85	0.28	0.28	0.04	1.17	1.17	XXX
70450	TC	A	Ct head/brain w/o dye	0.00	4.71	NA	0.25	4.96	NA	XXX
70460		A	Ct head/brain w/dye	1.13	6.02	NA	0.35	7.50	NA	XXX
70460	26	A	Ct head/brain w/dye	1.13	0.37	0.37	0.05	1.55	1.55	XXX
70460	TC	A	Ct head/brain w/dye	0.00	5.65	NA	0.30	5.95	NA	XXX
70470		A	Ct head/brain w/o & w/ dye	1.27	7.47	NA	0.43	9.17	NA	XXX
70470	26	A	Ct head/brain w/o & w/ dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX
70470	TC	A	Ct head/brain w/o & w/ dye	0.00	7.06	NA	0.37	7.43	NA	XXX
70480		A	Ct orbit/ear/fossa w/o dye	1.28	5.13	NA	0.31	6.72	NA	XXX
70480	26	A	Ct orbit/ear/fossa w/o dye	1.28	0.42	0.42	0.06	1.76	1.76	XXX
70480	TC	A	Ct orbit/ear/fossa w/o dye	0.00	4.71	NA	0.25	4.96	NA	XXX
70481		A	Ct orbit/ear/fossa w/dye	1.38	6.10	NA	0.36	7.84	NA	XXX
70481	26	A	Ct orbit/ear/fossa w/dye	1.38	0.45	0.45	0.06	1.89	1.89	XXX
70481	TC	A	Ct orbit/ear/fossa w/dye	0.00	5.65	NA	0.30	5.95	NA	XXX
70482		A	Ct orbit/ear/fossa w/o&w dye	1.45	7.53	NA	0.44	9.42	NA	XXX
70482	26	A	Ct orbit/ear/fossa w/o&w dye	1.45	0.47	0.47	0.07	1.99	1.99	XXX
70482	TC	A	Ct orbit/ear/fossa w/o&w dye	0.00	7.06	NA	0.37	7.43	NA	XXX
70486		A	Ct maxillofacial w/o dye	1.14	5.08	NA	0.30	6.52	NA	XXX
70486	26	A	Ct maxillofacial w/o dye	1.14	0.37	0.37	0.05	1.56	1.56	XXX
70486	TC	A	Ct maxillofacial w/o dye	0.00	4.71	NA	0.25	4.96	NA	XXX
70487		A	Ct maxillofacial w/dye	1.30	6.07	NA	0.36	7.73	NA	XXX
70487	26	A	Ct maxillofacial w/dye	1.30	0.43	0.43	0.06	1.79	1.79	XXX
70487	TC	A	Ct maxillofacial w/dye	0.00	5.65	NA	0.30	5.95	NA	XXX
70488		A	Ct maxillofacial w/o & w dye	1.42	7.52	NA	0.43	9.37	NA	XXX
70488	26	A	Ct maxillofacial w/o & w dye	1.42	0.46	0.46	0.06	1.94	1.94	XXX
70488	TC	A	Ct maxillofacial w/o & w dye	0.00	7.06	NA	0.37	7.43	NA	XXX
70490		A	Ct soft tissue neck w/o dye	1.28	5.13	NA	0.31	6.72	NA	XXX
70490	26	A	Ct soft tissue neck w/o dye	1.28	0.42	0.42	0.06	1.76	1.76	XXX
70490	TC	A	Ct soft tissue neck w/o dye	0.00	4.71	NA	0.25	4.96	NA	XXX
70491		A	Ct soft tissue neck w/dye	1.38	6.10	NA	0.36	7.84	NA	XXX
70491	26	A	Ct soft tissue neck w/dye	1.38	0.45	0.45	0.06	1.89	1.89	XXX
70491	TC	A	Ct soft tissue neck w/dye	0.00	5.65	NA	0.30	5.95	NA	XXX
70492		A	Ct sft tsue nck w/o & w/dye	1.45	7.53	NA	0.44	9.42	NA	XXX
70492	26	A	Ct sft tsue nck w/o & w/dye	1.45	0.47	0.47	0.07	1.99	1.99	XXX
70492	TC	A	Ct sft tsue nck w/o & w/dye	0.00	7.06	NA	0.37	7.43	NA	XXX
70496		A	Ct angiography, head	1.75	11.16	NA	0.66	13.57	NA	XXX
70496	26	A	Ct angiography, head	1.75	0.57	0.57	0.08	2.40	2.40	XXX
70496	TC	A	Ct angiography, head	0.00	10.59	NA	0.58	11.17	NA	XXX
70498		A	Ct angiography, neck	1.75	11.16	NA	0.66	13.57	NA	XXX
70498	26	A	Ct angiography, neck	1.75	0.57	0.57	0.08	2.40	2.40	XXX
70498	TC	A	Ct angiography, neck	0.00	10.59	NA	0.58	11.17	NA	XXX
70540		A	Mri orbit/face/neck w/o dye	1.35	11.63	NA	0.45	13.43	NA	XXX
70540	26	A	Mri orbit/face/neck w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
70540	TC	A	Mri orbit/face/neck w/o dye	0.00	11.19	NA	0.39	11.58	NA	XXX
70542		A	Mri orbit/face/neck w/dye	1.62	13.95	NA	0.54	16.11	NA	XXX
70542	26	A	Mri orbit/face/neck w/dye	1.62	0.53	0.53	0.07	2.22	2.22	XXX
70542	TC	A	Mri orbit/face/neck w/dye	0.00	13.42	NA	0.47	13.89	NA	XXX
70543		A	Mri orbt/fac/nck w/o & w dye	2.15	25.55	NA	0.94	28.64	NA	XXX
70543	26	A	Mri orbt/fac/nck w/o & w dye	2.15	0.71	0.71	0.10	2.96	2.96	XXX
70543	TC	A	Mri orbt/fac/nck w/o & w dye	0.00	24.84	NA	0.84	25.68	NA	XXX
70544		A	Mr angiography head w/o dye	1.20	11.58	NA	0.64	13.42	NA	XXX
70544	26	A	Mr angiography head w/o dye	1.20	0.39	0.39	0.05	1.64	1.64	XXX
70544	TC	A	Mr angiography head w/o dye	0.00	11.19	NA	0.59	11.78	NA	XXX
70545		A	Mr angiography head w/dye	1.20	11.58	NA	0.65	13.43	NA	XXX
70545	26	A	Mr angiography head w/dye	1.20	0.39	0.39	0.06	1.65	1.65	XXX
70545	TC	A	Mr angiography head w/dye	0.00	11.19	NA	0.59	11.78	NA	XXX
70546		A	Mr angiograph head w/o&w dye	1.80	22.96	NA	0.67	25.43	NA	XXX
70546	26	A	Mr angiograph head w/o&w dye	1.80	0.59	0.59	0.08	2.47	2.47	XXX
70546	TC	A	Mr angiograph head w/o&w dye	0.00	22.37	NA	0.59	22.96	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
70547		A	Mr angiography neck w/o dye	1.20	11.58	NA	0.64	13.42	NA	XXX
70547	26	A	Mr angiography neck w/o dye	1.20	0.39	0.39	0.05	1.64	1.64	XXX
70547	TC	A	Mr angiography neck w/o dye	0.00	11.19	NA	0.59	11.78	NA	XXX
70548		A	Mr angiography neck w/dye	1.20	11.58	NA	0.64	13.42	NA	XXX
70548	26	A	Mr angiography neck w/dye	1.20	0.39	0.39	0.05	1.64	1.64	XXX
70548	TC	A	Mr angiography neck w/dye	0.00	11.19	NA	0.59	11.78	NA	XXX
70549		A	Mr angiograph neck w/o&w dye	1.80	22.97	NA	0.67	25.44	NA	XXX
70549	26	A	Mr angiograph neck w/o&w dye	1.80	0.59	0.59	0.08	2.47	2.47	XXX
70549	TC	A	Mr angiograph neck w/o&w dye	0.00	22.37	NA	0.59	22.96	NA	XXX
70551		A	Mri brain w/o dye	1.48	11.67	NA	0.66	13.81	NA	XXX
70551	26	A	Mri brain w/o dye	1.48	0.49	0.49	0.07	2.04	2.04	XXX
70551	TC	A	Mri brain w/o dye	0.00	11.19	NA	0.59	11.78	NA	XXX
70552		A	Mri brain w/ dye	1.78	14.01	NA	0.79	16.58	NA	XXX
70552	26	A	Mri brain w/ dye	1.78	0.59	0.59	0.09	2.46	2.46	XXX
70552	TC	A	Mri brain w/ dye	0.00	13.42	NA	0.70	14.12	NA	XXX
70553		A	Mri brain w/o & w/ dye	2.36	25.62	NA	1.42	29.40	NA	XXX
70553	26	A	Mri brain w/o & w/ dye	2.36	0.77	0.77	0.11	3.24	3.24	XXX
70553	TC	A	Mri brain w/o & w/ dye	0.00	24.84	NA	1.31	26.15	NA	XXX
70557	26	A	Mri brain w/o dye	2.90	1.12	1.12	0.08	4.10	4.10	XXX
70558	26	A	Mri brain w/ dye	3.20	1.23	1.23	0.10	4.53	4.53	XXX
70559	26	A	Mri brain w/o & w/ dye	3.20	1.23	1.23	0.12	4.55	4.55	XXX
71010		A	Chest x-ray	0.18	0.53	NA	0.03	0.74	NA	XXX
71010	26	A	Chest x-ray	0.18	0.06	0.06	0.01	0.25	0.25	XXX
71010	TC	A	Chest x-ray	0.00	0.47	NA	0.02	0.49	NA	XXX
71015		A	Chest x-ray	0.21	0.59	NA	0.03	0.83	NA	XXX
71015	26	A	Chest x-ray	0.21	0.07	0.07	0.01	0.29	0.29	XXX
71015	TC	A	Chest x-ray	0.00	0.52	NA	0.02	0.54	NA	XXX
71020		A	Chest x-ray	0.22	0.69	NA	0.05	0.96	NA	XXX
71020	26	A	Chest x-ray	0.22	0.07	0.07	0.01	0.30	0.30	XXX
71020	TC	A	Chest x-ray	0.00	0.62	NA	0.04	0.66	NA	XXX
71021		A	Chest x-ray	0.27	0.82	NA	0.06	1.15	NA	XXX
71021	26	A	Chest x-ray	0.27	0.09	0.09	0.01	0.37	0.37	XXX
71021	TC	A	Chest x-ray	0.00	0.73	NA	0.05	0.78	NA	XXX
71022		A	Chest x-ray	0.31	0.83	NA	0.06	1.20	NA	XXX
71022	26	A	Chest x-ray	0.31	0.10	0.10	0.01	0.42	0.42	XXX
71022	TC	A	Chest x-ray	0.00	0.73	NA	0.05	0.78	NA	XXX
71023		A	Chest x-ray and fluoroscopy	0.38	0.91	NA	0.07	1.36	NA	XXX
71023	26	A	Chest x-ray and fluoroscopy	0.38	0.13	0.13	0.02	0.53	0.53	XXX
71023	TC	A	Chest x-ray and fluoroscopy	0.00	0.78	NA	0.05	0.83	NA	XXX
71030		A	Chest x-ray	0.31	0.88	NA	0.06	1.25	NA	XXX
71030	26	A	Chest x-ray	0.31	0.10	0.10	0.01	0.42	0.42	XXX
71030	TC	A	Chest x-ray	0.00	0.78	NA	0.05	0.83	NA	XXX
71034		A	Chest x-ray and fluoroscopy	0.46	1.60	NA	0.10	2.16	NA	XXX
71034	26	A	Chest x-ray and fluoroscopy	0.46	0.16	0.16	0.02	0.64	0.64	XXX
71034	TC	A	Chest x-ray and fluoroscopy	0.00	1.44	NA	0.08	1.52	NA	XXX
71035		A	Chest x-ray	0.18	0.58	NA	0.03	0.79	NA	XXX
71035	26	A	Chest x-ray	0.18	0.06	0.06	0.01	0.25	0.25	XXX
71035	TC	A	Chest x-ray	0.00	0.52	NA	0.02	0.54	NA	XXX
71040		A	Contrast x-ray of bronchi	0.58	1.65	NA	0.11	2.34	NA	XXX
71040	26	A	Contrast x-ray of bronchi	0.58	0.19	0.19	0.03	0.80	0.80	XXX
71040	TC	A	Contrast x-ray of bronchi	0.00	1.46	NA	0.08	1.54	NA	XXX
71060		A	Contrast x-ray of bronchi	0.74	2.44	NA	0.17	3.35	NA	XXX
71060	26	A	Contrast x-ray of bronchi	0.74	0.24	0.24	0.04	1.02	1.02	XXX
71060	TC	A	Contrast x-ray of bronchi	0.00	2.20	NA	0.13	2.33	NA	XXX
71090		A	X-ray & pacemaker insertion	0.54	1.89	NA	0.13	2.56	NA	XXX
71090	26	A	X-ray & pacemaker insertion	0.54	0.21	0.21	0.02	0.77	0.77	XXX
71090	TC	A	X-ray & pacemaker insertion	0.00	1.68	NA	0.11	1.79	NA	XXX
71100		A	X-ray exam of ribs	0.22	0.64	NA	0.05	0.91	NA	XXX
71100	26	A	X-ray exam of ribs	0.22	0.07	0.07	0.01	0.30	0.30	XXX
71100	TC	A	X-ray exam of ribs	0.00	0.57	NA	0.04	0.61	NA	XXX
71101		A	X-ray exam of ribs/chest	0.27	0.75	NA	0.05	1.07	NA	XXX
71101	26	A	X-ray exam of ribs/chest	0.27	0.09	0.09	0.01	0.37	0.37	XXX
71101	TC	A	X-ray exam of ribs/chest	0.00	0.67	NA	0.04	0.71	NA	XXX
71110		A	X-ray exam of ribs	0.27	0.87	NA	0.06	1.20	NA	XXX
71110	26	A	X-ray exam of ribs	0.27	0.09	0.09	0.01	0.37	0.37	XXX
71110	TC	A	X-ray exam of ribs	0.00	0.78	NA	0.05	0.83	NA	XXX
71111		A	X-ray exam of ribs/ chest	0.32	0.99	NA	0.07	1.38	NA	XXX
71111	26	A	X-ray exam of ribs/ chest	0.32	0.10	0.10	0.01	0.43	0.43	XXX
71111	TC	A	X-ray exam of ribs/ chest	0.00	0.89	NA	0.06	0.95	NA	XXX
71120		A	X-ray exam of breastbone	0.20	0.71	NA	0.05	0.96	NA	XXX
71120	26	A	X-ray exam of breastbone	0.20	0.07	0.07	0.01	0.28	0.28	XXX
71120	TC	A	X-ray exam of breastbone	0.00	0.65	NA	0.04	0.69	NA	XXX
71130		A	X-ray exam of breastbone	0.22	0.78	NA	0.05	1.05	NA	XXX
71130	26	A	X-ray exam of breastbone	0.22	0.07	0.07	0.01	0.30	0.30	XXX
71130	TC	A	X-ray exam of breastbone	0.00	0.70	NA	0.04	0.74	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
71250		A	Ct thorax w/o dye	1.16	6.28	NA	0.36	7.80	NA	XXX
71250	26	A	Ct thorax w/o dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
71250	TC	A	Ct thorax w/o dye	0.00	5.90	NA	0.31	6.21	NA	XXX
71260		A	Ct thorax w/dye	1.24	7.46	NA	0.43	9.13	NA	XXX
71260	26	A	Ct thorax w/dye	1.24	0.40	0.40	0.06	1.70	1.70	XXX
71260	TC	A	Ct thorax w/dye	0.00	7.06	NA	0.37	7.43	NA	XXX
71270		A	Ct thorax w/o & w/ dye	1.38	9.28	NA	0.52	11.18	NA	XXX
71270	26	A	Ct thorax w/o & w/ dye	1.38	0.45	0.45	0.06	1.89	1.89	XXX
71270	TC	A	Ct thorax w/o & w/ dye	0.00	8.83	NA	0.46	9.29	NA	XXX
71275		A	Ct angiography, chest	1.92	12.99	NA	0.48	15.39	NA	XXX
71275	26	A	Ct angiography, chest	1.92	0.63	0.63	0.09	2.64	2.64	XXX
71275	TC	A	Ct angiography, chest	0.00	12.36	NA	0.39	12.75	NA	XXX
71550		A	Mri chest w/o dye	1.46	11.66	NA	0.52	13.64	NA	XXX
71550	26	A	Mri chest w/o dye	1.46	0.48	0.48	0.07	2.01	2.01	XXX
71550	TC	A	Mri chest w/o dye	0.00	11.19	NA	0.45	11.64	NA	XXX
71551		A	Mri chest w/dye	1.73	13.98	NA	0.60	16.31	NA	XXX
71551	26	A	Mri chest w/dye	1.73	0.56	0.56	0.08	2.37	2.37	XXX
71551	TC	A	Mri chest w/dye	0.00	13.42	NA	0.52	13.94	NA	XXX
71552		A	Mri chest w/o & w/dye	2.26	25.58	NA	0.78	28.62	NA	XXX
71552	26	A	Mri chest w/o & w/dye	2.26	0.74	0.74	0.10	3.10	3.10	XXX
71552	TC	A	Mri chest w/o & w/dye	0.00	24.84	NA	0.68	25.52	NA	XXX
71555		R	Mri angio chest w or w/o dye	1.81	11.78	NA	0.67	14.26	NA	XXX
71555	26	R	Mri angio chest w or w/o dye	1.81	0.60	0.60	0.08	2.49	2.49	XXX
71555	TC	R	Mri angio chest w or w/o dye	0.00	11.19	NA	0.59	11.78	NA	XXX
72010		A	X-ray exam of spine	0.45	1.17	NA	0.08	1.70	NA	XXX
72010	26	A	X-ray exam of spine	0.45	0.15	0.15	0.02	0.62	0.62	XXX
72010	TC	A	X-ray exam of spine	0.00	1.02	NA	0.06	1.08	NA	XXX
72020		A	X-ray exam of spine	0.15	0.46	NA	0.03	0.64	NA	XXX
72020	26	A	X-ray exam of spine	0.15	0.05	0.05	0.01	0.21	0.21	XXX
72020	TC	A	X-ray exam of spine	0.00	0.42	NA	0.02	0.44	NA	XXX
72040		A	X-ray exam of neck spine	0.22	0.67	NA	0.05	0.94	NA	XXX
72040	26	A	X-ray exam of neck spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72040	TC	A	X-ray exam of neck spine	0.00	0.60	NA	0.04	0.64	NA	XXX
72050		A	X-ray exam of neck spine	0.31	0.99	NA	0.07	1.37	NA	XXX
72050	26	A	X-ray exam of neck spine	0.31	0.10	0.10	0.01	0.42	0.42	XXX
72050	TC	A	X-ray exam of neck spine	0.00	0.89	NA	0.06	0.95	NA	XXX
72052		A	X-ray exam of neck spine	0.36	1.25	NA	0.08	1.69	NA	XXX
72052	26	A	X-ray exam of neck spine	0.36	0.12	0.12	0.02	0.50	0.50	XXX
72052	TC	A	X-ray exam of neck spine	0.00	1.13	NA	0.06	1.19	NA	XXX
72069		A	X-ray exam of trunk spine	0.22	0.57	NA	0.03	0.82	NA	XXX
72069	26	A	X-ray exam of trunk spine	0.22	0.08	0.08	0.01	0.31	0.31	XXX
72069	TC	A	X-ray exam of trunk spine	0.00	0.49	NA	0.02	0.51	NA	XXX
72070		A	X-ray exam of thoracic spine	0.22	0.72	NA	0.05	0.99	NA	XXX
72070	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72070	TC	A	X-ray exam of thoracic spine	0.00	0.65	NA	0.04	0.69	NA	XXX
72072		A	X-ray exam of thoracic spine	0.22	0.81	NA	0.06	1.09	NA	XXX
72072	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72072	TC	A	X-ray exam of thoracic spine	0.00	0.73	NA	0.05	0.78	NA	XXX
72074		A	X-ray exam of thoracic spine	0.22	0.98	NA	0.07	1.27	NA	XXX
72074	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72074	TC	A	X-ray exam of thoracic spine	0.00	0.91	NA	0.06	0.97	NA	XXX
72080		A	X-ray exam of trunk spine	0.22	0.74	NA	0.05	1.01	NA	XXX
72080	26	A	X-ray exam of trunk spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72080	TC	A	X-ray exam of trunk spine	0.00	0.67	NA	0.04	0.71	NA	XXX
72090		A	X-ray exam of trunk spine	0.28	0.76	NA	0.05	1.09	NA	XXX
72090	26	A	X-ray exam of trunk spine	0.28	0.09	0.09	0.01	0.38	0.38	XXX
72090	TC	A	X-ray exam of trunk spine	0.00	0.67	NA	0.04	0.71	NA	XXX
72100		A	X-ray exam of lower spine	0.22	0.74	NA	0.05	1.01	NA	XXX
72100	26	A	X-ray exam of lower spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72100	TC	A	X-ray exam of lower spine	0.00	0.67	NA	0.04	0.71	NA	XXX
72110		A	X-ray exam of lower spine	0.31	1.01	NA	0.07	1.39	NA	XXX
72110	26	A	X-ray exam of lower spine	0.31	0.10	0.10	0.01	0.42	0.42	XXX
72110	TC	A	X-ray exam of lower spine	0.00	0.91	NA	0.06	0.97	NA	XXX
72114		A	X-ray exam of lower spine	0.36	1.31	NA	0.08	1.75	NA	XXX
72114	26	A	X-ray exam of lower spine	0.36	0.12	0.12	0.02	0.50	0.50	XXX
72114	TC	A	X-ray exam of lower spine	0.00	1.19	NA	0.06	1.25	NA	XXX
72120		A	X-ray exam of lower spine	0.22	0.96	NA	0.07	1.25	NA	XXX
72120	26	A	X-ray exam of lower spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72120	TC	A	X-ray exam of lower spine	0.00	0.89	NA	0.06	0.95	NA	XXX
72125		A	Ct neck spine w/o dye	1.16	6.28	NA	0.36	7.80	NA	XXX
72125	26	A	Ct neck spine w/o dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
72125	TC	A	Ct neck spine w/o dye	0.00	5.90	NA	0.31	6.21	NA	XXX
72126		A	Ct neck spine w/dye	1.22	7.45	NA	0.43	9.10	NA	XXX
72126	26	A	Ct neck spine w/dye	1.22	0.40	0.40	0.06	1.68	1.68	XXX
72126	TC	A	Ct neck spine w/dye	0.00	7.06	NA	0.37	7.43	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
72127		A	Ct neck spine w/o & w/dye	1.27	9.25	NA	0.52	11.04	NA	XXX
72127	26	A	Ct neck spine w/o & w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX
72127	TC	A	Ct neck spine w/o & w/dye	0.00	8.83	NA	0.46	9.29	NA	XXX
72128		A	Ct chest spine w/o dye	1.16	6.28	NA	0.36	7.80	NA	XXX
72128	26	A	Ct chest spine w/o dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
72128	TC	A	Ct chest spine w/o dye	0.00	5.90	NA	0.31	6.21	NA	XXX
72129		A	Ct chest spine w/dye	1.22	7.45	NA	0.43	9.10	NA	XXX
72129	26	A	Ct chest spine w/dye	1.22	0.40	0.40	0.06	1.68	1.68	XXX
72129	TC	A	Ct chest spine w/dye	0.00	7.06	NA	0.37	7.43	NA	XXX
72130		A	Ct chest spine w/o & w/dye	1.27	9.25	NA	0.52	11.04	NA	XXX
72130	26	A	Ct chest spine w/o & w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX
72130	TC	A	Ct chest spine w/o & w/dye	0.00	8.83	NA	0.46	9.29	NA	XXX
72131		A	Ct lumbar spine w/o dye	1.16	6.28	NA	0.36	7.80	NA	XXX
72131	26	A	Ct lumbar spine w/o dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
72131	TC	A	Ct lumbar spine w/o dye	0.00	5.90	NA	0.31	6.21	NA	XXX
72132		A	Ct lumbar spine w/dye	1.22	7.45	NA	0.43	9.10	NA	XXX
72132	26	A	Ct lumbar spine w/dye	1.22	0.40	0.40	0.06	1.68	1.68	XXX
72132	TC	A	Ct lumbar spine w/dye	0.00	7.06	NA	0.37	7.43	NA	XXX
72133		A	Ct lumbar spine w/o & w/dye	1.27	9.25	NA	0.52	11.04	NA	XXX
72133	26	A	Ct lumbar spine w/o & w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX
72133	TC	A	Ct lumbar spine w/o & w/dye	0.00	8.83	NA	0.46	9.29	NA	XXX
72141		A	Mri neck spine w/o dye	1.60	11.71	NA	0.66	13.97	NA	XXX
72141	26	A	Mri neck spine w/o dye	1.60	0.53	0.53	0.07	2.20	2.20	XXX
72141	TC	A	Mri neck spine w/o dye	0.00	11.19	NA	0.59	11.78	NA	XXX
72142		A	Mri neck spine w/dye	1.92	14.06	NA	0.79	16.77	NA	XXX
72142	26	A	Mri neck spine w/dye	1.92	0.64	0.64	0.09	2.65	2.65	XXX
72142	TC	A	Mri neck spine w/dye	0.00	13.42	NA	0.70	14.12	NA	XXX
72146		A	Mri chest spine w/o dye	1.60	12.95	NA	0.71	15.26	NA	XXX
72146	26	A	Mri chest spine w/o dye	1.60	0.52	0.52	0.07	2.19	2.19	XXX
72146	TC	A	Mri chest spine w/o dye	0.00	12.42	NA	0.64	13.06	NA	XXX
72147		A	Mri chest spine w/dye	1.92	14.05	NA	0.79	16.76	NA	XXX
72147	26	A	Mri chest spine w/dye	1.92	0.63	0.63	0.09	2.64	2.64	XXX
72147	TC	A	Mri chest spine w/dye	0.00	13.42	NA	0.70	14.12	NA	XXX
72148		A	Mri lumbar spine w/o dye	1.48	12.91	NA	0.71	15.10	NA	XXX
72148	26	A	Mri lumbar spine w/o dye	1.48	0.49	0.49	0.07	2.04	2.04	XXX
72148	TC	A	Mri lumbar spine w/o dye	0.00	12.42	NA	0.64	13.06	NA	XXX
72149		A	Mri lumbar spine w/dye	1.78	14.01	NA	0.79	16.58	NA	XXX
72149	26	A	Mri lumbar spine w/dye	1.78	0.59	0.59	0.09	2.46	2.46	XXX
72149	TC	A	Mri lumbar spine w/dye	0.00	13.42	NA	0.70	14.12	NA	XXX
72156		A	Mri neck spine w/o & w/dye	2.57	25.69	NA	1.43	29.69	NA	XXX
72156	26	A	Mri neck spine w/o & w/dye	2.57	0.85	0.85	0.12	3.54	3.54	XXX
72156	TC	A	Mri neck spine w/o & w/dye	0.00	24.84	NA	1.31	26.15	NA	XXX
72157		A	Mri chest spine w/o & w/dye	2.57	25.68	NA	1.43	29.68	NA	XXX
72157	26	A	Mri chest spine w/o & w/dye	2.57	0.84	0.84	0.12	3.53	3.53	XXX
72157	TC	A	Mri chest spine w/o & w/dye	0.00	24.84	NA	1.31	26.15	NA	XXX
72158		A	Mri lumbar spine w/o & w/dye	2.36	25.62	NA	1.42	29.40	NA	XXX
72158	26	A	Mri lumbar spine w/o & w/dye	2.36	0.77	0.77	0.11	3.24	3.24	XXX
72158	TC	A	Mri lumbar spine w/o & w/dye	0.00	24.84	NA	1.31	26.15	NA	XXX
72170		A	X-ray exam of pelvis	0.17	0.58	NA	0.03	0.78	NA	XXX
72170	26	A	X-ray exam of pelvis	0.17	0.06	0.06	0.01	0.24	0.24	XXX
72170	TC	A	X-ray exam of pelvis	0.00	0.52	NA	0.02	0.54	NA	XXX
72190		A	X-ray exam of pelvis	0.21	0.74	NA	0.05	1.00	NA	XXX
72190	26	A	X-ray exam of pelvis	0.21	0.07	0.07	0.01	0.29	0.29	XXX
72190	TC	A	X-ray exam of pelvis	0.00	0.67	NA	0.04	0.71	NA	XXX
72191		A	Ct angiograph pelv w/o&w/dye	1.81	12.60	NA	0.47	14.88	NA	XXX
72191	26	A	Ct angiograph pelv w/o&w/dye	1.81	0.60	0.60	0.08	2.49	2.49	XXX
72191	TC	A	Ct angiograph pelv w/o&w/dye	0.00	12.01	NA	0.39	12.40	NA	XXX
72192		A	Ct pelvis w/o dye	1.09	6.25	NA	0.36	7.70	NA	XXX
72192	26	A	Ct pelvis w/o dye	1.09	0.36	0.36	0.05	1.50	1.50	XXX
72192	TC	A	Ct pelvis w/o dye	0.00	5.90	NA	0.31	6.21	NA	XXX
72193		A	Ct pelvis w/dye	1.16	7.21	NA	0.41	8.78	NA	XXX
72193	26	A	Ct pelvis w/dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
72193	TC	A	Ct pelvis w/dye	0.00	6.83	NA	0.36	7.19	NA	XXX
72194		A	Ct pelvis w/o & w/dye	1.22	8.87	NA	0.48	10.57	NA	XXX
72194	26	A	Ct pelvis w/o & w/dye	1.22	0.40	0.40	0.05	1.67	1.67	XXX
72194	TC	A	Ct pelvis w/o & w/dye	0.00	8.47	NA	0.43	8.90	NA	XXX
72195		A	Mri pelvis w/o dye	1.46	11.66	NA	0.52	13.64	NA	XXX
72195	26	A	Mri pelvis w/o dye	1.46	0.48	0.48	0.07	2.01	2.01	XXX
72195	TC	A	Mri pelvis w/o dye	0.00	11.19	NA	0.45	11.64	NA	XXX
72196		A	Mri pelvis w/dye	1.73	13.98	NA	0.60	16.31	NA	XXX
72196	26	A	Mri pelvis w/dye	1.73	0.56	0.56	0.08	2.37	2.37	XXX
72196	TC	A	Mri pelvis w/dye	0.00	13.42	NA	0.52	13.94	NA	XXX
72197		A	Mri pelvis w/o & w/dye	2.26	25.58	NA	1.02	28.86	NA	XXX
72197	26	A	Mri pelvis w/o & w/dye	2.26	0.74	0.74	0.10	3.10	3.10	XXX
72197	TC	A	Mri pelvis w/o & w/dye	0.00	24.84	NA	0.92	25.76	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
72198		A	Mr angio pelvis w/o & w/dye	1.80	11.77	NA	0.69	14.26	NA	XXX
72198	26	A	Mr angio pelvis w/o & w/dye	1.80	0.59	0.59	0.10	2.49	2.49	XXX
72198	TC	A	Mr angio pelvis w/o & w/dye	0.00	11.19	NA	0.59	11.78	NA	XXX
72200		A	X-ray exam sacroiliac joints	0.17	0.58	NA	0.03	0.78	NA	XXX
72200	26	A	X-ray exam sacroiliac joints	0.17	0.06	0.06	0.01	0.24	0.24	XXX
72200	TC	A	X-ray exam sacroiliac joints	0.00	0.52	NA	0.02	0.54	NA	XXX
72202		A	X-ray exam sacroiliac joints	0.19	0.68	NA	0.05	0.92	NA	XXX
72202	26	A	X-ray exam sacroiliac joints	0.19	0.06	0.06	0.01	0.26	0.26	XXX
72202	TC	A	X-ray exam sacroiliac joints	0.00	0.62	NA	0.04	0.66	NA	XXX
72220		A	X-ray exam of tailbone	0.17	0.63	NA	0.05	0.85	NA	XXX
72220	26	A	X-ray exam of tailbone	0.17	0.06	0.06	0.01	0.24	0.24	XXX
72220	TC	A	X-ray exam of tailbone	0.00	0.57	NA	0.04	0.61	NA	XXX
72240		A	Contrast x-ray of neck spine	0.91	5.03	NA	0.29	6.23	NA	XXX
72240	26	A	Contrast x-ray of neck spine	0.91	0.29	0.29	0.04	1.24	1.24	XXX
72240	TC	A	Contrast x-ray of neck spine	0.00	4.74	NA	0.25	4.99	NA	XXX
72255		A	Contrast x-ray, thorax spine	0.91	4.59	NA	0.26	5.76	NA	XXX
72255	26	A	Contrast x-ray, thorax spine	0.91	0.27	0.27	0.04	1.22	1.22	XXX
72255	TC	A	Contrast x-ray, thorax spine	0.00	4.32	NA	0.22	4.54	NA	XXX
72265		A	Contrast x-ray, lower spine	0.83	4.32	NA	0.26	5.41	NA	XXX
72265	26	A	Contrast x-ray, lower spine	0.83	0.25	0.25	0.04	1.12	1.12	XXX
72265	TC	A	Contrast x-ray, lower spine	0.00	4.06	NA	0.22	4.28	NA	XXX
72270		A	Contrast x-ray, spine	1.33	6.51	NA	0.40	8.24	NA	XXX
72270	26	A	Contrast x-ray, spine	1.33	0.42	0.42	0.07	1.82	1.82	XXX
72270	TC	A	Contrast x-ray, spine	0.00	6.09	NA	0.33	6.42	NA	XXX
72275		A	Epidurography	0.76	2.29	NA	0.27	3.32	NA	XXX
72275	26	A	Epidurography	0.76	0.20	0.20	0.05	1.01	1.01	XXX
72275	TC	A	Epidurography	0.00	2.09	NA	0.22	2.31	NA	XXX
72285		A	X-ray c/t spine disk	1.16	8.72	NA	0.50	10.38	NA	XXX
72285	26	A	X-ray c/t spine disk	1.16	0.35	0.35	0.07	1.58	1.58	XXX
72285	TC	A	X-ray c/t spine disk	0.00	8.37	NA	0.43	8.80	NA	XXX
72295		A	X-ray of lower spine disk	0.83	8.11	NA	0.46	9.40	NA	XXX
72295	26	A	X-ray of lower spine disk	0.83	0.27	0.27	0.06	1.16	1.16	XXX
72295	TC	A	X-ray of lower spine disk	0.00	7.85	NA	0.40	8.25	NA	XXX
73000		A	X-ray exam of collar bone	0.16	0.57	NA	0.03	0.76	NA	XXX
73000	26	A	X-ray exam of collar bone	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73000	TC	A	X-ray exam of collar bone	0.00	0.52	NA	0.02	0.54	NA	XXX
73010		A	X-ray exam of shoulder blade	0.17	0.58	NA	0.03	0.78	NA	XXX
73010	26	A	X-ray exam of shoulder blade	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73010	TC	A	X-ray exam of shoulder blade	0.00	0.52	NA	0.02	0.54	NA	XXX
73020		A	X-ray exam of shoulder	0.15	0.52	NA	0.03	0.70	NA	XXX
73020	26	A	X-ray exam of shoulder	0.15	0.05	0.05	0.01	0.21	0.21	XXX
73020	TC	A	X-ray exam of shoulder	0.00	0.47	NA	0.02	0.49	NA	XXX
73030		A	X-ray exam of shoulder	0.18	0.63	NA	0.05	0.86	NA	XXX
73030	26	A	X-ray exam of shoulder	0.18	0.06	0.06	0.01	0.25	0.25	XXX
73030	TC	A	X-ray exam of shoulder	0.00	0.57	NA	0.04	0.61	NA	XXX
73040		A	Contrast x-ray of shoulder	0.54	2.27	NA	0.14	2.95	NA	XXX
73040	26	A	Contrast x-ray of shoulder	0.54	0.18	0.18	0.02	0.74	0.74	XXX
73040	TC	A	Contrast x-ray of shoulder	0.00	2.09	NA	0.12	2.21	NA	XXX
73050		A	X-ray exam of shoulders	0.20	0.73	NA	0.05	0.98	NA	XXX
73050	26	A	X-ray exam of shoulders	0.20	0.07	0.07	0.01	0.28	0.28	XXX
73050	TC	A	X-ray exam of shoulders	0.00	0.67	NA	0.04	0.71	NA	XXX
73060		A	X-ray exam of humerus	0.17	0.63	NA	0.05	0.85	NA	XXX
73060	26	A	X-ray exam of humerus	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73060	TC	A	X-ray exam of humerus	0.00	0.57	NA	0.04	0.61	NA	XXX
73070		A	X-ray exam of elbow	0.15	0.57	NA	0.03	0.75	NA	XXX
73070	26	A	X-ray exam of elbow	0.15	0.05	0.05	0.01	0.21	0.21	XXX
73070	TC	A	X-ray exam of elbow	0.00	0.52	NA	0.02	0.54	NA	XXX
73080		A	X-ray exam of elbow	0.17	0.63	NA	0.05	0.85	NA	XXX
73080	26	A	X-ray exam of elbow	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73080	TC	A	X-ray exam of elbow	0.00	0.57	NA	0.04	0.61	NA	XXX
73085		A	Contrast x-ray of elbow	0.54	2.28	NA	0.15	2.97	NA	XXX
73085	26	A	Contrast x-ray of elbow	0.54	0.18	0.18	0.03	0.75	0.75	XXX
73085	TC	A	Contrast x-ray of elbow	0.00	2.09	NA	0.12	2.21	NA	XXX
73090		A	X-ray exam of forearm	0.16	0.57	NA	0.03	0.76	NA	XXX
73090	26	A	X-ray exam of forearm	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73090	TC	A	X-ray exam of forearm	0.00	0.52	NA	0.02	0.54	NA	XXX
73092		A	X-ray exam of arm, infant	0.16	0.54	NA	0.03	0.73	NA	XXX
73092	26	A	X-ray exam of arm, infant	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73092	TC	A	X-ray exam of arm, infant	0.00	0.49	NA	0.02	0.51	NA	XXX
73100		A	X-ray exam of wrist	0.16	0.55	NA	0.03	0.74	NA	XXX
73100	26	A	X-ray exam of wrist	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73100	TC	A	X-ray exam of wrist	0.00	0.49	NA	0.02	0.51	NA	XXX
73110		A	X-ray exam of wrist	0.17	0.59	NA	0.03	0.79	NA	XXX
73110	26	A	X-ray exam of wrist	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73110	TC	A	X-ray exam of wrist	0.00	0.53	NA	0.02	0.55	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
73115		A	Contrast x-ray of wrist	0.54	1.76	NA	0.13	2.43	NA	XXX
73115	26	A	Contrast x-ray of wrist	0.54	0.18	0.18	0.03	0.75	0.75	XXX
73115	TC	A	Contrast x-ray of wrist	0.00	1.57	NA	0.10	1.67	NA	XXX
73120		A	X-ray exam of hand	0.16	0.55	NA	0.03	0.74	NA	XXX
73120	26	A	X-ray exam of hand	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73120	TC	A	X-ray exam of hand	0.00	0.49	NA	0.02	0.51	NA	XXX
73130		A	X-ray exam of hand	0.17	0.59	NA	0.03	0.79	NA	XXX
73130	26	A	X-ray exam of hand	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73130	TC	A	X-ray exam of hand	0.00	0.53	NA	0.02	0.55	NA	XXX
73140		A	X-ray exam of finger(s)	0.13	0.46	NA	0.03	0.62	NA	XXX
73140	26	A	X-ray exam of finger(s)	0.13	0.04	0.04	0.01	0.18	0.18	XXX
73140	TC	A	X-ray exam of finger(s)	0.00	0.42	NA	0.02	0.44	NA	XXX
73200		A	Ct upper extremity w/o dye	1.09	5.31	NA	0.30	6.70	NA	XXX
73200	26	A	Ct upper extremity w/o dye	1.09	0.36	0.36	0.05	1.50	1.50	XXX
73200	TC	A	Ct upper extremity w/o dye	0.00	4.95	NA	0.25	5.20	NA	XXX
73201		A	Ct upper extremity w/dye	1.16	6.28	NA	0.36	7.80	NA	XXX
73201	26	A	Ct upper extremity w/dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
73201	TC	A	Ct upper extremity w/dye	0.00	5.90	NA	0.31	6.21	NA	XXX
73202		A	Ct uppr extremity w/o&w/dye	1.22	7.81	NA	0.44	9.47	NA	XXX
73202	26	A	Ct uppr extremity w/o&w/dye	1.22	0.40	0.40	0.05	1.67	1.67	XXX
73202	TC	A	Ct uppr extremity w/o&w/dye	0.00	7.41	NA	0.39	7.80	NA	XXX
73206		A	Ct angio upr extrm w/o&w/dye	1.81	11.54	NA	0.47	13.82	NA	XXX
73206	26	A	Ct angio upr extrm w/o&w/dye	1.81	0.59	0.59	0.08	2.48	2.48	XXX
73206	TC	A	Ct angio upr extrm w/o&w/dye	0.00	10.94	NA	0.39	11.33	NA	XXX
73218		A	Mri upper extremity w/o dye	1.35	11.63	NA	0.45	13.43	NA	XXX
73218	26	A	Mri upper extremity w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
73218	TC	A	Mri upper extremity w/o dye	0.00	11.19	NA	0.39	11.58	NA	XXX
73219		A	Mri upper extremity w/dye	1.62	13.95	NA	0.54	16.11	NA	XXX
73219	26	A	Mri upper extremity w/dye	1.62	0.53	0.53	0.07	2.22	2.22	XXX
73219	TC	A	Mri upper extremity w/dye	0.00	13.42	NA	0.47	13.89	NA	XXX
73220		A	Mri uppr extremity w/o&w/dye	2.15	25.55	NA	0.94	28.64	NA	XXX
73220	26	A	Mri uppr extremity w/o&w/dye	2.15	0.71	0.71	0.10	2.96	2.96	XXX
73220	TC	A	Mri uppr extremity w/o&w/dye	0.00	24.84	NA	0.84	25.68	NA	XXX
73221		A	Mri joint upr extrem w/o dye	1.35	11.63	NA	0.45	13.43	NA	XXX
73221	26	A	Mri joint upr extrem w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
73221	TC	A	Mri joint upr extrem w/o dye	0.00	11.19	NA	0.39	11.58	NA	XXX
73222		A	Mri joint upr extrem w/dye	1.62	13.95	NA	0.54	16.11	NA	XXX
73222	26	A	Mri joint upr extrem w/dye	1.62	0.53	0.53	0.07	2.22	2.22	XXX
73222	TC	A	Mri joint upr extrem w/dye	0.00	13.42	NA	0.47	13.89	NA	XXX
73223		A	Mri joint upr extr w/o&w/dye	2.15	25.55	NA	0.94	28.64	NA	XXX
73223	26	A	Mri joint upr extr w/o&w/dye	2.15	0.71	0.71	0.10	2.96	2.96	XXX
73223	TC	A	Mri joint upr extr w/o&w/dye	0.00	24.84	NA	0.84	25.68	NA	XXX
73500		A	X-ray exam of hip	0.17	0.53	NA	0.03	0.73	NA	XXX
73500	26	A	X-ray exam of hip	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73500	TC	A	X-ray exam of hip	0.00	0.47	NA	0.02	0.49	NA	XXX
73510		A	X-ray exam of hip	0.21	0.64	NA	0.05	0.90	NA	XXX
73510	26	A	X-ray exam of hip	0.21	0.07	0.07	0.01	0.29	0.29	XXX
73510	TC	A	X-ray exam of hip	0.00	0.57	NA	0.04	0.61	NA	XXX
73520		A	X-ray exam of hips	0.26	0.75	NA	0.05	1.06	NA	XXX
73520	26	A	X-ray exam of hips	0.26	0.09	0.09	0.01	0.36	0.36	XXX
73520	TC	A	X-ray exam of hips	0.00	0.67	NA	0.04	0.71	NA	XXX
73525		A	Contrast x-ray of hip	0.54	2.27	NA	0.15	2.96	NA	XXX
73525	26	A	Contrast x-ray of hip	0.54	0.18	0.18	0.03	0.75	0.75	XXX
73525	TC	A	Contrast x-ray of hip	0.00	2.09	NA	0.12	2.21	NA	XXX
73530		A	X-ray exam of hip	0.29	0.62	NA	0.03	0.94	NA	XXX
73530	26	A	X-ray exam of hip	0.29	0.10	0.10	0.01	0.40	0.40	XXX
73530	TC	A	X-ray exam of hip	0.00	0.52	NA	0.02	0.54	NA	XXX
73540		A	X-ray exam of pelvis & hips	0.20	0.64	NA	0.05	0.89	NA	XXX
73540	26	A	X-ray exam of pelvis & hips	0.20	0.07	0.07	0.01	0.28	0.28	XXX
73540	TC	A	X-ray exam of pelvis & hips	0.00	0.57	NA	0.04	0.61	NA	XXX
73542		A	X-ray exam, sacroiliac joint	0.59	2.25	NA	0.15	2.99	NA	XXX
73542	26	A	X-ray exam, sacroiliac joint	0.59	0.16	0.16	0.03	0.78	0.78	XXX
73542	TC	A	X-ray exam, sacroiliac joint	0.00	2.09	NA	0.12	2.21	NA	XXX
73550		A	X-ray exam of thigh	0.17	0.63	NA	0.05	0.85	NA	XXX
73550	26	A	X-ray exam of thigh	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73550	TC	A	X-ray exam of thigh	0.00	0.57	NA	0.04	0.61	NA	XXX
73560		A	X-ray exam of knee, 1 or 2	0.17	0.58	NA	0.03	0.78	NA	XXX
73560	26	A	X-ray exam of knee, 1 or 2	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73560	TC	A	X-ray exam of knee, 1 or 2	0.00	0.52	NA	0.02	0.54	NA	XXX
73562		A	X-ray exam of knee, 3	0.18	0.63	NA	0.05	0.86	NA	XXX
73562	26	A	X-ray exam of knee, 3	0.18	0.06	0.06	0.01	0.25	0.25	XXX
73562	TC	A	X-ray exam of knee, 3	0.00	0.57	NA	0.04	0.61	NA	XXX
73564		A	X-ray exam, knee, 4 or more	0.22	0.69	NA	0.05	0.96	NA	XXX
73564	26	A	X-ray exam, knee, 4 or more	0.22	0.07	0.07	0.01	0.30	0.30	XXX
73564	TC	A	X-ray exam, knee, 4 or more	0.00	0.62	NA	0.04	0.66	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
73565		A	X-ray exam of knees	0.17	0.55	NA	0.03	0.75	NA	XXX
73565	26	A	X-ray exam of knees	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73565	TC	A	X-ray exam of knees	0.00	0.49	NA	0.02	0.51	NA	XXX
73580		A	Contrast x-ray of knee joint	0.54	2.79	NA	0.17	3.50	NA	XXX
73580	26	A	Contrast x-ray of knee joint	0.54	0.17	0.17	0.03	0.74	0.74	XXX
73580	TC	A	Contrast x-ray of knee joint	0.00	2.62	NA	0.14	2.76	NA	XXX
73590		A	X-ray exam of lower leg	0.17	0.58	NA	0.03	0.78	NA	XXX
73590	26	A	X-ray exam of lower leg	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73590	TC	A	X-ray exam of lower leg	0.00	0.52	NA	0.02	0.54	NA	XXX
73592		A	X-ray exam of leg, infant	0.16	0.55	NA	0.03	0.74	NA	XXX
73592	26	A	X-ray exam of leg, infant	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73592	TC	A	X-ray exam of leg, infant	0.00	0.49	NA	0.02	0.51	NA	XXX
73600		A	X-ray exam of ankle	0.16	0.55	NA	0.03	0.74	NA	XXX
73600	26	A	X-ray exam of ankle	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73600	TC	A	X-ray exam of ankle	0.00	0.49	NA	0.02	0.51	NA	XXX
73610		A	X-ray exam of ankle	0.17	0.59	NA	0.03	0.79	NA	XXX
73610	26	A	X-ray exam of ankle	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73610	TC	A	X-ray exam of ankle	0.00	0.53	NA	0.02	0.55	NA	XXX
73615		A	Contrast x-ray of ankle	0.54	2.28	NA	0.15	2.97	NA	XXX
73615	26	A	Contrast x-ray of ankle	0.54	0.18	0.18	0.03	0.75	0.75	XXX
73615	TC	A	Contrast x-ray of ankle	0.00	2.09	NA	0.12	2.21	NA	XXX
73620		A	X-ray exam of foot	0.16	0.55	NA	0.03	0.74	NA	XXX
73620	26	A	X-ray exam of foot	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73620	TC	A	X-ray exam of foot	0.00	0.49	NA	0.02	0.51	NA	XXX
73630		A	X-ray exam of foot	0.17	0.59	NA	0.03	0.79	NA	XXX
73630	26	A	X-ray exam of foot	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73630	TC	A	X-ray exam of foot	0.00	0.53	NA	0.02	0.55	NA	XXX
73650		A	X-ray exam of heel	0.16	0.53	NA	0.03	0.72	NA	XXX
73650	26	A	X-ray exam of heel	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73650	TC	A	X-ray exam of heel	0.00	0.47	NA	0.02	0.49	NA	XXX
73660		A	X-ray exam of toe(s)	0.13	0.46	NA	0.03	0.62	NA	XXX
73660	26	A	X-ray exam of toe(s)	0.13	0.04	0.04	0.01	0.18	0.18	XXX
73660	TC	A	X-ray exam of toe(s)	0.00	0.42	NA	0.02	0.44	NA	XXX
73700		A	Ct lower extremity w/o dye	1.09	5.31	NA	0.30	6.70	NA	XXX
73700	26	A	Ct lower extremity w/o dye	1.09	0.36	0.36	0.05	1.50	1.50	XXX
73700	TC	A	Ct lower extremity w/o dye	0.00	4.95	NA	0.25	5.20	NA	XXX
73701		A	Ct lower extremity w/dye	1.16	6.28	NA	0.36	7.80	NA	XXX
73701	26	A	Ct lower extremity w/dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
73701	TC	A	Ct lower extremity w/dye	0.00	5.90	NA	0.31	6.21	NA	XXX
73702		A	Ct lwr extremity w/o&w/dye	1.22	7.81	NA	0.45	9.48	NA	XXX
73702	26	A	Ct lwr extremity w/o&w/dye	1.22	0.40	0.40	0.06	1.68	1.68	XXX
73702	TC	A	Ct lwr extremity w/o&w/dye	0.00	7.41	NA	0.39	7.80	NA	XXX
73706		A	Ct angio lwr extr w/o&w/dye	1.90	11.57	NA	0.48	13.95	NA	XXX
73706	26	A	Ct angio lwr extr w/o&w/dye	1.90	0.62	0.62	0.09	2.61	2.61	XXX
73706	TC	A	Ct angio lwr extr w/o&w/dye	0.00	10.94	NA	0.39	11.33	NA	XXX
73718		A	Mri lower extremity w/o dye	1.35	11.63	NA	0.45	13.43	NA	XXX
73718	26	A	Mri lower extremity w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
73718	TC	A	Mri lower extremity w/o dye	0.00	11.19	NA	0.39	11.58	NA	XXX
73719		A	Mri lower extremity w/dye	1.62	13.95	NA	0.54	16.11	NA	XXX
73719	26	A	Mri lower extremity w/dye	1.62	0.53	0.53	0.07	2.22	2.22	XXX
73719	TC	A	Mri lower extremity w/dye	0.00	13.42	NA	0.47	13.89	NA	XXX
73720		A	Mri lwr extremity w/o&w/dye	2.15	25.55	NA	0.94	28.64	NA	XXX
73720	26	A	Mri lwr extremity w/o&w/dye	2.15	0.70	0.70	0.10	2.95	2.95	XXX
73720	TC	A	Mri lwr extremity w/o&w/dye	0.00	24.84	NA	0.84	25.68	NA	XXX
73721		A	Mri jnt of lwr extre w/o dye	1.35	11.63	NA	0.45	13.43	NA	XXX
73721	26	A	Mri jnt of lwr extre w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
73721	TC	A	Mri jnt of lwr extre w/o dye	0.00	11.19	NA	0.39	11.58	NA	XXX
73722		A	Mri joint of lwr extr w/dye	1.62	13.95	NA	0.55	16.12	NA	XXX
73722	26	A	Mri joint of lwr extr w/dye	1.62	0.53	0.53	0.08	2.23	2.23	XXX
73722	TC	A	Mri joint of lwr extr w/dye	0.00	13.42	NA	0.47	13.89	NA	XXX
73723		A	Mri joint lwr extr w/o&w/dye	2.15	25.55	NA	0.94	28.64	NA	XXX
73723	26	A	Mri joint lwr extr w/o&w/dye	2.15	0.71	0.71	0.10	2.96	2.96	XXX
73723	TC	A	Mri joint lwr extr w/o&w/dye	0.00	24.84	NA	0.84	25.68	NA	XXX
73725		R	Mr ang lwr ext w or w/o dye	1.82	11.78	NA	0.67	14.27	NA	XXX
73725	26	R	Mr ang lwr ext w or w/o dye	1.82	0.60	0.60	0.08	2.50	2.50	XXX
73725	TC	R	Mr ang lwr ext w or w/o dye	0.00	11.19	NA	0.59	11.78	NA	XXX
74000		A	X-ray exam of abdomen	0.18	0.58	NA	0.03	0.79	NA	XXX
74000	26	A	X-ray exam of abdomen	0.18	0.06	0.06	0.01	0.25	0.25	XXX
74000	TC	A	X-ray exam of abdomen	0.00	0.52	NA	0.02	0.54	NA	XXX
74010		A	X-ray exam of abdomen	0.23	0.64	NA	0.05	0.92	NA	XXX
74010	26	A	X-ray exam of abdomen	0.23	0.07	0.07	0.01	0.31	0.31	XXX
74010	TC	A	X-ray exam of abdomen	0.00	0.57	NA	0.04	0.61	NA	XXX
74020		A	X-ray exam of abdomen	0.27	0.71	NA	0.05	1.03	NA	XXX
74020	26	A	X-ray exam of abdomen	0.27	0.09	0.09	0.01	0.37	0.37	XXX
74020	TC	A	X-ray exam of abdomen	0.00	0.62	NA	0.04	0.66	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
74022		A	X-ray exam series, abdomen	0.32	0.84	NA	0.06	1.22	NA	XXX
74022	26	A	X-ray exam series, abdomen	0.32	0.10	0.10	0.01	0.43	0.43	XXX
74022	TC	A	X-ray exam series, abdomen	0.00	0.73	NA	0.05	0.78	NA	XXX
74150		A	Ct abdomen w/o dye	1.19	6.03	NA	0.35	7.57	NA	XXX
74150	26	A	Ct abdomen w/o dye	1.19	0.39	0.39	0.05	1.63	1.63	XXX
74150	TC	A	Ct abdomen w/o dye	0.00	5.65	NA	0.30	5.95	NA	XXX
74160		A	Ct abdomen w/dye	1.27	7.25	NA	0.42	8.94	NA	XXX
74160	26	A	Ct abdomen w/dye	1.27	0.41	0.41	0.06	1.74	1.74	XXX
74160	TC	A	Ct abdomen w/dye	0.00	6.83	NA	0.36	7.19	NA	XXX
74170		A	Ct abdomen w/o &w /dye	1.40	8.93	NA	0.49	10.82	NA	XXX
74170	26	A	Ct abdomen w/o &w /dye	1.40	0.46	0.46	0.06	1.92	1.92	XXX
74170	TC	A	Ct abdomen w/o &w /dye	0.00	8.47	NA	0.43	8.90	NA	XXX
74175		A	Ct angio abdom w/o & w/dye	1.90	12.63	NA	0.48	15.01	NA	XXX
74175	26	A	Ct angio abdom w/o & w/dye	1.90	0.62	0.62	0.09	2.61	2.61	XXX
74175	TC	A	Ct angio abdom w/o & w/dye	0.00	12.01	NA	0.39	12.40	NA	XXX
74181		A	Mri abdomen w/o dye	1.46	11.66	NA	0.52	13.64	NA	XXX
74181	26	A	Mri abdomen w/o dye	1.46	0.48	0.48	0.07	2.01	2.01	XXX
74181	TC	A	Mri abdomen w/o dye	0.00	11.19	NA	0.45	11.64	NA	XXX
74182		A	Mri abdomen w/dye	1.73	13.98	NA	0.60	16.31	NA	XXX
74182	26	A	Mri abdomen w/dye	1.73	0.56	0.56	0.08	2.37	2.37	XXX
74182	TC	A	Mri abdomen w/dye	0.00	13.42	NA	0.52	13.94	NA	XXX
74183		A	Mri abdomen w/o & w/dye	2.26	25.58	NA	1.02	28.86	NA	XXX
74183	26	A	Mri abdomen w/o & w/dye	2.26	0.74	0.74	0.10	3.10	3.10	XXX
74183	TC	A	Mri abdomen w/o & w/dye	0.00	24.84	NA	0.92	25.76	NA	XXX
74185		R	Mri angio, abdom w orw/o dye	1.80	11.78	NA	0.67	14.25	NA	XXX
74185	26	R	Mri angio, abdom w orw/o dye	1.80	0.59	0.59	0.08	2.47	2.47	XXX
74185	TC	R	Mri angio, abdom w orw/o dye	0.00	11.19	NA	0.59	11.78	NA	XXX
74190		A	X-ray exam of peritoneum	0.48	1.46	NA	0.09	2.03	NA	XXX
74190	26	A	X-ray exam of peritoneum	0.48	0.16	0.16	0.02	0.66	0.66	XXX
74190	TC	A	X-ray exam of peritoneum	0.00	1.30	NA	0.07	1.37	NA	XXX
74210		A	Contrst x-ray exam of throat	0.36	1.30	NA	0.08	1.74	NA	XXX
74210	26	A	Contrst x-ray exam of throat	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74210	TC	A	Contrst x-ray exam of throat	0.00	1.19	NA	0.06	1.25	NA	XXX
74220		A	Contrast x-ray, esophagus	0.46	1.34	NA	0.08	1.88	NA	XXX
74220	26	A	Contrast x-ray, esophagus	0.46	0.15	0.15	0.02	0.63	0.63	XXX
74220	TC	A	Contrast x-ray, esophagus	0.00	1.19	NA	0.06	1.25	NA	XXX
74230		A	Cine/vid x-ray, throat/esoph	0.53	1.48	NA	0.09	2.10	NA	XXX
74230	26	A	Cine/vid x-ray, throat/esoph	0.53	0.17	0.17	0.02	0.72	0.72	XXX
74230	TC	A	Cine/vid x-ray, throat/esoph	0.00	1.30	NA	0.07	1.37	NA	XXX
74235		A	Remove esophagus obstruction	1.19	3.01	NA	0.19	4.39	NA	XXX
74235	26	A	Remove esophagus obstruction	1.19	0.39	0.39	0.05	1.63	1.63	XXX
74235	TC	A	Remove esophagus obstruction	0.00	2.62	NA	0.14	2.76	NA	XXX
74240		A	X-ray exam, upper gi tract	0.69	1.68	NA	0.11	2.48	NA	XXX
74240	26	A	X-ray exam, upper gi tract	0.69	0.22	0.22	0.03	0.94	0.94	XXX
74240	TC	A	X-ray exam, upper gi tract	0.00	1.46	NA	0.08	1.54	NA	XXX
74241		A	X-ray exam, upper gi tract	0.69	1.71	NA	0.11	2.51	NA	XXX
74241	26	A	X-ray exam, upper gi tract	0.69	0.22	0.22	0.03	0.94	0.94	XXX
74241	TC	A	X-ray exam, upper gi tract	0.00	1.49	NA	0.08	1.57	NA	XXX
74245		A	X-ray exam, upper gi tract	0.91	2.67	NA	0.17	3.75	NA	XXX
74245	26	A	X-ray exam, upper gi tract	0.91	0.30	0.30	0.04	1.25	1.25	XXX
74245	TC	A	X-ray exam, upper gi tract	0.00	2.37	NA	0.13	2.50	NA	XXX
74246		A	Contrst x-ray uppr gi tract	0.69	1.87	NA	0.13	2.69	NA	XXX
74246	26	A	Contrst x-ray uppr gi tract	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74246	TC	A	Contrst x-ray uppr gi tract	0.00	1.64	NA	0.10	1.74	NA	XXX
74247		A	Contrst x-ray uppr gi tract	0.69	1.90	NA	0.14	2.73	NA	XXX
74247	26	A	Contrst x-ray uppr gi tract	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74247	TC	A	Contrst x-ray uppr gi tract	0.00	1.68	NA	0.11	1.79	NA	XXX
74249		A	Contrst x-ray uppr gi tract	0.91	2.86	NA	0.18	3.95	NA	XXX
74249	26	A	Contrst x-ray uppr gi tract	0.91	0.30	0.30	0.04	1.25	1.25	XXX
74249	TC	A	Contrst x-ray uppr gi tract	0.00	2.57	NA	0.14	2.71	NA	XXX
74250		A	X-ray exam of small bowel	0.47	1.46	NA	0.09	2.02	NA	XXX
74250	26	A	X-ray exam of small bowel	0.47	0.15	0.15	0.02	0.64	0.64	XXX
74250	TC	A	X-ray exam of small bowel	0.00	1.30	NA	0.07	1.37	NA	XXX
74251		A	X-ray exam of small bowel	0.69	1.53	NA	0.10	2.32	NA	XXX
74251	26	A	X-ray exam of small bowel	0.69	0.22	0.22	0.03	0.94	0.94	XXX
74251	TC	A	X-ray exam of small bowel	0.00	1.30	NA	0.07	1.37	NA	XXX
74260		A	X-ray exam of small bowel	0.50	1.65	NA	0.10	2.25	NA	XXX
74260	26	A	X-ray exam of small bowel	0.50	0.16	0.16	0.02	0.68	0.68	XXX
74260	TC	A	X-ray exam of small bowel	0.00	1.49	NA	0.08	1.57	NA	XXX
74270		A	Contrast x-ray exam of colon	0.69	1.92	NA	0.14	2.75	NA	XXX
74270	26	A	Contrast x-ray exam of colon	0.69	0.22	0.22	0.03	0.94	0.94	XXX
74270	TC	A	Contrast x-ray exam of colon	0.00	1.70	NA	0.11	1.81	NA	XXX
74280		A	Contrast x-ray exam of colon	0.99	2.55	NA	0.17	3.71	NA	XXX
74280	26	A	Contrast x-ray exam of colon	0.99	0.32	0.32	0.04	1.35	1.35	XXX
74280	TC	A	Contrast x-ray exam of colon	0.00	2.23	NA	0.13	2.36	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
74283		A	Contrast x-ray exam of colon	2.02	3.22	NA	0.23	5.47	NA	XXX
74283	26	A	Contrast x-ray exam of colon	2.02	0.66	0.66	0.09	2.77	2.77	XXX
74283	TC	A	Contrast x-ray exam of colon	0.00	2.56	NA	0.14	2.70	NA	XXX
74290		A	Contrast x-ray, gallbladder	0.32	0.84	NA	0.06	1.22	NA	XXX
74290	26	A	Contrast x-ray, gallbladder	0.32	0.10	0.10	0.01	0.43	0.43	XXX
74290	TC	A	Contrast x-ray, gallbladder	0.00	0.73	NA	0.05	0.78	NA	XXX
74291		A	Contrast x-rays, gallbladder	0.20	0.48	NA	0.03	0.71	NA	XXX
74291	26	A	Contrast x-rays, gallbladder	0.20	0.07	0.07	0.01	0.28	0.28	XXX
74291	TC	A	Contrast x-rays, gallbladder	0.00	0.42	NA	0.02	0.44	NA	XXX
74300	26	A	X-ray bile ducts/pancreas	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74301	26	A	X-rays at surgery add-on	0.21	0.07	0.07	0.01	0.29	0.29	ZZZ
74305		A	X-ray bile ducts/pancreas	0.42	0.92	NA	0.07	1.41	NA	XXX
74305	26	A	X-ray bile ducts/pancreas	0.42	0.14	0.14	0.02	0.58	0.58	XXX
74305	TC	A	X-ray bile ducts/pancreas	0.00	0.78	NA	0.05	0.83	NA	XXX
74320		A	Contrast x-ray of bile ducts	0.54	3.32	NA	0.19	4.05	NA	XXX
74320	26	A	Contrast x-ray of bile ducts	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74320	TC	A	Contrast x-ray of bile ducts	0.00	3.15	NA	0.17	3.32	NA	XXX
74327		A	X-ray bile stone removal	0.70	1.98	NA	0.14	2.82	NA	XXX
74327	26	A	X-ray bile stone removal	0.70	0.23	0.23	0.03	0.96	0.96	XXX
74327	TC	A	X-ray bile stone removal	0.00	1.76	NA	0.11	1.87	NA	XXX
74328		A	X-ray bile duct endoscopy	0.70	3.38	NA	0.20	4.28	NA	XXX
74328	26	A	X-ray bile duct endoscopy	0.70	0.23	0.23	0.03	0.96	0.96	XXX
74328	TC	A	X-ray bile duct endoscopy	0.00	3.15	NA	0.17	3.32	NA	XXX
74329		A	X-ray for pancreas endoscopy	0.70	3.38	NA	0.20	4.28	NA	XXX
74329	26	A	X-ray for pancreas endoscopy	0.70	0.23	0.23	0.03	0.96	0.96	XXX
74329	TC	A	X-ray for pancreas endoscopy	0.00	3.15	NA	0.17	3.32	NA	XXX
74330		A	X-ray bile/panc endoscopy	0.90	3.44	NA	0.21	4.55	NA	XXX
74330	26	A	X-ray bile/panc endoscopy	0.90	0.29	0.29	0.04	1.23	1.23	XXX
74330	TC	A	X-ray bile/panc endoscopy	0.00	3.15	NA	0.17	3.32	NA	XXX
74340		A	X-ray guide for GI tube	0.54	2.79	NA	0.16	3.49	NA	XXX
74340	26	A	X-ray guide for GI tube	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74340	TC	A	X-ray guide for GI tube	0.00	2.62	NA	0.14	2.76	NA	XXX
74350		A	X-ray guide, stomach tube	0.76	3.39	NA	0.20	4.35	NA	XXX
74350	26	A	X-ray guide, stomach tube	0.76	0.25	0.25	0.03	1.04	1.04	XXX
74350	TC	A	X-ray guide, stomach tube	0.00	3.15	NA	0.17	3.32	NA	XXX
74355		A	X-ray guide, intestinal tube	0.76	2.86	NA	0.17	3.79	NA	XXX
74355	26	A	X-ray guide, intestinal tube	0.76	0.25	0.25	0.03	1.04	1.04	XXX
74355	TC	A	X-ray guide, intestinal tube	0.00	2.62	NA	0.14	2.76	NA	XXX
74360		A	X-ray guide, GI dilation	0.54	3.33	NA	0.19	4.06	NA	XXX
74360	26	A	X-ray guide, GI dilation	0.54	0.19	0.19	0.02	0.75	0.75	XXX
74360	TC	A	X-ray guide, GI dilation	0.00	3.15	NA	0.17	3.32	NA	XXX
74363		A	X-ray, bile duct dilation	0.88	6.38	NA	0.37	7.63	NA	XXX
74363	26	A	X-ray, bile duct dilation	0.88	0.29	0.29	0.04	1.21	1.21	XXX
74363	TC	A	X-ray, bile duct dilation	0.00	6.09	NA	0.33	6.42	NA	XXX
74400		A	Contrst x-ray, urinary tract	0.49	1.84	NA	0.13	2.46	NA	XXX
74400	26	A	Contrst x-ray, urinary tract	0.49	0.16	0.16	0.02	0.67	0.67	XXX
74400	TC	A	Contrst x-ray, urinary tract	0.00	1.68	NA	0.11	1.79	NA	XXX
74410		A	Contrst x-ray, urinary tract	0.49	2.11	NA	0.13	2.73	NA	XXX
74410	26	A	Contrst x-ray, urinary tract	0.49	0.16	0.16	0.02	0.67	0.67	XXX
74410	TC	A	Contrst x-ray, urinary tract	0.00	1.95	NA	0.11	2.06	NA	XXX
74415		A	Contrst x-ray, urinary tract	0.49	2.27	NA	0.14	2.90	NA	XXX
74415	26	A	Contrst x-ray, urinary tract	0.49	0.16	0.16	0.02	0.67	0.67	XXX
74415	TC	A	Contrst x-ray, urinary tract	0.00	2.11	NA	0.12	2.23	NA	XXX
74420		A	Contrst x-ray, urinary tract	0.36	2.73	NA	0.16	3.25	NA	XXX
74420	26	A	Contrst x-ray, urinary tract	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74420	TC	A	Contrst x-ray, urinary tract	0.00	2.62	NA	0.14	2.76	NA	XXX
74425		A	Contrst x-ray, urinary tract	0.36	1.42	NA	0.09	1.87	NA	XXX
74425	26	A	Contrst x-ray, urinary tract	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74425	TC	A	Contrst x-ray, urinary tract	0.00	1.30	NA	0.07	1.37	NA	XXX
74430		A	Contrast x-ray, bladder	0.32	1.16	NA	0.08	1.56	NA	XXX
74430	26	A	Contrast x-ray, bladder	0.32	0.10	0.10	0.02	0.44	0.44	XXX
74430	TC	A	Contrast x-ray, bladder	0.00	1.05	NA	0.06	1.11	NA	XXX
74440		A	X-ray, male genital tract	0.38	1.25	NA	0.08	1.71	NA	XXX
74440	26	A	X-ray, male genital tract	0.38	0.12	0.12	0.02	0.52	0.52	XXX
74440	TC	A	X-ray, male genital tract	0.00	1.13	NA	0.06	1.19	NA	XXX
74445		A	X-ray exam of penis	1.14	1.50	NA	0.12	2.76	NA	XXX
74445	26	A	X-ray exam of penis	1.14	0.37	0.37	0.06	1.57	1.57	XXX
74445	TC	A	X-ray exam of penis	0.00	1.13	NA	0.06	1.19	NA	XXX
74450		A	X-ray, urethra/bladder	0.33	1.56	NA	0.10	1.99	NA	XXX
74450	26	A	X-ray, urethra/bladder	0.33	0.11	0.11	0.02	0.46	0.46	XXX
74450	TC	A	X-ray, urethra/bladder	0.00	1.46	NA	0.08	1.54	NA	XXX
74455		A	X-ray, urethra/bladder	0.33	1.68	NA	0.12	2.13	NA	XXX
74455	26	A	X-ray, urethra/bladder	0.33	0.11	0.11	0.02	0.46	0.46	XXX
74455	TC	A	X-ray, urethra/bladder	0.00	1.57	NA	0.10	1.67	NA	XXX
74470		A	X-ray exam of kidney lesion	0.54	1.42	NA	0.10	2.06	NA	XXX

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[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
74470	26	A	X-ray exam of kidney lesion	0.54	0.18	0.18	0.03	0.75	0.75	XXX
74470	TC	A	X-ray exam of kidney lesion	0.00	1.25	NA	0.07	1.32	NA	XXX
74475		A	X-ray control, cath insert	0.54	4.24	NA	0.24	5.02	NA	XXX
74475	26	A	X-ray control, cath insert	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74475	TC	A	X-ray control, cath insert	0.00	4.06	NA	0.22	4.28	NA	XXX
74480		A	X-ray control, cath insert	0.54	4.24	NA	0.24	5.02	NA	XXX
74480	26	A	X-ray control, cath insert	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74480	TC	A	X-ray control, cath insert	0.00	4.06	NA	0.22	4.28	NA	XXX
74485		A	X-ray guide, GU dilation	0.54	3.32	NA	0.20	4.06	NA	XXX
74485	26	A	X-ray guide, GU dilation	0.54	0.17	0.17	0.03	0.74	0.74	XXX
74485	TC	A	X-ray guide, GU dilation	0.00	3.15	NA	0.17	3.32	NA	XXX
74710		A	X-ray measurement of pelvis	0.34	1.16	NA	0.08	1.58	NA	XXX
74710	26	A	X-ray measurement of pelvis	0.34	0.11	0.11	0.02	0.47	0.47	XXX
74710	TC	A	X-ray measurement of pelvis	0.00	1.05	NA	0.06	1.11	NA	XXX
74740		A	X-ray, female genital tract	0.38	1.43	NA	0.09	1.90	NA	XXX
74740	26	A	X-ray, female genital tract	0.38	0.13	0.13	0.02	0.53	0.53	XXX
74740	TC	A	X-ray, female genital tract	0.00	1.30	NA	0.07	1.37	NA	XXX
74742		A	X-ray, fallopian tube	0.61	3.35	NA	0.20	4.16	NA	XXX
74742	26	A	X-ray, fallopian tube	0.61	0.20	0.20	0.03	0.84	0.84	XXX
74742	TC	A	X-ray, fallopian tube	0.00	3.15	NA	0.17	3.32	NA	XXX
74775		A	X-ray exam of perineum	0.62	1.66	NA	0.11	2.39	NA	XXX
74775	26	A	X-ray exam of perineum	0.62	0.21	0.21	0.03	0.86	0.86	XXX
74775	TC	A	X-ray exam of perineum	0.00	1.46	NA	0.08	1.54	NA	XXX
75552		A	Heart mri for morph w/o dye	1.60	11.71	NA	0.66	13.97	NA	XXX
75552	26	A	Heart mri for morph w/o dye	1.60	0.53	0.53	0.07	2.20	2.20	XXX
75552	TC	A	Heart mri for morph w/o dye	0.00	11.19	NA	0.59	11.78	NA	XXX
75553		A	Heart mri for morph w/dye	2.00	11.84	NA	0.68	14.52	NA	XXX
75553	26	A	Heart mri for morph w/dye	2.00	0.65	0.65	0.09	2.74	2.74	XXX
75553	TC	A	Heart mri for morph w/dye	0.00	11.19	NA	0.59	11.78	NA	XXX
75554		A	Cardiac MRI/function	1.83	11.83	NA	0.66	14.32	NA	XXX
75554	26	A	Cardiac MRI/function	1.83	0.64	0.64	0.07	2.54	2.54	XXX
75554	TC	A	Cardiac MRI/function	0.00	11.19	NA	0.59	11.78	NA	XXX
75555		A	Cardiac MRI/limited study	1.74	11.82	NA	0.66	14.22	NA	XXX
75555	26	A	Cardiac MRI/limited study	1.74	0.64	0.64	0.07	2.45	2.45	XXX
75555	TC	A	Cardiac MRI/limited study	0.00	11.19	NA	0.59	11.78	NA	XXX
75600		A	Contrast x-ray exam of aorta	0.49	12.76	NA	0.67	13.92	NA	XXX
75600	26	A	Contrast x-ray exam of aorta	0.49	0.19	0.19	0.02	0.70	0.70	XXX
75600	TC	A	Contrast x-ray exam of aorta	0.00	12.58	NA	0.65	13.23	NA	XXX
75605		A	Contrast x-ray exam of aorta	1.14	12.97	NA	0.70	14.81	NA	XXX
75605	26	A	Contrast x-ray exam of aorta	1.14	0.40	0.40	0.05	1.59	1.59	XXX
75605	TC	A	Contrast x-ray exam of aorta	0.00	12.58	NA	0.65	13.23	NA	XXX
75625		A	Contrast x-ray exam of aorta	1.14	12.95	NA	0.71	14.80	NA	XXX
75625	26	A	Contrast x-ray exam of aorta	1.14	0.38	0.38	0.06	1.58	1.58	XXX
75625	TC	A	Contrast x-ray exam of aorta	0.00	12.58	NA	0.65	13.23	NA	XXX
75630		A	X-ray aorta, leg arteries	1.79	13.72	NA	0.79	16.30	NA	XXX
75630	26	A	X-ray aorta, leg arteries	1.79	0.61	0.61	0.10	2.50	2.50	XXX
75630	TC	A	X-ray aorta, leg arteries	0.00	13.11	NA	0.69	13.80	NA	XXX
75635		A	Ct angio abdominal arteries	2.40	16.68	NA	0.50	19.58	NA	XXX
75635	26	A	Ct angio abdominal arteries	2.40	0.79	0.79	0.11	3.30	3.30	XXX
75635	TC	A	Ct angio abdominal arteries	0.00	15.89	NA	0.39	16.28	NA	XXX
75650		A	Artery x-rays, head & neck	1.49	13.07	NA	0.72	15.28	NA	XXX
75650	26	A	Artery x-rays, head & neck	1.49	0.49	0.49	0.07	2.05	2.05	XXX
75650	TC	A	Artery x-rays, head & neck	0.00	12.58	NA	0.65	13.23	NA	XXX
75658		A	Artery x-rays, arm	1.31	13.05	NA	0.72	15.08	NA	XXX
75658	26	A	Artery x-rays, arm	1.31	0.47	0.47	0.07	1.85	1.85	XXX
75658	TC	A	Artery x-rays, arm	0.00	12.58	NA	0.65	13.23	NA	XXX
75660		A	Artery x-rays, head & neck	1.31	13.02	NA	0.72	15.05	NA	XXX
75660	26	A	Artery x-rays, head & neck	1.31	0.44	0.44	0.07	1.82	1.82	XXX
75660	TC	A	Artery x-rays, head & neck	0.00	12.58	NA	0.65	13.23	NA	XXX
75662		A	Artery x-rays, head & neck	1.66	13.17	NA	0.73	15.56	NA	XXX
75662	26	A	Artery x-rays, head & neck	1.66	0.59	0.59	0.08	2.33	2.33	XXX
75662	TC	A	Artery x-rays, head & neck	0.00	12.58	NA	0.65	13.23	NA	XXX
75665		A	Artery x-rays, head & neck	1.31	13.01	NA	0.74	15.06	NA	XXX
75665	26	A	Artery x-rays, head & neck	1.31	0.44	0.44	0.09	1.84	1.84	XXX
75665	TC	A	Artery x-rays, head & neck	0.00	12.58	NA	0.65	13.23	NA	XXX
75671		A	Artery x-rays, head & neck	1.66	13.12	NA	0.73	15.51	NA	XXX
75671	26	A	Artery x-rays, head & neck	1.66	0.55	0.55	0.08	2.29	2.29	XXX
75671	TC	A	Artery x-rays, head & neck	0.00	12.58	NA	0.65	13.23	NA	XXX
75676		A	Artery x-rays, neck	1.31	13.01	NA	0.73	15.05	NA	XXX
75676	26	A	Artery x-rays, neck	1.31	0.44	0.44	0.08	1.83	1.83	XXX
75676	TC	A	Artery x-rays, neck	0.00	12.58	NA	0.65	13.23	NA	XXX
75680		A	Artery x-rays, neck	1.66	13.12	NA	0.73	15.51	NA	XXX
75680	26	A	Artery x-rays, neck	1.66	0.55	0.55	0.08	2.29	2.29	XXX
75680	TC	A	Artery x-rays, neck	0.00	12.58	NA	0.65	13.23	NA	XXX
75685		A	Artery x-rays, spine	1.31	13.01	NA	0.72	15.04	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
75685	26	A	Artery x-rays, spine	1.31	0.43	0.43	0.07	1.81	1.81	XXX
75685	TC	A	Artery x-rays, spine	0.00	12.58	NA	0.65	13.23	NA	XXX
75705		A	Artery x-rays, spine	2.18	13.31	NA	0.78	16.27	NA	XXX
75705	26	A	Artery x-rays, spine	2.18	0.73	0.73	0.13	3.04	3.04	XXX
75705	TC	A	Artery x-rays, spine	0.00	12.58	NA	0.65	13.23	NA	XXX
75710		A	Artery x-rays, arm/leg	1.14	12.96	NA	0.71	14.81	NA	XXX
75710	26	A	Artery x-rays, arm/leg	1.14	0.39	0.39	0.06	1.59	1.59	XXX
75710	TC	A	Artery x-rays, arm/leg	0.00	12.58	NA	0.65	13.23	NA	XXX
75716		A	Artery x-rays, arms/legs	1.31	13.01	NA	0.72	15.04	NA	XXX
75716	26	A	Artery x-rays, arms/legs	1.31	0.43	0.43	0.07	1.81	1.81	XXX
75716	TC	A	Artery x-rays, arms/legs	0.00	12.58	NA	0.65	13.23	NA	XXX
75722		A	Artery x-rays, kidney	1.14	12.97	NA	0.71	14.82	NA	XXX
75722	26	A	Artery x-rays, kidney	1.14	0.40	0.40	0.06	1.60	1.60	XXX
75722	TC	A	Artery x-rays, kidney	0.00	12.58	NA	0.65	13.23	NA	XXX
75724		A	Artery x-rays, kidneys	1.49	13.13	NA	0.71	15.33	NA	XXX
75724	26	A	Artery x-rays, kidneys	1.49	0.56	0.56	0.06	2.11	2.11	XXX
75724	TC	A	Artery x-rays, kidneys	0.00	12.58	NA	0.65	13.23	NA	XXX
75726		A	Artery x-rays, abdomen	1.14	12.95	NA	0.70	14.79	NA	XXX
75726	26	A	Artery x-rays, abdomen	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75726	TC	A	Artery x-rays, abdomen	0.00	12.58	NA	0.65	13.23	NA	XXX
75731		A	Artery x-rays, adrenal gland	1.14	12.95	NA	0.70	14.79	NA	XXX
75731	26	A	Artery x-rays, adrenal gland	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75731	TC	A	Artery x-rays, adrenal gland	0.00	12.58	NA	0.65	13.23	NA	XXX
75733		A	Artery x-rays, adrenals	1.31	13.01	NA	0.70	15.02	NA	XXX
75733	26	A	Artery x-rays, adrenals	1.31	0.43	0.43	0.05	1.79	1.79	XXX
75733	TC	A	Artery x-rays, adrenals	0.00	12.58	NA	0.65	13.23	NA	XXX
75736		A	Artery x-rays, pelvis	1.14	12.95	NA	0.71	14.80	NA	XXX
75736	26	A	Artery x-rays, pelvis	1.14	0.37	0.37	0.06	1.57	1.57	XXX
75736	TC	A	Artery x-rays, pelvis	0.00	12.58	NA	0.65	13.23	NA	XXX
75741		A	Artery x-rays, lung	1.31	13.01	NA	0.71	15.03	NA	XXX
75741	26	A	Artery x-rays, lung	1.31	0.43	0.43	0.06	1.80	1.80	XXX
75741	TC	A	Artery x-rays, lung	0.00	12.58	NA	0.65	13.23	NA	XXX
75743		A	Artery x-rays, lungs	1.66	13.12	NA	0.73	15.51	NA	XXX
75743	26	A	Artery x-rays, lungs	1.66	0.54	0.54	0.08	2.28	2.28	XXX
75743	TC	A	Artery x-rays, lungs	0.00	12.58	NA	0.65	13.23	NA	XXX
75746		A	Artery x-rays, lung	1.14	12.95	NA	0.70	14.79	NA	XXX
75746	26	A	Artery x-rays, lung	1.14	0.38	0.38	0.05	1.57	1.57	XXX
75746	TC	A	Artery x-rays, lung	0.00	12.58	NA	0.65	13.23	NA	XXX
75756		A	Artery x-rays, chest	1.14	13.02	NA	0.69	14.85	NA	XXX
75756	26	A	Artery x-rays, chest	1.14	0.45	0.45	0.04	1.63	1.63	XXX
75756	TC	A	Artery x-rays, chest	0.00	12.58	NA	0.65	13.23	NA	XXX
75774		A	Artery x-ray, each vessel	0.36	12.70	NA	0.67	13.73	NA	ZZZ
75774	26	A	Artery x-ray, each vessel	0.36	0.12	0.12	0.02	0.50	0.50	ZZZ
75774	TC	A	Artery x-ray, each vessel	0.00	12.58	NA	0.65	13.23	NA	ZZZ
75790		A	Visualize A-V shunt	1.84	1.95	NA	0.18	3.97	NA	XXX
75790	26	A	Visualize A-V shunt	1.84	0.60	0.60	0.10	2.54	2.54	XXX
75790	TC	A	Visualize A-V shunt	0.00	1.35	NA	0.08	1.43	NA	XXX
75801		A	Lymph vessel x-ray, arm/leg	0.81	5.67	NA	0.37	6.85	NA	XXX
75801	26	A	Lymph vessel x-ray, arm/leg	0.81	0.27	0.27	0.08	1.16	1.16	XXX
75801	TC	A	Lymph vessel x-ray, arm/leg	0.00	5.40	NA	0.29	5.69	NA	XXX
75803		A	Lymph vessel x-ray,arms/legs	1.17	5.79	NA	0.34	7.30	NA	XXX
75803	26	A	Lymph vessel x-ray,arms/legs	1.17	0.38	0.38	0.05	1.60	1.60	XXX
75803	TC	A	Lymph vessel x-ray,arms/legs	0.00	5.40	NA	0.29	5.69	NA	XXX
75805		A	Lymph vessel x-ray, trunk	0.81	6.36	NA	0.38	7.55	NA	XXX
75805	26	A	Lymph vessel x-ray, trunk	0.81	0.27	0.27	0.05	1.13	1.13	XXX
75805	TC	A	Lymph vessel x-ray, trunk	0.00	6.09	NA	0.33	6.42	NA	XXX
75807		A	Lymph vessel x-ray, trunk	1.17	6.47	NA	0.39	8.03	NA	XXX
75807	26	A	Lymph vessel x-ray, trunk	1.17	0.38	0.38	0.06	1.61	1.61	XXX
75807	TC	A	Lymph vessel x-ray, trunk	0.00	6.09	NA	0.33	6.42	NA	XXX
75809		A	Nonvascular shunt, x-ray	0.47	0.94	NA	0.07	1.48	NA	XXX
75809	26	A	Nonvascular shunt, x-ray	0.47	0.15	0.15	0.02	0.64	0.64	XXX
75809	TC	A	Nonvascular shunt, x-ray	0.00	0.78	NA	0.05	0.83	NA	XXX
75810		A	Vein x-ray, spleen/liver	1.14	12.95	NA	0.70	14.79	NA	XXX
75810	26	A	Vein x-ray, spleen/liver	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75810	TC	A	Vein x-ray, spleen/liver	0.00	12.58	NA	0.65	13.23	NA	XXX
75820		A	Vein x-ray, arm/leg	0.70	1.17	NA	0.10	1.97	NA	XXX
75820	26	A	Vein x-ray, arm/leg	0.70	0.23	0.23	0.04	0.97	0.97	XXX
75820	TC	A	Vein x-ray, arm/leg	0.00	0.95	NA	0.06	1.01	NA	XXX
75822		A	Vein x-ray, arms/legs	1.06	1.82	NA	0.13	3.01	NA	XXX
75822	26	A	Vein x-ray, arms/legs	1.06	0.35	0.35	0.05	1.46	1.46	XXX
75822	TC	A	Vein x-ray, arms/legs	0.00	1.48	NA	0.08	1.56	NA	XXX
75825		A	Vein x-ray, trunk	1.14	12.95	NA	0.72	14.81	NA	XXX
75825	26	A	Vein x-ray, trunk	1.14	0.37	0.37	0.07	1.58	1.58	XXX
75825	TC	A	Vein x-ray, trunk	0.00	12.58	NA	0.65	13.23	NA	XXX
75827		A	Vein x-ray, chest	1.14	12.95	NA	0.71	14.80	NA	XXX

[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
75827	26	A	Vein x-ray, chest	1.14	0.37	0.37	0.06	1.57	1.57	XXX
75827	TC	A	Vein x-ray, chest	0.00	12.58	NA	0.65	13.23	NA	XXX
75831		A	Vein x-ray, kidney	1.14	12.94	NA	0.70	14.78	NA	XXX
75831	26	A	Vein x-ray, kidney	1.14	0.37	0.37	0.06	1.57	1.57	XXX
75831	TC	A	Vein x-ray, kidney	0.00	12.58	NA	0.65	13.23	NA	XXX
75833		A	Vein x-ray, kidneys	1.49	13.06	NA	0.73	15.28	NA	XXX
75833	26	A	Vein x-ray, kidneys	1.49	0.49	0.49	0.08	2.06	2.06	XXX
75833	TC	A	Vein x-ray, kidneys	0.00	12.58	NA	0.65	13.23	NA	XXX
75840		A	Vein x-ray, adrenal gland	1.14	12.95	NA	0.70	14.79	NA	XXX
75840	26	A	Vein x-ray, adrenal gland	1.14	0.38	0.38	0.05	1.57	1.57	XXX
75840	TC	A	Vein x-ray, adrenal gland	0.00	12.58	NA	0.65	13.23	NA	XXX
75842		A	Vein x-ray, adrenal glands	1.49	13.06	NA	0.73	15.28	NA	XXX
75842	26	A	Vein x-ray, adrenal glands	1.49	0.48	0.48	0.08	2.05	2.05	XXX
75842	TC	A	Vein x-ray, adrenal glands	0.00	12.58	NA	0.65	13.23	NA	XXX
75860		A	Vein x-ray, neck	1.14	12.97	NA	0.70	14.81	NA	XXX
75860	26	A	Vein x-ray, neck	1.14	0.39	0.39	0.05	1.58	1.58	XXX
75860	TC	A	Vein x-ray, neck	0.00	12.58	NA	0.65	13.23	NA	XXX
75870		A	Vein x-ray, skull	1.14	12.96	NA	0.71	14.81	NA	XXX
75870	26	A	Vein x-ray, skull	1.14	0.39	0.39	0.06	1.59	1.59	XXX
75870	TC	A	Vein x-ray, skull	0.00	12.58	NA	0.65	13.23	NA	XXX
75872		A	Vein x-ray, skull	1.14	12.95	NA	0.76	14.85	NA	XXX
75872	26	A	Vein x-ray, skull	1.14	0.37	0.37	0.11	1.62	1.62	XXX
75872	TC	A	Vein x-ray, skull	0.00	12.58	NA	0.65	13.23	NA	XXX
75880		A	Vein x-ray, eye socket	0.70	1.18	NA	0.10	1.98	NA	XXX
75880	26	A	Vein x-ray, eye socket	0.70	0.23	0.23	0.04	0.97	0.97	XXX
75880	TC	A	Vein x-ray, eye socket	0.00	0.95	NA	0.06	1.01	NA	XXX
75885		A	Vein x-ray, liver	1.44	13.04	NA	0.72	15.20	NA	XXX
75885	26	A	Vein x-ray, liver	1.44	0.47	0.47	0.07	1.98	1.98	XXX
75885	TC	A	Vein x-ray, liver	0.00	12.58	NA	0.65	13.23	NA	XXX
75887		A	Vein x-ray, liver	1.44	13.04	NA	0.72	15.20	NA	XXX
75887	26	A	Vein x-ray, liver	1.44	0.47	0.47	0.07	1.98	1.98	XXX
75887	TC	A	Vein x-ray, liver	0.00	12.58	NA	0.65	13.23	NA	XXX
75889		A	Vein x-ray, liver	1.14	12.95	NA	0.70	14.79	NA	XXX
75889	26	A	Vein x-ray, liver	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75889	TC	A	Vein x-ray, liver	0.00	12.58	NA	0.65	13.23	NA	XXX
75891		A	Vein x-ray, liver	1.14	12.95	NA	0.70	14.79	NA	XXX
75891	26	A	Vein x-ray, liver	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75891	TC	A	Vein x-ray, liver	0.00	12.58	NA	0.65	13.23	NA	XXX
75893		A	Venous sampling by catheter	0.54	12.75	NA	0.68	13.97	NA	XXX
75893	26	A	Venous sampling by catheter	0.54	0.18	0.18	0.03	0.75	0.75	XXX
75893	TC	A	Venous sampling by catheter	0.00	12.58	NA	0.65	13.23	NA	XXX
75894		A	X-rays, transcath therapy	1.31	24.52	NA	1.35	27.18	NA	XXX
75894	26	A	X-rays, transcath therapy	1.31	0.43	0.43	0.08	1.82	1.82	XXX
75894	TC	A	X-rays, transcath therapy	0.00	24.09	NA	1.27	25.36	NA	XXX
75896		A	X-rays, transcath therapy	1.31	21.40	NA	1.16	23.87	NA	XXX
75896	26	A	X-rays, transcath therapy	1.31	0.45	0.45	0.06	1.82	1.82	XXX
75896	TC	A	X-rays, transcath therapy	0.00	20.95	NA	1.10	22.05	NA	XXX
75898		A	Follow-up angiography	1.65	1.60	NA	0.14	3.39	NA	XXX
75898	26	A	Follow-up angiography	1.65	0.55	0.55	0.08	2.28	2.28	XXX
75898	TC	A	Follow-up angiography	0.00	1.05	NA	0.06	1.11	NA	XXX
75900		A	Arterial catheter exchange	0.49	21.09	NA	1.14	22.72	NA	XXX
75900	26	A	Arterial catheter exchange	0.49	0.16	0.16	0.03	0.68	0.68	XXX
75900	TC	A	Arterial catheter exchange	0.00	20.93	NA	1.11	22.04	NA	XXX
75901		A	Remove cva device obstruct	0.49	1.46	NA	1.04	2.99	NA	XXX
75901	26	A	Remove cva device obstruct	0.49	0.16	0.16	0.21	0.86	0.86	XXX
75901	TC	A	Remove cva device obstruct	0.00	1.30	NA	0.83	2.13	NA	XXX
75902		A	Remove cva lumen obstruct	0.39	1.43	NA	0.86	2.68	NA	XXX
75902	26	A	Remove cva lumen obstruct	0.39	0.13	0.13	0.03	0.55	0.55	XXX
75902	TC	A	Remove cva lumen obstruct	0.00	1.30	NA	0.83	2.13	NA	XXX
75940		A	X-ray placement, vein filter	0.54	12.75	NA	0.68	13.97	NA	XXX
75940	26	A	X-ray placement, vein filter	0.54	0.18	0.18	0.03	0.75	0.75	XXX
75940	TC	A	X-ray placement, vein filter	0.00	12.58	NA	0.65	13.23	NA	XXX
75945		A	Intravascular us	0.40	4.70	NA	0.27	5.37	NA	XXX
75945	26	A	Intravascular us	0.40	0.14	0.14	0.03	0.57	0.57	XXX
75945	TC	A	Intravascular us	0.00	4.56	NA	0.24	4.80	NA	XXX
75946		A	Intravascular us add-on	0.40	2.42	NA	0.18	3.00	NA	ZZZ
75946	26	A	Intravascular us add-on	0.40	0.14	0.14	0.05	0.59	0.59	ZZZ
75946	TC	A	Intravascular us add-on	0.00	2.29	NA	0.13	2.42	NA	ZZZ
75952	26	A	Endovasc repair abdom aorta	4.49	1.49	1.49	0.43	6.41	6.41	XXX
75953	26	A	Abdom aneurysm endovas rpr	1.36	0.45	0.45	0.13	1.94	1.94	XXX
75954	26	A	Iliac aneurysm endovas rpr	2.25	0.77	0.77	0.05	3.07	3.07	XXX
75960		A	Transcatheter intro, stent	0.82	15.16	NA	0.82	16.80	NA	XXX
75960	26	A	Transcatheter intro, stent	0.82	0.28	0.28	0.05	1.15	1.15	XXX
75960	TC	A	Transcatheter intro, stent	0.00	14.87	NA	0.77	15.64	NA	XXX
75961		A	Retrieval, broken catheter	4.24	11.87	NA	0.76	16.87	NA	XXX

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[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
75961	26	A	Retrieval, broken catheter	4.24	1.39	1.39	0.21	5.84	5.84	XXX
75961	TC	A	Retrieval, broken catheter	0.00	10.48	NA	0.55	11.03	NA	XXX
75962		A	Repair arterial blockage	0.54	15.90	NA	0.86	17.30	NA	XXX
75962	26	A	Repair arterial blockage	0.54	0.18	0.18	0.03	0.75	0.75	XXX
75962	TC	A	Repair arterial blockage	0.00	15.71	NA	0.83	16.54	NA	XXX
75964		A	Repair artery blockage, each	0.36	8.50	NA	0.45	9.31	NA	ZZZ
75964	26	A	Repair artery blockage, each	0.36	0.12	0.12	0.02	0.50	0.50	ZZZ
75964	TC	A	Repair artery blockage, each	0.00	8.38	NA	0.43	8.81	NA	ZZZ
75966		A	Repair arterial blockage	1.31	16.18	NA	0.89	18.38	NA	XXX
75966	26	A	Repair arterial blockage	1.31	0.46	0.46	0.06	1.83	1.83	XXX
75966	TC	A	Repair arterial blockage	0.00	15.71	NA	0.83	16.54	NA	XXX
75968		A	Repair artery blockage, each	0.36	8.51	NA	0.45	9.32	NA	ZZZ
75968	26	A	Repair artery blockage, each	0.36	0.13	0.13	0.02	0.51	0.51	ZZZ
75968	TC	A	Repair artery blockage, each	0.00	8.38	NA	0.43	8.81	NA	ZZZ
75970		A	Vascular biopsy	0.83	11.80	NA	0.64	13.27	NA	XXX
75970	26	A	Vascular biopsy	0.83	0.28	0.28	0.04	1.15	1.15	XXX
75970	TC	A	Vascular biopsy	0.00	11.52	NA	0.60	12.12	NA	XXX
75978		A	Repair venous blockage	0.54	15.89	NA	0.86	17.29	NA	XXX
75978	26	A	Repair venous blockage	0.54	0.18	0.18	0.03	0.75	0.75	XXX
75978	TC	A	Repair venous blockage	0.00	15.71	NA	0.83	16.54	NA	XXX
75980		A	Contrast xray exam bile duct	1.44	5.87	NA	0.36	7.67	NA	XXX
75980	26	A	Contrast xray exam bile duct	1.44	0.47	0.47	0.07	1.98	1.98	XXX
75980	TC	A	Contrast xray exam bile duct	0.00	5.40	NA	0.29	5.69	NA	XXX
75982		A	Contrast xray exam bile duct	1.44	6.56	NA	0.40	8.40	NA	XXX
75982	26	A	Contrast xray exam bile duct	1.44	0.47	0.47	0.07	1.98	1.98	XXX
75982	TC	A	Contrast xray exam bile duct	0.00	6.09	NA	0.33	6.42	NA	XXX
75984		A	Xray control catheter change	0.72	2.18	NA	0.14	3.04	NA	XXX
75984	26	A	Xray control catheter change	0.72	0.23	0.23	0.03	0.98	0.98	XXX
75984	TC	A	Xray control catheter change	0.00	1.95	NA	0.11	2.06	NA	XXX
75989		A	Abscess drainage under x-ray	1.19	3.53	NA	0.22	4.94	NA	XXX
75989	26	A	Abscess drainage under x-ray	1.19	0.39	0.39	0.05	1.63	1.63	XXX
75989	TC	A	Abscess drainage under x-ray	0.00	3.15	NA	0.17	3.32	NA	XXX
75992		A	Atherectomy, x-ray exam	0.54	15.90	NA	0.86	17.30	NA	XXX
75992	26	A	Atherectomy, x-ray exam	0.54	0.19	0.19	0.03	0.76	0.76	XXX
75992	TC	A	Atherectomy, x-ray exam	0.00	15.71	NA	0.83	16.54	NA	XXX
75993		A	Atherectomy, x-ray exam	0.36	8.51	NA	0.45	9.32	NA	ZZZ
75993	26	A	Atherectomy, x-ray exam	0.36	0.13	0.13	0.02	0.51	0.51	ZZZ
75993	TC	A	Atherectomy, x-ray exam	0.00	8.38	NA	0.43	8.81	NA	ZZZ
75994		A	Atherectomy, x-ray exam	1.31	16.18	NA	0.87	18.36	NA	XXX
75994	26	A	Atherectomy, x-ray exam	1.31	0.46	0.46	0.04	1.81	1.81	XXX
75994	TC	A	Atherectomy, x-ray exam	0.00	15.71	NA	0.83	16.54	NA	XXX
75995		A	Atherectomy, x-ray exam	1.31	16.18	NA	0.91	18.40	NA	XXX
75995	26	A	Atherectomy, x-ray exam	1.31	0.47	0.47	0.08	1.86	1.86	XXX
75995	TC	A	Atherectomy, x-ray exam	0.00	15.71	NA	0.83	16.54	NA	XXX
75996		A	Atherectomy, x-ray exam	0.36	8.50	NA	0.44	9.30	NA	ZZZ
75996	26	A	Atherectomy, x-ray exam	0.36	0.12	0.12	0.01	0.49	0.49	ZZZ
75996	TC	A	Atherectomy, x-ray exam	0.00	8.38	NA	0.43	8.81	NA	ZZZ
75998		A	Fluoroguide for vein device	0.38	1.43	NA	0.11	1.92	NA	ZZZ
75998	26	A	Fluoroguide for vein device	0.38	0.13	0.13	0.01	0.52	0.52	ZZZ
75998	TC	A	Fluoroguide for vein device	0.00	1.30	NA	0.10	1.40	NA	ZZZ
76000		A	Fluoroscope examination	0.17	1.36	NA	0.08	1.61	NA	XXX
76000	26	A	Fluoroscope examination	0.17	0.05	0.05	0.01	0.23	0.23	XXX
76000	TC	A	Fluoroscope examination	0.00	1.30	NA	0.07	1.37	NA	XXX
76001		A	Fluoroscope exam, extensive	0.67	2.84	NA	0.18	3.69	NA	XXX
76001	26	A	Fluoroscope exam, extensive	0.67	0.22	0.22	0.04	0.93	0.93	XXX
76001	TC	A	Fluoroscope exam, extensive	0.00	2.62	NA	0.14	2.76	NA	XXX
76003		A	Needle localization by x-ray	0.54	1.47	NA	0.10	2.11	NA	XXX
76003	26	A	Needle localization by x-ray	0.54	0.17	0.17	0.03	0.74	0.74	XXX
76003	TC	A	Needle localization by x-ray	0.00	1.30	NA	0.07	1.37	NA	XXX
76005		A	Fluoroguide for spine inject	0.60	1.46	NA	0.11	2.17	NA	XXX
76005	26	A	Fluoroguide for spine inject	0.60	0.15	0.15	0.04	0.79	0.79	XXX
76005	TC	A	Fluoroguide for spine inject	0.00	1.30	NA	0.07	1.37	NA	XXX
76006		A	X-ray stress view	0.41	0.18	0.18	0.06	0.65	0.65	XXX
76010		A	X-ray, nose to rectum	0.18	0.58	NA	0.03	0.79	NA	XXX
76010	26	A	X-ray, nose to rectum	0.18	0.06	0.06	0.01	0.25	0.25	XXX
76010	TC	A	X-ray, nose to rectum	0.00	0.52	NA	0.02	0.54	NA	XXX
76012	26	A	Percut vertebroplasty fluor	1.31	0.47	0.47	0.09	1.87	1.87	XXX
76013	26	A	Percut vertebroplasty, ct	1.38	0.47	0.47	0.08	1.93	1.93	XXX
76020		A	X-rays for bone age	0.19	0.58	NA	0.03	0.80	NA	XXX
76020	26	A	X-rays for bone age	0.19	0.06	0.06	0.01	0.26	0.26	XXX
76020	TC	A	X-rays for bone age	0.00	0.52	NA	0.02	0.54	NA	XXX
76040		A	X-rays, bone evaluation	0.27	0.87	NA	0.06	1.20	NA	XXX
76040	26	A	X-rays, bone evaluation	0.27	0.09	0.09	0.01	0.37	0.37	XXX
76040	TC	A	X-rays, bone evaluation	0.00	0.78	NA	0.05	0.83	NA	XXX
76061		A	X-rays, bone survey	0.45	1.14	NA	0.08	1.67	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
76061	26	A	X-rays, bone survey	0.45	0.15	0.15	0.02	0.62	0.62	XXX
76061	TC	A	X-rays, bone survey	0.00	0.99	NA	0.06	1.05	NA	XXX
76062		A	X-rays, bone survey	0.54	1.61	NA	0.10	2.25	NA	XXX
76062	26	A	X-rays, bone survey	0.54	0.18	0.18	0.02	0.74	0.74	XXX
76062	TC	A	X-rays, bone survey	0.00	1.44	NA	0.08	1.52	NA	XXX
76065		A	X-rays, bone evaluation	0.70	0.97	NA	0.08	1.75	NA	XXX
76065	26	A	X-rays, bone evaluation	0.70	0.23	0.23	0.03	0.96	0.96	XXX
76065	TC	A	X-rays, bone evaluation	0.00	0.73	NA	0.05	0.78	NA	XXX
76066		A	Joint survey, single view	0.31	1.21	NA	0.08	1.60	NA	XXX
76066	26	A	Joint survey, single view	0.31	0.10	0.10	0.02	0.43	0.43	XXX
76066	TC	A	Joint survey, single view	0.00	1.11	NA	0.06	1.17	NA	XXX
76070		A	Ct bone density, axial	0.25	3.03	NA	0.17	3.45	NA	XXX
76070	26	A	Ct bone density, axial	0.25	0.08	0.08	0.01	0.34	0.34	XXX
76070	TC	A	Ct bone density, axial	0.00	2.94	NA	0.16	3.10	NA	XXX
76071		A	Ct bone density, peripheral	0.22	3.02	NA	0.06	3.30	NA	XXX
76071	26	A	Ct bone density, peripheral	0.22	0.07	0.07	0.01	0.30	0.30	XXX
76071	TC	A	Ct bone density, peripheral	0.00	2.94	NA	0.05	2.99	NA	XXX
76075		A	Dexa, axial skeleton study	0.30	3.19	NA	0.18	3.67	NA	XXX
76075	26	A	Dexa, axial skeleton study	0.30	0.10	0.10	0.01	0.41	0.41	XXX
76075	TC	A	Dexa, axial skeleton study	0.00	3.09	NA	0.17	3.26	NA	XXX
76076		A	Dexa, peripheral study	0.22	0.83	NA	0.06	1.11	NA	XXX
76076	26	A	Dexa, peripheral study	0.22	0.07	0.07	0.01	0.30	0.30	XXX
76076	TC	A	Dexa, peripheral study	0.00	0.75	NA	0.05	0.80	NA	XXX
76078		A	Radiographic absorptiometry	0.20	0.82	NA	0.06	1.08	NA	XXX
76078	26	A	Radiographic absorptiometry	0.20	0.07	0.07	0.01	0.28	0.28	XXX
76078	TC	A	Radiographic absorptiometry	0.00	0.75	NA	0.05	0.80	NA	XXX
76080		A	X-ray exam of fistula	0.54	1.23	NA	0.08	1.85	NA	XXX
76080	26	A	X-ray exam of fistula	0.54	0.18	0.18	0.02	0.74	0.74	XXX
76080	TC	A	X-ray exam of fistula	0.00	1.05	NA	0.06	1.11	NA	XXX
76082		A	Computer mammogram add-on	0.06	0.43	NA	0.01	0.50	NA	ZZZ
76082	26	A	Computer mammogram add-on	0.06	0.02	0.02	0.00	0.08	0.08	ZZZ
76082	TC	A	Computer mammogram add-on	0.00	0.42	NA	0.01	0.43	NA	ZZZ
76083		A	Computer mammogram add-on	0.06	0.43	NA	0.01	0.50	NA	ZZZ
76083	26	A	Computer mammogram add-on	0.06	0.02	0.02	0.00	0.08	0.08	ZZZ
76083	TC	A	Computer mammogram add-on	0.00	0.42	NA	0.01	0.43	NA	ZZZ
76086		A	X-ray of mammary duct	0.36	2.73	NA	0.16	3.25	NA	XXX
76086	26	A	X-ray of mammary duct	0.36	0.12	0.12	0.02	0.50	0.50	XXX
76086	TC	A	X-ray of mammary duct	0.00	2.62	NA	0.14	2.76	NA	XXX
76088		A	X-ray of mammary ducts	0.45	3.80	NA	0.21	4.46	NA	XXX
76088	26	A	X-ray of mammary ducts	0.45	0.15	0.15	0.02	0.62	0.62	XXX
76088	TC	A	X-ray of mammary ducts	0.00	3.66	NA	0.19	3.85	NA	XXX
76090		A	Mammogram, one breast	0.70	1.28	NA	0.09	2.07	NA	XXX
76090	26	A	Mammogram, one breast	0.70	0.23	0.23	0.03	0.96	0.96	XXX
76090	TC	A	Mammogram, one breast	0.00	1.05	NA	0.06	1.11	NA	XXX
76091		A	Mammogram, both breasts	0.87	1.59	NA	0.11	2.57	NA	XXX
76091	26	A	Mammogram, both breasts	0.87	0.28	0.28	0.04	1.19	1.19	XXX
76091	TC	A	Mammogram, both breasts	0.00	1.30	NA	0.07	1.37	NA	XXX
76092		A	Mammogram, screening	0.70	1.45	NA	0.10	2.25	NA	XXX
76092	26	A	Mammogram, screening	0.70	0.23	0.23	0.03	0.96	0.96	XXX
76092	TC	A	Mammogram, screening	0.00	1.23	NA	0.07	1.30	NA	XXX
76093		A	Magnetic image, breast	1.63	18.13	NA	0.99	20.75	NA	XXX
76093	26	A	Magnetic image, breast	1.63	0.53	0.53	0.07	2.23	2.23	XXX
76093	TC	A	Magnetic image, breast	0.00	17.59	NA	0.92	18.51	NA	XXX
76094		A	Magnetic image, both breasts	1.63	24.40	NA	1.31	27.34	NA	XXX
76094	26	A	Magnetic image, both breasts	1.63	0.53	0.53	0.07	2.23	2.23	XXX
76094	TC	A	Magnetic image, both breasts	0.00	23.87	NA	1.24	25.11	NA	XXX
76095		A	Stereotactic breast biopsy	1.59	7.67	NA	0.47	9.73	NA	XXX
76095	26	A	Stereotactic breast biopsy	1.59	0.52	0.52	0.10	2.21	2.21	XXX
76095	TC	A	Stereotactic breast biopsy	0.00	7.15	NA	0.37	7.52	NA	XXX
76096		A	X-ray of needle wire, breast	0.56	1.49	NA	0.10	2.15	NA	XXX
76096	26	A	X-ray of needle wire, breast	0.56	0.18	0.18	0.03	0.77	0.77	XXX
76096	TC	A	X-ray of needle wire, breast	0.00	1.30	NA	0.07	1.37	NA	XXX
76098		A	X-ray exam, breast specimen	0.16	0.47	NA	0.03	0.66	NA	XXX
76098	26	A	X-ray exam, breast specimen	0.16	0.05	0.05	0.01	0.22	0.22	XXX
76098	TC	A	X-ray exam, breast specimen	0.00	0.42	NA	0.02	0.44	NA	XXX
76100		A	X-ray exam of body section	0.58	1.43	NA	0.10	2.11	NA	XXX
76100	26	A	X-ray exam of body section	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76100	TC	A	X-ray exam of body section	0.00	1.25	NA	0.07	1.32	NA	XXX
76101		A	Complex body section x-ray	0.58	1.61	NA	0.11	2.30	NA	XXX
76101	26	A	Complex body section x-ray	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76101	TC	A	Complex body section x-ray	0.00	1.42	NA	0.08	1.50	NA	XXX
76102		A	Complex body section x-rays	0.58	1.92	NA	0.14	2.64	NA	XXX
76102	26	A	Complex body section x-rays	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76102	TC	A	Complex body section x-rays	0.00	1.73	NA	0.11	1.84	NA	XXX
76120		A	Cine/video x-rays	0.38	1.18	NA	0.08	1.64	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
76120	26	A	Cine/video x-rays	0.38	0.13	0.13	0.02	0.53	0.53	XXX
76120	TC	A	Cine/video x-rays	0.00	1.05	NA	0.06	1.11	NA	XXX
76125		A	Cine/video x-rays add-on	0.27	0.87	NA	0.06	1.20	NA	ZZZ
76125	26	A	Cine/video x-rays add-on	0.27	0.09	0.09	0.01	0.37	0.37	ZZZ
76125	TC	A	Cine/video x-rays add-on	0.00	0.78	NA	0.05	0.83	NA	ZZZ
76150		A	X-ray exam, dry process	0.00	0.42	NA	0.02	0.44	NA	XXX
76355		A	Ct scan for localization	1.21	8.64	NA	0.48	10.33	NA	XXX
76355	26	A	Ct scan for localization	1.21	0.40	0.40	0.06	1.67	1.67	XXX
76355	TC	A	Ct scan for localization	0.00	8.24	NA	0.42	8.66	NA	XXX
76360		A	Ct scan for needle biopsy	1.16	8.62	NA	0.47	10.25	NA	XXX
76360	26	A	Ct scan for needle biopsy	1.16	0.38	0.38	0.05	1.59	1.59	XXX
76360	TC	A	Ct scan for needle biopsy	0.00	8.24	NA	0.42	8.66	NA	XXX
76362		A	Ct guide for tissue ablation	3.99	9.54	NA	1.64	15.17	NA	XXX
76362	26	A	Ct guide for tissue ablation	3.99	1.30	1.30	0.18	5.47	5.47	XXX
76362	TC	A	Ct guide for tissue ablation	0.00	8.24	NA	1.46	9.70	NA	XXX
76370		A	Ct scan for therapy guide	0.85	3.22	NA	0.20	4.27	NA	XXX
76370	26	A	Ct scan for therapy guide	0.85	0.28	0.28	0.04	1.17	1.17	XXX
76370	TC	A	Ct scan for therapy guide	0.00	2.94	NA	0.16	3.10	NA	XXX
76375		A	3d/holograph reconstr add-on	0.16	3.58	NA	0.19	3.93	NA	XXX
76375	26	A	3d/holograph reconstr add-on	0.16	0.05	0.05	0.01	0.22	0.22	XXX
76375	TC	A	3d/holograph reconstr add-on	0.00	3.53	NA	0.18	3.71	NA	XXX
76380		A	CAT scan follow-up study	0.98	3.81	NA	0.22	5.01	NA	XXX
76380	26	A	CAT scan follow-up study	0.98	0.32	0.32	0.04	1.34	1.34	XXX
76380	TC	A	CAT scan follow-up study	0.00	3.49	NA	0.18	3.67	NA	XXX
76393		A	Mr guidance for needle place	1.50	11.68	NA	0.65	13.83	NA	XXX
76393	26	A	Mr guidance for needle place	1.50	0.50	0.50	0.10	2.10	2.10	XXX
76393	TC	A	Mr guidance for needle place	0.00	11.19	NA	0.55	11.74	NA	XXX
76394		A	Mri for tissue ablation	4.24	12.57	NA	1.80	18.61	NA	XXX
76394	26	A	Mri for tissue ablation	4.24	1.38	1.38	0.24	5.86	5.86	XXX
76394	TC	A	Mri for tissue ablation	0.00	11.19	NA	1.56	12.75	NA	XXX
76400		A	Magnetic image, bone marrow	1.60	11.71	NA	0.66	13.97	NA	XXX
76400	26	A	Magnetic image, bone marrow	1.60	0.52	0.52	0.07	2.19	2.19	XXX
76400	TC	A	Magnetic image, bone marrow	0.00	11.19	NA	0.59	11.78	NA	XXX
76506		A	Echo exam of head	0.63	1.66	NA	0.12	2.41	NA	XXX
76506	26	A	Echo exam of head	0.63	0.24	0.24	0.04	0.91	0.91	XXX
76506	TC	A	Echo exam of head	0.00	1.42	NA	0.08	1.50	NA	XXX
76511		A	Echo exam of eye	0.94	1.85	NA	0.10	2.89	NA	XXX
76511	26	A	Echo exam of eye	0.94	0.40	0.40	0.03	1.37	1.37	XXX
76511	TC	A	Echo exam of eye	0.00	1.45	NA	0.07	1.52	NA	XXX
76512		A	Echo exam of eye	0.66	1.73	NA	0.12	2.51	NA	XXX
76512	26	A	Echo exam of eye	0.66	0.29	0.29	0.02	0.97	0.97	XXX
76512	TC	A	Echo exam of eye	0.00	1.44	NA	0.10	1.54	NA	XXX
76513		A	Echo exam of eye, water bath	0.66	1.82	NA	0.12	2.60	NA	XXX
76513	26	A	Echo exam of eye, water bath	0.66	0.29	0.29	0.02	0.97	0.97	XXX
76513	TC	A	Echo exam of eye, water bath	0.00	1.52	NA	0.10	1.62	NA	XXX
76514		A	Echo exam of eye, thickness	0.17	0.13	NA	0.02	0.32	NA	XXX
76514	26	A	Echo exam of eye, thickness	0.17	0.08	0.08	0.01	0.26	0.26	XXX
76514	TC	A	Echo exam of eye, thickness	0.00	0.05	NA	0.01	0.06	NA	XXX
76516		A	Echo exam of eye	0.54	1.46	NA	0.08	2.08	NA	XXX
76516	26	A	Echo exam of eye	0.54	0.24	0.24	0.01	0.79	0.79	XXX
76516	TC	A	Echo exam of eye	0.00	1.22	NA	0.07	1.29	NA	XXX
76519		A	Echo exam of eye	0.54	1.56	NA	0.08	2.18	NA	XXX
76519	26	A	Echo exam of eye	0.54	0.24	0.24	0.01	0.79	0.79	XXX
76519	TC	A	Echo exam of eye	0.00	1.32	NA	0.07	1.39	NA	XXX
76529		A	Echo exam of eye	0.57	1.38	NA	0.10	2.05	NA	XXX
76529	26	A	Echo exam of eye	0.57	0.24	0.24	0.02	0.83	0.83	XXX
76529	TC	A	Echo exam of eye	0.00	1.14	NA	0.08	1.22	NA	XXX
76536		A	Us exam of head and neck	0.56	1.60	NA	0.11	2.27	NA	XXX
76536	26	A	Us exam of head and neck	0.56	0.18	0.18	0.03	0.77	0.77	XXX
76536	TC	A	Us exam of head and neck	0.00	1.42	NA	0.08	1.50	NA	XXX
76604		A	Us exam, chest, b-scan	0.55	1.48	NA	0.10	2.13	NA	XXX
76604	26	A	Us exam, chest, b-scan	0.55	0.18	0.18	0.03	0.76	0.76	XXX
76604	TC	A	Us exam, chest, b-scan	0.00	1.30	NA	0.07	1.37	NA	XXX
76645		A	Us exam, breast(s)	0.54	1.23	NA	0.08	1.85	NA	XXX
76645	26	A	Us exam, breast(s)	0.54	0.18	0.18	0.02	0.74	0.74	XXX
76645	TC	A	Us exam, breast(s)	0.00	1.05	NA	0.06	1.11	NA	XXX
76700		A	Us exam, abdom, complete	0.81	2.23	NA	0.15	3.19	NA	XXX
76700	26	A	Us exam, abdom, complete	0.81	0.26	0.26	0.04	1.11	1.11	XXX
76700	TC	A	Us exam, abdom, complete	0.00	1.97	NA	0.11	2.08	NA	XXX
76705		A	Echo exam of abdomen	0.59	1.61	NA	0.11	2.31	NA	XXX
76705	26	A	Echo exam of abdomen	0.59	0.19	0.19	0.03	0.81	0.81	XXX
76705	TC	A	Echo exam of abdomen	0.00	1.42	NA	0.08	1.50	NA	XXX
76770		A	Us exam abdo back wall, comp	0.74	2.21	NA	0.14	3.09	NA	XXX
76770	26	A	Us exam abdo back wall, comp	0.74	0.24	0.24	0.03	1.01	1.01	XXX
76770	TC	A	Us exam abdo back wall, comp	0.00	1.97	NA	0.11	2.08	NA	XXX

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[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
76775		A	Us exam abdo back wall, lim	0.58	1.61	NA	0.11	2.30	NA	XXX
76775	26	A	Us exam abdo back wall, lim	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76775	TC	A	Us exam abdo back wall, lim	0.00	1.42	NA	0.08	1.50	NA	XXX
76778		A	Us exam kidney transplant	0.74	2.21	NA	0.14	3.09	NA	XXX
76778	26	A	Us exam kidney transplant	0.74	0.24	0.24	0.03	1.01	1.01	XXX
76778	TC	A	Us exam kidney transplant	0.00	1.97	NA	0.11	2.08	NA	XXX
76800		A	Us exam, spinal canal	1.13	1.76	NA	0.14	3.03	NA	XXX
76800	26	A	Us exam, spinal canal	1.13	0.34	0.34	0.06	1.53	1.53	XXX
76800	TC	A	Us exam, spinal canal	0.00	1.42	NA	0.08	1.50	NA	XXX
76801		A	Ob us < 14 wks, single fetus	0.99	2.43	NA	0.17	3.59	NA	XXX
76801	26	A	Ob us < 14 wks, single fetus	0.99	0.34	0.34	0.05	1.38	1.38	XXX
76801	TC	A	Ob us < 14 wks, single fetus	0.00	2.09	NA	0.12	2.21	NA	XXX
76802		A	Ob us < 14 wks, add-l fetus	0.83	1.34	NA	0.17	2.34	NA	ZZZ
76802	26	A	Ob us < 14 wks, add-l fetus	0.83	0.29	0.29	0.05	1.17	1.17	ZZZ
76802	TC	A	Ob us < 14 wks, add-l fetus	0.00	1.05	NA	0.12	1.17	NA	ZZZ
76805		A	Ob us >/= 14 wks, sngl fetus	0.99	2.43	NA	0.17	3.59	NA	XXX
76805	26	A	Ob us >/= 14 wks, sngl fetus	0.99	0.34	0.34	0.05	1.38	1.38	XXX
76805	TC	A	Ob us >/= 14 wks, sngl fetus	0.00	2.09	NA	0.12	2.21	NA	XXX
76810		A	Ob us >/= 14 wks, addl fetus	0.98	1.39	NA	0.31	2.68	NA	ZZZ
76810	26	A	Ob us >/= 14 wks, addl fetus	0.98	0.34	0.34	0.09	1.41	1.41	ZZZ
76810	TC	A	Ob us >/= 14 wks, addl fetus	0.00	1.05	NA	0.22	1.27	NA	ZZZ
76811		A	Ob us, detailed, sngl fetus	1.90	4.23	NA	0.48	6.61	NA	XXX
76811	26	A	Ob us, detailed, sngl fetus	1.90	0.71	0.71	0.05	2.66	2.66	XXX
76811	TC	A	Ob us, detailed, sngl fetus	0.00	3.52	NA	0.43	3.95	NA	XXX
76812		A	Ob us, detailed, addl fetus	1.78	1.71	NA	0.50	3.99	NA	ZZZ
76812	26	A	Ob us, detailed, addl fetus	1.78	0.66	0.66	0.09	2.53	2.53	ZZZ
76812	TC	A	Ob us, detailed, addl fetus	0.00	1.05	NA	0.41	1.46	NA	ZZZ
76815		A	Ob us, limited, fetus(s)	0.65	1.65	NA	0.11	2.41	NA	XXX
76815	26	A	Ob us, limited, fetus(s)	0.65	0.23	0.23	0.03	0.91	0.91	XXX
76815	TC	A	Ob us, limited, fetus(s)	0.00	1.42	NA	0.08	1.50	NA	XXX
76816		A	Ob us, follow-up, per fetus	0.85	1.42	NA	0.09	2.36	NA	XXX
76816	26	A	Ob us, follow-up, per fetus	0.85	0.31	0.31	0.03	1.19	1.19	XXX
76816	TC	A	Ob us, follow-up, per fetus	0.00	1.11	NA	0.06	1.17	NA	XXX
76817		A	Transvaginal us, obstetric	0.75	1.78	NA	0.09	2.62	NA	XXX
76817	26	A	Transvaginal us, obstetric	0.75	0.26	0.26	0.03	1.04	1.04	XXX
76817	TC	A	Transvaginal us, obstetric	0.00	1.52	NA	0.06	1.58	NA	XXX
76818		A	Fetal biophys profile w/nst	1.05	2.00	NA	0.15	3.20	NA	XXX
76818	26	A	Fetal biophys profile w/nst	1.05	0.39	0.39	0.05	1.49	1.49	XXX
76818	TC	A	Fetal biophys profile w/nst	0.00	1.61	NA	0.10	1.71	NA	XXX
76819		A	Fetal biophys profil w/o nst	0.77	1.89	NA	0.14	2.80	NA	XXX
76819	26	A	Fetal biophys profil w/o nst	0.77	0.28	0.28	0.04	1.09	1.09	XXX
76819	TC	A	Fetal biophys profil w/o nst	0.00	1.61	NA	0.10	1.71	NA	XXX
76825		A	Echo exam of fetal heart	1.67	2.57	NA	0.18	4.42	NA	XXX
76825	26	A	Echo exam of fetal heart	1.67	0.60	0.60	0.07	2.34	2.34	XXX
76825	TC	A	Echo exam of fetal heart	0.00	1.97	NA	0.11	2.08	NA	XXX
76826		A	Echo exam of fetal heart	0.83	0.99	NA	0.09	1.91	NA	XXX
76826	26	A	Echo exam of fetal heart	0.83	0.29	0.29	0.04	1.16	1.16	XXX
76826	TC	A	Echo exam of fetal heart	0.00	0.70	NA	0.05	0.75	NA	XXX
76827		A	Echo exam of fetal heart	0.58	1.93	NA	0.15	2.66	NA	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.21	0.21	0.03	0.82	0.82	XXX
76827	TC	A	Echo exam of fetal heart	0.00	1.72	NA	0.12	1.84	NA	XXX
76828		A	Echo exam of fetal heart	0.56	1.32	NA	0.11	1.99	NA	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.21	0.21	0.03	0.80	0.80	XXX
76828	TC	A	Echo exam of fetal heart	0.00	1.11	NA	0.08	1.19	NA	XXX
76830		A	Transvaginal us, non-ob	0.69	1.74	NA	0.13	2.56	NA	XXX
76830	26	A	Transvaginal us, non-ob	0.69	0.23	0.23	0.03	0.95	0.95	XXX
76830	TC	A	Transvaginal us, non-ob	0.00	1.52	NA	0.10	1.62	NA	XXX
76831		A	Echo exam, uterus	0.72	1.77	NA	0.13	2.62	NA	XXX
76831	26	A	Echo exam, uterus	0.72	0.25	0.25	0.03	1.00	1.00	XXX
76831	TC	A	Echo exam, uterus	0.00	1.52	NA	0.10	1.62	NA	XXX
76856		A	Us exam, pelvic, complete	0.69	1.74	NA	0.13	2.56	NA	XXX
76856	26	A	Us exam, pelvic, complete	0.69	0.23	0.23	0.03	0.95	0.95	XXX
76856	TC	A	Us exam, pelvic, complete	0.00	1.52	NA	0.10	1.62	NA	XXX
76857		A	Us exam, pelvic, limited	0.38	1.83	NA	0.08	2.29	NA	XXX
76857	26	A	Us exam, pelvic, limited	0.38	0.12	0.12	0.02	0.52	0.52	XXX
76857	TC	A	Us exam, pelvic, limited	0.00	1.70	NA	0.06	1.76	NA	XXX
76870		A	Us exam, scrotum	0.64	1.72	NA	0.13	2.49	NA	XXX
76870	26	A	Us exam, scrotum	0.64	0.21	0.21	0.03	0.88	0.88	XXX
76870	TC	A	Us exam, scrotum	0.00	1.52	NA	0.10	1.62	NA	XXX
76872		A	Us, transrectal	0.69	2.25	NA	0.14	3.08	NA	XXX
76872	26	A	Us, transrectal	0.69	0.22	0.22	0.04	0.95	0.95	XXX
76872	TC	A	Us, transrectal	0.00	2.02	NA	0.10	2.12	NA	XXX
76873		A	Echograp trans r, pros study	1.55	2.59	NA	0.25	4.39	NA	XXX
76873	26	A	Echograp trans r, pros study	1.55	0.50	0.50	0.09	2.14	2.14	XXX
76873	TC	A	Echograp trans r, pros study	0.00	2.09	NA	0.16	2.25	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
76880		A	Us exam, extremity	0.59	1.61	NA	0.11	2.31	NA	XXX
76880	26	A	Us exam, extremity	0.59	0.19	0.19	0.03	0.81	0.81	XXX
76880	TC	A	Us exam, extremity	0.00	1.42	NA	0.08	1.50	NA	XXX
76885		A	Us exam infant hips, dynamic	0.74	1.76	NA	0.13	2.63	NA	XXX
76885	26	A	Us exam infant hips, dynamic	0.74	0.24	0.24	0.03	1.01	1.01	XXX
76885	TC	A	Us exam infant hips, dynamic	0.00	1.52	NA	0.10	1.62	NA	XXX
76886		A	Us exam infant hips, static	0.62	1.62	NA	0.11	2.35	NA	XXX
76886	26	A	Us exam infant hips, static	0.62	0.20	0.20	0.03	0.85	0.85	XXX
76886	TC	A	Us exam infant hips, static	0.00	1.42	NA	0.08	1.50	NA	XXX
76930		A	Echo guide, cardiocentesis	0.67	1.77	NA	0.12	2.56	NA	XXX
76930	26	A	Echo guide, cardiocentesis	0.67	0.25	0.25	0.02	0.94	0.94	XXX
76930	TC	A	Echo guide, cardiocentesis	0.00	1.52	NA	0.10	1.62	NA	XXX
76932		A	Echo guide for heart biopsy	0.67	1.77	NA	0.12	2.56	NA	XXX
76932	26	A	Echo guide for heart biopsy	0.67	0.25	0.25	0.02	0.94	0.94	XXX
76932	TC	A	Echo guide for heart biopsy	0.00	1.52	NA	0.10	1.62	NA	XXX
76936		A	Echo guide for artery repair	1.99	6.94	NA	0.47	9.40	NA	XXX
76936	26	A	Echo guide for artery repair	1.99	0.66	0.66	0.13	2.78	2.78	XXX
76936	TC	A	Echo guide for artery repair	0.00	6.28	NA	0.34	6.62	NA	XXX
76937		A	Us guide, vascular access	0.30	0.47	NA	0.13	0.90	NA	ZZZ
76937	26	A	Us guide, vascular access	0.30	0.10	0.10	0.03	0.43	0.43	ZZZ
76937	TC	A	Us guide, vascular access	0.00	0.38	NA	0.10	0.48	NA	ZZZ
76940		A	Us guide, tissue ablation	2.00	2.17	NA	0.48	4.65	NA	XXX
76940	26	A	Us guide, tissue ablation	2.00	0.65	0.65	0.19	2.84	2.84	XXX
76940	TC	A	Us guide, tissue ablation	0.00	1.52	NA	0.29	1.81	NA	XXX
76941		A	Echo guide for transfusion	1.34	2.00	NA	0.14	3.48	NA	XXX
76941	26	A	Echo guide for transfusion	1.34	0.47	0.47	0.06	1.87	1.87	XXX
76941	TC	A	Echo guide for transfusion	0.00	1.52	NA	0.08	1.60	NA	XXX
76942		A	Echo guide for biopsy	0.67	3.03	NA	0.13	3.83	NA	XXX
76942	26	A	Echo guide for biopsy	0.67	0.22	0.22	0.03	0.92	0.92	XXX
76942	TC	A	Echo guide for biopsy	0.00	2.81	NA	0.10	2.91	NA	XXX
76945		A	Echo guide, villus sampling	0.67	1.75	NA	0.11	2.53	NA	XXX
76945	26	A	Echo guide, villus sampling	0.67	0.22	0.22	0.03	0.92	0.92	XXX
76945	TC	A	Echo guide, villus sampling	0.00	1.52	NA	0.08	1.60	NA	XXX
76946		A	Echo guide for amniocentesis	0.38	1.66	NA	0.12	2.16	NA	XXX
76946	26	A	Echo guide for amniocentesis	0.38	0.14	0.14	0.02	0.54	0.54	XXX
76946	TC	A	Echo guide for amniocentesis	0.00	1.52	NA	0.10	1.62	NA	XXX
76948		A	Echo guide, ova aspiration	0.38	1.64	NA	0.12	2.14	NA	XXX
76948	26	A	Echo guide, ova aspiration	0.38	0.13	0.13	0.02	0.53	0.53	XXX
76948	TC	A	Echo guide, ova aspiration	0.00	1.52	NA	0.10	1.62	NA	XXX
76950		A	Echo guidance radiotherapy	0.58	1.49	NA	0.10	2.17	NA	XXX
76950	26	A	Echo guidance radiotherapy	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76950	TC	A	Echo guidance radiotherapy	0.00	1.30	NA	0.07	1.37	NA	XXX
76965		A	Echo guidance radiotherapy	1.34	5.99	NA	0.38	7.71	NA	XXX
76965	26	A	Echo guidance radiotherapy	1.34	0.43	0.43	0.09	1.86	1.86	XXX
76965	TC	A	Echo guidance radiotherapy	0.00	5.56	NA	0.29	5.85	NA	XXX
76970		A	Ultrasound exam follow-up	0.40	1.18	NA	0.08	1.66	NA	XXX
76970	26	A	Ultrasound exam follow-up	0.40	0.13	0.13	0.02	0.55	0.55	XXX
76970	TC	A	Ultrasound exam follow-up	0.00	1.05	NA	0.06	1.11	NA	XXX
76975		A	GI endoscopic ultrasound	0.81	1.79	NA	0.14	2.74	NA	XXX
76975	26	A	GI endoscopic ultrasound	0.81	0.28	0.28	0.04	1.13	1.13	XXX
76975	TC	A	GI endoscopic ultrasound	0.00	1.52	NA	0.10	1.62	NA	XXX
76977		A	Us bone density measure	0.05	0.84	NA	0.05	0.94	NA	XXX
76977	26	A	Us bone density measure	0.05	0.02	0.02	0.00	0.07	0.07	XXX
76977	TC	A	Us bone density measure	0.00	0.82	NA	0.05	0.87	NA	XXX
76986		A	Ultrasound guide intraoper	1.20	3.01	NA	0.24	4.45	NA	XXX
76986	26	A	Ultrasound guide intraoper	1.20	0.40	0.40	0.10	1.70	1.70	XXX
76986	TC	A	Ultrasound guide intraoper	0.00	2.62	NA	0.14	2.76	NA	XXX
77261		A	Radiation therapy planning	1.39	0.51	0.51	0.07	1.97	1.97	XXX
77262		A	Radiation therapy planning	2.11	0.76	0.76	0.11	2.98	2.98	XXX
77263		A	Radiation therapy planning	3.14	1.11	1.11	0.16	4.41	4.41	XXX
77280		A	Set radiation therapy field	0.70	3.69	NA	0.22	4.61	NA	XXX
77280	26	A	Set radiation therapy field	0.70	0.22	0.22	0.04	0.96	0.96	XXX
77280	TC	A	Set radiation therapy field	0.00	3.46	NA	0.18	3.64	NA	XXX
77285		A	Set radiation therapy field	1.05	5.89	NA	0.35	7.29	NA	XXX
77285	26	A	Set radiation therapy field	1.05	0.34	0.34	0.05	1.44	1.44	XXX
77285	TC	A	Set radiation therapy field	0.00	5.56	NA	0.30	5.86	NA	XXX
77290		A	Set radiation therapy field	1.56	6.99	NA	0.43	8.98	NA	XXX
77290	26	A	Set radiation therapy field	1.56	0.50	0.50	0.08	2.14	2.14	XXX
77290	TC	A	Set radiation therapy field	0.00	6.50	NA	0.35	6.85	NA	XXX
77295		A	Set radiation therapy field	4.56	29.34	NA	1.72	35.62	NA	XXX
77295	26	A	Set radiation therapy field	4.56	1.46	1.46	0.24	6.26	6.26	XXX
77295	TC	A	Set radiation therapy field	0.00	27.88	NA	1.48	29.36	NA	XXX
77300		A	Radiation therapy dose plan	0.62	1.54	NA	0.10	2.26	NA	XXX
77300	26	A	Radiation therapy dose plan	0.62	0.20	0.20	0.03	0.85	0.85	XXX
77300	TC	A	Radiation therapy dose plan	0.00	1.34	NA	0.07	1.41	NA	XXX

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[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
77301		A	Radiotherapy dose plan, imrt	7.99	30.44	NA	1.88	40.31	NA	XXX
77301	26	A	Radiotherapy dose plan, imrt	7.99	2.55	2.55	0.40	10.94	10.94	XXX
77301	TC	A	Radiotherapy dose plan, imrt	0.00	27.88	NA	1.48	29.36	NA	XXX
77305		A	Teletx isodose plan simple	0.70	2.08	NA	0.15	2.93	NA	XXX
77305	26	A	Teletx isodose plan simple	0.70	0.23	0.23	0.04	0.97	0.97	XXX
77305	TC	A	Teletx isodose plan simple	0.00	1.85	NA	0.11	1.96	NA	XXX
77310		A	Teletx isodose plan intermed	1.05	2.66	NA	0.18	3.89	NA	XXX
77310	26	A	Teletx isodose plan intermed	1.05	0.34	0.34	0.05	1.44	1.44	XXX
77310	TC	A	Teletx isodose plan intermed	0.00	2.33	NA	0.13	2.46	NA	XXX
77315		A	Teletx isodose plan complex	1.56	3.15	NA	0.22	4.93	NA	XXX
77315	26	A	Teletx isodose plan complex	1.56	0.50	0.50	0.08	2.14	2.14	XXX
77315	TC	A	Teletx isodose plan complex	0.00	2.65	NA	0.14	2.79	NA	XXX
77321		A	Special teletx port plan	0.95	4.34	NA	0.26	5.55	NA	XXX
77321	26	A	Special teletx port plan	0.95	0.30	0.30	0.05	1.30	1.30	XXX
77321	TC	A	Special teletx port plan	0.00	4.03	NA	0.21	4.24	NA	XXX
77326		A	Brachytx isodose calc simp	0.93	2.65	NA	0.18	3.76	NA	XXX
77326	26	A	Brachytx isodose calc simp	0.93	0.30	0.30	0.05	1.28	1.28	XXX
77326	TC	A	Brachytx isodose calc simp	0.00	2.35	NA	0.13	2.48	NA	XXX
77327		A	Brachytx isodose calc interm	1.39	3.91	NA	0.25	5.55	NA	XXX
77327	26	A	Brachytx isodose calc interm	1.39	0.44	0.44	0.07	1.90	1.90	XXX
77327	TC	A	Brachytx isodose calc interm	0.00	3.46	NA	0.18	3.64	NA	XXX
77328		A	Brachytx isodose plan compl	2.09	5.62	NA	0.36	8.07	NA	XXX
77328	26	A	Brachytx isodose plan compl	2.09	0.67	0.67	0.11	2.87	2.87	XXX
77328	TC	A	Brachytx isodose plan compl	0.00	4.95	NA	0.25	5.20	NA	XXX
77331		A	Special radiation dosimetry	0.87	0.78	NA	0.06	1.71	NA	XXX
77331	26	A	Special radiation dosimetry	0.87	0.28	0.28	0.04	1.19	1.19	XXX
77331	TC	A	Special radiation dosimetry	0.00	0.50	NA	0.02	0.52	NA	XXX
77332		A	Radiation treatment aid(s)	0.54	1.51	NA	0.10	2.15	NA	XXX
77332	26	A	Radiation treatment aid(s)	0.54	0.17	0.17	0.03	0.74	0.74	XXX
77332	TC	A	Radiation treatment aid(s)	0.00	1.34	NA	0.07	1.41	NA	XXX
77333		A	Radiation treatment aid(s)	0.84	2.16	NA	0.15	3.15	NA	XXX
77333	26	A	Radiation treatment aid(s)	0.84	0.27	0.27	0.04	1.15	1.15	XXX
77333	TC	A	Radiation treatment aid(s)	0.00	1.89	NA	0.11	2.00	NA	XXX
77334		A	Radiation treatment aid(s)	1.24	3.64	NA	0.23	5.11	NA	XXX
77334	26	A	Radiation treatment aid(s)	1.24	0.40	0.40	0.06	1.70	1.70	XXX
77334	TC	A	Radiation treatment aid(s)	0.00	3.24	NA	0.17	3.41	NA	XXX
77336		A	Radiation physics consult	0.00	2.97	NA	0.16	3.13	NA	XXX
77370		A	Radiation physics consult	0.00	3.48	NA	0.18	3.66	NA	XXX
77401		A	Radiation treatment delivery	0.00	1.77	NA	0.11	1.88	NA	XXX
77402		A	Radiation treatment delivery	0.00	1.77	NA	0.11	1.88	NA	XXX
77403		A	Radiation treatment delivery	0.00	1.77	NA	0.11	1.88	NA	XXX
77404		A	Radiation treatment delivery	0.00	1.77	NA	0.11	1.88	NA	XXX
77406		A	Radiation treatment delivery	0.00	1.77	NA	0.11	1.88	NA	XXX
77407		A	Radiation treatment delivery	0.00	2.08	NA	0.12	2.20	NA	XXX
77408		A	Radiation treatment delivery	0.00	2.08	NA	0.12	2.20	NA	XXX
77409		A	Radiation treatment delivery	0.00	2.08	NA	0.12	2.20	NA	XXX
77411		A	Radiation treatment delivery	0.00	2.08	NA	0.12	2.20	NA	XXX
77412		A	Radiation treatment delivery	0.00	2.33	NA	0.13	2.46	NA	XXX
77413		A	Radiation treatment delivery	0.00	2.33	NA	0.13	2.46	NA	XXX
77414		A	Radiation treatment delivery	0.00	2.33	NA	0.13	2.46	NA	XXX
77416		A	Radiation treatment delivery	0.00	2.33	NA	0.13	2.46	NA	XXX
77417		A	Radiology port film(s)	0.00	0.59	NA	0.04	0.63	NA	XXX
77418		A	Radiation tx delivery, imrt	0.00	17.95	NA	0.13	18.08	NA	XXX
77427		A	Radiation tx management, x5	3.31	1.06	1.06	0.17	4.54	4.54	090
77431		A	Radiation therapy management	1.81	0.68	0.68	0.09	2.58	2.58	XXX
77432		A	Stereotactic radiation trmt	7.92	2.91	2.91	0.42	11.25	11.25	XXX
77470		A	Special radiation treatment	2.09	11.79	NA	0.70	14.58	NA	XXX
77470	26	A	Special radiation treatment	2.09	0.67	0.67	0.11	2.87	2.87	XXX
77470	TC	A	Special radiation treatment	0.00	11.13	NA	0.59	11.72	NA	XXX
77600		R	Hyperthermia treatment	1.56	3.54	NA	0.24	5.34	NA	XXX
77600	26	R	Hyperthermia treatment	1.56	0.50	0.50	0.08	2.14	2.14	XXX
77600	TC	R	Hyperthermia treatment	0.00	3.04	NA	0.16	3.20	NA	XXX
77605		R	Hyperthermia treatment	2.09	4.72	NA	0.33	7.14	NA	XXX
77605	26	R	Hyperthermia treatment	2.09	0.66	0.66	0.11	2.86	2.86	XXX
77605	TC	R	Hyperthermia treatment	0.00	4.05	NA	0.22	4.27	NA	XXX
77610		R	Hyperthermia treatment	1.56	3.55	NA	0.24	5.35	NA	XXX
77610	26	R	Hyperthermia treatment	1.56	0.51	0.51	0.07	2.14	2.14	XXX
77610	TC	R	Hyperthermia treatment	0.00	3.04	NA	0.16	3.20	NA	XXX
77615		R	Hyperthermia treatment	2.09	4.72	NA	0.33	7.14	NA	XXX
77615	26	R	Hyperthermia treatment	2.09	0.66	0.66	0.11	2.86	2.86	XXX
77615	TC	R	Hyperthermia treatment	0.00	4.05	NA	0.22	4.27	NA	XXX
77620		R	Hyperthermia treatment	1.56	3.56	NA	0.23	5.35	NA	XXX
77620	26	R	Hyperthermia treatment	1.56	0.52	0.52	0.19	2.27	2.27	XXX
77620	TC	R	Hyperthermia treatment	0.00	3.04	NA	0.16	3.20	NA	XXX
77750		A	Infuse radioactive materials	4.90	2.91	NA	0.32	8.13	NA	090

[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
77750	26	A	Infuse radioactive materials	4.90	1.58	1.58	0.25	6.73	6.73	090
77750	TC	A	Infuse radioactive materials	0.00	1.33	NA	0.07	1.40	NA	090
77761		A	Apply intrcav radiat simple	3.80	3.59	NA	0.33	7.72	NA	090
77761	26	A	Apply intrcav radiat simple	3.80	1.09	1.09	0.19	5.08	5.08	090
77761	TC	A	Apply intrcav radiat simple	0.00	2.50	NA	0.14	2.64	NA	090
77762		A	Apply intrcav radiat interm	5.71	5.43	NA	0.48	11.62	NA	090
77762	26	A	Apply intrcav radiat interm	5.71	1.83	1.83	0.29	7.83	7.83	090
77762	TC	A	Apply intrcav radiat interm	0.00	3.60	NA	0.19	3.79	NA	090
77763		A	Apply intrcav radiat compl	8.56	7.21	NA	0.67	16.44	NA	090
77763	26	A	Apply intrcav radiat compl	8.56	2.73	2.73	0.44	11.73	11.73	090
77763	TC	A	Apply intrcav radiat compl	0.00	4.48	NA	0.23	4.71	NA	090
77776		A	Apply interstit radiat simpl	4.65	3.12	NA	0.48	8.25	NA	090
77776	26	A	Apply interstit radiat simpl	4.65	0.95	0.95	0.35	5.95	5.95	090
77776	TC	A	Apply interstit radiat simpl	0.00	2.17	NA	0.13	2.30	NA	090
77777		A	Apply interstit radiat inter	7.47	6.59	NA	0.62	14.68	NA	090
77777	26	A	Apply interstit radiat inter	7.47	2.37	2.37	0.40	10.24	10.24	090
77777	TC	A	Apply interstit radiat inter	0.00	4.23	NA	0.22	4.45	NA	090
77778		A	Apply interstit radiat compl	11.17	8.69	NA	0.85	20.71	NA	090
77778	26	A	Apply interstit radiat compl	11.17	3.56	3.56	0.58	15.31	15.31	090
77778	TC	A	Apply interstit radiat compl	0.00	5.12	NA	0.27	5.39	NA	090
77781		A	High intensity brachytherapy	1.66	20.80	NA	1.14	23.60	NA	090
77781	26	A	High intensity brachytherapy	1.66	0.53	0.53	0.08	2.27	2.27	090
77781	TC	A	High intensity brachytherapy	0.00	20.27	NA	1.06	21.33	NA	090
77782		A	High intensity brachytherapy	2.49	21.07	NA	1.19	24.75	NA	090
77782	26	A	High intensity brachytherapy	2.49	0.80	0.80	0.13	3.42	3.42	090
77782	TC	A	High intensity brachytherapy	0.00	20.27	NA	1.06	21.33	NA	090
77783		A	High intensity brachytherapy	3.72	21.46	NA	1.25	26.43	NA	090
77783	26	A	High intensity brachytherapy	3.72	1.19	1.19	0.19	5.10	5.10	090
77783	TC	A	High intensity brachytherapy	0.00	20.27	NA	1.06	21.33	NA	090
77784		A	High intensity brachytherapy	5.60	22.06	NA	1.35	29.01	NA	090
77784	26	A	High intensity brachytherapy	5.60	1.79	1.79	0.29	7.68	7.68	090
77784	TC	A	High intensity brachytherapy	0.00	20.27	NA	1.06	21.33	NA	090
77789		A	Apply surface radiation	1.12	0.82	NA	0.08	2.02	NA	000
77789	26	A	Apply surface radiation	1.12	0.37	0.37	0.06	1.55	1.55	000
77789	TC	A	Apply surface radiation	0.00	0.45	NA	0.02	0.47	NA	000
77790		A	Radiation handling	1.05	0.84	NA	0.07	1.96	NA	XXX
77790	26	A	Radiation handling	1.05	0.34	0.34	0.05	1.44	1.44	XXX
77790	TC	A	Radiation handling	0.00	0.50	NA	0.02	0.52	NA	XXX
78000		A	Thyroid, single uptake	0.19	1.03	NA	0.07	1.29	NA	XXX
78000	26	A	Thyroid, single uptake	0.19	0.06	0.06	0.01	0.26	0.26	XXX
78000	TC	A	Thyroid, single uptake	0.00	0.97	NA	0.06	1.03	NA	XXX
78001		A	Thyroid, multiple uptakes	0.26	1.39	NA	0.08	1.73	NA	XXX
78001	26	A	Thyroid, multiple uptakes	0.26	0.09	0.09	0.01	0.36	0.36	XXX
78001	TC	A	Thyroid, multiple uptakes	0.00	1.30	NA	0.07	1.37	NA	XXX
78003		A	Thyroid suppress/stimul	0.33	1.07	NA	0.07	1.47	NA	XXX
78003	26	A	Thyroid suppress/stimul	0.33	0.11	0.11	0.01	0.45	0.45	XXX
78003	TC	A	Thyroid suppress/stimul	0.00	0.97	NA	0.06	1.03	NA	XXX
78006		A	Thyroid imaging with uptake	0.49	2.54	NA	0.15	3.18	NA	XXX
78006	26	A	Thyroid imaging with uptake	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78006	TC	A	Thyroid imaging with uptake	0.00	2.37	NA	0.13	2.50	NA	XXX
78007		A	Thyroid image, mult uptakes	0.50	2.73	NA	0.16	3.39	NA	XXX
78007	26	A	Thyroid image, mult uptakes	0.50	0.17	0.17	0.02	0.69	0.69	XXX
78007	TC	A	Thyroid image, mult uptakes	0.00	2.57	NA	0.14	2.71	NA	XXX
78010		A	Thyroid imaging	0.39	1.94	NA	0.13	2.46	NA	XXX
78010	26	A	Thyroid imaging	0.39	0.13	0.13	0.02	0.54	0.54	XXX
78010	TC	A	Thyroid imaging	0.00	1.81	NA	0.11	1.92	NA	XXX
78011		A	Thyroid imaging with flow	0.45	2.55	NA	0.15	3.15	NA	XXX
78011	26	A	Thyroid imaging with flow	0.45	0.15	0.15	0.02	0.62	0.62	XXX
78011	TC	A	Thyroid imaging with flow	0.00	2.40	NA	0.13	2.53	NA	XXX
78015		A	Thyroid met imaging	0.67	2.79	NA	0.17	3.63	NA	XXX
78015	26	A	Thyroid met imaging	0.67	0.23	0.23	0.03	0.93	0.93	XXX
78015	TC	A	Thyroid met imaging	0.00	2.57	NA	0.14	2.71	NA	XXX
78016		A	Thyroid met imaging/studies	0.82	3.76	NA	0.21	4.79	NA	XXX
78016	26	A	Thyroid met imaging/studies	0.82	0.28	0.28	0.03	1.13	1.13	XXX
78016	TC	A	Thyroid met imaging/studies	0.00	3.47	NA	0.18	3.65	NA	XXX
78018		A	Thyroid met imaging, body	0.86	5.71	NA	0.33	6.90	NA	XXX
78018	26	A	Thyroid met imaging, body	0.86	0.29	0.29	0.04	1.19	1.19	XXX
78018	TC	A	Thyroid met imaging, body	0.00	5.41	NA	0.29	5.70	NA	XXX
78020		A	Thyroid met uptake	0.60	1.51	NA	0.17	2.28	NA	ZZZ
78020	26	A	Thyroid met uptake	0.60	0.21	0.21	0.03	0.84	0.84	ZZZ
78020	TC	A	Thyroid met uptake	0.00	1.30	NA	0.14	1.44	NA	ZZZ
78070		A	Parathyroid nuclear imaging	0.82	4.54	NA	0.15	5.51	NA	XXX
78070	26	A	Parathyroid nuclear imaging	0.82	0.28	0.28	0.04	1.14	1.14	XXX
78070	TC	A	Parathyroid nuclear imaging	0.00	4.27	NA	0.11	4.38	NA	XXX
78075		A	Adrenal nuclear imaging	0.74	5.68	NA	0.32	6.74	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
78075	26	A	Adrenal nuclear imaging	0.74	0.26	0.26	0.03	1.03	1.03	XXX
78075	TC	A	Adrenal nuclear imaging	0.00	5.41	NA	0.29	5.70	NA	XXX
78102		A	Bone marrow imaging, ltd	0.55	2.23	NA	0.14	2.92	NA	XXX
78102	26	A	Bone marrow imaging, ltd	0.55	0.19	0.19	0.02	0.76	0.76	XXX
78102	TC	A	Bone marrow imaging, ltd	0.00	2.04	NA	0.12	2.16	NA	XXX
78103		A	Bone marrow imaging, mult	0.75	3.42	NA	0.20	4.37	NA	XXX
78103	26	A	Bone marrow imaging, mult	0.75	0.26	0.26	0.03	1.04	1.04	XXX
78103	TC	A	Bone marrow imaging, mult	0.00	3.17	NA	0.17	3.34	NA	XXX
78104		A	Bone marrow imaging, body	0.80	4.33	NA	0.26	5.39	NA	XXX
78104	26	A	Bone marrow imaging, body	0.80	0.27	0.27	0.04	1.11	1.11	XXX
78104	TC	A	Bone marrow imaging, body	0.00	4.06	NA	0.22	4.28	NA	XXX
78110		A	Plasma volume, single	0.19	1.02	NA	0.07	1.28	NA	XXX
78110	26	A	Plasma volume, single	0.19	0.07	0.07	0.01	0.27	0.27	XXX
78110	TC	A	Plasma volume, single	0.00	0.95	NA	0.06	1.01	NA	XXX
78111		A	Plasma volume, multiple	0.22	2.65	NA	0.15	3.02	NA	XXX
78111	26	A	Plasma volume, multiple	0.22	0.08	0.08	0.01	0.31	0.31	XXX
78111	TC	A	Plasma volume, multiple	0.00	2.57	NA	0.14	2.71	NA	XXX
78120		A	Red cell mass, single	0.23	1.81	NA	0.12	2.16	NA	XXX
78120	26	A	Red cell mass, single	0.23	0.08	0.08	0.01	0.32	0.32	XXX
78120	TC	A	Red cell mass, single	0.00	1.73	NA	0.11	1.84	NA	XXX
78121		A	Red cell mass, multiple	0.32	3.02	NA	0.15	3.49	NA	XXX
78121	26	A	Red cell mass, multiple	0.32	0.11	0.11	0.01	0.44	0.44	XXX
78121	TC	A	Red cell mass, multiple	0.00	2.91	NA	0.14	3.05	NA	XXX
78122		A	Blood volume	0.45	4.75	NA	0.26	5.46	NA	XXX
78122	26	A	Blood volume	0.45	0.16	0.16	0.02	0.63	0.63	XXX
78122	TC	A	Blood volume	0.00	4.59	NA	0.24	4.83	NA	XXX
78130		A	Red cell survival study	0.61	3.06	NA	0.17	3.84	NA	XXX
78130	26	A	Red cell survival study	0.61	0.21	0.21	0.03	0.85	0.85	XXX
78130	TC	A	Red cell survival study	0.00	2.85	NA	0.14	2.99	NA	XXX
78135		A	Red cell survival kinetics	0.64	5.08	NA	0.28	6.00	NA	XXX
78135	26	A	Red cell survival kinetics	0.64	0.22	0.22	0.03	0.89	0.89	XXX
78135	TC	A	Red cell survival kinetics	0.00	4.86	NA	0.25	5.11	NA	XXX
78140		A	Red cell sequestration	0.61	4.13	NA	0.24	4.98	NA	XXX
78140	26	A	Red cell sequestration	0.61	0.20	0.20	0.03	0.84	0.84	XXX
78140	TC	A	Red cell sequestration	0.00	3.93	NA	0.21	4.14	NA	XXX
78160		A	Plasma iron turnover	0.33	3.78	NA	0.20	4.31	NA	XXX
78160	26	A	Plasma iron turnover	0.33	0.12	0.12	0.01	0.46	0.46	XXX
78160	TC	A	Plasma iron turnover	0.00	3.66	NA	0.19	3.85	NA	XXX
78162		A	Radioiron absorption exam	0.45	3.38	NA	0.18	4.01	NA	XXX
78162	26	A	Radioiron absorption exam	0.45	0.19	0.19	0.01	0.65	0.65	XXX
78162	TC	A	Radioiron absorption exam	0.00	3.19	NA	0.17	3.36	NA	XXX
78170		A	Red cell iron utilization	0.41	5.44	NA	0.30	6.15	NA	XXX
78170	26	A	Red cell iron utilization	0.41	0.14	0.14	0.02	0.57	0.57	XXX
78170	TC	A	Red cell iron utilization	0.00	5.30	NA	0.28	5.58	NA	XXX
78172	26	A	Total body iron estimation	0.53	0.17	0.17	0.02	0.72	0.72	XXX
78185		A	Spleen imaging	0.40	2.49	NA	0.15	3.04	NA	XXX
78185	26	A	Spleen imaging	0.40	0.14	0.14	0.02	0.56	0.56	XXX
78185	TC	A	Spleen imaging	0.00	2.35	NA	0.13	2.48	NA	XXX
78190		A	Platelet survival, kinetics	1.09	6.10	NA	0.34	7.53	NA	XXX
78190	26	A	Platelet survival, kinetics	1.09	0.39	0.39	0.04	1.52	1.52	XXX
78190	TC	A	Platelet survival, kinetics	0.00	5.70	NA	0.30	6.00	NA	XXX
78191		A	Platelet survival	0.61	7.53	NA	0.40	8.54	NA	XXX
78191	26	A	Platelet survival	0.61	0.20	0.20	0.03	0.84	0.84	XXX
78191	TC	A	Platelet survival	0.00	7.33	NA	0.37	7.70	NA	XXX
78195		A	Lymph system imaging	1.20	4.47	NA	0.28	5.95	NA	XXX
78195	26	A	Lymph system imaging	1.20	0.41	0.41	0.06	1.67	1.67	XXX
78195	TC	A	Lymph system imaging	0.00	4.06	NA	0.22	4.28	NA	XXX
78201		A	Liver imaging	0.44	2.50	NA	0.15	3.09	NA	XXX
78201	26	A	Liver imaging	0.44	0.15	0.15	0.02	0.61	0.61	XXX
78201	TC	A	Liver imaging	0.00	2.35	NA	0.13	2.48	NA	XXX
78202		A	Liver imaging with flow	0.51	3.05	NA	0.16	3.72	NA	XXX
78202	26	A	Liver imaging with flow	0.51	0.17	0.17	0.02	0.70	0.70	XXX
78202	TC	A	Liver imaging with flow	0.00	2.88	NA	0.14	3.02	NA	XXX
78205		A	Liver imaging (3D)	0.71	6.14	NA	0.34	7.19	NA	XXX
78205	26	A	Liver imaging (3D)	0.71	0.24	0.24	0.03	0.98	0.98	XXX
78205	TC	A	Liver imaging (3D)	0.00	5.90	NA	0.31	6.21	NA	XXX
78206		A	Liver image (3d) with flow	0.96	6.23	NA	0.15	7.34	NA	XXX
78206	26	A	Liver image (3d) with flow	0.96	0.33	0.33	0.04	1.33	1.33	XXX
78206	TC	A	Liver image (3d) with flow	0.00	5.90	NA	0.11	6.01	NA	XXX
78215		A	Liver and spleen imaging	0.49	3.10	NA	0.16	3.75	NA	XXX
78215	26	A	Liver and spleen imaging	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78215	TC	A	Liver and spleen imaging	0.00	2.93	NA	0.14	3.07	NA	XXX
78216		A	Liver & spleen image/flow	0.57	3.67	NA	0.20	4.44	NA	XXX
78216	26	A	Liver & spleen image/flow	0.57	0.19	0.19	0.02	0.78	0.78	XXX
78216	TC	A	Liver & spleen image/flow	0.00	3.47	NA	0.18	3.65	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
78220		A	Liver function study	0.49	3.88	NA	0.21	4.58	NA	XXX
78220	26	A	Liver function study	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78220	TC	A	Liver function study	0.00	3.72	NA	0.19	3.91	NA	XXX
78223		A	Hepatobiliary imaging	0.84	3.94	NA	0.23	5.01	NA	XXX
78223	26	A	Hepatobiliary imaging	0.84	0.28	0.28	0.04	1.16	1.16	XXX
78223	TC	A	Hepatobiliary imaging	0.00	3.66	NA	0.19	3.85	NA	XXX
78230		A	Salivary gland imaging	0.45	2.32	NA	0.15	2.92	NA	XXX
78230	26	A	Salivary gland imaging	0.45	0.15	0.15	0.02	0.62	0.62	XXX
78230	TC	A	Salivary gland imaging	0.00	2.17	NA	0.13	2.30	NA	XXX
78231		A	Serial salivary imaging	0.52	3.35	NA	0.19	4.06	NA	XXX
78231	26	A	Serial salivary imaging	0.52	0.18	0.18	0.02	0.72	0.72	XXX
78231	TC	A	Serial salivary imaging	0.00	3.17	NA	0.17	3.34	NA	XXX
78232		A	Salivary gland function exam	0.47	3.70	NA	0.20	4.37	NA	XXX
78232	26	A	Salivary gland function exam	0.47	0.16	0.16	0.02	0.65	0.65	XXX
78232	TC	A	Salivary gland function exam	0.00	3.53	NA	0.18	3.71	NA	XXX
78258		A	Esophageal motility study	0.74	3.12	NA	0.17	4.03	NA	XXX
78258	26	A	Esophageal motility study	0.74	0.25	0.25	0.03	1.02	1.02	XXX
78258	TC	A	Esophageal motility study	0.00	2.88	NA	0.14	3.02	NA	XXX
78261		A	Gastric mucosa imaging	0.69	4.33	NA	0.25	5.27	NA	XXX
78261	26	A	Gastric mucosa imaging	0.69	0.24	0.24	0.03	0.96	0.96	XXX
78261	TC	A	Gastric mucosa imaging	0.00	4.09	NA	0.22	4.31	NA	XXX
78262		A	Gastroesophageal reflux exam	0.68	4.48	NA	0.25	5.41	NA	XXX
78262	26	A	Gastroesophageal reflux exam	0.68	0.23	0.23	0.03	0.94	0.94	XXX
78262	TC	A	Gastroesophageal reflux exam	0.00	4.25	NA	0.22	4.47	NA	XXX
78264		A	Gastric emptying study	0.78	4.38	NA	0.25	5.41	NA	XXX
78264	26	A	Gastric emptying study	0.78	0.26	0.26	0.03	1.07	1.07	XXX
78264	TC	A	Gastric emptying study	0.00	4.12	NA	0.22	4.34	NA	XXX
78270		A	Vit B-12 absorption exam	0.20	1.61	NA	0.11	1.92	NA	XXX
78270	26	A	Vit B-12 absorption exam	0.20	0.07	0.07	0.01	0.28	0.28	XXX
78270	TC	A	Vit B-12 absorption exam	0.00	1.54	NA	0.10	1.64	NA	XXX
78271		A	Vit b-12 absrp exam, int fac	0.20	1.71	NA	0.11	2.02	NA	XXX
78271	26	A	Vit b-12 absrp exam, int fac	0.20	0.07	0.07	0.01	0.28	0.28	XXX
78271	TC	A	Vit b-12 absrp exam, int fac	0.00	1.64	NA	0.10	1.74	NA	XXX
78272		A	Vit B-12 absorp, combined	0.27	2.41	NA	0.14	2.82	NA	XXX
78272	26	A	Vit B-12 absorp, combined	0.27	0.09	0.09	0.01	0.37	0.37	XXX
78272	TC	A	Vit B-12 absorp, combined	0.00	2.32	NA	0.13	2.45	NA	XXX
78278		A	Acute GI blood loss imaging	0.99	5.19	NA	0.29	6.47	NA	XXX
78278	26	A	Acute GI blood loss imaging	0.99	0.33	0.33	0.04	1.36	1.36	XXX
78278	TC	A	Acute GI blood loss imaging	0.00	4.86	NA	0.25	5.11	NA	XXX
78282	26	A	GI protein loss exam	0.38	0.13	0.13	0.02	0.53	0.53	XXX
78290		A	Meckel-s divert exam	0.68	3.27	NA	0.19	4.14	NA	XXX
78290	26	A	Meckel-s divert exam	0.68	0.23	0.23	0.03	0.94	0.94	XXX
78290	TC	A	Meckel-s divert exam	0.00	3.04	NA	0.16	3.20	NA	XXX
78291		A	Leveen/shunt patency exam	0.88	3.36	NA	0.20	4.44	NA	XXX
78291	26	A	Leveen/shunt patency exam	0.88	0.30	0.30	0.04	1.22	1.22	XXX
78291	TC	A	Leveen/shunt patency exam	0.00	3.06	NA	0.16	3.22	NA	XXX
78300		A	Bone imaging, limited area	0.62	2.69	NA	0.17	3.48	NA	XXX
78300	26	A	Bone imaging, limited area	0.62	0.21	0.21	0.03	0.86	0.86	XXX
78300	TC	A	Bone imaging, limited area	0.00	2.48	NA	0.14	2.62	NA	XXX
78305		A	Bone imaging, multiple areas	0.83	3.93	NA	0.23	4.99	NA	XXX
78305	26	A	Bone imaging, multiple areas	0.83	0.28	0.28	0.04	1.15	1.15	XXX
78305	TC	A	Bone imaging, multiple areas	0.00	3.66	NA	0.19	3.85	NA	XXX
78306		A	Bone imaging, whole body	0.86	4.55	NA	0.26	5.67	NA	XXX
78306	26	A	Bone imaging, whole body	0.86	0.29	0.29	0.04	1.19	1.19	XXX
78306	TC	A	Bone imaging, whole body	0.00	4.27	NA	0.22	4.49	NA	XXX
78315		A	Bone imaging, 3 phase	1.02	5.11	NA	0.29	6.42	NA	XXX
78315	26	A	Bone imaging, 3 phase	1.02	0.34	0.34	0.04	1.40	1.40	XXX
78315	TC	A	Bone imaging, 3 phase	0.00	4.77	NA	0.25	5.02	NA	XXX
78320		A	Bone imaging (3D)	1.04	6.26	NA	0.36	7.66	NA	XXX
78320	26	A	Bone imaging (3D)	1.04	0.36	0.36	0.05	1.45	1.45	XXX
78320	TC	A	Bone imaging (3D)	0.00	5.90	NA	0.31	6.21	NA	XXX
78350		A	Bone mineral, single photon	0.22	0.83	NA	0.06	1.11	NA	XXX
78350	26	A	Bone mineral, single photon	0.22	0.07	0.07	0.01	0.30	0.30	XXX
78350	TC	A	Bone mineral, single photon	0.00	0.75	NA	0.05	0.80	NA	XXX
78414	26	A	Non-imaging heart function	0.45	0.16	0.16	0.02	0.63	0.63	XXX
78428		A	Cardiac shunt imaging	0.78	2.54	NA	0.16	3.48	NA	XXX
78428	26	A	Cardiac shunt imaging	0.78	0.29	0.29	0.03	1.10	1.10	XXX
78428	TC	A	Cardiac shunt imaging	0.00	2.25	NA	0.13	2.38	NA	XXX
78445		A	Vascular flow imaging	0.49	2.02	NA	0.13	2.64	NA	XXX
78445	26	A	Vascular flow imaging	0.49	0.17	0.17	0.02	0.68	0.68	XXX
78445	TC	A	Vascular flow imaging	0.00	1.85	NA	0.11	1.96	NA	XXX
78455		A	Venous thrombosis study	0.73	4.22	NA	0.24	5.19	NA	XXX
78455	26	A	Venous thrombosis study	0.73	0.25	0.25	0.03	1.01	1.01	XXX
78455	TC	A	Venous thrombosis study	0.00	3.98	NA	0.21	4.19	NA	XXX
78456		A	Acute venous thrombus image	1.00	4.32	NA	0.33	5.65	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
78456	26	A	Acute venous thrombus image	1.00	0.34	0.34	0.04	1.38	1.38	XXX
78456	TC	A	Acute venous thrombus image	0.00	3.98	NA	0.29	4.27	NA	XXX
78457		A	Venous thrombosis imaging	0.77	2.91	NA	0.18	3.86	NA	XXX
78457	26	A	Venous thrombosis imaging	0.77	0.26	0.26	0.04	1.07	1.07	XXX
78457	TC	A	Venous thrombosis imaging	0.00	2.65	NA	0.14	2.79	NA	XXX
78458		A	Ven thrombosis images, bilat	0.90	4.34	NA	0.25	5.49	NA	XXX
78458	26	A	Ven thrombosis images, bilat	0.90	0.32	0.32	0.04	1.26	1.26	XXX
78458	TC	A	Ven thrombosis images, bilat	0.00	4.02	NA	0.21	4.23	NA	XXX
78459	26	R	Heart muscle imaging (PET)	1.50	0.57	0.57	0.06	2.13	2.13	XXX
78460		A	Heart muscle blood, single	0.86	2.65	NA	0.17	3.68	NA	XXX
78460	26	A	Heart muscle blood, single	0.86	0.29	0.29	0.04	1.19	1.19	XXX
78460	TC	A	Heart muscle blood, single	0.00	2.35	NA	0.13	2.48	NA	XXX
78461		A	Heart muscle blood, multiple	1.23	5.14	NA	0.30	6.67	NA	XXX
78461	26	A	Heart muscle blood, multiple	1.23	0.43	0.43	0.05	1.71	1.71	XXX
78461	TC	A	Heart muscle blood, multiple	0.00	4.71	NA	0.25	4.96	NA	XXX
78464		A	Heart image (3d), single	1.09	7.44	NA	0.41	8.94	NA	XXX
78464	26	A	Heart image (3d), single	1.09	0.38	0.38	0.04	1.51	1.51	XXX
78464	TC	A	Heart image (3d), single	0.00	7.06	NA	0.37	7.43	NA	XXX
78465		A	Heart image (3d), multiple	1.46	12.30	NA	0.68	14.44	NA	XXX
78465	26	A	Heart image (3d), multiple	1.46	0.52	0.52	0.06	2.04	2.04	XXX
78465	TC	A	Heart image (3d), multiple	0.00	11.77	NA	0.62	12.39	NA	XXX
78466		A	Heart infarct image	0.69	2.86	NA	0.17	3.72	NA	XXX
78466	26	A	Heart infarct image	0.69	0.24	0.24	0.03	0.96	0.96	XXX
78466	TC	A	Heart infarct image	0.00	2.62	NA	0.14	2.76	NA	XXX
78468		A	Heart infarct image (ef)	0.80	3.93	NA	0.22	4.95	NA	XXX
78468	26	A	Heart infarct image (ef)	0.80	0.27	0.27	0.03	1.10	1.10	XXX
78468	TC	A	Heart infarct image (ef)	0.00	3.66	NA	0.19	3.85	NA	XXX
78469		A	Heart infarct image (3D)	0.92	5.53	NA	0.31	6.76	NA	XXX
78469	26	A	Heart infarct image (3D)	0.92	0.31	0.31	0.03	1.26	1.26	XXX
78469	TC	A	Heart infarct image (3D)	0.00	5.21	NA	0.28	5.49	NA	XXX
78472		A	Gated heart, planar, single	0.98	5.84	NA	0.34	7.16	NA	XXX
78472	26	A	Gated heart, planar, single	0.98	0.34	0.34	0.04	1.36	1.36	XXX
78472	TC	A	Gated heart, planar, single	0.00	5.50	NA	0.30	5.80	NA	XXX
78473		A	Gated heart, multiple	1.47	8.75	NA	0.48	10.70	NA	XXX
78473	26	A	Gated heart, multiple	1.47	0.51	0.51	0.06	2.04	2.04	XXX
78473	TC	A	Gated heart, multiple	0.00	8.24	NA	0.42	8.66	NA	XXX
78478		A	Heart wall motion add-on	0.62	1.78	NA	0.12	2.52	NA	XXX
78478	26	A	Heart wall motion add-on	0.62	0.22	0.22	0.02	0.86	0.86	XXX
78478	TC	A	Heart wall motion add-on	0.00	1.55	NA	0.10	1.65	NA	XXX
78480		A	Heart function add-on	0.62	1.78	NA	0.12	2.52	NA	XXX
78480	26	A	Heart function add-on	0.62	0.22	0.22	0.02	0.86	0.86	XXX
78480	TC	A	Heart function add-on	0.00	1.55	NA	0.10	1.65	NA	XXX
78481		A	Heart first pass, single	0.98	5.57	NA	0.32	6.87	NA	XXX
78481	26	A	Heart first pass, single	0.98	0.36	0.36	0.04	1.38	1.38	XXX
78481	TC	A	Heart first pass, single	0.00	5.21	NA	0.28	5.49	NA	XXX
78483		A	Heart first pass, multiple	1.47	8.39	NA	0.46	10.32	NA	XXX
78483	26	A	Heart first pass, multiple	1.47	0.54	0.54	0.05	2.06	2.06	XXX
78483	TC	A	Heart first pass, multiple	0.00	7.86	NA	0.41	8.27	NA	XXX
78494		A	Heart image, spect	1.19	7.47	NA	0.35	9.01	NA	XXX
78494	26	A	Heart image, spect	1.19	0.42	0.42	0.05	1.66	1.66	XXX
78494	TC	A	Heart image, spect	0.00	7.06	NA	0.30	7.36	NA	XXX
78496		A	Heart first pass add-on	0.50	7.24	NA	0.32	8.06	NA	ZZZ
78496	26	A	Heart first pass add-on	0.50	0.18	0.18	0.02	0.70	0.70	ZZZ
78496	TC	A	Heart first pass add-on	0.00	7.06	NA	0.30	7.36	NA	ZZZ
78580		A	Lung perfusion imaging	0.74	3.67	NA	0.21	4.62	NA	XXX
78580	26	A	Lung perfusion imaging	0.74	0.25	0.25	0.03	1.02	1.02	XXX
78580	TC	A	Lung perfusion imaging	0.00	3.43	NA	0.18	3.61	NA	XXX
78584		A	Lung V/Q image single breath	0.99	3.52	NA	0.21	4.72	NA	XXX
78584	26	A	Lung V/Q image single breath	0.99	0.32	0.32	0.04	1.35	1.35	XXX
78584	TC	A	Lung V/Q image single breath	0.00	3.19	NA	0.17	3.36	NA	XXX
78585		A	Lung V/Q imaging	1.09	5.99	NA	0.35	7.43	NA	XXX
78585	26	A	Lung V/Q imaging	1.09	0.36	0.36	0.05	1.50	1.50	XXX
78585	TC	A	Lung V/Q imaging	0.00	5.63	NA	0.30	5.93	NA	XXX
78586		A	Aerosol lung image, single	0.40	2.72	NA	0.16	3.28	NA	XXX
78586	26	A	Aerosol lung image, single	0.40	0.13	0.13	0.02	0.55	0.55	XXX
78586	TC	A	Aerosol lung image, single	0.00	2.59	NA	0.14	2.73	NA	XXX
78587		A	Aerosol lung image, multiple	0.49	2.96	NA	0.16	3.61	NA	XXX
78587	26	A	Aerosol lung image, multiple	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78587	TC	A	Aerosol lung image, multiple	0.00	2.80	NA	0.14	2.94	NA	XXX
78588		A	Perfusion lung image	1.09	3.56	NA	0.23	4.88	NA	XXX
78588	26	A	Perfusion lung image	1.09	0.36	0.36	0.05	1.50	1.50	XXX
78588	TC	A	Perfusion lung image	0.00	3.19	NA	0.18	3.37	NA	XXX
78591		A	Vent image, 1 breath, 1 proj	0.40	2.98	NA	0.16	3.54	NA	XXX
78591	26	A	Vent image, 1 breath, 1 proj	0.40	0.13	0.13	0.02	0.55	0.55	XXX
78591	TC	A	Vent image, 1 breath, 1 proj	0.00	2.85	NA	0.14	2.99	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
78593		A	Vent image, 1 proj, gas	0.49	3.61	NA	0.20	4.30	NA	XXX
78593	26	A	Vent image, 1 proj, gas	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78593	TC	A	Vent image, 1 proj, gas	0.00	3.45	NA	0.18	3.63	NA	XXX
78594		A	Vent image, mult proj, gas	0.53	5.15	NA	0.27	5.95	NA	XXX
78594	26	A	Vent image, mult proj, gas	0.53	0.18	0.18	0.02	0.73	0.73	XXX
78594	TC	A	Vent image, mult proj, gas	0.00	4.97	NA	0.25	5.22	NA	XXX
78596		A	Lung differential function	1.27	7.48	NA	0.43	9.18	NA	XXX
78596	26	A	Lung differential function	1.27	0.42	0.42	0.06	1.75	1.75	XXX
78596	TC	A	Lung differential function	0.00	7.06	NA	0.37	7.43	NA	XXX
78600		A	Brain imaging, ltd static	0.44	3.03	NA	0.16	3.63	NA	XXX
78600	26	A	Brain imaging, ltd static	0.44	0.15	0.15	0.02	0.61	0.61	XXX
78600	TC	A	Brain imaging, ltd static	0.00	2.88	NA	0.14	3.02	NA	XXX
78601		A	Brain imaging, ltd w/flow	0.51	3.57	NA	0.20	4.28	NA	XXX
78601	26	A	Brain imaging, ltd w/flow	0.51	0.17	0.17	0.02	0.70	0.70	XXX
78601	TC	A	Brain imaging, ltd w/flow	0.00	3.40	NA	0.18	3.58	NA	XXX
78605		A	Brain imaging, complete	0.53	3.58	NA	0.20	4.31	NA	XXX
78605	26	A	Brain imaging, complete	0.53	0.18	0.18	0.02	0.73	0.73	XXX
78605	TC	A	Brain imaging, complete	0.00	3.40	NA	0.18	3.58	NA	XXX
78606		A	Brain imaging, compl w/flow	0.64	4.07	NA	0.24	4.95	NA	XXX
78606	26	A	Brain imaging, compl w/flow	0.64	0.21	0.21	0.03	0.88	0.88	XXX
78606	TC	A	Brain imaging, compl w/flow	0.00	3.86	NA	0.21	4.07	NA	XXX
78607		A	Brain imaging (3D)	1.23	6.97	NA	0.40	8.60	NA	XXX
78607	26	A	Brain imaging (3D)	1.23	0.43	0.43	0.05	1.71	1.71	XXX
78607	TC	A	Brain imaging (3D)	0.00	6.54	NA	0.35	6.89	NA	XXX
78610		A	Brain flow imaging only	0.30	1.68	NA	0.11	2.09	NA	XXX
78610	26	A	Brain flow imaging only	0.30	0.11	0.11	0.01	0.42	0.42	XXX
78610	TC	A	Brain flow imaging only	0.00	1.57	NA	0.10	1.67	NA	XXX
78615		A	Cerebral vascular flow image	0.42	3.99	NA	0.23	4.64	NA	XXX
78615	26	A	Cerebral vascular flow image	0.42	0.15	0.15	0.02	0.59	0.59	XXX
78615	TC	A	Cerebral vascular flow image	0.00	3.84	NA	0.21	4.05	NA	XXX
78630		A	Cerebrospinal fluid scan	0.68	5.26	NA	0.30	6.24	NA	XXX
78630	26	A	Cerebrospinal fluid scan	0.68	0.23	0.23	0.03	0.94	0.94	XXX
78630	TC	A	Cerebrospinal fluid scan	0.00	5.03	NA	0.27	5.30	NA	XXX
78635		A	CSF ventriculography	0.61	2.77	NA	0.16	3.54	NA	XXX
78635	26	A	CSF ventriculography	0.61	0.23	0.23	0.02	0.86	0.86	XXX
78635	TC	A	CSF ventriculography	0.00	2.54	NA	0.14	2.68	NA	XXX
78645		A	CSF shunt evaluation	0.57	3.62	NA	0.20	4.39	NA	XXX
78645	26	A	CSF shunt evaluation	0.57	0.19	0.19	0.02	0.78	0.78	XXX
78645	TC	A	CSF shunt evaluation	0.00	3.43	NA	0.18	3.61	NA	XXX
78647		A	Cerebrospinal fluid scan	0.90	6.21	NA	0.35	7.46	NA	XXX
78647	26	A	Cerebrospinal fluid scan	0.90	0.31	0.31	0.04	1.25	1.25	XXX
78647	TC	A	Cerebrospinal fluid scan	0.00	5.90	NA	0.31	6.21	NA	XXX
78650		A	CSF leakage imaging	0.61	4.84	NA	0.27	5.72	NA	XXX
78650	26	A	CSF leakage imaging	0.61	0.21	0.21	0.03	0.85	0.85	XXX
78650	TC	A	CSF leakage imaging	0.00	4.63	NA	0.24	4.87	NA	XXX
78660		A	Nuclear exam of tear flow	0.53	2.29	NA	0.14	2.96	NA	XXX
78660	26	A	Nuclear exam of tear flow	0.53	0.18	0.18	0.02	0.73	0.73	XXX
78660	TC	A	Nuclear exam of tear flow	0.00	2.11	NA	0.12	2.23	NA	XXX
78700		A	Kidney imaging, static	0.45	3.19	NA	0.18	3.82	NA	XXX
78700	26	A	Kidney imaging, static	0.45	0.15	0.15	0.02	0.62	0.62	XXX
78700	TC	A	Kidney imaging, static	0.00	3.04	NA	0.16	3.20	NA	XXX
78701		A	Kidney imaging with flow	0.49	3.71	NA	0.20	4.40	NA	XXX
78701	26	A	Kidney imaging with flow	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78701	TC	A	Kidney imaging with flow	0.00	3.55	NA	0.18	3.73	NA	XXX
78704		A	Imaging renogram	0.74	4.19	NA	0.24	5.17	NA	XXX
78704	26	A	Imaging renogram	0.74	0.25	0.25	0.03	1.02	1.02	XXX
78704	TC	A	Imaging renogram	0.00	3.95	NA	0.21	4.16	NA	XXX
78707		A	Kidney flow/function image	0.96	4.78	NA	0.27	6.01	NA	XXX
78707	26	A	Kidney flow/function image	0.96	0.32	0.32	0.04	1.32	1.32	XXX
78707	TC	A	Kidney flow/function image	0.00	4.46	NA	0.23	4.69	NA	XXX
78708		A	Kidney flow/function image	1.21	4.87	NA	0.28	6.36	NA	XXX
78708	26	A	Kidney flow/function image	1.21	0.41	0.41	0.05	1.67	1.67	XXX
78708	TC	A	Kidney flow/function image	0.00	4.46	NA	0.23	4.69	NA	XXX
78709		A	Kidney flow/function image	1.41	4.93	NA	0.29	6.63	NA	XXX
78709	26	A	Kidney flow/function image	1.41	0.47	0.47	0.06	1.94	1.94	XXX
78709	TC	A	Kidney flow/function image	0.00	4.46	NA	0.23	4.69	NA	XXX
78710		A	Kidney imaging (3D)	0.66	6.12	NA	0.34	7.12	NA	XXX
78710	26	A	Kidney imaging (3D)	0.66	0.22	0.22	0.03	0.91	0.91	XXX
78710	TC	A	Kidney imaging (3D)	0.00	5.90	NA	0.31	6.21	NA	XXX
78715		A	Renal vascular flow exam	0.30	1.68	NA	0.11	2.09	NA	XXX
78715	26	A	Renal vascular flow exam	0.30	0.11	0.11	0.01	0.42	0.42	XXX
78715	TC	A	Renal vascular flow exam	0.00	1.57	NA	0.10	1.67	NA	XXX
78725		A	Kidney function study	0.38	1.90	NA	0.13	2.41	NA	XXX
78725	26	A	Kidney function study	0.38	0.13	0.13	0.02	0.53	0.53	XXX
78725	TC	A	Kidney function study	0.00	1.78	NA	0.11	1.89	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
78730		A	Urinary bladder retention	0.36	1.58	NA	0.10	2.04	NA	XXX
78730	26	A	Urinary bladder retention	0.36	0.12	0.12	0.02	0.50	0.50	XXX
78730	TC	A	Urinary bladder retention	0.00	1.46	NA	0.08	1.54	NA	XXX
78740		A	Ureteral reflux study	0.57	2.30	NA	0.15	3.02	NA	XXX
78740	26	A	Ureteral reflux study	0.57	0.19	0.19	0.03	0.79	0.79	XXX
78740	TC	A	Ureteral reflux study	0.00	2.11	NA	0.12	2.23	NA	XXX
78760		A	Testicular imaging	0.66	2.89	NA	0.17	3.72	NA	XXX
78760	26	A	Testicular imaging	0.66	0.22	0.22	0.03	0.91	0.91	XXX
78760	TC	A	Testicular imaging	0.00	2.67	NA	0.14	2.81	NA	XXX
78761		A	Testicular imaging/flow	0.71	3.43	NA	0.20	4.34	NA	XXX
78761	26	A	Testicular imaging/flow	0.71	0.24	0.24	0.03	0.98	0.98	XXX
78761	TC	A	Testicular imaging/flow	0.00	3.19	NA	0.17	3.36	NA	XXX
78800		A	Tumor imaging, limited area	0.66	3.62	NA	0.22	4.50	NA	XXX
78800	26	A	Tumor imaging, limited area	0.66	0.22	0.22	0.04	0.92	0.92	XXX
78800	TC	A	Tumor imaging, limited area	0.00	3.40	NA	0.18	3.58	NA	XXX
78801		A	Tumor imaging, mult areas	0.79	4.48	NA	0.27	5.54	NA	XXX
78801	26	A	Tumor imaging, mult areas	0.79	0.27	0.27	0.05	1.11	1.11	XXX
78801	TC	A	Tumor imaging, mult areas	0.00	4.22	NA	0.22	4.44	NA	XXX
78802		A	Tumor imaging, whole body	0.86	5.81	NA	0.34	7.01	NA	XXX
78802	26	A	Tumor imaging, whole body	0.86	0.29	0.29	0.04	1.19	1.19	XXX
78802	TC	A	Tumor imaging, whole body	0.00	5.52	NA	0.30	5.82	NA	XXX
78803		A	Tumor imaging (3D)	1.09	6.93	NA	0.40	8.42	NA	XXX
78803	26	A	Tumor imaging (3D)	1.09	0.38	0.38	0.05	1.52	1.52	XXX
78803	TC	A	Tumor imaging (3D)	0.00	6.54	NA	0.35	6.89	NA	XXX
78804		A	Tumor imaging, whole body	1.07	11.41	NA	0.34	12.82	NA	XXX
78804	26	A	Tumor imaging, whole body	1.07	0.37	0.37	0.04	1.48	1.48	XXX
78804	TC	A	Tumor imaging, whole body	0.00	11.04	NA	0.30	11.34	NA	XXX
78805		A	Abscess imaging, ltd area	0.73	3.65	NA	0.21	4.59	NA	XXX
78805	26	A	Abscess imaging, ltd area	0.73	0.25	0.25	0.03	1.01	1.01	XXX
78805	TC	A	Abscess imaging, ltd area	0.00	3.40	NA	0.18	3.58	NA	XXX
78806		A	Abscess imaging, whole body	0.86	6.71	NA	0.39	7.96	NA	XXX
78806	26	A	Abscess imaging, whole body	0.86	0.29	0.29	0.04	1.19	1.19	XXX
78806	TC	A	Abscess imaging, whole body	0.00	6.42	NA	0.35	6.77	NA	XXX
78807		A	Nuclear localization/abscess	1.09	6.93	NA	0.40	8.42	NA	XXX
78807	26	A	Nuclear localization/abscess	1.09	0.39	0.39	0.05	1.53	1.53	XXX
78807	TC	A	Nuclear localization/abscess	0.00	6.54	NA	0.35	6.89	NA	XXX
78890		B	Nuclear medicine data proc	0.05	1.32	NA	0.07	1.44	NA	XXX
78890	26	B	Nuclear medicine data proc	0.05	0.02	0.02	0.01	0.08	0.08	XXX
78890	TC	B	Nuclear medicine data proc	0.00	1.30	NA	0.06	1.36	NA	XXX
78891		B	Nuclear med data proc	0.10	2.65	NA	0.14	2.89	NA	XXX
78891	26	B	Nuclear med data proc	0.10	0.04	0.04	0.01	0.15	0.15	XXX
78891	TC	B	Nuclear med data proc	0.00	2.62	NA	0.13	2.75	NA	XXX
79000		A	Init hyperthyroid therapy	1.80	3.22	NA	0.22	5.24	NA	XXX
79000	26	A	Init hyperthyroid therapy	1.80	0.60	0.60	0.08	2.48	2.48	XXX
79000	TC	A	Init hyperthyroid therapy	0.00	2.62	NA	0.14	2.76	NA	XXX
79001		A	Repeat hyperthyroid therapy	1.05	1.66	NA	0.12	2.83	NA	XXX
79001	26	A	Repeat hyperthyroid therapy	1.05	0.36	0.36	0.05	1.46	1.46	XXX
79001	TC	A	Repeat hyperthyroid therapy	0.00	1.30	NA	0.07	1.37	NA	XXX
79020		A	Thyroid ablation	1.81	3.21	NA	0.22	5.24	NA	XXX
79020	26	A	Thyroid ablation	1.81	0.60	0.60	0.08	2.49	2.49	XXX
79020	TC	A	Thyroid ablation	0.00	2.62	NA	0.14	2.76	NA	XXX
79030		A	Thyroid ablation, carcinoma	2.10	3.32	NA	0.23	5.65	NA	XXX
79030	26	A	Thyroid ablation, carcinoma	2.10	0.71	0.71	0.09	2.90	2.90	XXX
79030	TC	A	Thyroid ablation, carcinoma	0.00	2.62	NA	0.14	2.76	NA	XXX
79035		A	Thyroid metastatic therapy	2.52	3.49	NA	0.25	6.26	NA	XXX
79035	26	A	Thyroid metastatic therapy	2.52	0.87	0.87	0.11	3.50	3.50	XXX
79035	TC	A	Thyroid metastatic therapy	0.00	2.62	NA	0.14	2.76	NA	XXX
79100		A	Hematopoetic nuclear therapy	1.32	3.08	NA	0.20	4.60	NA	XXX
79100	26	A	Hematopoetic nuclear therapy	1.32	0.46	0.46	0.06	1.84	1.84	XXX
79100	TC	A	Hematopoetic nuclear therapy	0.00	2.62	NA	0.14	2.76	NA	XXX
79200		A	Intracavitary nuclear trmt	1.99	3.30	NA	0.23	5.52	NA	XXX
79200	26	A	Intracavitary nuclear trmt	1.99	0.69	0.69	0.09	2.77	2.77	XXX
79200	TC	A	Intracavitary nuclear trmt	0.00	2.62	NA	0.14	2.76	NA	XXX
79300	26	A	Interstitial nuclear therapy	1.60	0.56	0.56	0.08	2.24	2.24	XXX
79400		A	Nonhemato nuclear therapy	1.96	3.29	NA	0.23	5.48	NA	XXX
79400	26	A	Nonhemato nuclear therapy	1.96	0.67	0.67	0.09	2.72	2.72	XXX
79400	TC	A	Nonhemato nuclear therapy	0.00	2.62	NA	0.14	2.76	NA	XXX
79403		A	Hematopoetic nuclear therapy	2.25	5.16	NA	0.24	7.65	NA	XXX
79403	26	A	Hematopoetic nuclear therapy	2.25	0.89	0.89	0.10	3.24	3.24	XXX
79403	TC	A	Hematopoetic nuclear therapy	0.00	4.27	NA	0.14	4.41	NA	XXX
79420	26	A	Intravascular nuclear ther	1.51	0.49	0.49	0.07	2.07	2.07	XXX
79440		A	Nuclear joint therapy	1.99	3.34	NA	0.24	5.57	NA	XXX
79440	26	A	Nuclear joint therapy	1.99	0.72	0.72	0.10	2.81	2.81	XXX
79440	TC	A	Nuclear joint therapy	0.00	2.62	NA	0.14	2.76	NA	XXX
80500		A	Lab pathology consultation	0.37	0.21	0.16	0.01	0.59	0.54	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
80502		A	Lab pathology consultation	1.33	0.55	0.55	0.06	1.94	1.94	XXX
83020	26	A	Hemoglobin electrophoresis	0.37	0.15	0.15	0.01	0.53	0.53	XXX
83912	26	A	Genetic examination	0.37	0.12	0.12	0.01	0.50	0.50	XXX
84165	26	A	Electrophoreisis of proteins	0.37	0.14	0.14	0.01	0.52	0.52	XXX
84181	26	A	Western blot test	0.37	0.14	0.14	0.02	0.53	0.53	XXX
84182	26	A	Protein, western blot test	0.37	0.16	0.16	0.01	0.54	0.54	XXX
85060		A	Blood smear interpretation	0.45	0.18	0.18	0.02	0.65	0.65	XXX
85097		A	Bone marrow interpretation	0.94	2.02	0.42	0.04	3.00	1.40	XXX
85390	26	A	Fibrinolysins screen	0.37	0.13	0.13	0.02	0.52	0.52	XXX
85396		A	Clotting assay, whole blood	0.37	NA	0.16	0.04	NA	0.57	XXX
85576	26	A	Blood platelet aggregation	0.37	0.16	0.16	0.02	0.55	0.55	XXX
86077		A	Physician blood bank service	0.94	0.40	0.40	0.04	1.38	1.38	XXX
86078		A	Physician blood bank service	0.94	0.47	0.41	0.04	1.45	1.39	XXX
86079		A	Physician blood bank service	0.94	0.45	0.41	0.04	1.43	1.39	XXX
86255	26	A	Fluorescent antibody, screen	0.37	0.16	0.16	0.01	0.54	0.54	XXX
86256	26	A	Fluorescent antibody, titer	0.37	0.15	0.15	0.01	0.53	0.53	XXX
86320	26	A	Serum immunoelectrophoresis	0.37	0.15	0.15	0.01	0.53	0.53	XXX
86325	26	A	Other immunoelectrophoresis	0.37	0.13	0.13	0.01	0.51	0.51	XXX
86327	26	A	Immunoelectrophoresis assay	0.42	0.18	0.18	0.02	0.62	0.62	XXX
86334	26	A	Immunofixation procedure	0.37	0.16	0.16	0.01	0.54	0.54	XXX
86490		A	Coccidioidomycosis skin test	0.00	0.29	NA	0.02	0.31	NA	XXX
86510		A	Histoplasmosis skin test	0.00	0.32	NA	0.02	0.34	NA	XXX
86580		A	TB intradermal test	0.00	0.25	NA	0.02	0.27	NA	XXX
86585		A	TB tine test	0.00	0.20	NA	0.01	0.21	NA	XXX
87164	26	A	Dark field examination	0.37	0.12	0.12	0.01	0.50	0.50	XXX
87207	26	A	Smear, special stain	0.37	0.16	0.16	0.01	0.54	0.54	XXX
88104		A	Cytopathology, fluids	0.56	0.86	NA	0.04	1.46	NA	XXX
88104	26	A	Cytopathology, fluids	0.56	0.24	0.24	0.02	0.82	0.82	XXX
88104	TC	A	Cytopathology, fluids	0.00	0.62	NA	0.02	0.64	NA	XXX
88106		A	Cytopathology, fluids	0.56	1.37	NA	0.04	1.97	NA	XXX
88106	26	A	Cytopathology, fluids	0.56	0.24	0.24	0.02	0.82	0.82	XXX
88106	TC	A	Cytopathology, fluids	0.00	1.13	NA	0.02	1.15	NA	XXX
88107		A	Cytopathology, fluids	0.76	1.56	NA	0.05	2.37	NA	XXX
88107	26	A	Cytopathology, fluids	0.76	0.33	0.33	0.03	1.12	1.12	XXX
88107	TC	A	Cytopathology, fluids	0.00	1.23	NA	0.02	1.25	NA	XXX
88108		A	Cytopath, concentrate tech	0.56	1.22	NA	0.04	1.82	NA	XXX
88108	26	A	Cytopath, concentrate tech	0.56	0.24	0.24	0.02	0.82	0.82	XXX
88108	TC	A	Cytopath, concentrate tech	0.00	0.98	NA	0.02	1.00	NA	XXX
88112		A	Cytopath, cell enhance tech	1.18	1.98	NA	0.04	3.20	NA	XXX
88112	26	A	Cytopath, cell enhance tech	1.18	0.51	0.51	0.02	1.71	1.71	XXX
88112	TC	A	Cytopath, cell enhance tech	0.00	1.47	NA	0.02	1.49	NA	XXX
88125		A	Forensic cytopathology	0.26	0.09	NA	0.02	0.37	NA	XXX
88125	26	A	Forensic cytopathology	0.26	0.11	0.11	0.01	0.38	0.38	XXX
88125	TC	A	Forensic cytopathology	0.00	-0.03	NA	0.01	-0.02	NA	XXX
88141		A	Cytopath, c/v, interpret	0.42	0.15	0.15	0.02	0.59	0.59	XXX
88160		A	Cytopath smear, other source	0.50	0.85	NA	0.04	1.39	NA	XXX
88160	26	A	Cytopath smear, other source	0.50	0.22	0.22	0.02	0.74	0.74	XXX
88160	TC	A	Cytopath smear, other source	0.00	0.63	NA	0.02	0.65	NA	XXX
88161		A	Cytopath smear, other source	0.50	0.95	NA	0.04	1.49	NA	XXX
88161	26	A	Cytopath smear, other source	0.50	0.21	0.21	0.02	0.73	0.73	XXX
88161	TC	A	Cytopath smear, other source	0.00	0.74	NA	0.02	0.76	NA	XXX
88162		A	Cytopath smear, other source	0.76	1.04	NA	0.05	1.85	NA	XXX
88162	26	A	Cytopath smear, other source	0.76	0.33	0.33	0.03	1.12	1.12	XXX
88162	TC	A	Cytopath smear, other source	0.00	0.71	NA	0.02	0.73	NA	XXX
88172		A	Cytopathology eval of fna	0.60	0.74	NA	0.04	1.38	NA	XXX
88172	26	A	Cytopathology eval of fna	0.60	0.26	0.26	0.02	0.88	0.88	XXX
88172	TC	A	Cytopathology eval of fna	0.00	0.48	NA	0.02	0.50	NA	XXX
88173		A	Cytopath eval, fna, report	1.39	2.18	NA	0.07	3.64	NA	XXX
88173	26	A	Cytopath eval, fna, report	1.39	0.60	0.60	0.05	2.04	2.04	XXX
88173	TC	A	Cytopath eval, fna, report	0.00	1.58	NA	0.02	1.60	NA	XXX
88180		A	Cell marker study	0.36	1.27	NA	0.03	1.66	NA	XXX
88180	26	A	Cell marker study	0.36	0.16	0.16	0.01	0.53	0.53	XXX
88180	TC	A	Cell marker study	0.00	1.11	NA	0.02	1.13	NA	XXX
88182		A	Cell marker study	0.77	2.04	NA	0.07	2.88	NA	XXX
88182	26	A	Cell marker study	0.77	0.33	0.33	0.03	1.13	1.13	XXX
88182	TC	A	Cell marker study	0.00	1.70	NA	0.04	1.74	NA	XXX
88291		A	Cyto/molecular report	0.52	0.18	0.18	0.03	0.73	0.73	XXX
88300		A	Surgical path, gross	0.08	0.46	NA	0.01	0.55	NA	XXX
88300	26	A	Surgical path, gross	0.08	0.03	0.03	0.00	0.11	0.11	XXX
88300	TC	A	Surgical path, gross	0.00	0.42	NA	0.01	0.43	NA	XXX
88302		A	Tissue exam by pathologist	0.13	1.03	NA	0.02	1.18	NA	XXX
88302	26	A	Tissue exam by pathologist	0.13	0.06	0.06	0.00	0.19	0.19	XXX
88302	TC	A	Tissue exam by pathologist	0.00	0.97	NA	0.02	0.99	NA	XXX
88304		A	Tissue exam by pathologist	0.22	1.34	NA	0.03	1.59	NA	XXX
88304	26	A	Tissue exam by pathologist	0.22	0.10	0.10	0.01	0.33	0.33	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
88304	TC	A	Tissue exam by pathologist	0.00	1.24	NA	0.02	1.26	NA	XXX
88305		A	Tissue exam by pathologist	0.75	1.92	NA	0.07	2.74	NA	XXX
88305	26	A	Tissue exam by pathologist	0.75	0.33	0.33	0.03	1.11	1.11	XXX
88305	TC	A	Tissue exam by pathologist	0.00	1.59	NA	0.04	1.63	NA	XXX
88307		A	Tissue exam by pathologist	1.59	3.16	NA	0.12	4.87	NA	XXX
88307	26	A	Tissue exam by pathologist	1.59	0.69	0.69	0.06	2.34	2.34	XXX
88307	TC	A	Tissue exam by pathologist	0.00	2.47	NA	0.06	2.53	NA	XXX
88309		A	Tissue exam by pathologist	2.28	4.41	NA	0.15	6.84	NA	XXX
88309	26	A	Tissue exam by pathologist	2.28	0.99	0.99	0.09	3.36	3.36	XXX
88309	TC	A	Tissue exam by pathologist	0.00	3.43	NA	0.06	3.49	NA	XXX
88311		A	Decalcify tissue	0.24	0.24	NA	0.02	0.50	NA	XXX
88311	26	A	Decalcify tissue	0.24	0.10	0.10	0.01	0.35	0.35	XXX
88311	TC	A	Decalcify tissue	0.00	0.13	NA	0.01	0.14	NA	XXX
88312		A	Special stains	0.54	1.52	NA	0.03	2.09	NA	XXX
88312	26	A	Special stains	0.54	0.23	0.23	0.02	0.79	0.79	XXX
88312	TC	A	Special stains	0.00	1.28	NA	0.01	1.29	NA	XXX
88313		A	Special stains	0.24	1.25	NA	0.02	1.51	NA	XXX
88313	26	A	Special stains	0.24	0.10	0.10	0.01	0.35	0.35	XXX
88313	TC	A	Special stains	0.00	1.14	NA	0.01	1.15	NA	XXX
88314		A	Histochemical stain	0.45	2.05	NA	0.04	2.54	NA	XXX
88314	26	A	Histochemical stain	0.45	0.19	0.19	0.02	0.66	0.66	XXX
88314	TC	A	Histochemical stain	0.00	1.86	NA	0.02	1.88	NA	XXX
88318		A	Chemical histochemistry	0.42	1.66	NA	0.03	2.11	NA	XXX
88318	26	A	Chemical histochemistry	0.42	0.18	0.18	0.02	0.62	0.62	XXX
88318	TC	A	Chemical histochemistry	0.00	1.48	NA	0.01	1.49	NA	XXX
88319		A	Enzyme histochemistry	0.53	3.44	NA	0.04	4.01	NA	XXX
88319	26	A	Enzyme histochemistry	0.53	0.23	0.23	0.02	0.78	0.78	XXX
88319	TC	A	Enzyme histochemistry	0.00	3.21	NA	0.02	3.23	NA	XXX
88321		A	Microslide consultation	1.30	0.80	0.56	0.05	2.15	1.91	XXX
88323		A	Microslide consultation	1.35	1.80	NA	0.07	3.22	NA	XXX
88323	26	A	Microslide consultation	1.35	0.58	0.58	0.05	1.98	1.98	XXX
88323	TC	A	Microslide consultation	0.00	1.22	NA	0.02	1.24	NA	XXX
88325		A	Comprehensive review of data	2.22	2.97	0.96	0.10	5.29	3.28	XXX
88329		A	Path consult introp	0.67	0.65	0.29	0.03	1.35	0.99	XXX
88331		A	Path consult intraop, 1 bloc	1.19	1.11	NA	0.09	2.39	NA	XXX
88331	26	A	Path consult intraop, 1 bloc	1.19	0.52	0.52	0.05	1.76	1.76	XXX
88331	TC	A	Path consult intraop, 1 bloc	0.00	0.60	NA	0.04	0.64	NA	XXX
88332		A	Path consult intraop, add-l	0.59	0.46	NA	0.04	1.09	NA	XXX
88332	26	A	Path consult intraop, add-l	0.59	0.26	0.26	0.02	0.87	0.87	XXX
88332	TC	A	Path consult intraop, add-l	0.00	0.21	NA	0.02	0.23	NA	XXX
88342		A	Immunohistochemistry	0.85	1.48	NA	0.05	2.38	NA	XXX
88342	26	A	Immunohistochemistry	0.85	0.37	0.37	0.03	1.25	1.25	XXX
88342	TC	A	Immunohistochemistry	0.00	1.11	NA	0.02	1.13	NA	XXX
88346		A	Immunofluorescent study	0.86	1.57	NA	0.05	2.48	NA	XXX
88346	26	A	Immunofluorescent study	0.86	0.37	0.37	0.03	1.26	1.26	XXX
88346	TC	A	Immunofluorescent study	0.00	1.21	NA	0.02	1.23	NA	XXX
88347		A	Immunofluorescent study	0.86	1.27	NA	0.05	2.18	NA	XXX
88347	26	A	Immunofluorescent study	0.86	0.35	0.35	0.03	1.24	1.24	XXX
88347	TC	A	Immunofluorescent study	0.00	0.92	NA	0.02	0.94	NA	XXX
88348		A	Electron microscopy	1.51	9.58	NA	0.13	11.22	NA	XXX
88348	26	A	Electron microscopy	1.51	0.65	0.65	0.06	2.22	2.22	XXX
88348	TC	A	Electron microscopy	0.00	8.93	NA	0.07	9.00	NA	XXX
88349		A	Scanning electron microscopy	0.76	3.67	NA	0.09	4.52	NA	XXX
88349	26	A	Scanning electron microscopy	0.76	0.33	0.33	0.03	1.12	1.12	XXX
88349	TC	A	Scanning electron microscopy	0.00	3.34	NA	0.06	3.40	NA	XXX
88355		A	Analysis, skeletal muscle	1.85	6.71	NA	0.13	8.69	NA	XXX
88355	26	A	Analysis, skeletal muscle	1.85	0.80	0.80	0.07	2.72	2.72	XXX
88355	TC	A	Analysis, skeletal muscle	0.00	5.91	NA	0.06	5.97	NA	XXX
88356		A	Analysis, nerve	3.02	3.80	NA	0.20	7.02	NA	XXX
88356	26	A	Analysis, nerve	3.02	1.27	1.27	0.13	4.42	4.42	XXX
88356	TC	A	Analysis, nerve	0.00	2.53	NA	0.07	2.60	NA	XXX
88358		A	Analysis, tumor	0.95	0.71	NA	0.18	1.84	NA	XXX
88358	26	A	Analysis, tumor	0.95	0.41	0.41	0.11	1.47	1.47	XXX
88358	TC	A	Analysis, tumor	0.00	0.30	NA	0.07	0.37	NA	XXX
88361		A	Immunohistochemistry, tumor	0.94	2.59	NA	0.18	3.71	NA	XXX
88361	26	A	Immunohistochemistry, tumor	0.94	0.40	0.40	0.11	1.45	1.45	XXX
88361	TC	A	Immunohistochemistry, tumor	0.00	2.19	NA	0.07	2.26	NA	XXX
88362		A	Nerve teasing preparations	2.17	4.73	NA	0.15	7.05	NA	XXX
88362	26	A	Nerve teasing preparations	2.17	0.92	0.92	0.09	3.18	3.18	XXX
88362	TC	A	Nerve teasing preparations	0.00	3.80	NA	0.06	3.86	NA	XXX
88365		A	Tissue hybridization	0.93	3.04	NA	0.06	4.03	NA	XXX
88365	26	A	Tissue hybridization	0.93	0.40	0.40	0.04	1.37	1.37	XXX
88365	TC	A	Tissue hybridization	0.00	2.63	NA	0.02	2.65	NA	XXX
88371	26	A	Protein, western blot tissue	0.37	0.13	0.13	0.02	0.52	0.52	XXX
88372	26	A	Protein analysis w/probe	0.37	0.16	0.16	0.01	0.54	0.54	XXX

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[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
89060	26	A	Exam,synovial fluid crystals	0.37	0.16	0.16	0.01	0.54	0.54	XXX
89100		A	Sample intestinal contents	0.60	1.85	0.21	0.03	2.48	0.84	XXX
89105		A	Sample intestinal contents	0.50	2.24	0.17	0.02	2.76	0.69	XXX
89130		A	Sample stomach contents	0.45	1.74	0.13	0.03	2.22	0.61	XXX
89132		A	Sample stomach contents	0.19	1.54	0.06	0.01	1.74	0.26	XXX
89135		A	Sample stomach contents	0.79	1.91	0.25	0.03	2.73	1.07	XXX
89136		A	Sample stomach contents	0.21	1.78	0.09	0.01	2.00	0.31	XXX
89140		A	Sample stomach contents	0.94	2.12	0.27	0.04	3.10	1.25	XXX
89141		A	Sample stomach contents	0.85	2.82	0.34	0.03	3.70	1.22	XXX
89220		A	Sputum specimen collection	0.00	NA	NA	0.00	NA	NA	XXX
89230		A	Collect sweat for test	0.00	NA	NA	0.00	NA	NA	XXX
90471		A	Immunization admin	0.00	0.20	NA	0.01	0.21	NA	XXX
90472		A	Immunization admin, each add	0.00	0.14	NA	0.01	0.15	NA	ZZZ
90780		A	IV infusion therapy, 1 hour	0.17	2.14	NA	0.07	2.38	NA	XXX
90781		A	IV infusion, additional hour	0.17	0.46	NA	0.04	0.67	NA	ZZZ
90782		T	Injection, sc/im	0.17	0.31	NA	0.01	0.49	NA	XXX
90783		T	Injection, ia	0.17	0.32	NA	0.02	0.51	NA	XXX
90784		T	Injection, iv	0.17	0.80	NA	0.04	1.01	NA	XXX
90788		T	Injection of antibiotic	0.17	0.27	NA	0.01	0.45	NA	XXX
90801		A	Psy dx interview	2.80	1.17	0.93	0.08	4.05	3.81	XXX
90802		A	Intac psy dx interview	3.01	1.20	0.97	0.08	4.29	4.06	XXX
90804		A	Psytx, office, 20-30 min	1.21	0.49	0.38	0.03	1.73	1.62	XXX
90805		A	Psytx, off, 20-30 min w/e&m	1.37	0.50	0.42	0.04	1.91	1.83	XXX
90806		A	Psytx, off, 45-50 min	1.86	0.70	0.60	0.05	2.61	2.51	XXX
90807		A	Psytx, off, 45-50 min w/e&m	2.02	0.70	0.63	0.05	2.77	2.70	XXX
90808		A	Psytx, office, 75-80 min	2.79	1.02	0.90	0.07	3.88	3.76	XXX
90809		A	Psytx, off, 75-80, w/e&m	2.95	1.00	0.92	0.08	4.03	3.95	XXX
90810		A	Intac psytx, off, 20-30 min	1.32	0.51	0.42	0.04	1.87	1.78	XXX
90811		A	Intac psytx, 20-30, w/e&m	1.48	0.57	0.46	0.04	2.09	1.98	XXX
90812		A	Intac psytx, off, 45-50 min	1.97	0.78	0.64	0.05	2.80	2.66	XXX
90813		A	Intac psytx, 45-50 min w/e&m	2.13	0.77	0.67	0.05	2.95	2.85	XXX
90814		A	Intac psytx, off, 75-80 min	2.90	1.10	0.98	0.07	4.07	3.95	XXX
90815		A	Intac psytx, 75-80 w/e&m	3.06	1.05	0.95	0.07	4.18	4.08	XXX
90816		A	Psytx, hosp, 20-30 min	1.25	NA	0.46	0.03	NA	1.74	XXX
90817		A	Psytx, hosp, 20-30 min w/e&m	1.41	NA	0.46	0.04	NA	1.91	XXX
90818		A	Psytx, hosp, 45-50 min	1.89	NA	0.69	0.05	NA	2.63	XXX
90819		A	Psytx, hosp, 45-50 min w/e&m	2.05	NA	0.65	0.05	NA	2.75	XXX
90821		A	Psytx, hosp, 75-80 min	2.83	NA	1.00	0.07	NA	3.90	XXX
90822		A	Psytx, hosp, 75-80 min w/e&m	2.99	NA	0.94	0.09	NA	4.02	XXX
90823		A	Intac psytx, hosp, 20-30 min	1.36	NA	0.48	0.03	NA	1.87	XXX
90824		A	Intac psytx, hsp 20-30 w/e&m	1.52	NA	0.49	0.04	NA	2.05	XXX
90826		A	Intac psytx, hosp, 45-50 min	2.01	NA	0.72	0.05	NA	2.78	XXX
90827		A	Intac psytx, hsp 45-50 w/e&m	2.16	NA	0.68	0.05	NA	2.89	XXX
90828		A	Intac psytx, hosp, 75-80 min	2.94	NA	1.06	0.07	NA	4.07	XXX
90829		A	Intac psytx, hsp 75-80 w/e&m	3.10	NA	0.98	0.07	NA	4.15	XXX
90845		A	Psychoanalysis	1.79	0.58	0.55	0.04	2.41	2.38	XXX
90846		R	Family psytx w/o patient	1.83	0.65	0.64	0.05	2.53	2.52	XXX
90847		R	Family psytx w/patient	2.21	0.81	0.76	0.06	3.08	3.03	XXX
90849		R	Multiple family group psytx	0.59	0.27	0.24	0.02	0.88	0.85	XXX
90853		A	Group psychotherapy	0.59	0.25	0.23	0.02	0.86	0.84	XXX
90857		A	Intac group psytx	0.63	0.29	0.25	0.02	0.94	0.90	XXX
90862		A	Medication management	0.95	0.40	0.32	0.03	1.38	1.30	XXX
90865		A	Narcosynthesis	2.84	1.38	0.91	0.11	4.33	3.86	XXX
90870		A	Electroconvulsive therapy	1.88	1.43	0.59	0.05	3.36	2.52	000
90880		A	Hypnotherapy	2.19	1.04	0.69	0.06	3.29	2.94	XXX
90885		B	Psy evaluation of records	0.97	0.37	0.37	0.02	1.36	1.36	XXX
90887		B	Consultation with family	1.48	0.82	0.56	0.04	2.34	2.08	XXX
90901		A	Biofeedback train, any meth	0.41	0.65	0.14	0.02	1.08	0.57	000
90911		A	Biofeedback peri/uro/rectal	0.89	1.56	0.31	0.06	2.51	1.26	000
90918		A	ESRD related services, month	11.16	7.29	7.29	0.36	18.81	18.81	XXX
90919		A	ESRD related services, month	8.53	4.04	4.04	0.29	12.86	12.86	XXX
90920		A	ESRD related services, month	7.26	3.78	3.78	0.23	11.27	11.27	XXX
90921		A	ESRD related services, month	4.46	2.45	2.45	0.14	7.05	7.05	XXX
90922		A	ESRD related services, day	0.37	0.21	0.21	0.01	0.59	0.59	XXX
90923		A	Esrd related services, day	0.28	0.13	0.13	0.01	0.42	0.42	XXX
90924		A	Esrd related services, day	0.24	0.12	0.12	0.01	0.37	0.37	XXX
90925		A	Esrd related services, day	0.15	0.08	0.08	0.01	0.24	0.24	XXX
90935		A	Hemodialysis, one evaluation	1.22	NA	0.67	0.04	NA	1.93	000
90937		A	Hemodialysis, repeated eval	2.11	NA	0.97	0.08	NA	3.16	000
90945		A	Dialysis, one evaluation	1.28	NA	0.69	0.05	NA	2.02	000
90947		A	Dialysis, repeated eval	2.16	NA	1.00	0.08	NA	3.24	000
90997		A	Hemoperfusion	1.84	NA	0.66	0.06	NA	2.56	000
91000		A	Esophageal intubation	0.73	0.32	NA	0.04	1.09	NA	000
91000	26	A	Esophageal intubation	0.73	0.24	0.24	0.03	1.00	1.00	000
91000	TC	A	Esophageal intubation	0.00	0.08	NA	0.01	0.09	NA	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
91010		A	Esophagus motility study	1.25	4.45	NA	0.12	5.82	NA	000
91010	26	A	Esophagus motility study	1.25	0.44	0.44	0.06	1.75	1.75	000
91010	TC	A	Esophagus motility study	0.00	4.01	NA	0.06	4.07	NA	000
91011		A	Esophagus motility study	1.50	5.27	NA	0.13	6.90	NA	000
91011	26	A	Esophagus motility study	1.50	0.53	0.53	0.07	2.10	2.10	000
91011	TC	A	Esophagus motility study	0.00	4.74	NA	0.06	4.80	NA	000
91012		A	Esophagus motility study	1.46	5.79	NA	0.14	7.39	NA	000
91012	26	A	Esophagus motility study	1.46	0.51	0.51	0.07	2.04	2.04	000
91012	TC	A	Esophagus motility study	0.00	5.28	NA	0.07	5.35	NA	000
91020		A	Gastric motility	1.44	4.58	NA	0.13	6.15	NA	000
91020	26	A	Gastric motility	1.44	0.49	0.49	0.07	2.00	2.00	000
91020	TC	A	Gastric motility	0.00	4.10	NA	0.06	4.16	NA	000
91030		A	Acid perfusion of esophagus	0.91	2.45	NA	0.06	3.42	NA	000
91030	26	A	Acid perfusion of esophagus	0.91	0.32	0.32	0.04	1.27	1.27	000
91030	TC	A	Acid perfusion of esophagus	0.00	2.13	NA	0.02	2.15	NA	000
91032		A	Esophagus, acid reflux test	1.21	4.16	NA	0.12	5.49	NA	000
91032	26	A	Esophagus, acid reflux test	1.21	0.42	0.42	0.06	1.69	1.69	000
91032	TC	A	Esophagus, acid reflux test	0.00	3.74	NA	0.06	3.80	NA	000
91033		A	Prolonged acid reflux test	1.30	4.24	NA	0.18	5.72	NA	000
91033	26	A	Prolonged acid reflux test	1.30	0.45	0.45	0.07	1.82	1.82	000
91033	TC	A	Prolonged acid reflux test	0.00	3.78	NA	0.11	3.89	NA	000
91052		A	Gastric analysis test	0.79	2.47	NA	0.06	3.32	NA	000
91052	26	A	Gastric analysis test	0.79	0.28	0.28	0.04	1.11	1.11	000
91052	TC	A	Gastric analysis test	0.00	2.19	NA	0.02	2.21	NA	000
91055		A	Gastric intubation for smear	0.94	2.94	NA	0.07	3.95	NA	000
91055	26	A	Gastric intubation for smear	0.94	0.27	0.27	0.05	1.26	1.26	000
91055	TC	A	Gastric intubation for smear	0.00	2.67	NA	0.02	2.69	NA	000
91060		A	Gastric saline load test	0.45	1.98	NA	0.04	2.47	NA	000
91060	26	A	Gastric saline load test	0.45	0.14	0.14	0.02	0.61	0.61	000
91060	TC	A	Gastric saline load test	0.00	1.84	NA	0.02	1.86	NA	000
91065		A	Breath hydrogen test	0.20	1.47	NA	0.03	1.70	NA	000
91065	26	A	Breath hydrogen test	0.20	0.07	0.07	0.01	0.28	0.28	000
91065	TC	A	Breath hydrogen test	0.00	1.40	NA	0.02	1.42	NA	000
91100		A	Pass intestine bleeding tube	1.08	2.85	0.28	0.07	4.00	1.43	000
91105		A	Gastric intubation treatment	0.37	2.13	0.09	0.03	2.53	0.49	000
91110		A	Gi tract capsule endoscopy	3.64	22.19	NA	0.09	25.92	NA	XXX
91110	26	A	Gi tract capsule endoscopy	3.64	1.27	1.27	0.02	4.93	4.93	XXX
91110	TC	A	Gi tract capsule endoscopy	0.00	20.92	NA	0.07	20.99	NA	XXX
91122		A	Anal pressure record	1.77	5.10	NA	0.20	7.07	NA	000
91122	26	A	Anal pressure record	1.77	0.60	0.60	0.12	2.49	2.49	000
91122	TC	A	Anal pressure record	0.00	4.50	NA	0.08	4.58	NA	000
91132	26	A	Electrogastrography	0.52	0.18	0.18	0.03	0.73	0.73	XXX
91133	26	A	Electrogastrography w/test	0.66	0.23	0.23	0.03	0.92	0.92	XXX
92002		A	Eye exam, new patient	0.88	0.97	0.34	0.02	1.87	1.24	XXX
92004		A	Eye exam, new patient	1.67	1.70	0.67	0.05	3.42	2.39	XXX
92012		A	Eye exam established pat	0.67	1.03	0.29	0.02	1.72	0.98	XXX
92014		A	Eye exam & treatment	1.10	1.41	0.47	0.03	2.54	1.60	XXX
92018		A	New eye exam & treatment	2.50	NA	1.07	0.07	NA	3.64	XXX
92019		A	Eye exam & treatment	1.31	NA	0.56	0.04	NA	1.91	XXX
92020		A	Special eye evaluation	0.37	0.34	0.16	0.01	0.72	0.54	XXX
92060		A	Special eye evaluation	0.69	0.74	NA	0.03	1.46	NA	XXX
92060	26	A	Special eye evaluation	0.69	0.29	0.29	0.02	1.00	1.00	XXX
92060	TC	A	Special eye evaluation	0.00	0.45	NA	0.01	0.46	NA	XXX
92065		A	Orthoptic/pleoptic training	0.37	0.55	NA	0.02	0.94	NA	XXX
92065	26	A	Orthoptic/pleoptic training	0.37	0.15	0.15	0.01	0.53	0.53	XXX
92065	TC	A	Orthoptic/pleoptic training	0.00	0.40	NA	0.01	0.41	NA	XXX
92070		A	Fitting of contact lens	0.70	1.07	0.32	0.02	1.79	1.04	XXX
92081		A	Visual field examination(s)	0.36	0.95	NA	0.02	1.33	NA	XXX
92081	26	A	Visual field examination(s)	0.36	0.15	0.15	0.01	0.52	0.52	XXX
92081	TC	A	Visual field examination(s)	0.00	0.79	NA	0.01	0.80	NA	XXX
92082		A	Visual field examination(s)	0.44	1.23	NA	0.02	1.69	NA	XXX
92082	26	A	Visual field examination(s)	0.44	0.19	0.19	0.01	0.64	0.64	XXX
92082	TC	A	Visual field examination(s)	0.00	1.05	NA	0.01	1.06	NA	XXX
92083		A	Visual field examination(s)	0.50	1.43	NA	0.02	1.95	NA	XXX
92083	26	A	Visual field examination(s)	0.50	0.22	0.22	0.01	0.73	0.73	XXX
92083	TC	A	Visual field examination(s)	0.00	1.21	NA	0.01	1.22	NA	XXX
92100		A	Serial tonometry exam(s)	0.92	1.35	0.36	0.03	2.30	1.31	XXX
92120		A	Tonography & eye evaluation	0.81	1.07	0.32	0.02	1.90	1.15	XXX
92130		A	Water provocation tonography	0.81	1.28	0.37	0.02	2.11	1.20	XXX
92135		A	Opthalmic dx imaging	0.35	0.80	NA	0.02	1.17	NA	XXX
92135	26	A	Opthalmic dx imaging	0.35	0.15	0.15	0.01	0.51	0.51	XXX
92135	TC	A	Opthalmic dx imaging	0.00	0.65	NA	0.01	0.66	NA	XXX
92136		A	Ophthalmic biometry	0.54	1.54	NA	0.08	2.16	NA	XXX
92136	26	A	Ophthalmic biometry	0.54	0.24	0.24	0.01	0.79	0.79	XXX
92136	TC	A	Ophthalmic biometry	0.00	1.30	NA	0.07	1.37	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
92140		A	Glaucoma provocative tests	0.50	0.99	0.21	0.01	1.50	0.72	XXX
92225		A	Special eye exam, initial	0.38	0.22	0.16	0.01	0.61	0.55	XXX
92226		A	Special eye exam, subsequent	0.33	0.21	0.14	0.01	0.55	0.48	XXX
92230		A	Eye exam with photos	0.60	1.54	0.20	0.02	2.16	0.82	XXX
92235		A	Eye exam with photos	0.81	2.61	NA	0.08	3.50	NA	XXX
92235	26	A	Eye exam with photos	0.81	0.37	0.37	0.02	1.20	1.20	XXX
92235	TC	A	Eye exam with photos	0.00	2.25	NA	0.06	2.31	NA	XXX
92240		A	Icg angiography	1.10	6.13	NA	0.09	7.32	NA	XXX
92240	26	A	Icg angiography	1.10	0.50	0.50	0.03	1.63	1.63	XXX
92240	TC	A	Icg angiography	0.00	5.64	NA	0.06	5.70	NA	XXX
92250		A	Eye exam with photos	0.44	1.53	NA	0.02	1.99	NA	XXX
92250	26	A	Eye exam with photos	0.44	0.19	0.19	0.01	0.64	0.64	XXX
92250	TC	A	Eye exam with photos	0.00	1.34	NA	0.01	1.35	NA	XXX
92260		A	Ophthalmoscopy/dynamometry	0.20	0.26	0.09	0.01	0.47	0.30	XXX
92265		A	Eye muscle evaluation	0.81	1.51	NA	0.06	2.38	NA	XXX
92265	26	A	Eye muscle evaluation	0.81	0.28	0.28	0.04	1.13	1.13	XXX
92265	TC	A	Eye muscle evaluation	0.00	1.23	NA	0.02	1.25	NA	XXX
92270		A	Electro-oculography	0.81	1.54	NA	0.05	2.40	NA	XXX
92270	26	A	Electro-oculography	0.81	0.33	0.33	0.03	1.17	1.17	XXX
92270	TC	A	Electro-oculography	0.00	1.21	NA	0.02	1.23	NA	XXX
92275		A	Electroretinography	1.01	1.94	NA	0.05	3.00	NA	XXX
92275	26	A	Electroretinography	1.01	0.43	0.43	0.03	1.47	1.47	XXX
92275	TC	A	Electroretinography	0.00	1.52	NA	0.02	1.54	NA	XXX
92283		A	Color vision examination	0.17	0.84	NA	0.02	1.03	NA	XXX
92283	26	A	Color vision examination	0.17	0.07	0.07	0.01	0.25	0.25	XXX
92283	TC	A	Color vision examination	0.00	0.77	NA	0.01	0.78	NA	XXX
92284		A	Dark adaptation eye exam	0.24	1.88	NA	0.02	2.14	NA	XXX
92284	26	A	Dark adaptation eye exam	0.24	0.08	0.08	0.01	0.33	0.33	XXX
92284	TC	A	Dark adaptation eye exam	0.00	1.80	NA	0.01	1.81	NA	XXX
92285		A	Eye photography	0.20	0.99	NA	0.02	1.21	NA	XXX
92285	26	A	Eye photography	0.20	0.09	0.09	0.01	0.30	0.30	XXX
92285	TC	A	Eye photography	0.00	0.91	NA	0.01	0.92	NA	XXX
92286		A	Internal eye photography	0.66	3.07	NA	0.04	3.77	NA	XXX
92286	26	A	Internal eye photography	0.66	0.29	0.29	0.02	0.97	0.97	XXX
92286	TC	A	Internal eye photography	0.00	2.78	NA	0.02	2.80	NA	XXX
92287		A	Internal eye photography	0.81	2.39	0.31	0.02	3.22	1.14	XXX
92311		A	Contact lens fitting	1.08	1.10	0.35	0.04	2.22	1.47	XXX
92312		A	Contact lens fitting	1.26	1.08	0.49	0.04	2.38	1.79	XXX
92313		A	Contact lens fitting	0.92	1.07	0.28	0.02	2.01	1.22	XXX
92315		A	Prescription of contact lens	0.45	0.85	0.16	0.01	1.31	0.62	XXX
92316		A	Prescription of contact lens	0.68	0.91	0.29	0.02	1.61	0.99	XXX
92317		A	Prescription of contact lens	0.45	0.94	0.15	0.01	1.40	0.61	XXX
92325		A	Modification of contact lens	0.00	0.40	NA	0.01	0.41	NA	XXX
92326		A	Replacement of contact lens	0.00	1.63	NA	0.06	1.69	NA	XXX
92330		A	Fitting of artificial eye	1.08	0.99	0.32	0.03	2.10	1.43	XXX
92335		A	Fitting of artificial eye	0.45	0.91	0.16	0.02	1.38	0.63	XXX
92352		B	Special spectacles fitting	0.37	0.68	0.14	0.01	1.06	0.52	XXX
92353		B	Special spectacles fitting	0.50	0.73	0.19	0.02	1.25	0.71	XXX
92354		B	Special spectacles fitting	0.00	8.84	NA	0.10	8.94	NA	XXX
92355		B	Special spectacles fitting	0.00	4.32	NA	0.01	4.33	NA	XXX
92358		B	Eye prosthesis service	0.00	0.97	NA	0.05	1.02	NA	XXX
92371		B	Repair & adjust spectacles	0.00	0.62	NA	0.02	0.64	NA	XXX
92502		A	Ear and throat examination	1.51	NA	1.11	0.05	NA	2.67	000
92504		A	Ear microscopy examination	0.18	0.50	0.09	0.01	0.69	0.28	XXX
92506		A	Speech/hearing evaluation	0.86	2.60	0.40	0.03	3.49	1.29	XXX
92507		A	Speech/hearing therapy	0.52	1.12	0.23	0.02	1.66	0.77	XXX
92508		A	Speech/hearing therapy	0.26	0.51	0.12	0.01	0.78	0.39	XXX
92511		A	Nasopharyngoscopy	0.84	3.32	0.78	0.03	4.19	1.65	000
92512		A	Nasal function studies	0.55	1.14	0.18	0.02	1.71	0.75	XXX
92516		A	Facial nerve function test	0.43	1.17	0.22	0.02	1.62	0.67	XXX
92520		A	Laryngeal function studies	0.76	0.51	0.39	0.03	1.30	1.18	XXX
92526		A	Oral function therapy	0.55	1.64	0.20	0.02	2.21	0.77	XXX
92541		A	Spontaneous nystagmus test	0.40	1.03	NA	0.04	1.47	NA	XXX
92541	26	A	Spontaneous nystagmus test	0.40	0.19	0.19	0.02	0.61	0.61	XXX
92541	TC	A	Spontaneous nystagmus test	0.00	0.84	NA	0.02	0.86	NA	XXX
92542		A	Positional nystagmus test	0.33	1.14	NA	0.03	1.50	NA	XXX
92542	26	A	Positional nystagmus test	0.33	0.16	0.16	0.01	0.50	0.50	XXX
92542	TC	A	Positional nystagmus test	0.00	0.98	NA	0.02	1.00	NA	XXX
92543		A	Caloric vestibular test	0.10	0.57	NA	0.01	0.68	NA	XXX
92543	26	A	Caloric vestibular test	0.10	0.05	0.05	0.00	0.15	0.15	XXX
92543	TC	A	Caloric vestibular test	0.00	0.52	NA	0.01	0.53	NA	XXX
92544		A	Optokinetic nystagmus test	0.26	0.90	NA	0.03	1.19	NA	XXX
92544	26	A	Optokinetic nystagmus test	0.26	0.12	0.12	0.01	0.39	0.39	XXX
92544	TC	A	Optokinetic nystagmus test	0.00	0.78	NA	0.02	0.80	NA	XXX
92545		A	Oscillating tracking test	0.23	0.80	NA	0.03	1.06	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
92545	26	A	Oscillating tracking test	0.23	0.11	0.11	0.01	0.35	0.35	XXX
92545	TC	A	Oscillating tracking test	0.00	0.69	NA	0.02	0.71	NA	XXX
92546		A	Sinusoidal rotational test	0.29	1.99	NA	0.03	2.31	NA	XXX
92546	26	A	Sinusoidal rotational test	0.29	0.13	0.13	0.01	0.43	0.43	XXX
92546	TC	A	Sinusoidal rotational test	0.00	1.86	NA	0.02	1.88	NA	XXX
92547		A	Supplemental electrical test	0.00	0.08	NA	0.06	0.14	NA	ZZZ
92548		A	Posturography	0.50	2.26	NA	0.15	2.91	NA	XXX
92548	26	A	Posturography	0.50	0.26	0.26	0.02	0.78	0.78	XXX
92548	TC	A	Posturography	0.00	2.00	NA	0.13	2.13	NA	XXX
92552		A	Pure tone audiometry, air	0.00	0.44	NA	0.04	0.48	NA	XXX
92553		A	Audiometry, air & bone	0.00	0.66	NA	0.06	0.72	NA	XXX
92555		A	Speech threshold audiometry	0.00	0.38	NA	0.04	0.42	NA	XXX
92556		A	Speech audiometry, complete	0.00	0.57	NA	0.06	0.63	NA	XXX
92557		A	Comprehensive hearing test	0.00	1.19	NA	0.12	1.31	NA	XXX
92561		A	Bekesy audiometry, diagnosis	0.00	0.71	NA	0.06	0.77	NA	XXX
92562		A	Loudness balance test	0.00	0.41	NA	0.04	0.45	NA	XXX
92563		A	Tone decay hearing test	0.00	0.38	NA	0.04	0.42	NA	XXX
92564		A	Sisi hearing test	0.00	0.47	NA	0.05	0.52	NA	XXX
92565		A	Stenger test, pure tone	0.00	0.40	NA	0.04	0.44	NA	XXX
92567		A	Tympanometry	0.00	0.52	NA	0.06	0.58	NA	XXX
92568		A	Acoustic reflex testing	0.00	0.38	NA	0.04	0.42	NA	XXX
92569		A	Acoustic reflex decay test	0.00	0.41	NA	0.04	0.45	NA	XXX
92571		A	Filtered speech hearing test	0.00	0.39	NA	0.04	0.43	NA	XXX
92572		A	Staggered spondaic word test	0.00	0.09	NA	0.01	0.10	NA	XXX
92573		A	Lombard test	0.00	0.35	NA	0.04	0.39	NA	XXX
92575		A	Sensorineural acuity test	0.00	0.30	NA	0.02	0.32	NA	XXX
92576		A	Synthetic sentence test	0.00	0.44	NA	0.05	0.49	NA	XXX
92577		A	Stenger test, speech	0.00	0.71	NA	0.07	0.78	NA	XXX
92579		A	Visual audiometry (vra)	0.00	0.72	NA	0.06	0.78	NA	XXX
92582		A	Conditioning play audiometry	0.00	0.72	NA	0.06	0.78	NA	XXX
92583		A	Select picture audiometry	0.00	0.89	NA	0.08	0.97	NA	XXX
92584		A	Electrocochleography	0.00	2.47	NA	0.21	2.68	NA	XXX
92585		A	Auditor evoke potent, compre	0.50	2.06	NA	0.17	2.73	NA	XXX
92585	26	A	Auditor evoke potent, compre	0.50	0.21	0.21	0.03	0.74	0.74	XXX
92585	TC	A	Auditor evoke potent, compre	0.00	1.84	NA	0.14	1.98	NA	XXX
92586		A	Auditor evoke potent, limit	0.00	1.84	NA	0.14	1.98	NA	XXX
92587		A	Evoked auditory test	0.13	1.37	NA	0.11	1.61	NA	XXX
92587	26	A	Evoked auditory test	0.13	0.06	0.06	0.00	0.19	0.19	XXX
92587	TC	A	Evoked auditory test	0.00	1.30	NA	0.11	1.41	NA	XXX
92588		A	Evoked auditory test	0.36	1.63	NA	0.14	2.13	NA	XXX
92588	26	A	Evoked auditory test	0.36	0.16	0.16	0.01	0.53	0.53	XXX
92588	TC	A	Evoked auditory test	0.00	1.47	NA	0.13	1.60	NA	XXX
92589		A	Auditory function test(s)	0.00	0.53	NA	0.06	0.59	NA	XXX
92596		A	Ear protector evaluation	0.00	0.59	NA	0.06	0.65	NA	XXX
92597		A	Oral speech device eval	0.86	1.69	0.45	0.05	2.60	1.36	XXX
92601		A	Cochlear implt f/up exam < 7	0.00	3.51	NA	0.05	3.56	NA	XXX
92602		A	Reprogram cochlear implt < 7	0.00	2.38	NA	0.05	2.43	NA	XXX
92603		A	Cochlear implt f/up exam 7 >	0.00	2.15	NA	0.05	2.20	NA	XXX
92604		A	Reprogram cochlear implt 7 >	0.00	1.35	NA	0.05	1.40	NA	XXX
92607		A	Ex for speech device rx, 1hr	0.00	3.08	NA	0.04	3.12	NA	XXX
92608		A	Ex for speech device rx addl	0.00	0.56	NA	0.04	0.60	NA	XXX
92609		A	Use of speech device service	0.00	1.65	NA	0.03	1.68	NA	XXX
92610		A	Evaluate swallowing function	0.00	3.43	NA	0.06	3.49	NA	XXX
92611		A	Motion fluoroscopy/swallow	0.00	3.43	NA	0.07	3.50	NA	XXX
92612		A	Endoscopy swallow tst (fees)	1.27	2.75	0.66	0.08	4.10	2.01	XXX
92613		A	Endoscopy swallow tst (fees)	0.71	0.40	0.39	0.05	1.16	1.15	XXX
92614		A	Laryngoscopic sensory test	1.27	2.00	0.66	0.08	3.35	2.01	XXX
92615		A	Eval laryngoscopy sense tst	0.63	0.35	0.35	0.05	1.03	1.03	XXX
92616		A	Fees w/laryngeal sense test	1.88	2.67	0.99	0.08	4.63	2.95	XXX
92617		A	Interprt fees/laryngeal test	0.79	0.44	0.44	0.05	1.28	1.28	XXX
92950		A	Heart/lung resuscitation cpr	3.79	4.25	0.97	0.26	8.30	5.02	000
92953		A	Temporary external pacing	0.23	NA	0.07	0.01	NA	0.31	000
92960		A	Cardioversion electric, ext	2.25	6.45	1.17	0.08	8.78	3.50	000
92961		A	Cardioversion, electric, int	4.59	NA	2.07	0.27	NA	6.93	000
92970		A	Cardioassist, internal	3.51	NA	1.05	0.19	NA	4.75	000
92971		A	Cardioassist, external	1.77	NA	0.85	0.06	NA	2.68	000
92973		A	Percut coronary thrombectomy	3.28	NA	1.29	0.11	NA	4.68	ZZZ
92974		A	Cath place, cardio brachytx	3.00	NA	1.18	0.10	NA	4.28	ZZZ
92975		A	Dissolve clot, heart vessel	7.24	NA	2.80	0.23	NA	10.27	000
92977		A	Dissolve clot, heart vessel	0.00	8.04	NA	0.46	8.50	NA	XXX
92978		A	Intravasc us, heart add-on	1.80	5.26	NA	0.30	7.36	NA	ZZZ
92978	26	A	Intravasc us, heart add-on	1.80	0.71	0.71	0.06	2.57	2.57	ZZZ
92978	TC	A	Intravasc us, heart add-on	0.00	4.56	NA	0.24	4.80	NA	ZZZ
92979		A	Intravasc us, heart add-on	1.44	2.85	NA	0.20	4.49	NA	ZZZ
92979	26	A	Intravasc us, heart add-on	1.44	0.56	0.56	0.07	2.07	2.07	ZZZ

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
92979	TC	A	Intravasc us, heart add-on	0.00	2.29	NA	0.13	2.42	NA	ZZZ
92980		A	Insert intracoronary stent	14.82	NA	6.03	1.04	NA	21.89	000
92981		A	Insert intracoronary stent	4.16	NA	1.63	0.29	NA	6.08	ZZZ
92982		A	Coronary artery dilation	10.96	NA	4.52	0.77	NA	16.25	000
92984		A	Coronary artery dilation	2.97	NA	1.16	0.21	NA	4.34	ZZZ
92986		A	Revision of aortic valve	21.77	NA	11.85	1.52	NA	35.14	090
92987		A	Revision of mitral valve	22.67	NA	12.23	1.58	NA	36.48	090
92990		A	Revision of pulmonary valve	17.31	NA	9.83	1.21	NA	28.35	090
92995		A	Coronary atherectomy	12.07	NA	4.95	0.84	NA	17.86	000
92996		A	Coronary atherectomy add-on	3.26	NA	1.27	0.23	NA	4.76	ZZZ
92997		A	Pul art balloon repr, percut	11.98	NA	4.81	0.84	NA	17.63	000
92998		A	Pul art balloon repr, percut	5.99	NA	2.20	0.42	NA	8.61	ZZZ
93000		A	Electrocardiogram, complete	0.17	0.51	NA	0.03	0.71	NA	XXX
93005		A	Electrocardiogram, tracing	0.00	0.45	NA	0.02	0.47	NA	XXX
93010		A	Electrocardiogram report	0.17	0.06	0.06	0.01	0.24	0.24	XXX
93012		A	Transmission of ecg	0.00	6.00	NA	0.18	6.18	NA	XXX
93014		A	Report on transmitted ecg	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93015		A	Cardiovascular stress test	0.75	1.96	NA	0.14	2.85	NA	XXX
93016		A	Cardiovascular stress test	0.45	0.17	0.17	0.02	0.64	0.64	XXX
93017		A	Cardiovascular stress test	0.00	1.68	NA	0.11	1.79	NA	XXX
93018		A	Cardiovascular stress test	0.30	0.11	0.11	0.01	0.42	0.42	XXX
93024		A	Cardiac drug stress test	1.17	1.57	NA	0.13	2.87	NA	XXX
93024	26	A	Cardiac drug stress test	1.17	0.45	0.45	0.05	1.67	1.67	XXX
93024	TC	A	Cardiac drug stress test	0.00	1.12	NA	0.08	1.20	NA	XXX
93025		A	Microvolt t-wave assess	0.75	7.84	NA	0.14	8.73	NA	XXX
93025	26	A	Microvolt t-wave assess	0.75	0.29	0.29	0.03	1.07	1.07	XXX
93025	TC	A	Microvolt t-wave assess	0.00	7.55	NA	0.11	7.66	NA	XXX
93040		A	Rhythm ECG with report	0.16	0.19	NA	0.02	0.37	NA	XXX
93041		A	Rhythm ECG, tracing	0.00	0.14	NA	0.01	0.15	NA	XXX
93042		A	Rhythm ECG, report	0.16	0.05	0.05	0.01	0.22	0.22	XXX
93224		A	ECG monitor/report, 24 hrs	0.52	3.61	NA	0.24	4.37	NA	XXX
93225		A	ECG monitor/record, 24 hrs	0.00	1.24	NA	0.08	1.32	NA	XXX
93226		A	ECG monitor/report, 24 hrs	0.00	2.18	NA	0.14	2.32	NA	XXX
93227		A	ECG monitor/review, 24 hrs	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93230		A	ECG monitor/report, 24 hrs	0.52	3.88	NA	0.26	4.66	NA	XXX
93231		A	Ecg monitor/record, 24 hrs	0.00	1.52	NA	0.11	1.63	NA	XXX
93232		A	ECG monitor/report, 24 hrs	0.00	2.17	NA	0.13	2.30	NA	XXX
93233		A	ECG monitor/review, 24 hrs	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93235		A	ECG monitor/report, 24 hrs	0.45	2.78	NA	0.16	3.39	NA	XXX
93236		A	ECG monitor/report, 24 hrs	0.00	2.62	NA	0.14	2.76	NA	XXX
93237		A	ECG monitor/review, 24 hrs	0.45	0.16	0.16	0.02	0.63	0.63	XXX
93268		A	ECG record/review	0.52	7.43	NA	0.28	8.23	NA	XXX
93270		A	ECG recording	0.00	1.24	NA	0.08	1.32	NA	XXX
93271		A	Ecg/monitoring and analysis	0.00	6.00	NA	0.18	6.18	NA	XXX
93272		A	Ecg/review, interpret only	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93278		A	ECG/signal-averaged	0.25	1.24	NA	0.12	1.61	NA	XXX
93278	26	A	ECG/signal-averaged	0.25	0.10	0.10	0.01	0.36	0.36	XXX
93278	TC	A	ECG/signal-averaged	0.00	1.15	NA	0.11	1.26	NA	XXX
93303		A	Echo transthoracic	1.30	4.33	NA	0.28	5.91	NA	XXX
93303	26	A	Echo transthoracic	1.30	0.48	0.48	0.05	1.83	1.83	XXX
93303	TC	A	Echo transthoracic	0.00	3.85	NA	0.23	4.08	NA	XXX
93304		A	Echo transthoracic	0.75	2.22	NA	0.16	3.13	NA	XXX
93304	26	A	Echo transthoracic	0.75	0.28	0.28	0.03	1.06	1.06	XXX
93304	TC	A	Echo transthoracic	0.00	1.94	NA	0.13	2.07	NA	XXX
93307		A	Echo exam of heart	0.92	4.20	NA	0.26	5.38	NA	XXX
93307	26	A	Echo exam of heart	0.92	0.35	0.35	0.03	1.30	1.30	XXX
93307	TC	A	Echo exam of heart	0.00	3.85	NA	0.23	4.08	NA	XXX
93308		A	Echo exam of heart	0.53	2.14	NA	0.15	2.82	NA	XXX
93308	26	A	Echo exam of heart	0.53	0.20	0.20	0.02	0.75	0.75	XXX
93308	TC	A	Echo exam of heart	0.00	1.94	NA	0.13	2.07	NA	XXX
93312		A	Echo transesophageal	2.20	4.56	NA	0.37	7.13	NA	XXX
93312	26	A	Echo transesophageal	2.20	0.79	0.79	0.08	3.07	3.07	XXX
93312	TC	A	Echo transesophageal	0.00	3.77	NA	0.29	4.06	NA	XXX
93313		A	Echo transesophageal	0.95	NA	0.21	0.06	NA	1.22	XXX
93314		A	Echo transesophageal	1.25	4.24	NA	0.34	5.83	NA	XXX
93314	26	A	Echo transesophageal	1.25	0.47	0.47	0.05	1.77	1.77	XXX
93314	TC	A	Echo transesophageal	0.00	3.77	NA	0.29	4.06	NA	XXX
93315	26	A	Echo transesophageal	2.78	1.01	1.01	0.13	3.92	3.92	XXX
93316		A	Echo transesophageal	0.95	NA	0.23	0.05	NA	1.23	XXX
93317	26	A	Echo transesophageal	1.83	0.66	0.66	0.09	2.58	2.58	XXX
93318	26	A	Echo transesophageal intraop	2.20	0.48	0.48	0.13	2.81	2.81	XXX
93320		A	Doppler echo exam, heart	0.38	1.85	NA	0.13	2.36	NA	ZZZ
93320	26	A	Doppler echo exam, heart	0.38	0.15	0.15	0.01	0.54	0.54	ZZZ
93320	TC	A	Doppler echo exam, heart	0.00	1.71	NA	0.12	1.83	NA	ZZZ
93321		A	Doppler echo exam, heart	0.15	1.17	NA	0.09	1.41	NA	ZZZ

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
93321	26	A	Doppler echo exam, heart	0.15	0.06	0.06	0.01	0.22	0.22	ZZZ
93321	TC	A	Doppler echo exam, heart	0.00	1.11	NA	0.08	1.19	NA	ZZZ
93325		A	Doppler color flow add-on	0.07	2.92	NA	0.21	3.20	NA	ZZZ
93325	26	A	Doppler color flow add-on	0.07	0.03	0.03	0.00	0.10	0.10	ZZZ
93325	TC	A	Doppler color flow add-on	0.00	2.90	NA	0.21	3.11	NA	ZZZ
93350		A	Echo transthoracic	1.48	2.32	NA	0.18	3.98	NA	XXX
93350	26	A	Echo transthoracic	1.48	0.57	0.57	0.05	2.10	2.10	XXX
93350	TC	A	Echo transthoracic	0.00	1.76	NA	0.13	1.89	NA	XXX
93501		A	Right heart catheterization	3.02	18.02	NA	1.26	22.30	NA	000
93501	26	A	Right heart catheterization	3.02	1.15	1.15	0.21	4.38	4.38	000
93501	TC	A	Right heart catheterization	0.00	16.87	NA	1.05	17.92	NA	000
93503		A	Insert/place heart catheter	2.91	NA	0.68	0.20	NA	3.79	000
93505		A	Biopsy of heart lining	4.37	3.66	NA	0.48	8.51	NA	000
93505	26	A	Biopsy of heart lining	4.37	1.68	1.68	0.32	6.37	6.37	000
93505	TC	A	Biopsy of heart lining	0.00	1.98	NA	0.16	2.14	NA	000
93508		A	Cath placement, angiography	4.09	14.65	NA	0.94	19.68	NA	000
93508	26	A	Cath placement, angiography	4.09	2.07	2.07	0.29	6.45	6.45	000
93508	TC	A	Cath placement, angiography	0.00	12.58	NA	0.65	13.23	NA	000
93510		A	Left heart catheterization	4.32	39.06	NA	2.60	45.98	NA	000
93510	26	A	Left heart catheterization	4.32	2.17	2.17	0.30	6.79	6.79	000
93510	TC	A	Left heart catheterization	0.00	36.89	NA	2.30	39.19	NA	000
93511		A	Left heart catheterization	5.02	38.35	NA	2.58	45.95	NA	000
93511	26	A	Left heart catheterization	5.02	2.44	2.44	0.35	7.81	7.81	000
93511	TC	A	Left heart catheterization	0.00	35.91	NA	2.23	38.14	NA	000
93514		A	Left heart catheterization	7.04	39.03	NA	2.72	48.79	NA	000
93514	26	A	Left heart catheterization	7.04	3.12	3.12	0.49	10.65	10.65	000
93514	TC	A	Left heart catheterization	0.00	35.91	NA	2.23	38.14	NA	000
93524		A	Left heart catheterization	6.94	50.10	NA	3.42	60.46	NA	000
93524	26	A	Left heart catheterization	6.94	3.17	3.17	0.49	10.60	10.60	000
93524	TC	A	Left heart catheterization	0.00	46.93	NA	2.93	49.86	NA	000
93526		A	Rt & Lt heart catheters	5.98	51.02	NA	3.44	60.44	NA	000
93526	26	A	Rt & Lt heart catheters	5.98	2.81	2.81	0.42	9.21	9.21	000
93526	TC	A	Rt & Lt heart catheters	0.00	48.21	NA	3.02	51.23	NA	000
93527		A	Rt & Lt heart catheters	7.27	50.24	NA	3.44	60.95	NA	000
93527	26	A	Rt & Lt heart catheters	7.27	3.31	3.31	0.51	11.09	11.09	000
93527	TC	A	Rt & Lt heart catheters	0.00	46.93	NA	2.93	49.86	NA	000
93528		A	Rt & Lt heart catheters	8.99	50.95	NA	3.56	63.50	NA	000
93528	26	A	Rt & Lt heart catheters	8.99	4.02	4.02	0.63	13.64	13.64	000
93528	TC	A	Rt & Lt heart catheters	0.00	46.93	NA	2.93	49.86	NA	000
93529		A	Rt, lt heart catheterization	4.79	49.20	NA	3.26	57.25	NA	000
93529	26	A	Rt, lt heart catheterization	4.79	2.27	2.27	0.33	7.39	7.39	000
93529	TC	A	Rt, lt heart catheterization	0.00	46.93	NA	2.93	49.86	NA	000
93530		A	Rt heart cath, congenital	4.22	18.80	NA	1.35	24.37	NA	000
93530	26	A	Rt heart cath, congenital	4.22	1.93	1.93	0.30	6.45	6.45	000
93530	TC	A	Rt heart cath, congenital	0.00	16.87	NA	1.05	17.92	NA	000
93531		A	R & l heart cath, congenital	8.34	51.79	NA	3.60	63.73	NA	000
93531	26	A	R & l heart cath, congenital	8.34	3.58	3.58	0.58	12.50	12.50	000
93531	TC	A	R & l heart cath, congenital	0.00	48.21	NA	3.02	51.23	NA	000
93532		A	R & l heart cath, congenital	9.99	51.17	NA	3.63	64.79	NA	000
93532	26	A	R & l heart cath, congenital	9.99	4.25	4.25	0.70	14.94	14.94	000
93532	TC	A	R & l heart cath, congenital	0.00	46.93	NA	2.93	49.86	NA	000
93533		A	R & l heart cath, congenital	6.69	49.72	NA	3.40	59.81	NA	000
93533	26	A	R & l heart cath, congenital	6.69	2.80	2.80	0.47	9.96	9.96	000
93533	TC	A	R & l heart cath, congenital	0.00	46.93	NA	2.93	49.86	NA	000
93539		A	Injection, cardiac cath	0.40	NA	0.16	0.01	NA	0.57	000
93540		A	Injection, cardiac cath	0.43	NA	0.17	0.01	NA	0.61	000
93541		A	Injection for lung angiogram	0.29	NA	0.11	0.01	NA	0.41	000
93542		A	Injection for heart x-rays	0.29	NA	0.11	0.01	NA	0.41	000
93543		A	Injection for heart x-rays	0.29	NA	0.11	0.01	NA	0.41	000
93544		A	Injection for aortography	0.25	NA	0.10	0.01	NA	0.36	000
93545		A	Inject for coronary x-rays	0.40	NA	0.16	0.01	NA	0.57	000
93555		A	Imaging, cardiac cath	0.81	6.58	NA	0.37	7.76	NA	XXX
93555	26	A	Imaging, cardiac cath	0.81	0.32	0.32	0.03	1.16	1.16	XXX
93555	TC	A	Imaging, cardiac cath	0.00	6.26	NA	0.34	6.60	NA	XXX
93556		A	Imaging, cardiac cath	0.83	10.20	NA	0.54	11.57	NA	XXX
93556	26	A	Imaging, cardiac cath	0.83	0.32	0.32	0.03	1.18	1.18	XXX
93556	TC	A	Imaging, cardiac cath	0.00	9.87	NA	0.51	10.38	NA	XXX
93561		A	Cardiac output measurement	0.50	0.68	NA	0.09	1.27	NA	000
93561	26	A	Cardiac output measurement	0.50	0.16	0.16	0.03	0.69	0.69	000
93561	TC	A	Cardiac output measurement	0.00	0.52	NA	0.06	0.58	NA	000
93562		A	Cardiac output measurement	0.16	0.37	NA	0.05	0.58	NA	000
93562	26	A	Cardiac output measurement	0.16	0.05	0.05	0.01	0.22	0.22	000
93562	TC	A	Cardiac output measurement	0.00	0.32	NA	0.04	0.36	NA	000
93571		A	Heart flow reserve measure	1.80	5.24	NA	0.30	7.34	NA	ZZZ
93571	26	A	Heart flow reserve measure	1.80	0.68	0.68	0.06	2.54	2.54	ZZZ

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
93571	TC	A	Heart flow reserve measure	0.00	4.56	NA	0.24	4.80	NA	ZZZ
93572		A	Heart flow reserve measure	1.44	2.79	NA	0.18	4.41	NA	ZZZ
93572	26	A	Heart flow reserve measure	1.44	0.50	0.50	0.05	1.99	1.99	ZZZ
93572	TC	A	Heart flow reserve measure	0.00	2.29	NA	0.13	2.42	NA	ZZZ
93580		A	Transcath closure of asd	17.97	NA	7.37	1.37	NA	26.71	000
93581		A	Transcath closure of vsd	24.39	NA	9.38	1.37	NA	35.14	000
93600		A	Bundle of His recording	2.12	2.78	NA	0.29	5.19	NA	000
93600	26	A	Bundle of His recording	2.12	0.83	0.83	0.16	3.11	3.11	000
93600	TC	A	Bundle of His recording	0.00	1.95	NA	0.13	2.08	NA	000
93602		A	Intra-atrial recording	2.12	1.93	NA	0.24	4.29	NA	000
93602	26	A	Intra-atrial recording	2.12	0.82	0.82	0.17	3.11	3.11	000
93602	TC	A	Intra-atrial recording	0.00	1.11	NA	0.07	1.18	NA	000
93603		A	Right ventricular recording	2.12	2.49	NA	0.29	4.90	NA	000
93603	26	A	Right ventricular recording	2.12	0.81	0.81	0.18	3.11	3.11	000
93603	TC	A	Right ventricular recording	0.00	1.68	NA	0.11	1.79	NA	000
93609		A	Map tachycardia, add-on	4.99	4.65	NA	0.50	10.14	NA	ZZZ
93609	26	A	Map tachycardia, add-on	4.99	1.94	1.94	0.33	7.26	7.26	ZZZ
93609	TC	A	Map tachycardia, add-on	0.00	2.71	NA	0.17	2.88	NA	ZZZ
93610		A	Intra-atrial pacing	3.02	2.51	NA	0.35	5.88	NA	000
93610	26	A	Intra-atrial pacing	3.02	1.16	1.16	0.25	4.43	4.43	000
93610	TC	A	Intra-atrial pacing	0.00	1.35	NA	0.10	1.45	NA	000
93612		A	Intraventricular pacing	3.02	2.77	NA	0.36	6.15	NA	000
93612	26	A	Intraventricular pacing	3.02	1.16	1.16	0.25	4.43	4.43	000
93612	TC	A	Intraventricular pacing	0.00	1.61	NA	0.11	1.72	NA	000
93613		A	Electrophys map 3d, add-on	6.99	NA	2.75	0.63	NA	10.37	ZZZ
93615		A	Esophageal recording	0.99	0.58	NA	0.05	1.62	NA	000
93615	26	A	Esophageal recording	0.99	0.27	0.27	0.03	1.29	1.29	000
93615	TC	A	Esophageal recording	0.00	0.32	NA	0.02	0.34	NA	000
93616		A	Esophageal recording	1.49	0.74	NA	0.10	2.33	NA	000
93616	26	A	Esophageal recording	1.49	0.43	0.43	0.08	2.00	2.00	000
93616	TC	A	Esophageal recording	0.00	0.32	NA	0.02	0.34	NA	000
93618		A	Heart rhythm pacing	4.25	5.62	NA	0.54	10.41	NA	000
93618	26	A	Heart rhythm pacing	4.25	1.66	1.66	0.30	6.21	6.21	000
93618	TC	A	Heart rhythm pacing	0.00	3.96	NA	0.24	4.20	NA	000
93619		A	Electrophysiology evaluation	7.31	10.87	NA	0.98	19.16	NA	000
93619	26	A	Electrophysiology evaluation	7.31	3.18	3.18	0.51	11.00	11.00	000
93619	TC	A	Electrophysiology evaluation	0.00	7.69	NA	0.47	8.16	NA	000
93620	26	A	Electrophysiology evaluation	11.57	4.83	4.83	0.81	17.21	17.21	000
93621	26	A	Electrophysiology evaluation	2.10	0.82	0.82	0.15	3.07	3.07	ZZZ
93622	26	A	Electrophysiology evaluation	3.10	1.20	1.20	0.22	4.52	4.52	ZZZ
93623	26	A	Stimulation, pacing heart	2.85	1.11	1.11	0.20	4.16	4.16	ZZZ
93624		A	Electrophysiologic study	4.80	4.17	NA	0.47	9.44	NA	000
93624	26	A	Electrophysiologic study	4.80	2.19	2.19	0.34	7.33	7.33	000
93624	TC	A	Electrophysiologic study	0.00	1.98	NA	0.13	2.11	NA	000
93631		A	Heart pacing, mapping	7.59	8.90	NA	1.47	17.96	NA	000
93631	26	A	Heart pacing, mapping	7.59	2.76	2.76	0.85	11.20	11.20	000
93631	TC	A	Heart pacing, mapping	0.00	6.14	NA	0.62	6.76	NA	000
93640		A	Evaluation heart device	3.51	8.52	NA	0.67	12.70	NA	000
93640	26	A	Evaluation heart device	3.51	1.36	1.36	0.25	5.12	5.12	000
93640	TC	A	Evaluation heart device	0.00	7.16	NA	0.42	7.58	NA	000
93641		A	Electrophysiology evaluation	5.92	9.46	NA	0.84	16.22	NA	000
93641	26	A	Electrophysiology evaluation	5.92	2.30	2.30	0.42	8.64	8.64	000
93641	TC	A	Electrophysiology evaluation	0.00	7.16	NA	0.42	7.58	NA	000
93642		A	Electrophysiology evaluation	4.88	9.37	NA	0.58	14.83	NA	000
93642	26	A	Electrophysiology evaluation	4.88	2.21	2.21	0.16	7.25	7.25	000
93642	TC	A	Electrophysiology evaluation	0.00	7.16	NA	0.42	7.58	NA	000
93650		A	Ablate heart dysrhythm focus	10.49	NA	4.42	0.74	NA	15.65	000
93651		A	Ablate heart dysrhythm focus	16.23	NA	6.31	1.13	NA	23.67	000
93652		A	Ablate heart dysrhythm focus	17.65	NA	6.86	1.23	NA	25.74	000
93660		A	Tilt table evaluation	1.89	2.42	NA	0.08	4.39	NA	000
93660	26	A	Tilt table evaluation	1.89	0.74	0.74	0.06	2.69	2.69	000
93660	TC	A	Tilt table evaluation	0.00	1.68	NA	0.02	1.70	NA	000
93662	26	A	Intracardiac ecg (ice)	2.80	1.10	1.10	0.09	3.99	3.99	ZZZ
93701		A	Bioimpedance, thoracic	0.17	1.00	NA	0.02	1.19	NA	XXX
93701	26	A	Bioimpedance, thoracic	0.17	0.07	0.07	0.01	0.25	0.25	XXX
93701	TC	A	Bioimpedance, thoracic	0.00	0.94	NA	0.01	0.95	NA	XXX
93720		A	Total body plethysmography	0.17	1.16	NA	0.07	1.40	NA	XXX
93721		A	Plethysmography tracing	0.00	0.70	NA	0.06	0.76	NA	XXX
93722		A	Plethysmography report	0.17	0.05	0.05	0.01	0.23	0.23	XXX
93724		A	Analyze pacemaker system	4.88	5.86	NA	0.43	11.17	NA	000
93724	26	A	Analyze pacemaker system	4.88	1.91	1.91	0.19	6.98	6.98	000
93724	TC	A	Analyze pacemaker system	0.00	3.96	NA	0.24	4.20	NA	000
93727		A	Analyze ilr system	0.52	0.20	0.20	0.02	0.74	0.74	XXX
93731		A	Analyze pacemaker system	0.45	0.67	NA	0.06	1.18	NA	XXX
93731	26	A	Analyze pacemaker system	0.45	0.17	0.17	0.02	0.64	0.64	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
93731	TC	A	Analyze pacemaker system	0.00	0.49	NA	0.04	0.53	NA	XXX
93732		A	Analyze pacemaker system	0.92	0.86	NA	0.07	1.85	NA	XXX
93732	26	A	Analyze pacemaker system	0.92	0.35	0.35	0.03	1.30	1.30	XXX
93732	TC	A	Analyze pacemaker system	0.00	0.51	NA	0.04	0.55	NA	XXX
93733		A	Telephone analy, pacemaker	0.17	0.79	NA	0.07	1.03	NA	XXX
93733	26	A	Telephone analy, pacemaker	0.17	0.07	0.07	0.01	0.25	0.25	XXX
93733	TC	A	Telephone analy, pacemaker	0.00	0.72	NA	0.06	0.78	NA	XXX
93734		A	Analyze pacemaker system	0.38	0.49	NA	0.03	0.90	NA	XXX
93734	26	A	Analyze pacemaker system	0.38	0.14	0.14	0.01	0.53	0.53	XXX
93734	TC	A	Analyze pacemaker system	0.00	0.35	NA	0.02	0.37	NA	XXX
93735		A	Analyze pacemaker system	0.74	0.73	NA	0.07	1.54	NA	XXX
93735	26	A	Analyze pacemaker system	0.74	0.28	0.28	0.03	1.05	1.05	XXX
93735	TC	A	Analyze pacemaker system	0.00	0.44	NA	0.04	0.48	NA	XXX
93736		A	Telephonic analy, pacemaker	0.15	0.69	NA	0.07	0.91	NA	XXX
93736	26	A	Telephonic analy, pacemaker	0.15	0.06	0.06	0.01	0.22	0.22	XXX
93736	TC	A	Telephonic analy, pacemaker	0.00	0.63	NA	0.06	0.69	NA	XXX
93740		B	Temperature gradient studies	0.16	0.19	NA	0.02	0.37	NA	XXX
93740	26	B	Temperature gradient studies	0.16	0.04	0.04	0.01	0.21	0.21	XXX
93740	TC	B	Temperature gradient studies	0.00	0.15	NA	0.01	0.16	NA	XXX
93741		A	Analyze ht pace device sngl	0.80	0.98	NA	0.07	1.85	NA	XXX
93741	26	A	Analyze ht pace device sngl	0.80	0.31	0.31	0.03	1.14	1.14	XXX
93741	TC	A	Analyze ht pace device sngl	0.00	0.67	NA	0.04	0.71	NA	XXX
93742		A	Analyze ht pace device sngl	0.91	1.02	NA	0.07	2.00	NA	XXX
93742	26	A	Analyze ht pace device sngl	0.91	0.36	0.36	0.03	1.30	1.30	XXX
93742	TC	A	Analyze ht pace device sngl	0.00	0.67	NA	0.04	0.71	NA	XXX
93743		A	Analyze ht pace device dual	1.03	1.13	NA	0.08	2.24	NA	XXX
93743	26	A	Analyze ht pace device dual	1.03	0.40	0.40	0.04	1.47	1.47	XXX
93743	TC	A	Analyze ht pace device dual	0.00	0.73	NA	0.04	0.77	NA	XXX
93744		A	Analyze ht pace device dual	1.18	1.12	NA	0.08	2.38	NA	XXX
93744	26	A	Analyze ht pace device dual	1.18	0.46	0.46	0.04	1.68	1.68	XXX
93744	TC	A	Analyze ht pace device dual	0.00	0.67	NA	0.04	0.71	NA	XXX
93770		B	Measure venous pressure	0.16	0.08	NA	0.02	0.26	NA	XXX
93770	26	B	Measure venous pressure	0.16	0.05	0.05	0.01	0.22	0.22	XXX
93770	TC	B	Measure venous pressure	0.00	0.03	NA	0.01	0.04	NA	XXX
93784		A	Ambulatory BP monitoring	0.38	1.55	NA	0.03	1.96	NA	XXX
93786		A	Ambulatory BP recording	0.00	0.91	NA	0.01	0.92	NA	XXX
93788		A	Ambulatory BP analysis	0.00	0.51	NA	0.01	0.52	NA	XXX
93790		A	Review/report BP recording	0.38	0.13	0.13	0.01	0.52	0.52	XXX
93797		A	Cardiac rehab	0.18	0.30	0.07	0.01	0.49	0.26	000
93798		A	Cardiac rehab/monitor	0.28	0.47	0.11	0.01	0.76	0.40	000
93875		A	Extracranial study	0.22	2.10	NA	0.12	2.44	NA	XXX
93875	26	A	Extracranial study	0.22	0.08	0.08	0.01	0.31	0.31	XXX
93875	TC	A	Extracranial study	0.00	2.02	NA	0.11	2.13	NA	XXX
93880		A	Extracranial study	0.60	5.06	NA	0.39	6.05	NA	XXX
93880	26	A	Extracranial study	0.60	0.20	0.20	0.04	0.84	0.84	XXX
93880	TC	A	Extracranial study	0.00	4.85	NA	0.35	5.20	NA	XXX
93882		A	Extracranial study	0.40	3.31	NA	0.26	3.97	NA	XXX
93882	26	A	Extracranial study	0.40	0.14	0.14	0.04	0.58	0.58	XXX
93882	TC	A	Extracranial study	0.00	3.17	NA	0.22	3.39	NA	XXX
93886		A	Intracranial study	0.94	6.05	NA	0.45	7.44	NA	XXX
93886	26	A	Intracranial study	0.94	0.37	0.37	0.06	1.37	1.37	XXX
93886	TC	A	Intracranial study	0.00	5.68	NA	0.39	6.07	NA	XXX
93888		A	Intracranial study	0.62	3.85	NA	0.32	4.79	NA	XXX
93888	26	A	Intracranial study	0.62	0.23	0.23	0.05	0.90	0.90	XXX
93888	TC	A	Intracranial study	0.00	3.62	NA	0.27	3.89	NA	XXX
93922		A	Extremity study	0.25	2.43	NA	0.15	2.83	NA	XXX
93922	26	A	Extremity study	0.25	0.08	0.08	0.02	0.35	0.35	XXX
93922	TC	A	Extremity study	0.00	2.34	NA	0.13	2.47	NA	XXX
93923		A	Extremity study	0.45	3.68	NA	0.26	4.39	NA	XXX
93923	26	A	Extremity study	0.45	0.15	0.15	0.04	0.64	0.64	XXX
93923	TC	A	Extremity study	0.00	3.53	NA	0.22	3.75	NA	XXX
93924		A	Extremity study	0.50	4.42	NA	0.30	5.22	NA	XXX
93924	26	A	Extremity study	0.50	0.17	0.17	0.05	0.72	0.72	XXX
93924	TC	A	Extremity study	0.00	4.25	NA	0.25	4.50	NA	XXX
93925		A	Lower extremity study	0.58	6.11	NA	0.39	7.08	NA	XXX
93925	26	A	Lower extremity study	0.58	0.20	0.20	0.04	0.82	0.82	XXX
93925	TC	A	Lower extremity study	0.00	5.91	NA	0.35	6.26	NA	XXX
93926		A	Lower extremity study	0.39	3.82	NA	0.27	4.48	NA	XXX
93926	26	A	Lower extremity study	0.39	0.13	0.13	0.04	0.56	0.56	XXX
93926	TC	A	Lower extremity study	0.00	3.69	NA	0.23	3.92	NA	XXX
93930		A	Upper extremity study	0.46	4.85	NA	0.41	5.72	NA	XXX
93930	26	A	Upper extremity study	0.46	0.16	0.16	0.04	0.66	0.66	XXX
93930	TC	A	Upper extremity study	0.00	4.69	NA	0.37	5.06	NA	XXX
93931		A	Upper extremity study	0.31	3.22	NA	0.27	3.80	NA	XXX
93931	26	A	Upper extremity study	0.31	0.10	0.10	0.03	0.44	0.44	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
93931	TC	A	Upper extremity study	0.00	3.12	NA	0.24	3.36	NA	XXX
93965		A	Extremity study	0.35	2.48	NA	0.14	2.97	NA	XXX
93965	26	A	Extremity study	0.35	0.12	0.12	0.02	0.49	0.49	XXX
93965	TC	A	Extremity study	0.00	2.36	NA	0.12	2.48	NA	XXX
93970		A	Extremity study	0.68	4.77	NA	0.45	5.90	NA	XXX
93970	26	A	Extremity study	0.68	0.23	0.23	0.05	0.96	0.96	XXX
93970	TC	A	Extremity study	0.00	4.54	NA	0.40	4.94	NA	XXX
93971		A	Extremity study	0.45	3.28	NA	0.30	4.03	NA	XXX
93971	26	A	Extremity study	0.45	0.15	0.15	0.03	0.63	0.63	XXX
93971	TC	A	Extremity study	0.00	3.13	NA	0.27	3.40	NA	XXX
93975		A	Vascular study	1.80	6.91	NA	0.56	9.27	NA	XXX
93975	26	A	Vascular study	1.80	0.60	0.60	0.13	2.53	2.53	XXX
93975	TC	A	Vascular study	0.00	6.32	NA	0.43	6.75	NA	XXX
93976		A	Vascular study	1.21	3.92	NA	0.36	5.49	NA	XXX
93976	26	A	Vascular study	1.21	0.40	0.40	0.06	1.67	1.67	XXX
93976	TC	A	Vascular study	0.00	3.52	NA	0.30	3.82	NA	XXX
93978		A	Vascular study	0.65	4.17	NA	0.43	5.25	NA	XXX
93978	26	A	Vascular study	0.65	0.22	0.22	0.06	0.93	0.93	XXX
93978	TC	A	Vascular study	0.00	3.95	NA	0.37	4.32	NA	XXX
93979		A	Vascular study	0.44	3.00	NA	0.28	3.72	NA	XXX
93979	26	A	Vascular study	0.44	0.15	0.15	0.04	0.63	0.63	XXX
93979	TC	A	Vascular study	0.00	2.85	NA	0.24	3.09	NA	XXX
93980		A	Penile vascular study	1.25	2.88	NA	0.43	4.56	NA	XXX
93980	26	A	Penile vascular study	1.25	0.41	0.41	0.09	1.75	1.75	XXX
93980	TC	A	Penile vascular study	0.00	2.48	NA	0.34	2.82	NA	XXX
93981		A	Penile vascular study	0.44	2.96	NA	0.33	3.73	NA	XXX
93981	26	A	Penile vascular study	0.44	0.14	0.14	0.02	0.60	0.60	XXX
93981	TC	A	Penile vascular study	0.00	2.81	NA	0.31	3.12	NA	XXX
93990		A	Doppler flow testing	0.25	3.76	NA	0.26	4.27	NA	XXX
93990	26	A	Doppler flow testing	0.25	0.09	0.09	0.03	0.37	0.37	XXX
93990	TC	A	Doppler flow testing	0.00	3.67	NA	0.23	3.90	NA	XXX
94010		A	Breathing capacity test	0.17	0.69	NA	0.03	0.89	NA	XXX
94010	26	A	Breathing capacity test	0.17	0.05	0.05	0.01	0.23	0.23	XXX
94010	TC	A	Breathing capacity test	0.00	0.63	NA	0.02	0.65	NA	XXX
94014		A	Patient recorded spirometry	0.52	0.77	NA	0.04	1.33	NA	XXX
94015		A	Patient recorded spirometry	0.00	0.60	NA	0.01	0.61	NA	XXX
94016		A	Review patient spirometry	0.52	0.16	0.16	0.03	0.71	0.71	XXX
94060		A	Evaluation of wheezing	0.31	1.10	NA	0.07	1.48	NA	XXX
94060	26	A	Evaluation of wheezing	0.31	0.09	0.09	0.01	0.41	0.41	XXX
94060	TC	A	Evaluation of wheezing	0.00	1.01	NA	0.06	1.07	NA	XXX
94070		A	Evaluation of wheezing	0.60	0.84	NA	0.13	1.57	NA	XXX
94070	26	A	Evaluation of wheezing	0.60	0.18	0.18	0.03	0.81	0.81	XXX
94070	TC	A	Evaluation of wheezing	0.00	0.66	NA	0.10	0.76	NA	XXX
94150		B	Vital capacity test	0.07	0.48	NA	0.02	0.57	NA	XXX
94150	26	B	Vital capacity test	0.07	0.03	0.03	0.01	0.11	0.11	XXX
94150	TC	B	Vital capacity test	0.00	0.45	NA	0.01	0.46	NA	XXX
94200		A	Lung function test (MBC/MVV)	0.11	0.46	NA	0.03	0.60	NA	XXX
94200	26	A	Lung function test (MBC/MVV)	0.11	0.03	0.03	0.01	0.15	0.15	XXX
94200	TC	A	Lung function test (MBC/MVV)	0.00	0.42	NA	0.02	0.44	NA	XXX
94240		A	Residual lung capacity	0.26	0.67	NA	0.06	0.99	NA	XXX
94240	26	A	Residual lung capacity	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94240	TC	A	Residual lung capacity	0.00	0.59	NA	0.05	0.64	NA	XXX
94250		A	Expired gas collection	0.11	0.65	NA	0.02	0.78	NA	XXX
94250	26	A	Expired gas collection	0.11	0.03	0.03	0.01	0.15	0.15	XXX
94250	TC	A	Expired gas collection	0.00	0.62	NA	0.01	0.63	NA	XXX
94260		A	Thoracic gas volume	0.13	0.59	NA	0.05	0.77	NA	XXX
94260	26	A	Thoracic gas volume	0.13	0.04	0.04	0.01	0.18	0.18	XXX
94260	TC	A	Thoracic gas volume	0.00	0.55	NA	0.04	0.59	NA	XXX
94350		A	Lung nitrogen washout curve	0.26	0.77	NA	0.05	1.08	NA	XXX
94350	26	A	Lung nitrogen washout curve	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94350	TC	A	Lung nitrogen washout curve	0.00	0.70	NA	0.04	0.74	NA	XXX
94360		A	Measure airflow resistance	0.26	0.71	NA	0.07	1.04	NA	XXX
94360	26	A	Measure airflow resistance	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94360	TC	A	Measure airflow resistance	0.00	0.63	NA	0.06	0.69	NA	XXX
94370		A	Breath airway closing volume	0.26	0.74	NA	0.03	1.03	NA	XXX
94370	26	A	Breath airway closing volume	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94370	TC	A	Breath airway closing volume	0.00	0.66	NA	0.02	0.68	NA	XXX
94375		A	Respiratory flow volume loop	0.31	0.62	NA	0.03	0.96	NA	XXX
94375	26	A	Respiratory flow volume loop	0.31	0.09	0.09	0.01	0.41	0.41	XXX
94375	TC	A	Respiratory flow volume loop	0.00	0.53	NA	0.02	0.55	NA	XXX
94400		A	CO2 breathing response curve	0.40	0.86	NA	0.09	1.35	NA	XXX
94400	26	A	CO2 breathing response curve	0.40	0.12	0.12	0.03	0.55	0.55	XXX
94400	TC	A	CO2 breathing response curve	0.00	0.74	NA	0.06	0.80	NA	XXX
94450		A	Hypoxia response curve	0.40	0.87	NA	0.04	1.31	NA	XXX
94450	26	A	Hypoxia response curve	0.40	0.12	0.12	0.02	0.54	0.54	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
94450	TC	A	Hypoxia response curve	0.00	0.75	NA	0.02	0.77	NA	XXX
94620		A	Pulmonary stress test/simple	0.64	2.54	NA	0.13	3.31	NA	XXX
94620	26	A	Pulmonary stress test/simple	0.64	0.20	0.20	0.03	0.87	0.87	XXX
94620	TC	A	Pulmonary stress test/simple	0.00	2.34	NA	0.10	2.44	NA	XXX
94621		A	Pulm stress test/complex	1.42	2.24	NA	0.16	3.82	NA	XXX
94621	26	A	Pulm stress test/complex	1.42	0.43	0.43	0.06	1.91	1.91	XXX
94621	TC	A	Pulm stress test/complex	0.00	1.80	NA	0.10	1.90	NA	XXX
94640		A	Airway inhalation treatment	0.00	0.31	NA	0.02	0.33	NA	XXX
94656		A	Initial ventilator mgmt	1.22	1.18	0.31	0.07	2.47	1.60	XXX
94657		A	Continued ventilator mgmt	0.83	1.00	0.25	0.04	1.87	1.12	XXX
94660		A	Pos airway pressure, CPAP	0.76	0.66	0.23	0.04	1.46	1.03	XXX
94662		A	Neg press ventilation, cnp	0.76	NA	0.23	0.06	NA	1.05	XXX
94664		A	Evaluate pt use of inhaler	0.00	0.32	NA	0.04	0.36	NA	XXX
94667		A	Chest wall manipulation	0.00	0.54	NA	0.05	0.59	NA	XXX
94668		A	Chest wall manipulation	0.00	0.46	NA	0.02	0.48	NA	XXX
94680		A	Exhaled air analysis, o2	0.26	1.89	NA	0.07	2.22	NA	XXX
94680	26	A	Exhaled air analysis, o2	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94680	TC	A	Exhaled air analysis, o2	0.00	1.81	NA	0.06	1.87	NA	XXX
94681		A	Exhaled air analysis, o2/co2	0.20	2.58	NA	0.13	2.91	NA	XXX
94681	26	A	Exhaled air analysis, o2/co2	0.20	0.06	0.06	0.01	0.27	0.27	XXX
94681	TC	A	Exhaled air analysis, o2/co2	0.00	2.52	NA	0.12	2.64	NA	XXX
94690		A	Exhaled air analysis	0.07	2.02	NA	0.04	2.13	NA	XXX
94690	26	A	Exhaled air analysis	0.07	0.02	0.02	0.00	0.09	0.09	XXX
94690	TC	A	Exhaled air analysis	0.00	2.00	NA	0.04	2.04	NA	XXX
94720		A	Monoxide diffusing capacity	0.26	1.02	NA	0.07	1.35	NA	XXX
94720	26	A	Monoxide diffusing capacity	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94720	TC	A	Monoxide diffusing capacity	0.00	0.94	NA	0.06	1.00	NA	XXX
94725		A	Membrane diffusion capacity	0.26	2.94	NA	0.13	3.33	NA	XXX
94725	26	A	Membrane diffusion capacity	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94725	TC	A	Membrane diffusion capacity	0.00	2.86	NA	0.12	2.98	NA	XXX
94750		A	Pulmonary compliance study	0.23	1.35	NA	0.05	1.63	NA	XXX
94750	26	A	Pulmonary compliance study	0.23	0.07	0.07	0.01	0.31	0.31	XXX
94750	TC	A	Pulmonary compliance study	0.00	1.29	NA	0.04	1.33	NA	XXX
94760		T	Measure blood oxygen level	0.00	0.04	NA	0.02	0.06	NA	XXX
94761		T	Measure blood oxygen level	0.00	0.07	NA	0.06	0.13	NA	XXX
94762		A	Measure blood oxygen level	0.00	0.49	NA	0.10	0.59	NA	XXX
94770		A	Exhaled carbon dioxide test	0.15	0.76	NA	0.08	0.99	NA	XXX
94770	26	A	Exhaled carbon dioxide test	0.15	0.04	0.04	0.01	0.20	0.20	XXX
94770	TC	A	Exhaled carbon dioxide test	0.00	0.72	NA	0.07	0.79	NA	XXX
95004		A	Percut allergy skin tests	0.00	0.10	NA	0.01	0.11	NA	XXX
95010		A	Percut allergy titrate test	0.15	0.32	0.06	0.00	0.47	0.21	XXX
95015		A	Id allergy titrate-drug/bug	0.15	0.14	0.06	0.01	0.30	0.22	XXX
95024		A	Id allergy test, drug/bug	0.00	0.14	NA	0.01	0.15	NA	XXX
95027		A	Id allergy titrate-airborne	0.00	0.14	NA	0.01	0.15	NA	XXX
95028		A	Id allergy test-delayed type	0.00	0.23	NA	0.01	0.24	NA	XXX
95044		A	Allergy patch tests	0.00	0.20	NA	0.01	0.21	NA	XXX
95052		A	Photo patch test	0.00	0.25	NA	0.01	0.26	NA	XXX
95056		A	Photosensitivity tests	0.00	0.17	NA	0.01	0.18	NA	XXX
95060		A	Eye allergy tests	0.00	0.35	NA	0.02	0.37	NA	XXX
95065		A	Nose allergy test	0.00	0.20	NA	0.01	0.21	NA	XXX
95070		A	Bronchial allergy tests	0.00	2.28	NA	0.02	2.30	NA	XXX
95071		A	Bronchial allergy tests	0.00	2.91	NA	0.02	2.93	NA	XXX
95075		A	Ingestion challenge test	0.95	0.83	0.38	0.03	1.81	1.36	XXX
95078		A	Provocative testing	0.00	0.25	NA	0.02	0.27	NA	XXX
95115		A	Immunotherapy, one injection	0.00	0.39	NA	0.02	0.41	NA	000
95117		A	Immunotherapy injections	0.00	0.50	NA	0.02	0.52	NA	000
95144		A	Antigen therapy services	0.06	0.19	0.02	0.00	0.25	0.08	000
95145		A	Antigen therapy services	0.06	0.32	0.02	0.00	0.38	0.08	000
95146		A	Antigen therapy services	0.06	0.44	0.03	0.00	0.50	0.09	000
95147		A	Antigen therapy services	0.06	0.42	0.02	0.00	0.48	0.08	000
95148		A	Antigen therapy services	0.06	0.58	0.03	0.00	0.64	0.09	000
95149		A	Antigen therapy services	0.06	0.80	0.03	0.00	0.86	0.09	000
95165		A	Antigen therapy services	0.06	0.19	0.02	0.00	0.25	0.08	000
95170		A	Antigen therapy services	0.06	0.13	0.02	0.00	0.19	0.08	000
95180		A	Rapid desensitization	2.01	2.05	0.93	0.05	4.11	2.99	000
95250		A	Glucose monitoring, cont	0.00	4.22	NA	0.01	4.23	NA	XXX
95805		A	Multiple sleep latency test	1.88	18.00	NA	0.43	20.31	NA	XXX
95805	26	A	Multiple sleep latency test	1.88	0.66	0.66	0.09	2.63	2.63	XXX
95805	TC	A	Multiple sleep latency test	0.00	17.35	NA	0.34	17.69	NA	XXX
95806		A	Sleep study, unattended	1.66	3.40	NA	0.39	5.45	NA	XXX
95806	26	A	Sleep study, unattended	1.66	0.53	0.53	0.08	2.27	2.27	XXX
95806	TC	A	Sleep study, unattended	0.00	2.87	NA	0.31	3.18	NA	XXX
95807		A	Sleep study, attended	1.66	12.10	NA	0.50	14.26	NA	XXX
95807	26	A	Sleep study, attended	1.66	0.53	0.53	0.08	2.27	2.27	XXX
95807	TC	A	Sleep study, attended	0.00	11.57	NA	0.42	11.99	NA	XXX

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[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
95808		A	Polysomnography, 1-3	2.65	13.54	NA	0.55	16.74	NA	XXX
95808	26	A	Polysomnography, 1-3	2.65	0.92	0.92	0.13	3.70	3.70	XXX
95808	TC	A	Polysomnography, 1-3	0.00	12.62	NA	0.42	13.04	NA	XXX
95810		A	Polysomnography, 4 or more	3.52	18.02	NA	0.59	22.13	NA	XXX
95810	26	A	Polysomnography, 4 or more	3.52	1.18	1.18	0.17	4.87	4.87	XXX
95810	TC	A	Polysomnography, 4 or more	0.00	16.84	NA	0.42	17.26	NA	XXX
95811		A	Polysomnography w/cpap	3.79	19.53	NA	0.61	23.93	NA	XXX
95811	26	A	Polysomnography w/cpap	3.79	1.27	1.27	0.18	5.24	5.24	XXX
95811	TC	A	Polysomnography w/cpap	0.00	18.26	NA	0.43	18.69	NA	XXX
95812		A	Eeg, 41-60 minutes	1.08	4.03	NA	0.17	5.28	NA	XXX
95812	26	A	Eeg, 41-60 minutes	1.08	0.45	0.45	0.06	1.59	1.59	XXX
95812	TC	A	Eeg, 41-60 minutes	0.00	3.58	NA	0.11	3.69	NA	XXX
95813		A	Eeg, over 1 hour	1.73	5.04	NA	0.21	6.98	NA	XXX
95813	26	A	Eeg, over 1 hour	1.73	0.70	0.70	0.10	2.53	2.53	XXX
95813	TC	A	Eeg, over 1 hour	0.00	4.35	NA	0.11	4.46	NA	XXX
95816		A	Eeg, awake and drowsy	1.08	4.78	NA	0.16	6.02	NA	XXX
95816	26	A	Eeg, awake and drowsy	1.08	0.46	0.46	0.06	1.60	1.60	XXX
95816	TC	A	Eeg, awake and drowsy	0.00	4.32	NA	0.10	4.42	NA	XXX
95819		A	Eeg, awake and asleep	1.08	2.76	NA	0.16	4.00	NA	XXX
95819	26	A	Eeg, awake and asleep	1.08	0.46	0.46	0.06	1.60	1.60	XXX
95819	TC	A	Eeg, awake and asleep	0.00	2.30	NA	0.10	2.40	NA	XXX
95822		A	Eeg, coma or sleep only	1.08	4.63	NA	0.19	5.90	NA	XXX
95822	26	A	Eeg, coma or sleep only	1.08	0.46	0.46	0.06	1.60	1.60	XXX
95822	TC	A	Eeg, coma or sleep only	0.00	4.18	NA	0.13	4.31	NA	XXX
95824	26	A	Eeg, cerebral death only	0.74	0.31	0.31	0.04	1.09	1.09	XXX
95827		A	Eeg, all night recording	1.08	2.69	NA	0.20	3.97	NA	XXX
95827	26	A	Eeg, all night recording	1.08	0.41	0.41	0.06	1.55	1.55	XXX
95827	TC	A	Eeg, all night recording	0.00	2.29	NA	0.14	2.43	NA	XXX
95829		A	Surgery electrocorticogram	6.20	31.16	NA	0.51	37.87	NA	XXX
95829	26	A	Surgery electrocorticogram	6.20	2.31	2.31	0.49	9.00	9.00	XXX
95829	TC	A	Surgery electrocorticogram	0.00	28.85	NA	0.02	28.87	NA	XXX
95830		A	Insert electrodes for EEG	1.70	3.29	0.73	0.10	5.09	2.53	XXX
95831		A	Limb muscle testing, manual	0.28	0.46	0.13	0.02	0.76	0.43	XXX
95832		A	Hand muscle testing, manual	0.29	0.33	0.12	0.02	0.64	0.43	XXX
95833		A	Body muscle testing, manual	0.47	0.59	0.23	0.02	1.08	0.72	XXX
95834		A	Body muscle testing, manual	0.60	0.64	0.28	0.03	1.27	0.91	XXX
95851		A	Range of motion measurements	0.16	0.37	0.08	0.01	0.54	0.25	XXX
95852		A	Range of motion measurements	0.11	0.26	0.05	0.01	0.38	0.17	XXX
95857		A	Tensilon test	0.53	0.60	0.23	0.03	1.16	0.79	XXX
95858		A	Tensilon test & myogram	1.56	1.06	NA	0.12	2.74	NA	XXX
95858	26	A	Tensilon test & myogram	1.56	0.67	0.67	0.08	2.31	2.31	XXX
95858	TC	A	Tensilon test & myogram	0.00	0.40	NA	0.04	0.44	NA	XXX
95860		A	Muscle test, one limb	0.96	1.43	NA	0.07	2.46	NA	XXX
95860	26	A	Muscle test, one limb	0.96	0.42	0.42	0.05	1.43	1.43	XXX
95860	TC	A	Muscle test, one limb	0.00	1.01	NA	0.02	1.03	NA	XXX
95861		A	Muscle test, 2 limbs	1.54	1.41	NA	0.14	3.09	NA	XXX
95861	26	A	Muscle test, 2 limbs	1.54	0.67	0.67	0.08	2.29	2.29	XXX
95861	TC	A	Muscle test, 2 limbs	0.00	0.73	NA	0.06	0.79	NA	XXX
95863		A	Muscle test, 3 limbs	1.87	1.74	NA	0.15	3.76	NA	XXX
95863	26	A	Muscle test, 3 limbs	1.87	0.80	0.80	0.09	2.76	2.76	XXX
95863	TC	A	Muscle test, 3 limbs	0.00	0.94	NA	0.06	1.00	NA	XXX
95864		A	Muscle test, 4 limbs	1.99	2.64	NA	0.22	4.85	NA	XXX
95864	26	A	Muscle test, 4 limbs	1.99	0.87	0.87	0.10	2.96	2.96	XXX
95864	TC	A	Muscle test, 4 limbs	0.00	1.78	NA	0.12	1.90	NA	XXX
95867		A	Muscle test cran nerv unilat	0.79	0.92	NA	0.08	1.79	NA	XXX
95867	26	A	Muscle test cran nerv unilat	0.79	0.35	0.35	0.04	1.18	1.18	XXX
95867	TC	A	Muscle test cran nerv unilat	0.00	0.58	NA	0.04	0.62	NA	XXX
95868		A	Muscle test cran nerve bilat	1.18	1.21	NA	0.11	2.50	NA	XXX
95868	26	A	Muscle test cran nerve bilat	1.18	0.51	0.51	0.06	1.75	1.75	XXX
95868	TC	A	Muscle test cran nerve bilat	0.00	0.69	NA	0.05	0.74	NA	XXX
95869		A	Muscle test, thor paraspinal	0.37	0.37	NA	0.04	0.78	NA	XXX
95869	26	A	Muscle test, thor paraspinal	0.37	0.16	0.16	0.02	0.55	0.55	XXX
95869	TC	A	Muscle test, thor paraspinal	0.00	0.21	NA	0.02	0.23	NA	XXX
95870		A	Muscle test, nonparaspinal	0.37	0.37	NA	0.04	0.78	NA	XXX
95870	26	A	Muscle test, nonparaspinal	0.37	0.16	0.16	0.02	0.55	0.55	XXX
95870	TC	A	Muscle test, nonparaspinal	0.00	0.21	NA	0.02	0.23	NA	XXX
95872		A	Muscle test, one fiber	1.50	1.23	NA	0.14	2.87	NA	XXX
95872	26	A	Muscle test, one fiber	1.50	0.63	0.63	0.09	2.22	2.22	XXX
95872	TC	A	Muscle test, one fiber	0.00	0.60	NA	0.05	0.65	NA	XXX
95875		A	Limb exercise test	1.10	1.45	NA	0.14	2.69	NA	XXX
95875	26	A	Limb exercise test	1.10	0.47	0.47	0.08	1.65	1.65	XXX
95875	TC	A	Limb exercise test	0.00	0.98	NA	0.06	1.04	NA	XXX
95900		A	Motor nerve conduction test	0.42	1.26	NA	0.04	1.72	NA	XXX
95900	26	A	Motor nerve conduction test	0.42	0.18	0.18	0.02	0.62	0.62	XXX
95900	TC	A	Motor nerve conduction test	0.00	1.08	NA	0.02	1.10	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
95903		A	Motor nerve conduction test	0.60	1.20	NA	0.05	1.85	NA	XXX
95903	26	A	Motor nerve conduction test	0.60	0.26	0.26	0.03	0.89	0.89	XXX
95903	TC	A	Motor nerve conduction test	0.00	0.94	NA	0.02	0.96	NA	XXX
95904		A	Sense nerve conduction test	0.34	1.09	NA	0.04	1.47	NA	XXX
95904	26	A	Sense nerve conduction test	0.34	0.15	0.15	0.02	0.51	0.51	XXX
95904	TC	A	Sense nerve conduction test	0.00	0.95	NA	0.02	0.97	NA	XXX
95920		A	Intraop nerve test add-on	2.11	2.23	NA	0.24	4.58	NA	ZZZ
95920	26	A	Intraop nerve test add-on	2.11	0.93	0.93	0.17	3.21	3.21	ZZZ
95920	TC	A	Intraop nerve test add-on	0.00	1.30	NA	0.07	1.37	NA	ZZZ
95921		A	Autonomic nerv function test	0.90	0.70	NA	0.06	1.66	NA	XXX
95921	26	A	Autonomic nerv function test	0.90	0.33	0.33	0.04	1.27	1.27	XXX
95921	TC	A	Autonomic nerv function test	0.00	0.38	NA	0.02	0.40	NA	XXX
95922		A	Autonomic nerv function test	0.96	0.78	NA	0.07	1.81	NA	XXX
95922	26	A	Autonomic nerv function test	0.96	0.40	0.40	0.05	1.41	1.41	XXX
95922	TC	A	Autonomic nerv function test	0.00	0.38	NA	0.02	0.40	NA	XXX
95923		A	Autonomic nerv function test	0.90	1.95	NA	0.07	2.92	NA	XXX
95923	26	A	Autonomic nerv function test	0.90	0.38	0.38	0.05	1.33	1.33	XXX
95923	TC	A	Autonomic nerv function test	0.00	1.57	NA	0.02	1.59	NA	XXX
95925		A	Somatosensory testing	0.54	1.13	NA	0.09	1.76	NA	XXX
95925	26	A	Somatosensory testing	0.54	0.22	0.22	0.03	0.79	0.79	XXX
95925	TC	A	Somatosensory testing	0.00	0.91	NA	0.06	0.97	NA	XXX
95926		A	Somatosensory testing	0.54	1.14	NA	0.09	1.77	NA	XXX
95926	26	A	Somatosensory testing	0.54	0.23	0.23	0.03	0.80	0.80	XXX
95926	TC	A	Somatosensory testing	0.00	0.91	NA	0.06	0.97	NA	XXX
95927		A	Somatosensory testing	0.54	1.16	NA	0.09	1.79	NA	XXX
95927	26	A	Somatosensory testing	0.54	0.25	0.25	0.03	0.82	0.82	XXX
95927	TC	A	Somatosensory testing	0.00	0.91	NA	0.06	0.97	NA	XXX
95930		A	Visual evoked potential test	0.35	2.25	NA	0.03	2.63	NA	XXX
95930	26	A	Visual evoked potential test	0.35	0.15	0.15	0.02	0.52	0.52	XXX
95930	TC	A	Visual evoked potential test	0.00	2.10	NA	0.01	2.11	NA	XXX
95933		A	Blink reflex test	0.59	1.02	NA	0.10	1.71	NA	XXX
95933	26	A	Blink reflex test	0.59	0.24	0.24	0.04	0.87	0.87	XXX
95933	TC	A	Blink reflex test	0.00	0.78	NA	0.06	0.84	NA	XXX
95934		A	H-reflex test	0.51	0.43	NA	0.04	0.98	NA	XXX
95934	26	A	H-reflex test	0.51	0.22	0.22	0.02	0.75	0.75	XXX
95934	TC	A	H-reflex test	0.00	0.21	NA	0.02	0.23	NA	XXX
95936		A	H-reflex test	0.55	0.45	NA	0.05	1.05	NA	XXX
95936	26	A	H-reflex test	0.55	0.24	0.24	0.03	0.82	0.82	XXX
95936	TC	A	H-reflex test	0.00	0.21	NA	0.02	0.23	NA	XXX
95937		A	Neuromuscular junction test	0.65	0.60	NA	0.08	1.33	NA	XXX
95937	26	A	Neuromuscular junction test	0.65	0.27	0.27	0.06	0.98	0.98	XXX
95937	TC	A	Neuromuscular junction test	0.00	0.34	NA	0.02	0.36	NA	XXX
95950		A	Ambulatory eeg monitoring	1.51	4.98	NA	0.51	7.00	NA	XXX
95950	26	A	Ambulatory eeg monitoring	1.51	0.63	0.63	0.08	2.22	2.22	XXX
95950	TC	A	Ambulatory eeg monitoring	0.00	4.35	NA	0.43	4.78	NA	XXX
95951	26	A	EEG monitoring/videorecord	5.99	2.54	2.54	0.34	8.87	8.87	XXX
95953		A	EEG monitoring/computer	3.08	7.61	NA	0.61	11.30	NA	XXX
95953	26	A	EEG monitoring/computer	3.08	1.29	1.29	0.18	4.55	4.55	XXX
95953	TC	A	EEG monitoring/computer	0.00	6.32	NA	0.43	6.75	NA	XXX
95954		A	EEG monitoring/giving drugs	2.45	4.28	NA	0.19	6.92	NA	XXX
95954	26	A	EEG monitoring/giving drugs	2.45	1.04	1.04	0.13	3.62	3.62	XXX
95954	TC	A	EEG monitoring/giving drugs	0.00	3.24	NA	0.06	3.30	NA	XXX
95955		A	EEG during surgery	1.01	2.32	NA	0.23	3.56	NA	XXX
95955	26	A	EEG during surgery	1.01	0.36	0.36	0.06	1.43	1.43	XXX
95955	TC	A	EEG during surgery	0.00	1.96	NA	0.17	2.13	NA	XXX
95956		A	Eeg monitoring, cable/radio	3.08	15.93	NA	0.60	19.61	NA	XXX
95956	26	A	Eeg monitoring, cable/radio	3.08	1.30	1.30	0.17	4.55	4.55	XXX
95956	TC	A	Eeg monitoring, cable/radio	0.00	14.63	NA	0.43	15.06	NA	XXX
95957		A	EEG digital analysis	1.98	2.55	NA	0.23	4.76	NA	XXX
95957	26	A	EEG digital analysis	1.98	0.85	0.85	0.11	2.94	2.94	XXX
95957	TC	A	EEG digital analysis	0.00	1.70	NA	0.12	1.82	NA	XXX
95958		A	EEG monitoring/function test	4.24	3.47	NA	0.39	8.10	NA	XXX
95958	26	A	EEG monitoring/function test	4.24	1.73	1.73	0.26	6.23	6.23	XXX
95958	TC	A	EEG monitoring/function test	0.00	1.74	NA	0.13	1.87	NA	XXX
95961		A	Electrode stimulation, brain	2.97	2.62	NA	0.53	6.12	NA	XXX
95961	26	A	Electrode stimulation, brain	2.97	1.32	1.32	0.46	4.75	4.75	XXX
95961	TC	A	Electrode stimulation, brain	0.00	1.30	NA	0.07	1.37	NA	XXX
95962		A	Electrode stim, brain add-on	3.21	2.69	NA	0.38	6.28	NA	ZZZ
95962	26	A	Electrode stim, brain add-on	3.21	1.39	1.39	0.31	4.91	4.91	ZZZ
95962	TC	A	Electrode stim, brain add-on	0.00	1.30	NA	0.07	1.37	NA	ZZZ
95965	26	A	Meg, spontaneous	7.99	3.41	3.41	0.41	11.81	11.81	XXX
95966	26	A	Meg, evoked, single	3.99	1.71	1.71	0.21	5.91	5.91	XXX
95967	26	A	Meg, evoked, each add-l	3.49	1.18	1.18	0.16	4.83	4.83	ZZZ
95970		A	Analyze neurostim, no prog	0.45	0.86	0.14	0.03	1.34	0.62	XXX
95971		A	Analyze neurostim, simple	0.78	0.68	0.22	0.07	1.53	1.07	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
95972		A	Analyze neurostim, complex	1.50	1.21	0.49	0.14	2.85	2.13	XXX
95973		A	Analyze neurostim, complex	0.92	0.62	0.34	0.07	1.61	1.33	ZZZ
95974		A	Cranial neurostim, complex	3.00	1.70	1.29	0.18	4.88	4.47	XXX
95975		A	Cranial neurostim, complex	1.70	0.89	0.73	0.11	2.70	2.54	ZZZ
95990		A	Spin/brain pump refil & main	0.00	1.50	NA	0.06	1.56	NA	XXX
95991		A	Spin/brain pump refil & main	0.77	1.53	0.17	0.06	2.36	1.00	XXX
96000		A	Motion analysis, video/3d	1.80	NA	0.53	0.05	NA	2.38	XXX
96001		A	Motion test w/ft press meas	2.15	NA	0.66	0.06	NA	2.87	XXX
96002		A	Dynamic surface emg	0.41	NA	0.15	0.01	NA	0.57	XXX
96003		A	Dynamic fine wire emg	0.37	NA	0.12	0.04	NA	0.53	XXX
96004		A	Phys review of motion tests	2.14	0.94	0.94	0.07	3.15	3.15	XXX
96100		A	Psychological testing	0.00	1.76	NA	0.18	1.94	NA	XXX
96105		A	Assessment of aphasia	0.00	1.76	NA	0.18	1.94	NA	XXX
96110		A	Developmental test, lim	0.00	0.18	NA	0.18	0.36	NA	XXX
96111		A	Developmental test, extend	2.60	1.05	NA	0.18	3.83	NA	XXX
96115		A	Neurobehavior status exam	0.00	1.76	NA	0.18	1.94	NA	XXX
96117		A	Neuropsych test battery	0.00	1.76	NA	0.18	1.94	NA	XXX
96150		A	Assess lth/behave, init	0.50	0.18	0.18	0.01	0.69	0.69	XXX
96151		A	Assess hlth/behave, subseq	0.48	0.18	0.17	0.01	0.67	0.66	XXX
96152		A	Intervene hlth/behave, indiv	0.46	0.17	0.16	0.01	0.64	0.63	XXX
96153		A	Intervene hlth/behave, group	0.10	0.04	0.03	0.00	0.14	0.13	XXX
96154		A	Interv hlth/behav, fam w/pt	0.45	0.17	0.16	0.01	0.63	0.62	XXX
96400		A	Chemotherapy, sc/im	0.17	1.13	NA	0.01	1.31	NA	XXX
96405		A	Intralesional chemo admin	0.52	2.33	0.24	0.03	2.88	0.79	000
96406		A	Intralesional chemo admin	0.80	3.11	0.29	0.03	3.94	1.12	000
96408		A	Chemotherapy, push technique	0.17	2.92	NA	0.06	3.15	NA	XXX
96410		A	Chemotherapy,infusion method	0.17	4.15	NA	0.08	4.40	NA	XXX
96412		A	Chemo, infuse method add-on	0.17	0.73	NA	0.07	0.97	NA	ZZZ
96414		A	Chemo, infuse method add-on	0.17	5.23	NA	0.08	5.48	NA	XXX
96420		A	Chemotherapy, push technique	0.17	2.82	NA	0.08	3.07	NA	XXX
96422		A	Chemotherapy,infusion method	0.17	5.18	NA	0.08	5.43	NA	XXX
96423		A	Chemo, infuse method add-on	0.17	2.00	NA	0.02	2.19	NA	ZZZ
96425		A	Chemotherapy,infusion method	0.17	4.74	NA	0.08	4.99	NA	XXX
96440		A	Chemotherapy, intracavitary	2.37	8.44	1.24	0.16	10.97	3.77	000
96445		A	Chemotherapy, intracavitary	2.20	8.56	1.19	0.12	10.88	3.51	000
96450		A	Chemotherapy, into CNS	1.89	7.37	1.09	0.09	9.35	3.07	000
96520		A	Port pump refill & main	0.17	3.94	NA	0.06	4.17	NA	XXX
96530		A	Syst pump refill & main	0.17	2.86	NA	0.06	3.09	NA	XXX
96542		A	Chemotherapy injection	1.42	4.45	0.65	0.07	5.94	2.14	XXX
96567		A	Photodynamic tx, skin	0.00	0.94	NA	0.04	0.98	NA	XXX
96570		A	Photodynamic tx, 30 min	1.10	NA	0.37	0.11	NA	1.58	ZZZ
96571		A	Photodynamic tx, addl 15 min	0.55	NA	0.19	0.03	NA	0.77	ZZZ
96900		A	Ultraviolet light therapy	0.00	0.44	NA	0.02	0.46	NA	XXX
96902		B	Trichogram	0.41	0.18	0.15	0.01	0.60	0.57	XXX
96910		A	Photochemotherapy with UV-B	0.00	0.99	NA	0.04	1.03	NA	XXX
96912		A	Photochemotherapy with UV-A	0.00	1.26	NA	0.05	1.31	NA	XXX
96913		A	Photochemotherapy, UV-A or B	0.00	1.68	NA	0.10	1.78	NA	XXX
96920		A	Laser tx, skin < 250 sq cm	1.15	2.52	0.56	0.11	3.78	1.82	000
96921		A	Laser tx, skin 250-500 sq cm	1.17	2.60	0.57	0.11	3.88	1.85	000
96922		A	Laser tx, skin > 500 sq cm	2.10	3.48	0.62	0.19	5.77	2.91	000
97001		A	Pt evaluation	1.20	0.75	0.45	0.06	2.01	1.71	XXX
97002		A	Pt re-evaluation	0.60	0.45	0.23	0.02	1.07	0.85	XXX
97003		A	Ot evaluation	1.20	0.88	0.40	0.07	2.15	1.67	XXX
97004		A	Ot re-evaluation	0.60	0.67	0.19	0.02	1.29	0.81	XXX
97010		B	Hot or cold packs therapy	0.06	0.05	NA	0.01	0.12	NA	XXX
97012		A	Mechanical traction therapy	0.25	0.13	NA	0.01	0.39	NA	XXX
97016		A	Vasopneumatic device therapy	0.18	0.18	NA	0.01	0.37	NA	XXX
97018		A	Paraffin bath therapy	0.06	0.10	NA	0.00	0.16	NA	XXX
97020		A	Microwave therapy	0.06	0.05	NA	0.00	0.11	NA	XXX
97022		A	Whirlpool therapy	0.17	0.21	NA	0.01	0.39	NA	XXX
97024		A	Diathermy treatment	0.06	0.07	NA	0.00	0.13	NA	XXX
97026		A	Infrared therapy	0.06	0.06	NA	0.00	0.12	NA	XXX
97028		A	Ultraviolet therapy	0.08	0.07	NA	0.00	0.15	NA	XXX
97032		A	Electrical stimulation	0.25	0.16	NA	0.01	0.42	NA	XXX
97033		A	Electric current therapy	0.26	0.27	NA	0.01	0.54	NA	XXX
97034		A	Contrast bath therapy	0.21	0.15	NA	0.01	0.37	NA	XXX
97035		A	Ultrasound therapy	0.21	0.10	NA	0.01	0.32	NA	XXX
97036		A	Hydrotherapy	0.28	0.32	NA	0.01	0.61	NA	XXX
97039		A	Physical therapy treatment	0.20	0.10	NA	0.01	0.31	NA	XXX
97110		A	Therapeutic exercises	0.45	0.27	NA	0.02	0.74	NA	XXX
97112		A	Neuromuscular reeducation	0.45	0.31	NA	0.02	0.78	NA	XXX
97113		A	Aquatic therapy/exercises	0.44	0.39	NA	0.02	0.85	NA	XXX
97116		A	Gait training therapy	0.40	0.24	NA	0.01	0.65	NA	XXX
97124		A	Massage therapy	0.35	0.23	NA	0.01	0.59	NA	XXX
97139		A	Physical medicine procedure	0.21	0.20	NA	0.01	0.42	NA	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
97140		A	Manual therapy	0.43	0.25	NA	0.02	0.70	NA	XXX
97150		A	Group therapeutic procedures	0.27	0.18	NA	0.02	0.47	NA	XXX
97504		A	Orthotic training	0.45	0.33	NA	0.03	0.81	NA	XXX
97520		A	Prosthetic training	0.45	0.27	NA	0.02	0.74	NA	XXX
97530		A	Therapeutic activities	0.44	0.32	NA	0.02	0.78	NA	XXX
97532		A	Cognitive skills development	0.44	0.20	NA	0.01	0.65	NA	XXX
97533		A	Sensory integration	0.44	0.24	NA	0.01	0.69	NA	XXX
97535		A	Self care mngment training	0.45	0.33	NA	0.01	0.79	NA	XXX
97537		A	Community/work reintegration	0.45	0.26	NA	0.01	0.72	NA	XXX
97542		A	Wheelchair mngment training	0.45	0.28	NA	0.01	0.74	NA	XXX
97601		A	Wound(s) care, selective	0.50	0.49	NA	0.03	1.02	NA	XXX
97703		A	Prosthetic checkout	0.25	0.41	NA	0.02	0.68	NA	XXX
97750		A	Physical performance test	0.45	0.32	NA	0.02	0.79	NA	XXX
97755		A	Assistive technology assess	0.62	0.28	NA	0.02	0.92	NA	XXX
97802		A	Medical nutrition, indiv, in	0.00	0.47	NA	0.01	0.48	NA	XXX
97803		A	Med nutrition, indiv, subseq	0.00	0.47	NA	0.01	0.48	NA	XXX
97804		A	Medical nutrition, group	0.00	0.18	NA	0.01	0.19	NA	XXX
98925		A	Osteopathic manipulation	0.45	0.32	0.14	0.02	0.79	0.61	000
98926		A	Osteopathic manipulation	0.65	0.42	0.25	0.03	1.10	0.93	000
98927		A	Osteopathic manipulation	0.87	0.51	0.29	0.03	1.41	1.19	000
98928		A	Osteopathic manipulation	1.03	0.60	0.34	0.04	1.67	1.41	000
98929		A	Osteopathic manipulation	1.19	0.68	0.37	0.05	1.92	1.61	000
98940		A	Chiropractic manipulation	0.45	0.23	0.12	0.01	0.69	0.58	000
98941		A	Chiropractic manipulation	0.65	0.30	0.17	0.02	0.97	0.84	000
98942		A	Chiropractic manipulation	0.87	0.36	0.23	0.02	1.25	1.12	000
99141		B	Sedation, iv/im or inhalant	0.80	1.89	0.38	0.05	2.74	1.23	XXX
99142		B	Sedation, oral/rectal/nasal	0.60	0.96	0.31	0.04	1.60	0.95	XXX
99170		A	Anogenital exam, child	1.75	1.80	0.55	0.10	3.65	2.40	000
99175		A	Induction of vomiting	0.00	1.39	NA	0.10	1.49	NA	XXX
99183		A	Hyperbaric oxygen therapy	2.34	4.07	0.72	0.16	6.57	3.22	XXX
99185		A	Regional hypothermia	0.00	0.64	NA	0.04	0.68	NA	XXX
99186		A	Total body hypothermia	0.00	1.78	NA	0.45	2.23	NA	XXX
99195		A	Phlebotomy	0.00	0.44	NA	0.02	0.46	NA	XXX
99201		A	Office/outpatient visit, new	0.45	0.50	0.15	0.03	0.98	0.63	XXX
99202		A	Office/outpatient visit, new	0.88	0.79	0.31	0.05	1.72	1.24	XXX
99203		A	Office/outpatient visit, new	1.34	1.14	0.48	0.09	2.57	1.91	XXX
99204		A	Office/outpatient visit, new	2.00	1.51	0.71	0.12	3.63	2.83	XXX
99205		A	Office/outpatient visit, new	2.67	1.79	0.94	0.15	4.61	3.76	XXX
99211		A	Office/outpatient visit, est	0.17	0.40	0.06	0.01	0.58	0.24	XXX
99212		A	Office/outpatient visit, est	0.45	0.54	0.16	0.03	1.02	0.64	XXX
99213		A	Office/outpatient visit, est	0.67	0.70	0.23	0.03	1.40	0.93	XXX
99214		A	Office/outpatient visit, est	1.10	1.04	0.40	0.05	2.19	1.55	XXX
99215		A	Office/outpatient visit, est	1.77	1.34	0.65	0.09	3.20	2.51	XXX
99217		A	Observation care discharge	1.28	NA	0.53	0.06	NA	1.87	XXX
99218		A	Observation care	1.28	NA	0.44	0.06	NA	1.78	XXX
99219		A	Observation care	2.14	NA	0.72	0.10	NA	2.96	XXX
99220		A	Observation care	2.99	NA	1.02	0.14	NA	4.15	XXX
99221		A	Initial hospital care	1.28	NA	0.45	0.07	NA	1.80	XXX
99222		A	Initial hospital care	2.14	NA	0.74	0.10	NA	2.98	XXX
99223		A	Initial hospital care	2.99	NA	1.03	0.13	NA	4.15	XXX
99231		A	Subsequent hospital care	0.64	NA	0.23	0.03	NA	0.90	XXX
99232		A	Subsequent hospital care	1.06	NA	0.37	0.05	NA	1.48	XXX
99233		A	Subsequent hospital care	1.51	NA	0.52	0.07	NA	2.10	XXX
99234		A	Observ/hosp same date	2.56	NA	0.88	0.13	NA	3.57	XXX
99235		A	Observ/hosp same date	3.41	NA	1.15	0.16	NA	4.72	XXX
99236		A	Observ/hosp same date	4.26	NA	1.44	0.20	NA	5.90	XXX
99238		A	Hospital discharge day	1.28	NA	0.54	0.05	NA	1.87	XXX
99239		A	Hospital discharge day	1.75	NA	0.60	0.07	NA	2.42	XXX
99241		A	Office consultation	0.64	0.64	0.22	0.05	1.33	0.91	XXX
99242		A	Office consultation	1.29	1.05	0.46	0.10	2.44	1.85	XXX
99243		A	Office consultation	1.72	1.39	0.63	0.13	3.24	2.48	XXX
99244		A	Office consultation	2.58	1.82	0.92	0.16	4.56	3.66	XXX
99245		A	Office consultation	3.42	2.29	1.24	0.21	5.92	4.87	XXX
99251		A	Initial inpatient consult	0.66	NA	0.24	0.05	NA	0.95	XXX
99252		A	Initial inpatient consult	1.32	NA	0.50	0.10	NA	1.92	XXX
99253		A	Initial inpatient consult	1.82	NA	0.68	0.11	NA	2.61	XXX
99254		A	Initial inpatient consult	2.64	NA	0.98	0.13	NA	3.75	XXX
99255		A	Initial inpatient consult	3.64	NA	1.34	0.18	NA	5.16	XXX
99261		A	Follow-up inpatient consult	0.42	NA	0.15	0.02	NA	0.59	XXX
99262		A	Follow-up inpatient consult	0.85	NA	0.31	0.04	NA	1.20	XXX
99263		A	Follow-up inpatient consult	1.27	NA	0.45	0.06	NA	1.78	XXX
99271		A	Confirmatory consultation	0.45	0.56	0.16	0.03	1.04	0.64	XXX
99272		A	Confirmatory consultation	0.84	0.83	0.31	0.06	1.73	1.21	XXX
99273		A	Confirmatory consultation	1.19	1.12	0.45	0.10	2.41	1.74	XXX
99274		A	Confirmatory consultation	1.73	1.38	0.64	0.12	3.23	2.49	XXX

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
99275		A	Confirmatory consultation	2.31	1.66	0.84	0.15	4.12	3.30	XXX
99281		A	Emergency dept visit	0.33	NA	0.09	0.02	NA	0.44	XXX
99282		A	Emergency dept visit	0.55	NA	0.14	0.04	NA	0.73	XXX
99283		A	Emergency dept visit	1.24	NA	0.31	0.09	NA	1.64	XXX
99284		A	Emergency dept visit	1.95	NA	0.47	0.14	NA	2.56	XXX
99285		A	Emergency dept visit	3.06	NA	0.72	0.23	NA	4.01	XXX
99289		A	Ped crit care transport	4.79	NA	1.45	0.17	NA	6.41	XXX
99290		A	Ped crit care transport addl	2.40	NA	0.81	0.08	NA	3.29	ZZZ
99291		A	Critical care, first hour	3.99	2.59	1.28	0.21	6.79	5.48	XXX
99292		A	Critical care, add-l 30 min	2.00	0.91	0.63	0.11	3.02	2.74	ZZZ
99293		A	Ped critical care, initial	15.98	NA	4.74	0.21	NA	20.93	XXX
99294		A	Ped critical care, subseq	7.99	NA	2.39	0.21	NA	10.59	XXX
99295		A	Neonate crit care, initial	18.46	NA	5.35	1.00	NA	24.81	XXX
99296		A	Neonate critical care subseq	7.99	NA	2.53	0.34	NA	10.86	XXX
99298		A	Ic for lbw infant < 1500 gm	2.75	NA	0.93	0.14	NA	3.82	XXX
99299		A	Ic, lbw infant 1500-2500 gm	2.50	NA	0.85	0.12	NA	3.47	XXX
99301		A	Nursing facility care	1.20	0.50	0.50	0.05	1.75	1.75	XXX
99302		A	Nursing facility care	1.61	0.64	0.64	0.07	2.32	2.32	XXX
99303		A	Nursing facility care	2.01	0.76	0.76	0.09	2.86	2.86	XXX
99311		A	Nursing fac care, subseq	0.60	0.28	0.28	0.03	0.91	0.91	XXX
99312		A	Nursing fac care, subseq	1.00	0.45	0.45	0.05	1.50	1.50	XXX
99313		A	Nursing fac care, subseq	1.42	0.62	0.62	0.07	2.11	2.11	XXX
99315		A	Nursing fac discharge day	1.13	0.46	0.46	0.05	1.64	1.64	XXX
99316		A	Nursing fac discharge day	1.50	0.59	0.59	0.07	2.16	2.16	XXX
99321		A	Rest home visit, new patient	0.71	0.34	NA	0.04	1.09	NA	XXX
99322		A	Rest home visit, new patient	1.01	0.46	NA	0.06	1.53	NA	XXX
99323		A	Rest home visit, new patient	1.28	0.55	NA	0.06	1.89	NA	XXX
99331		A	Rest home visit, est pat	0.60	0.32	NA	0.03	0.95	NA	XXX
99332		A	Rest home visit, est pat	0.80	0.39	NA	0.04	1.23	NA	XXX
99333		A	Rest home visit, est pat	1.00	0.46	NA	0.05	1.51	NA	XXX
99341		A	Home visit, new patient	1.01	0.48	NA	0.06	1.55	NA	XXX
99342		A	Home visit, new patient	1.52	0.68	NA	0.09	2.29	NA	XXX
99343		A	Home visit, new patient	2.27	0.94	NA	0.12	3.33	NA	XXX
99344		A	Home visit, new patient	3.03	1.18	NA	0.15	4.36	NA	XXX
99345		A	Home visit, new patient	3.78	1.43	NA	0.18	5.39	NA	XXX
99347		A	Home visit, est patient	0.76	0.40	NA	0.04	1.20	NA	XXX
99348		A	Home visit, est patient	1.26	0.58	NA	0.06	1.90	NA	XXX
99349		A	Home visit, est patient	2.02	0.84	NA	0.10	2.96	NA	XXX
99350		A	Home visit, est patient	3.03	1.18	NA	0.15	4.36	NA	XXX
99354		A	Prolonged service, office	1.77	0.77	0.65	0.08	2.62	2.50	ZZZ
99355		A	Prolonged service, office	1.77	0.75	0.62	0.08	2.60	2.47	ZZZ
99356		A	Prolonged service, inpatient	1.71	NA	0.62	0.08	NA	2.41	ZZZ
99357		A	Prolonged service, inpatient	1.71	NA	0.63	0.08	NA	2.42	ZZZ
99374		B	Home health care supervision	1.10	0.70	0.42	0.05	1.85	1.57	XXX
99377		B	Hospice care supervision	1.10	0.70	0.42	0.05	1.85	1.57	XXX
99379		B	Nursing fac care supervision	1.10	0.70	0.42	0.04	1.84	1.56	XXX
99380		B	Nursing fac care supervision	1.73	1.00	0.65	0.06	2.79	2.44	XXX
99431		A	Initial care, normal newborn	1.17	NA	0.38	0.04	NA	1.59	XXX
99432		A	Newborn care, not in hosp	1.26	0.93	0.40	0.05	2.24	1.71	XXX
99433		A	Normal newborn care/hospital	0.62	NA	0.20	0.03	NA	0.85	XXX
99435		A	Newborn discharge day hosp	1.50	NA	0.59	0.06	NA	2.15	XXX
99436		A	Attendance, birth	1.50	NA	0.47	0.11	NA	2.08	XXX
99440		A	Newborn resuscitation	2.93	NA	0.93	0.13	NA	3.99	XXX
G0030	26	A	PET imaging prev PET single	1.50	0.58	0.58	0.05	2.13	2.13	XXX
G0031	26	A	PET imaging prev PET multple	1.87	0.72	0.72	0.07	2.66	2.66	XXX
G0032	26	A	PET follow SPECT 78464 singl	1.50	0.54	0.54	0.07	2.11	2.11	XXX
G0033	26	A	PET follow SPECT 78464 mult	1.87	0.73	0.73	0.07	2.67	2.67	XXX
G0034	26	A	PET follow SPECT 76865 singl	1.50	0.57	0.57	0.05	2.12	2.12	XXX
G0035	26	A	PET follow SPECT 78465 mult	1.87	0.72	0.72	0.07	2.66	2.66	XXX
G0036	26	A	PET follow cornry angio sing	1.50	0.56	0.56	0.05	2.11	2.11	XXX
G0037	26	A	PET follow cornry angio mult	1.87	0.71	0.71	0.06	2.64	2.64	XXX
G0038	26	A	PET follow myocard perf sing	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0039	26	A	PET follow myocard perf mult	1.87	0.71	0.71	0.07	2.65	2.65	XXX
G0040	26	A	PET follow stress echo singl	1.50	0.59	0.59	0.07	2.16	2.16	XXX
G0041	26	A	PET follow stress echo mult	1.87	0.73	0.73	0.07	2.67	2.67	XXX
G0042	26	A	PET follow ventriculogm sing	1.50	0.61	0.61	0.05	2.16	2.16	XXX
G0043	26	A	PET follow ventriculogm mult	1.87	0.75	0.75	0.06	2.68	2.68	XXX
G0044	26	A	PET following rest ECG singl	1.50	0.59	0.59	0.05	2.14	2.14	XXX
G0045	26	A	PET following rest ECG mult	1.87	0.72	0.72	0.06	2.65	2.65	XXX
G0046	26	A	PET follow stress ECG singl	1.50	0.59	0.59	0.05	2.14	2.14	XXX
G0047	26	A	PET follow stress ECG mult	1.87	0.73	0.73	0.06	2.66	2.66	XXX
G0101		A	CA screen;pelvic/breast exam	0.45	0.52	0.17	0.02	0.99	0.64	XXX
G0102		A	Prostate ca screening; dre	0.17	0.40	0.06	0.01	0.58	0.24	XXX
G0104		A	CA screen;flexi sigmoidscope	0.96	2.30	0.50	0.08	3.34	1.54	000
G0105		A	Colorectal scrn; hi risk ind	3.69	6.20	1.47	0.24	10.13	5.40	000

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ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
G0105	53	A	Colorectal scrn; hi risk ind	0.96	2.30	0.50	0.08	3.34	1.54	000
G0106		A	Colon CA screen;barium enema	0.99	2.55	NA	0.17	3.71	NA	XXX
G0106	26	A	Colon CA screen;barium enema	0.99	0.32	0.32	0.04	1.35	1.35	XXX
G0106	TC	A	Colon CA screen;barium enema	0.00	2.23	NA	0.13	2.36	NA	XXX
G0108		A	Diab manage trn per indiv	0.00	0.83	NA	0.01	0.84	NA	XXX
G0109		A	Diab manage trn ind/group	0.00	0.48	NA	0.01	0.49	NA	XXX
G0110		R	Nett pulm-rehab educ; ind	0.90	0.68	0.29	0.04	1.62	1.23	XXX
G0111		R	Nett pulm-rehab educ; group	0.27	0.29	0.13	0.01	0.57	0.41	XXX
G0112		R	Nett;nutrition guid, initial	1.72	1.21	0.65	0.07	3.00	2.44	XXX
G0113		R	Nett;nutrition guid,subseqnt	1.29	0.82	0.41	0.05	2.16	1.75	XXX
G0114		R	Nett; psychosocial consult	1.20	0.48	0.37	0.04	1.72	1.61	XXX
G0115		R	Nett; psychological testing	1.20	0.84	0.37	0.03	2.07	1.60	XXX
G0116		R	Nett; psychosocial counsel	1.11	0.98	0.33	0.03	2.12	1.47	XXX
G0117		T	Glaucoma scrn hgh risk direc	0.45	0.72	0.19	0.01	1.18	0.65	XXX
G0118		T	Glaucoma scrn hgh risk direc	0.17	0.53	0.06	0.00	0.70	0.23	XXX
G0120		A	Colon ca scrn; barium enema	0.99	2.55	NA	0.17	3.71	NA	XXX
G0120	26	A	Colon ca scrn; barium enema	0.99	0.32	0.32	0.04	1.35	1.35	XXX
G0120	TC	A	Colon ca scrn; barium enema	0.00	2.23	NA	0.13	2.36	NA	XXX
G0121		A	Colon ca scrn not hi rsk ind	3.69	6.20	1.47	0.24	10.13	5.40	000
G0121	53	A	Colon ca scrn not hi rsk ind	0.96	2.30	0.50	0.08	3.34	1.54	000
G0124		A	Screen c/v thin layer by MD	0.42	0.15	0.15	0.02	0.59	0.59	XXX
G0125	26	A	PET image pulmonary nodule	1.50	0.52	0.52	0.07	2.09	2.09	XXX
G0127		R	Trim nail(s)	0.17	0.25	0.07	0.01	0.43	0.25	000
G0128		R	CORF skilled nursing service	0.08	0.03	0.03	0.01	0.12	0.12	XXX
G0130		A	Single energy x-ray study	0.22	0.87	NA	0.06	1.15	NA	XXX
G0130	26	A	Single energy x-ray study	0.22	0.07	0.07	0.01	0.30	0.30	XXX
G0130	TC	A	Single energy x-ray study	0.00	0.80	NA	0.05	0.85	NA	XXX
G0141		A	Scr c/v cyto,autosys and md	0.42	0.15	0.15	0.02	0.59	0.59	XXX
G0166		A	Extrnl counterpulse, per tx	0.07	3.22	0.03	0.00	3.29	0.10	XXX
G0168		A	Wound closure by adhesive	0.45	1.94	0.22	0.03	2.42	0.70	000
G0179		A	MD recertification HHA PT	0.45	1.06	NA	0.02	1.53	NA	XXX
G0180		A	MD certification HHA patient	0.67	1.29	NA	0.04	2.00	NA	XXX
G0181		A	Home health care supervision	1.73	1.51	NA	0.08	3.32	NA	XXX
G0182		A	Hospice care supervision	1.73	1.71	NA	0.07	3.51	NA	XXX
G0202		A	Screeningmammographydigital	0.70	2.77	NA	0.10	3.57	NA	XXX
G0202	26	A	Screeningmammographydigital	0.70	0.23	0.23	0.03	0.96	0.96	XXX
G0202	TC	A	Screeningmammographydigital	0.00	2.54	NA	0.07	2.61	NA	XXX
G0204		A	Diagnosticmammographydigital	0.87	2.78	NA	0.11	3.76	NA	XXX
G0204	26	A	Diagnosticmammographydigital	0.87	0.28	0.28	0.04	1.19	1.19	XXX
G0204	TC	A	Diagnosticmammographydigital	0.00	2.50	NA	0.07	2.57	NA	XXX
G0206		A	Diagnosticmammographydigital	0.70	2.25	NA	0.09	3.04	NA	XXX
G0206	26	A	Diagnosticmammographydigital	0.70	0.23	0.23	0.03	0.96	0.96	XXX
G0206	TC	A	Diagnosticmammographydigital	0.00	2.02	NA	0.06	2.08	NA	XXX
G0210	26	A	PET img wholebody dxlung	1.50	0.51	0.51	0.07	2.08	2.08	XXX
G0211	26	A	PET img wholbody init lung	1.50	0.51	0.51	0.07	2.08	2.08	XXX
G0212	26	A	PET img wholebod restag lung	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0213	26	A	PET img wholbody dx	1.50	0.51	0.51	0.07	2.08	2.08	XXX
G0214	26	A	PET img wholebod init	1.50	0.51	0.51	0.07	2.08	2.08	XXX
G0215	26	A	PETimg wholebod restag	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0216	26	A	PET img wholebod dx melanoma	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0217	26	A	PET img wholebod init melan	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0218	26	A	PET img wholebod restag mela	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0220	26	A	PET img wholebod dx lymphoma	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0221	26	A	PET imag wholbod init lympho	1.50	0.51	0.51	0.07	2.08	2.08	XXX
G0222	26	A	PET imag wholbod resta lymph	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0223	26	A	PET imag wholbod reg dx head	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0224	26	A	PET imag wholbod reg ini hea	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0225	26	A	PET whol restag headneckonly	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0226	26	A	PET img wholbody dx esophagl	1.50	0.53	0.53	0.06	2.09	2.09	XXX
G0227	26	A	PET img wholbod ini esophage	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0228	26	A	PET img wholbod restg esopha	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0229	26	A	PET img metaboloc brain pres	1.50	0.52	0.52	0.07	2.09	2.09	XXX
G0230	26	A	PET myocard viability post	1.50	0.53	0.53	0.06	2.09	2.09	XXX
G0231	26	A	PET WhBD colorec; gamma cam	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0232	26	A	PET whbd lymphoma; gamma cam	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0233	26	A	PET whbd melanoma; gamma cam	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0234	26	A	PET WhBD pulm nod; gamma cam	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0237		A	Therapeutic procd strg endur	0.00	0.47	NA	0.02	0.49	NA	XXX
G0238		A	Oth resp proc, indiv	0.00	0.47	NA	0.02	0.49	NA	XXX
G0239		A	Oth resp proc, group	0.00	0.32	NA	0.02	0.34	NA	XXX
G0245		R	Initial foot exam pt lops	0.88	0.79	0.31	0.05	1.72	1.24	XXX
G0246		R	Followup eval of foot pt lop	0.45	0.54	0.16	0.03	1.02	0.64	XXX
G0247		R	Routine footcare pt w lops	0.50	0.52	0.21	0.03	1.05	0.74	ZZZ
G0248		R	Demonstrate use home inr mon	0.00	6.61	NA	0.01	6.62	NA	XXX
G0249		R	Provide test material,equipm	0.00	3.97	NA	0.01	3.98	NA	XXX

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[3] + Indicates RVUs are not used for Medicare Payments.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility total	Global
G0250		R	MD review interpret of test	0.18	0.06	0.06	0.01	0.25	0.25	XXX
G0253	26	A	PET image brst dection recur	1.87	0.63	0.63	0.06	2.56	2.56	XXX
G0254	26	A	PET image brst eval to tx	1.87	0.65	0.65	0.06	2.58	2.58	XXX
G0268		A	Removal of impacted wax md	0.61	0.63	0.24	0.02	1.26	0.87	000
G0270		A	MNT subs tx for change dx	0.00	0.47	NA	0.01	0.48	NA	XXX
G0271		A	Group MNT 2 or more 30 mins	0.00	0.18	NA	0.01	0.19	NA	XXX
G0275		A	Renal angio, cardiac cath	0.25	NA	0.10	0.01	NA	0.36	ZZZ
G0278		A	Iliac art angio,cardiac cath	0.25	NA	0.10	0.01	NA	0.36	ZZZ
G0281		A	Elec stim unattend for press	0.18	0.11	NA	0.01	0.30	NA	XXX
G0283		A	Elec stim other than wound	0.18	0.11	NA	0.01	0.30	NA	XXX
G0288		A	Recon, CTA for surg plan	0.00	10.60	NA	0.18	10.78	NA	XXX
G0289		A	Arthro, loose body + chondro	1.48	NA	0.80	0.33	NA	2.61	ZZZ
G0296	26	A	PET imge restag thyrod cance	1.87	0.71	0.71	0.08	2.66	2.66	XXX
G0308		A	ESRD related svc 4+mo<2yrs	12.74	8.54	8.54	0.42	21.70	21.70	XXX
G0309		A	ESRD related svc 2-3mo<2yrs	10.61	7.10	7.10	0.36	18.07	18.07	XXX
G0310		A	ESRD related svc 1 visit<2yr	8.49	5.68	5.68	0.28	14.45	14.45	XXX
G0311		A	ESRD related svs 4+mo 2-11yr	9.73	4.72	4.72	0.34	14.79	14.79	XXX
G0312		A	ESRD relate svs 2-3 mo 2-11y	8.11	3.92	3.92	0.29	12.32	12.32	XXX
G0313		A	ESRD related svs 1 mon 2-11y	6.49	3.14	3.14	0.22	9.85	9.85	XXX
G0314		A	ESRD related svs 4+ mo 12-19	8.28	4.42	4.42	0.27	12.97	12.97	XXX
G0315		A	ESRD related svs 2-3mo 12-19	6.90	3.67	3.67	0.23	10.80	10.80	XXX
G0316		A	ESRD relate svs 1 vist 12-19	5.52	2.94	2.94	0.17	8.63	8.63	XXX
G0317		A	ESRD related svs 4+mo 20+yrs	5.09	2.86	2.86	0.17	8.12	8.12	XXX
G0318		A	ESRD related svs 2-3 mo 20+y	4.24	2.38	2.38	0.14	6.76	6.76	XXX
G0319		A	ESRD related svs 1 visit 20+	3.39	1.90	1.90	0.11	5.40	5.40	XXX
G0320		A	ESRD related svs home under2	10.61	7.10	7.10	0.36	18.07	18.07	XXX
G0321		A	ESRDrelatedsvs home mo 2-11y	8.11	3.92	3.92	0.23	12.26	12.26	XXX
G0322		A	ESRD relate svs home mo12-19	6.90	3.67	3.67	0.29	10.86	10.86	XXX
G0323		A	ESRD related svs home mo 20+	4.24	2.38	2.38	0.14	6.76	6.76	XXX
G0324		A	ESRD related svs home/dy<2y	0.35	0.24	0.24	0.01	0.60	0.60	XXX
G0325		A	ESRD relate home/dy 2-11 yr	0.23	0.12	0.12	0.01	0.36	0.36	XXX
G0326		A	ESRD relate home/dy 12-19y	0.27	0.13	0.13	0.01	0.41	0.41	XXX
G0327		A	ESRD relate home/dy 20+yrs	0.14	0.08	0.08	0.01	0.23	0.23	XXX
G0329		A	Electromagntic tx for ulcers	0.06	0.12	0.02	0.01	0.19	0.09	XXX
G0XX1		A	Bone marrow aspir	0.16	0.21	0.08	0.04	0.41	0.28	ZZZ
G0XX2		A	Preventative exam	1.51	1.65	0.54	0.13	3.29	2.18	XXX
G0XX3		A	Venous mapping	0.45	3.28	NA	0.30	4.03	NA	XXX
G0XX3	26	A	Venous mapping	0.45	0.15	0.15	0.03	0.63	0.63	XXX
G0XX3	TC	A	Venous mapping	0.00	3.13	NA	0.27	3.40	NA	XXX
G0XX4		X	Hospice, pre-elect	1.34	0.00	0.00	0.10	1.44	1.44	XXX
M0064		A	Visit for drug monitoring	0.37	0.34	0.12	0.01	0.72	0.50	XXX
P3001		A	Screening pap smear by phys	0.42	0.15	0.15	0.02	0.59	0.59	XXX
Q0035		A	Cardiokymography	0.17	0.45	NA	0.03	0.65	NA	XXX
Q0035	26	A	Cardiokymography	0.17	0.06	0.06	0.01	0.24	0.24	XXX
Q0035	TC	A	Cardiokymography	0.00	0.39	NA	0.02	0.41	NA	XXX
Q0091		A	Obtaining screen pap smear	0.37	0.67	0.14	0.02	1.06	0.53	XXX
Q0092		A	Set up port xray equipment	0.00	0.32	NA	0.01	0.33	NA	XXX

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ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS

CPT code	Short descriptors
00100	Disability examination
00102	Anesth, salivary gland
00103	Anesth, repair of cleft lip
00120	Anesth, blepharoplasty
00126	Anesth, ear surgery
00140	Anesth, tympanotomy
00142	Anesth, procedures on eye
00144	Anesth, lens surgery
00145	Anesth, corneal transplant
00147	Anesth, vitreoretinal surg
00148	Anesth, iridectomy

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
00160	Anesth, eye exam
00162	Anesth, nose/sinus surgery
00164	Anesth, nose/sinus surgery
00170	Anesth, biopsy of nose
00172	Anesth, procedure on mouth
00174	Anesth, cleft palate repair
00176	Anesth, pharyngeal surgery
00190	Anesth, pharyngeal surgery
00192	Anesth, face/skull bone surg
00210	Anesth, facial bone surgery
00212	Anesth, open head surgery

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
00214	Anesth, skull drainage
00215	Anesth, skull drainage
00216	Anesth, skull repair/fract
00218	Anesth, head vessel surgery
00220	Anesth, special head surgery
00222	Anesth, intrcrn nerve
00300	Anesth, head nerve surgery
00320	Anesth, head/neck/ptrunk
00322	Anesth, neck organ, 1 & over
00326	Anesth, biopsy of thyroid
00350	Anesth, larynx/trach, < 1 yr

Some of these codes have previously been refined and additional refinements were made by the PEAC.
All anesthesia codes were reviewed with the exception of 00104 abd 00124.
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ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
00352	Anesth, neck vessel surgery
00400	Anesth, neck vessel surgery
00402	Anesth, skin, ext/per/atrunk
00404	Anesth, surgery of breast
00406	Anesth, surgery of breast
00410	Anesth, surgery of breast
00450	Anesth, correct heart rhythm
00452	Anesth, surgery of shoulder
00454	Anesth, surgery of shoulder
00470	Anesth, collar bone biopsy
00472	Anesth, removal of rib
00474	Anesth, chest wall repair
00500	Anesth, surgery of rib(s)
00520	Anesth, esophageal surgery
00522	Anesth, chest procedure
00524	Anesth, chest lining biopsy
00528	Anesth, chest drainage
00529	Anesth, chest partition view
00530	Anesth, chest partition view
00532	Anesth, pacemaker insertion
00534	Anesth, vascular access
00537	Anesth, cardioverter/defib
00539	Anesth, cardiac electrophys
00540	Anesth, trach-bronch reconst
00541	Anesth, chest surgery
00542	Anesth, one lung ventilation
00546	Anesth, release of lung
00548	Anesth, lung,chest wall surg
00550	Anesth, trachea,bronchi surg
00560	Anesth, sternal debridement
00562	Anesth, open heart surgery
00563	Anesth, open heart surgery
00566	Anesth, heart proc w/pump
00580	Anesth, cabg w/o pump
00600	Anesth, heart/lung transplnt
00604	Anesth, spine, cord surgery
00620	Anesth, sitting procedure
00622	Anesth, spine, cord surgery
00630	Anesth, removal of nerves
00632	Anesth, spine, cord surgery
00634	Anesth, removal of nerves
00635	Anesth for chemonucleolysis
00640	Anesth, lumbar puncture
00670	Anesth, spine manipulation
00700	Anesth, spine, cord surgery
00702	Anesth, abdominal wall surg
00730	Anesth, for liver biopsy
00740	Anesth, abdominal wall surg
00750	Anesth, upper gi visualize
00752	Anesth, repair of hernia
00754	Anesth, repair of hernia
00756	Anesth, repair of hernia
00770	Anesth, repair of hernia
00790	Anesth, blood vessel repair
00792	Anesth, surg upper abdomen
00794	Anesth, hemorr/excise liver
00796	Anesth, pancreas removal
00797	Anesth, for liver transplant
00800	Anesth, surgery for obesity
00802	Anesth, abdominal wall surg
00810	Anesth, fat layer removal
00820	Anesth, low intestine scope
00830	Anesth, abdominal wall surg

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
00832	Anesth, repair of hernia
00834	Anesth, repair of hernia
00836	Anesth, hernia repair< 1 yr
00840	Anesth hernia repair preemie
00842	Anesth, surg lower abdomen
00844	Anesth, amniocentesis
00846	Anesth, pelvis surgery
00848	Anesth, hysterectomy
00851	Anesth, pelvic organ surg
00860	Anesth, tubal ligation
00862	Anesth, surgery of abdomen
00864	Anesth, kidney/ureter surg
00865	Anesth, removal of bladder
00866	Anesth, removal of prostate
00868	Anesth, removal of adrenal
00870	Anesth, kidney transplant
00872	Anesth, bladder stone surg
00873	Anesth kidney stone destruct
00880	Anesth kidney stone destruct
00882	Anesth, abdomen vessel surg
00902	Anesth, major vein ligation
00904	Anesth, anorectal surgery
00906	Anesth, perineal surgery
00908	Anesth, removal of vulva
00910	Anesth, removal of prostate
00912	Anesth, bladder surgery
00914	Anesth, bladder tumor surg
00916	Anesth, removal of prostate
00918	Anesth, bleeding control
00920	Anesth, stone removal
00921	Anesth, genitalia surgery
00922	Anesth, vasectomy
00924	Anesth, sperm duct surgery
00926	Anesth, testis exploration
00928	Anesth, removal of testis
00930	Anesth, removal of testis
00932	Anesth, testis suspension
00934	Anesth, amputation of penis
00936	Anesth, penis, nodes removal
00938	Anesth, penis, nodes removal
00940	Anesth, insert penis device
00942	Anesth, vaginal procedures
00944	Anesth, surg on vag/urethral
00948	Anesth, vaginal hysterectomy
00950	Anesth, repair of cervix
00952	Anesth, vaginal endoscopy
01112	Anesth, hysteroscope/graph
01120	Anesth, bone aspirate/bx
01130	Anesth, pelvis surgery
01140	Anesth, body cast procedure
01150	Anesth, amputation at pelvis
01160	Anesth, pelvic tumor surgery
01170	Anesth, pelvis procedure
01173	Anesth, pelvis surgery
01180	Anesth, fx repair, pelvis
01190	Anesth, pelvis nerve removal
01200	Anesth, pelvis nerve removal
01202	Anesth, hip joint procedure
01210	Anesth, arthroscopy of hip
01212	Anesth, hip joint surgery
01214	Anesth, hip disarticulation
01215	Anesth, hip arthroplasty
01220	Anesth, revise hip repair

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
01230	Anesth, procedure on femur
01232	Anesth, surgery of femur
01234	Anesth, amputation of femur
01250	Anesth, radical femur surg
01260	Anesth, upper leg surgery
01270	Anesth, upper leg veins surg
01272	Anesth, thigh arteries surg
01274	Anesth, femoral artery surg
01320	Anesth, femoral embolectomy
01340	Anesth, knee area surgery
01360	Anesth, knee area procedure
01380	Anesth, knee area surgery
01382	Anesth, knee joint procedure
01390	Anesth, dx knee arthroscopy
01392	Anesth, knee area procedure
01400	Anesth, knee area surgery
01402	Anesth, knee joint surgery
01404	Anesth, knee arthroplasty
01420	Anesth, amputation at knee
01430	Anesth, knee joint casting
01432	Anesth, knee veins surgery
01440	Anesth, knee vessel surg
01442	Anesth, knee arteries surg
01444	Anesth, knee artery surg
01462	Anesth, knee artery repair
01464	Anesth, lower leg procedure
01470	Anesth, ankle/ft arthroscopy
01472	Anesth, lower leg surgery
01474	Anesth, achilles tendon surg
01480	Anesth, lower leg surgery
01482	Anesth, lower leg bone surg
01484	Anesth, radical leg surgery
01486	Anesth, lower leg revision
01490	Anesth, ankle replacement
01500	Anesth, lower leg casting
01502	Anesth, leg arteries surg
01520	Anesth, lwr leg embolectomy
01522	Anesth, lower leg vein surg
01610	Anesth, lower leg vein surg
01620	Anesth, surgery of shoulder
01622	Anesth, shoulder procedure
01630	Anes dx shoulder arthroscopy
01632	Anesth, surgery of shoulder
01634	Anesth, surgery of shoulder
01636	Anesth, shoulder joint amput
01638	Anesth, forequarter amput
01650	Anesth, shoulder replacement
01652	Anesth, shoulder artery surg
01654	Anesth, shoulder vessel surg
01656	Anesth, shoulder vessel surg
01670	Anesth, arm-leg vessel surg
01680	Anesth, shoulder vein surg
01682	Anesth, shoulder casting
01710	Anesth, airplane cast
01712	Anesth, elbow area surgery
01714	Anesth, uppr arm tendon surg
01716	Anesth, uppr arm tendon surg
01730	Anesth, biceps tendon repair
01732	Anesth, uppr arm procedure
01740	Anesth, dx elbow arthroscopy
01742	Anesth, upper arm surgery
01744	Anesth, humerus surgery
01756	Anesth, humerus repair

Some of these codes have previously been refined and additional refinements were made by the PEAC.
All anesthesia codes were reviewed with the exception of 00104 abd 00124.

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
01758	Anesth, radical humerus surg
01760	Anesth, humeral lesion surg
01770	Anesth, elbow replacement
01772	Anesth, uppr arm artery surg
01780	Anesth, uppr arm embolectomy
01782	Anesth, upper arm vein surg
01810	Anesth, uppr arm vein repair
01820	Anesth, lower arm surgery
01829	Anesth, lower arm procedure
01830	Anesth, dx wrist arthroscopy
01832	Anesth, lower arm surgery
01840	Anesth, wrist replacement
01842	Anesth, lwr arm artery surg
01844	Anesth, lwr arm embolectomy
01850	Anesth, vascular shunt surg
01852	Anesth, lower arm vein surg
01860	Anesth, lwr arm vein repair
01905	Anesth, lower arm casting
01916	Anes, spine inject, x-ray/re
01920	Anesth, dx arteriography
01922	Anesth, catheterize heart
01924	Anesth, cat or MRI scan
01925	Anes, ther interven rad, art
01926	Anes, ther interven rad, car
01930	Anes, tx interv rad hrt/cran
01931	Anes, ther interven rad, vei
01932	Anes, ther interven rad, tip
01933	Anes, tx interv rad, th vein
01951	Anes, tx interv rad, cran v
01952	Anesth, burn, less 4 percent
01953	Anesth, burn, 4-9 percent
01958	Anesth, burn, each 9 percent
01960	Anesth, antepartum manipul
01961	Anesth, vaginal delivery
01962	Anesth, cs delivery
01963	Anesth, emer hysterectomy
01964	Anesth, cs hysterectomy
01967	Anesth, abortion procedures
01968	Anesth/analg, vag delivery
01969	Anes/analg cs deliver add-on
01990	Anesth/analg cs hyst add-on
01991	Support for organ donor
01992	Anesth, nerve block/inj
01995	Anesth, n block/inj, prone
01996	Regional anesthesia limb
01999	Hosp manage cont drug admin
10120	Remove foreign body
10121	Remove foreign body
10140	Drainage of hematoma/fluid
10160	Puncture drainage of lesion
10180	Complex drainage, wound
11010	Debride skin, fx
11011	Debride skin/muscle, fx
11012	Debride skin/muscle/bone, fx
11740	Drain blood from under nail
11755	Biopsy, nail unit
11760	Repair of nail bed
11762	Reconstruction of nail bed
11765	Excision of nail fold, toe
11772	Removal of pilonidal lesion
11920	Correct skin color defects
11921	Correct skin color defects
11922	Correct skin color defects

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
11971	Remove tissue expander(s)
12020	Closure of split wound
12021	Closure of split wound
12036	Layer closure of wound(s)
12037	Layer closure of wound(s)
12045	Layer closure of wound(s)
13100	Repair of wound or lesion
13101	Repair of wound or lesion
13102	Repair wound/lesion add-on
13120	Repair of wound or lesion
13121	Repair of wound or lesion
13122	Repair wound/lesion add-on
13131	Repair of wound or lesion
13132	Repair of wound or lesion
13133	Repair wound/lesion add-on
13150	Repair of wound or lesion
13151	Repair of wound or lesion
13152	Repair of wound or lesion
13153	Repair wound/lesion add-on
14000	Skin tissue rearrangement
14001	Skin tissue rearrangement
14020	Skin tissue rearrangement
14021	Skin tissue rearrangement
14040	Skin tissue rearrangement
14060	Skin tissue rearrangement
15050	Skin pinch graft
15200	Skin full graft
15201	Skin full graft add-on
15220	Skin full graft
15221	Skin full graft add-on
15240	Skin full graft
15241	Skin full graft add-on
15260	Skin full graft
15350	Skin homograft
15351	Skin homograft add-on
15400	Skin heterograft
15401	Skin heterograft add-on
15570	Form skin pedicle flap
15572	Form skin pedicle flap
15574	Form skin pedicle flap
15576	Form skin pedicle flap
15600	Skin graft
15610	Skin graft
15620	Skin graft
15630	Skin graft
15650	Transfer skin pedicle flap
15740	Island pedicle flap graft
15760	Composite skin graft
15780	Abrasion treatment of skin
15781	Abrasion treatment of skin
15782	Abrasion treatment of skin
15783	Abrasion treatment of skin
15786	Abrasion, lesion, single
15787	Abrasion, lesions, add-on
15788	Chemical peel, face, epiderm
15789	Chemical peel, face, dermal
15792	Chemical peel, nonfacial
15793	Chemical peel, nonfacial
15810	Salabrasion
15811	Salabrasion
15835	Excise excessive skin tissue
15837	Excise excessive skin tissue
15839	Excise excessive skin tissue

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
15860	Test for blood flow in graft
19000	Drainage of breast lesion
19001	Drain breast lesion add-on
19020	Incision of breast lesion
19030	Injection for breast x-ray
19110	Nipple exploration
19112	Excise breast duct fistula
19291	Place needle wire, breast
19295	Place breast clip, percut
19350	Breast reconstruction
19355	Correct inverted nipple(s)
20000	Incision of abscess
20005	Incision of deep abscess
20100	Explore wound, neck
20101	Explore wound, chest
20102	Explore wound, abdomen
20103	Explore wound, extremity
20150	Excise epiphyseal bar
20206	Needle biopsy, muscle
20220	Bone biopsy, trocar/needle
20225	Bone biopsy, trocar/needle
20240	Bone biopsy, excisional
20245	Bone biopsy, excisional
20250	Open bone biopsy
20251	Open bone biopsy
20520	Removal of foreign body
20525	Removal of foreign body
20615	Treatment of bone cyst
20650	Insert and remove bone pin
20670	Removal of support implant
20680	Removal of support implant
20690	Apply bone fixation device
20694	Remove bone fixation device
20900	Removal of bone for graft
20910	Remove cartilage for graft
20922	Removal of fascia for graft
20950	Fluid pressure, muscle
20972	Bone/skin graft, metatarsal
20974	Electrical bone stimulation
20975	Electrical bone stimulation
21025	Excision of bone, lower jaw
21026	Excision of facial bone(s)
21029	Contour of face bone lesion
21030	Excise max/zygoma b9 tumor
21031	Remove exostosis, mandible
21032	Remove exostosis, maxilla
21034	Excise max/zygoma mlg tumor
21040	Excise mandible lesion
21044	Removal of jaw bone lesion
21045	Extensive jaw surgery
21050	Removal of jaw joint
21060	Remove jaw joint cartilage
21070	Remove coronoid process
21100	Maxillofacial fixation
21110	Interdental fixation
21116	Injection, jaw joint x-ray
21120	Reconstruction of chin
21121	Reconstruction of chin
21122	Reconstruction of chin
21123	Reconstruction of chin
21125	Augmentation, lower jaw bone
21127	Augmentation, lower jaw bone
21137	Reduction of forehead

Some of these codes have previously been refined and additional refinements were made by the PEAC.
All anesthesia codes were reviewed with the exception of 00104 abd 00124.

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
21138	Reduction of forehead
21139	Reduction of forehead
21143	Reconstruct midface, lefort
21150	Reconstruct midface, lefort
21151	Reconstruct midface, lefort
21154	Reconstruct midface, lefort
21155	Reconstruct midface, lefort
21159	Reconstruct midface, lefort
21160	Reconstruct midface, lefort
21188	Reconstruction of midface
21195	Reconst lwr jaw w/o fixation
21196	Reconst lwr jaw w/fixation
21198	Reconstr lwr jaw segment
21206	Reconstruct upper jaw bone
21208	Augmentation of facial bones
21209	Reduction of facial bones
21210	Face bone graft
21215	Lower jaw bone graft
21235	Ear cartilage graft
21244	Reconstruction of lower jaw
21245	Reconstruction of jaw
21246	Reconstruction of jaw
21248	Reconstruction of jaw
21249	Reconstruction of jaw
21255	Reconstruct lower jaw bone
21260	Revise eye sockets
21261	Revise eye sockets
21263	Revise eye sockets
21267	Revise eye sockets
21268	Revise eye sockets
21270	Augmentation, cheek bone
21295	Revision of jaw muscle/bone
21296	Revision of jaw muscle/bone
21315	Treatment of nose fracture
21320	Treatment of nose fracture
21325	Treatment of nose fracture
21330	Treatment of nose fracture
21335	Treatment of nose fracture
21336	Treat nasal septal fracture
21337	Treat nasal septal fracture
21338	Treat nasoethmoid fracture
21339	Treat nasoethmoid fracture
21343	Treatment of sinus fracture
21344	Treatment of sinus fracture
21345	Treat nose/jaw fracture
21346	Treat nose/jaw fracture
21347	Treat nose/jaw fracture
21355	Treat cheek bone fracture
21356	Treat cheek bone fracture
21360	Treat cheek bone fracture
21365	Treat cheek bone fracture
21385	Treat eye socket fracture
21386	Treat eye socket fracture
21387	Treat eye socket fracture
21400	Treat eye socket fracture
21401	Treat eye socket fracture
21421	Treat mouth roof fracture
21422	Treat mouth roof fracture
21423	Treat mouth roof fracture
21431	Treat craniofacial fracture
21432	Treat craniofacial fracture
21440	Treat dental ridge fracture
21445	Treat dental ridge fracture

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
21450	Treat lower jaw fracture
21451	Treat lower jaw fracture
21452	Treat lower jaw fracture
21453	Treat lower jaw fracture
21461	Treat lower jaw fracture
21462	Treat lower jaw fracture
21485	Reset dislocated jaw
21493	Treat hyoid bone fracture
21494	Treat hyoid bone fracture
21495	Treat hyoid bone fracture
21497	Interdental wiring
21501	Drain neck/chest lesion
21555	Remove lesion, neck/chest
21700	Revision of neck muscle
21720	Revision of neck muscle
21800	Treatment of rib fracture
21820	Treat sternum fracture
21925	Biopsy soft tissue of back
21930	Remove lesion, back or flank
22305	Treat spine process fracture
22310	Treat spine fracture
22315	Treat spine fracture
23000	Removal of calcium deposits
23030	Drain shoulder lesion
23031	Drain shoulder bursa
23065	Biopsy shoulder tissues
23066	Biopsy shoulder tissues
23075	Removal of shoulder lesion
23330	Remove shoulder foreign body
23350	Injection for shoulder x-ray
23500	Treat clavicle fracture
23505	Treat clavicle fracture
23520	Treat clavicle dislocation
23525	Treat clavicle dislocation
23540	Treat clavicle dislocation
23545	Treat clavicle dislocation
23570	Treat shoulder blade fx
23575	Treat shoulder blade fx
23600	Treat humerus fracture
23605	Treat humerus fracture
23620	Treat humerus fracture
23625	Treat humerus fracture
23650	Treat shoulder dislocation
23665	Treat dislocation/fracture
23675	Treat dislocation/fracture
23700	Fixation of shoulder
23921	Amputation follow-up surgery
23930	Drainage of arm lesion
23931	Drainage of arm bursa
24065	Biopsy arm/elbow soft tissue
24066	Biopsy arm/elbow soft tissue
24075	Remove arm/elbow lesion
24200	Removal of arm foreign body
24201	Removal of arm foreign body
24220	Injection for elbow x-ray
24500	Treat humerus fracture
24505	Treat humerus fracture
24530	Treat humerus fracture
24535	Treat humerus fracture
24560	Treat humerus fracture
24565	Treat humerus fracture
24576	Treat humerus fracture
24577	Treat humerus fracture

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
24600	Treat elbow dislocation
24640	Treat elbow dislocation
24650	Treat radius fracture
24655	Treat radius fracture
24670	Treat ulnar fracture
24675	Treat ulnar fracture
25065	Biopsy forearm soft tissues
25246	Injection for wrist x-ray
25500	Treat fracture of radius
25505	Treat fracture of radius
25520	Treat fracture of radius
25530	Treat fracture of ulna
25535	Treat fracture of ulna
25560	Treat fracture radius & ulna
25565	Treat fracture radius & ulna
25600	Treat fracture radius/ulna
25605	Treat fracture radius/ulna
25622	Treat wrist bone fracture
25624	Treat wrist bone fracture
25630	Treat wrist bone fracture
25635	Treat wrist bone fracture
25650	Treat wrist bone fracture
25675	Treat wrist dislocation
26600	Treat metacarpal fracture
26605	Treat metacarpal fracture
26641	Treat thumb dislocation
26645	Treat thumb fracture
26670	Treat hand dislocation
26675	Treat hand dislocation
26700	Treat knuckle dislocation
26705	Treat knuckle dislocation
26720	Treat finger fracture, each
26725	Treat finger fracture, each
26740	Treat finger fracture, each
26742	Treat finger fracture, each
26750	Treat finger fracture, each
26755	Treat finger fracture, each
26770	Treat finger dislocation
26775	Treat finger dislocation
26863	Fuse/graft added joint
26991	Drainage of pelvis bursa
27040	Biopsy of soft tissues
27047	Remove hip/pelvis lesion
27086	Remove hip foreign body
27093	Injection for hip x-ray
27095	Injection for hip x-ray
27193	Treat pelvic ring fracture
27194	Treat pelvic ring fracture
27200	Treat tail bone fracture
27220	Treat hip socket fracture
27230	Treat thigh fracture
27246	Treat thigh fracture
27256	Treat hip dislocation
27257	Treat hip dislocation
27275	Manipulation of hip joint
27301	Drain thigh/knee lesion
27323	Biopsy, thigh soft tissues
27327	Removal of thigh lesion
27370	Injection for knee x-ray
27372	Removal of foreign body
27500	Treatment of thigh fracture
27501	Treatment of thigh fracture
27508	Treatment of thigh fracture

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All anesthesia codes were reviewed with the exception of 00104 abd 00124.

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
27516	Treat thigh fx growth plate
27517	Treat thigh fx growth plate
27520	Treat kneecap fracture
27530	Treat knee fracture
27532	Treat knee fracture
27538	Treat knee fracture(s)
27550	Treat knee dislocation
27560	Treat kneecap dislocation
27570	Fixation of knee joint
27603	Drain lower leg lesion
27604	Drain lower leg bursa
27605	Incision of achilles tendon
27606	Incision of achilles tendon
27613	Biopsy lower leg soft tissue
27614	Biopsy lower leg soft tissue
27618	Remove lower leg lesion
27619	Remove lower leg lesion
27630	Removal of tendon lesion
27648	Injection for ankle x-ray
27656	Repair leg fascia defect
27658	Repair of leg tendon, each
27659	Repair of leg tendon, each
27664	Repair of leg tendon, each
27665	Repair of leg tendon, each
27685	Revision of lower leg tendon
27686	Revise lower leg tendons
27692	Revise additional leg tendon
27730	Repair of tibia epiphysis
27732	Repair of fibula epiphysis
27740	Repair of leg epiphyses
27742	Repair of leg epiphyses
27750	Treatment of tibia fracture
27752	Treatment of tibia fracture
27760	Treatment of ankle fracture
27762	Treatment of ankle fracture
27780	Treatment of fibula fracture
27781	Treatment of fibula fracture
27786	Treatment of ankle fracture
27788	Treatment of ankle fracture
27808	Treatment of ankle fracture
27810	Treatment of ankle fracture
27816	Treatment of ankle fracture
27818	Treatment of ankle fracture
27824	Treat lower leg fracture
27825	Treat lower leg fracture
27830	Treat lower leg dislocation
27860	Fixation of ankle joint
28001	Drainage of bursa of foot
28002	Treatment of foot infection
28003	Treatment of foot infection
28008	Incision of foot fascia
28010	Incision of toe tendon
28011	Incision of toe tendons
28020	Exploration of foot joint
28022	Exploration of foot joint
28024	Exploration of toe joint
28035	Decompression of tibia nerve
28043	Excision of foot lesion
28045	Excision of foot lesion
28046	Resection of tumor, foot
28050	Biopsy of foot joint lining
28052	Biopsy of foot joint lining
28054	Biopsy of toe joint lining

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
28060	Partial removal, foot fascia
28062	Removal of foot fascia
28070	Removal of foot joint lining
28072	Removal of foot joint lining
28080	Removal of foot lesion
28086	Excise foot tendon sheath
28088	Excise foot tendon sheath
28090	Removal of foot lesion
28092	Removal of toe lesions
28100	Removal of ankle/heel lesion
28103	Remove/graft foot lesion
28104	Removal of foot lesion
28107	Remove/graft foot lesion
28108	Removal of toe lesions
28110	Part removal of metatarsal
28111	Part removal of metatarsal
28112	Part removal of metatarsal
28113	Part removal of metatarsal
28114	Removal of metatarsal heads
28116	Revision of foot
28118	Removal of heel bone
28119	Removal of heel spur
28120	Part removal of ankle/heel
28122	Partial removal of foot bone
28124	Partial removal of toe
28126	Partial removal of toe
28140	Removal of metatarsal
28150	Removal of toe
28153	Partial removal of toe
28160	Partial removal of toe
28173	Extensive foot surgery
28175	Extensive foot surgery
28190	Removal of foot foreign body
28192	Removal of foot foreign body
28193	Removal of foot foreign body
28200	Repair of foot tendon
28202	Repair/graft of foot tendon
28208	Repair of foot tendon
28210	Repair/graft of foot tendon
28220	Release of foot tendon
28222	Release of foot tendons
28225	Release of foot tendon
28226	Release of foot tendons
28230	Incision of foot tendon(s)
28232	Incision of toe tendon
28234	Incision of foot tendon
28238	Revision of foot tendon
28288	Partial removal of foot bone
28289	Repair hallux rigidus
28290	Correction of bunion
28292	Correction of bunion
28294	Correction of bunion
28296	Correction of bunion
28297	Correction of bunion
28298	Correction of bunion
28299	Correction of bunion
28300	Incision of heel bone
28302	Incision of ankle bone
28305	Incise/graft midfoot bones
28400	Treatment of heel fracture
28405	Treatment of heel fracture
28430	Treatment of ankle fracture
28435	Treatment of ankle fracture

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
28450	Treat midfoot fracture, each
28455	Treat midfoot fracture, each
28470	Treat metatarsal fracture
28475	Treat metatarsal fracture
28490	Treat big toe fracture
28495	Treat big toe fracture
28510	Treatment of toe fracture
28515	Treatment of toe fracture
28530	Treat sesamoid bone fracture
28540	Treat foot dislocation
28545	Treat foot dislocation
28570	Treat foot dislocation
28575	Treat foot dislocation
28600	Treat foot dislocation
28605	Treat foot dislocation
28630	Treat toe dislocation
28635	Treat toe dislocation
28636	Treat toe dislocation
28660	Treat toe dislocation
28665	Treat toe dislocation
30115	Removal of nose polyp(s)
30117	Removal of intranasal lesion
30118	Removal of intranasal lesion
30120	Revision of nose
30124	Removal of nose lesion
30125	Removal of nose lesion
30130	Removal of turbinate bones
30140	Removal of turbinate bones
30150	Partial removal of nose
30160	Removal of nose
30320	Remove nasal foreign body
30400	Reconstruction of nose
30410	Reconstruction of nose
30420	Reconstruction of nose
30430	Revision of nose
30435	Revision of nose
30450	Revision of nose
30460	Revision of nose
30462	Revision of nose
30465	Repair nasal stenosis
30520	Repair of nasal septum
30540	Repair nasal defect
30545	Repair nasal defect
30580	Repair upper jaw fistula
30600	Repair mouth/nose fistula
30620	Intranasal reconstruction
30630	Repair nasal septum defect
30801	Cauterization, inner nose
30802	Cauterization, inner nose
30915	Ligation, nasal sinus artery
30920	Ligation, upper jaw artery
31020	Exploration, maxillary sinus
31030	Exploration, maxillary sinus
31032	Explore sinus, remove polyps
31040	Exploration behind upper jaw
31050	Exploration, sphenoid sinus
31051	Sphenoid sinus surgery
31070	Exploration of frontal sinus
31075	Exploration of frontal sinus
31080	Removal of frontal sinus
31081	Removal of frontal sinus
31084	Removal of frontal sinus
31085	Removal of frontal sinus

Some of these codes have previously been refined and additional refinements were made by the PEAC.
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ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
31086	Removal of frontal sinus
31087	Removal of frontal sinus
31090	Exploration of sinuses
31200	Removal of ethmoid sinus
31201	Removal of ethmoid sinus
31205	Removal of ethmoid sinus
31225	Removal of upper jaw
31230	Removal of upper jaw
31300	Removal of larynx lesion
31320	Diagnostic incision, larynx
31360	Removal of larynx
31365	Removal of larynx
31367	Partial removal of larynx
31368	Partial removal of larynx
31370	Partial removal of larynx
31375	Partial removal of larynx
31380	Partial removal of larynx
31382	Partial removal of larynx
31390	Removal of larynx & pharynx
31395	Reconstruct larynx & pharynx
31400	Revision of larynx
31420	Removal of epiglottis
31502	Change of windpipe airway
31580	Revision of larynx
31582	Revision of larynx
31584	Treat larynx fracture
31585	Treat larynx fracture
31586	Treat larynx fracture
31587	Revision of larynx
31588	Revision of larynx
31590	Reinnervate larynx
31595	Larynx nerve surgery
31610	Incision of windpipe
31611	Surgery/speech prosthesis
31613	Repair windpipe opening
31614	Repair windpipe opening
31622	Dx bronchoscope/wash
31623	Dx bronchoscope/brush
31624	Dx bronchoscope/lavage
31625	Bronchoscopy w/biopsy(s)
31628	Bronchoscopy/lung bx, each
31629	Bronchoscopy/needle bx, each
31630	Bronchoscopy dilate/fx repr
31631	Bronchoscopy, dilate w/stent
31635	Bronchoscopy w/fb removal
31640	Bronchoscopy w/tumor excise
31641	Bronchoscopy, treat blockage
31643	Diag bronchoscope/catheter
31645	Bronchoscopy, clear airways
31646	Bronchoscopy, reclear airway
31656	Bronchoscopy, inj for x-ray
31708	Instill airway contrast dye
31710	Insertion of airway catheter
31715	Injection for bronchus x-ray
31717	Bronchial brush biopsy
31720	Clearance of airways
31725	Clearance of airways
31750	Repair of windpipe
31755	Repair of windpipe
31800	Repair of windpipe injury
31820	Closure of windpipe lesion
31825	Repair of windpipe defect
31830	Revise windpipe scar

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
32002	Treatment of collapsed lung
32020	Insertion of chest tube
32201	Drain, percut, lung lesion
32400	Needle biopsy chest lining
32405	Biopsy, lung or mediastinum
32420	Puncture/clear lung
32851	Lung transplant, single
32852	Lung transplant with bypass
32853	Lung transplant, double
32854	Lung transplant with bypass
33010	Drainage of heart sac
33011	Repeat drainage of heart sac
33210	Insertion of heart electrode
33211	Insertion of heart electrode
33225	L ventric pacing lead add-on
33508	Endoscopic vein harvest
33935	Transplantation, heart/lung
33945	Transplantation of heart
33960	External circulation assist
33967	Insert ia percut device
33968	Remove aortic assist device
33970	Aortic circulation assist
33973	Insert balloon device
33975	Implant ventricular device
33976	Implant ventricular device
33979	Insert intracorporeal device
35450	Repair arterial blockage
35452	Repair arterial blockage
35454	Repair arterial blockage
35456	Repair arterial blockage
35458	Repair arterial blockage
35459	Repair arterial blockage
35460	Repair venous blockage
35470	Repair arterial blockage
35471	Repair arterial blockage
35472	Repair arterial blockage
35473	Repair arterial blockage
35474	Repair arterial blockage
35475	Repair arterial blockage
35476	Repair venous blockage
35480	Atherectomy, open
35481	Atherectomy, open
35482	Atherectomy, open
35483	Atherectomy, open
35484	Atherectomy, open
35485	Atherectomy, open
35572	Harvest femoropopliteal vein
35697	Reimplant artery each
36010	Place catheter in vein
36011	Place catheter in vein
36012	Place catheter in vein
36013	Place catheter in artery
36014	Place catheter in artery
36015	Place catheter in artery
36100	Establish access to artery
36120	Establish access to artery
36140	Establish access to artery
36145	Artery to vein shunt
36160	Establish access to aorta
36200	Place catheter in aorta
36215	Place catheter in artery
36216	Place catheter in artery
36217	Place catheter in artery

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
36218	Place catheter in artery
36245	Place catheter in artery
36246	Place catheter in artery
36247	Place catheter in artery
36248	Place catheter in artery
36420	Vein access cutdown < 1 yr
36430	Blood transfusion service
36481	Insertion of catheter, vein
36500	Insertion of catheter, vein
36514	Apheresis plasma
36515	Apheresis, adsorp/reinfuse
36516	Apheresis, selective
36625	Insertion catheter, artery
36680	Insert needle, bone cavity
37195	Thrombolytic therapy, stroke
37200	Transcatheter biopsy
37203	Transcatheter retrieval
37204	Transcatheter occlusion
37209	Exchange arterial catheter
37785	Ligate/divide/excise vein
38200	Injection for spleen x-ray
38204	Bl donor search management
38205	Harvest allogenic stem cells
38206	Harvest auto stem cells
38207	Cryopreserve stem cells
38208	Thaw preserved stem cells
38209	Wash harvest stem cells
38210	T-cell depletion of harvest
38211	Tumor cell deplete of harvst
38212	Rbc depletion of harvest
38213	Platelet deplete of harvest
38214	Volume deplete of harvest
38215	Harvest stem cell concentrte
38240	Bone marrow/stem transplant
38241	Bone marrow/stem transplant
38242	Lymphocyte infuse transplant
38305	Drainage, lymph node lesion
38308	Incision of lymph channels
38380	Thoracic duct procedure
38520	Biopsy/removal, lymph nodes
38542	Explore deep node(s), neck
38700	Removal of lymph nodes, neck
38720	Removal of lymph nodes, neck
38724	Removal of lymph nodes, neck
40500	Partial excision of lip
40510	Partial excision of lip
40520	Partial excision of lip
40525	Reconstruct lip with flap
40527	Reconstruct lip with flap
40530	Partial removal of lip
40650	Repair lip
40652	Repair lip
40654	Repair lip
40700	Repair cleft lip/nasal
40701	Repair cleft lip/nasal
40702	Repair cleft lip/nasal
40720	Repair cleft lip/nasal
40761	Repair cleft lip/nasal
40800	Drainage of mouth lesion
40801	Drainage of mouth lesion
40804	Removal, foreign body, mouth
40805	Removal, foreign body, mouth
40806	Incision of lip fold

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ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
40808	Biopsy of mouth lesion
40810	Excision of mouth lesion
40812	Excise/repair mouth lesion
40814	Excise/repair mouth lesion
40816	Excision of mouth lesion
40818	Excise oral mucosa for graft
40819	Excise lip or cheek fold
40820	Treatment of mouth lesion
40830	Repair mouth laceration
40831	Repair mouth laceration
40840	Reconstruction of mouth
40842	Reconstruction of mouth
40843	Reconstruction of mouth
40844	Reconstruction of mouth
40845	Reconstruction of mouth
41005	Drainage of mouth lesion
41006	Drainage of mouth lesion
41007	Drainage of mouth lesion
41008	Drainage of mouth lesion
41009	Drainage of mouth lesion
41010	Incision of tongue fold
41015	Drainage of mouth lesion
41016	Drainage of mouth lesion
41017	Drainage of mouth lesion
41018	Drainage of mouth lesion
41110	Excision of tongue lesion
41112	Excision of tongue lesion
41113	Excision of tongue lesion
41114	Excision of tongue lesion
41115	Excision of tongue fold
41116	Excision of mouth lesion
41120	Partial removal of tongue
41130	Partial removal of tongue
41135	Tongue and neck surgery
41140	Removal of tongue
41145	Tongue removal, neck surgery
41150	Tongue, mouth, jaw surgery
41153	Tongue, mouth, neck surgery
41155	Tongue, jaw, & neck surgery
41500	Fixation of tongue
41510	Tongue to lip surgery
41520	Reconstruction, tongue fold
41823	Excision of gum lesion
41827	Excision of gum lesion
41872	Repair gum
41874	Repair tooth socket
42107	Excision lesion, mouth roof
42120	Remove palate/lesion
42140	Excision of uvula
42145	Repair palate, pharynx/uvula
42200	Reconstruct cleft palate
42205	Reconstruct cleft palate
42210	Reconstruct cleft palate
42215	Reconstruct cleft palate
42220	Reconstruct cleft palate
42225	Reconstruct cleft palate
42226	Lengthening of palate
42227	Lengthening of palate
42235	Repair palate
42260	Repair nose to lip fistula
42305	Drainage of salivary gland
42325	Create salivary cyst drain
42326	Create salivary cyst drain

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
42335	Removal of salivary stone
42340	Removal of salivary stone
42408	Excision of salivary cyst
42409	Drainage of salivary cyst
42410	Excise parotid gland/lesion
42415	Excise parotid gland/lesion
42420	Excise parotid gland/lesion
42425	Excise parotid gland/lesion
42426	Excise parotid gland/lesion
42440	Excise submaxillary gland
42450	Excise sublingual gland
42500	Repair salivary duct
42505	Repair salivary duct
42507	Parotid duct diversion
42508	Parotid duct diversion
42509	Parotid duct diversion
42510	Parotid duct diversion
42550	Injection for salivary x-ray
42600	Closure of salivary fistula
42665	Ligation of salivary duct
42725	Drainage of throat abscess
42810	Excision of neck cyst
42815	Excision of neck cyst
42820	Remove tonsils and adenoids
42821	Remove tonsils and adenoids
42825	Removal of tonsils
42826	Removal of tonsils
42830	Removal of adenoids
42831	Removal of adenoids
42835	Removal of adenoids
42836	Removal of adenoids
42842	Extensive surgery of throat
42844	Extensive surgery of throat
42845	Extensive surgery of throat
42860	Excision of tonsil tags
42870	Excision of lingual tonsil
42890	Partial removal of pharynx
42892	Revision of pharyngeal walls
42894	Revision of pharyngeal walls
42950	Reconstruction of throat
42953	Repair throat, esophagus
42955	Surgical opening of throat
42961	Control throat bleeding
42962	Control throat bleeding
42970	Control nose/throat bleeding
42971	Control nose/throat bleeding
42972	Control nose/throat bleeding
43020	Incision of esophagus
43030	Throat muscle surgery
43600	Biopsy of stomach
43761	Reposition gastrostomy tube
44100	Biopsy of bowel
44385	Endoscopy of bowel pouch
44386	Endoscopy, bowel pouch/biop
44500	Intro, gastrointestinal tube
44701	Intraop colon lavage add-on
44901	Drain app abscess, percut
45005	Drainage of rectal abscess
45520	Treatment of rectal prolapse
45915	Remove rectal obstruction
46040	Incision of rectal abscess
46200	Removal of anal fissure
46210	Removal of anal crypt

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
46211	Removal of anal crypts
46221	Ligation of hemorrhoid(s)
46250	Hemorrhoidectomy
46255	Hemorrhoidectomy
46270	Removal of anal fistula
46275	Removal of anal fistula
46285	Removal of anal fistula
46500	Injection into hemorrhoid(s)
46900	Destruction, anal lesion(s)
46910	Destruction, anal lesion(s)
46934	Destruction of hemorrhoids
46936	Destruction of hemorrhoids
46938	Cryotherapy of rectal lesion
46945	Ligation of hemorrhoids
46946	Ligation of hemorrhoids
47135	Transplantation of liver
47136	Transplantation of liver
47140	Partial removal, donor liver
47141	Partial removal, donor liver
47142	Partial removal, donor liver
47500	Injection for liver x-rays
47525	Change bile duct catheter
47530	Revise/reinsert bile tube
47553	Biliary endoscopy thru skin
47556	Biliary endoscopy thru skin
47561	Laparo w/cholangio/biopsy
48511	Drain pancreatic pseudocyst
48554	Transpl allograft pancreas
48556	Removal, allograft pancreas
49021	Drain abdominal abscess
49041	Drain, percut, abdom abscess
49061	Drain, percut, retroper absc
49400	Air injection into abdomen
49423	Exchange drainage catheter
49424	Assess cyst, contrast inject
49427	Injection, abdominal shunt
49505	Prp i/hern init reduc>5 yr
50010	Exploration of kidney
50020	Renal abscess, open drain
50021	Renal abscess, percut drain
50040	Drainage of kidney
50045	Exploration of kidney
50060	Removal of kidney stone
50065	Incision of kidney
50070	Incision of kidney
50075	Removal of kidney stone
50080	Removal of kidney stone
50081	Removal of kidney stone
50100	Revise kidney blood vessels
50120	Exploration of kidney
50125	Explore and drain kidney
50130	Removal of kidney stone
50135	Exploration of kidney
50200	Biopsy of kidney
50205	Biopsy of kidney
50220	Remove kidney, open
50225	Removal kidney open, complex
50230	Removal kidney open, radical
50234	Removal of kidney & ureter
50236	Removal of kidney & ureter
50240	Partial removal of kidney
50280	Removal of kidney lesion
50290	Removal of kidney lesion

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ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
50300	Removal of donor kidney
50320	Removal of donor kidney
50340	Removal of kidney
50360	Transplantation of kidney
50365	Transplantation of kidney
50370	Remove transplanted kidney
50380	Reimplantation of kidney
50390	Drainage of kidney lesion
50392	Insert kidney drain
50393	Insert ureteral tube
50394	Injection for kidney x-ray
50395	Create passage to kidney
50396	Measure kidney pressure
50398	Change kidney tube
50400	Revision of kidney/ureter
50405	Revision of kidney/ureter
50500	Repair of kidney wound
50520	Close kidney-skin fistula
50525	Repair renal-abdomen fistula
50526	Repair renal-abdomen fistula
50540	Revision of horseshoe kidney
50541	Laparo ablate renal cyst
50542	Laparo ablate renal mass
50544	Laparoscopy, pyeloplasty
50545	Laparo radical nephrectomy
50546	Laparoscopic nephrectomy
50547	Laparo removal donor kidney
50548	Laparo remove w/ ureter
50551	Kidney endoscopy
50553	Kidney endoscopy
50555	Kidney endoscopy & biopsy
50555	Kidney endoscopy & biopsy
50557	Kidney endoscopy & treatment
50559	Renal endoscopy/radiotracer
50561	Kidney endoscopy & treatment
50562	Renal scope w/tumor resect
50570	Kidney endoscopy
50572	Kidney endoscopy
50574	Kidney endoscopy & biopsy
50575	Kidney endoscopy
50576	Kidney endoscopy & treatment
50578	Renal endoscopy/radiotracer
50580	Kidney endoscopy & treatment
50590	Fragmenting of kidney stone
50600	Exploration of ureter
50605	Insert ureteral support
50610	Removal of ureter stone
50620	Removal of ureter stone
50630	Removal of ureter stone
50650	Removal of ureter
50660	Removal of ureter
50684	Injection for ureter x-ray
50686	Measure ureter pressure
50688	Change of ureter tube
50690	Injection for ureter x-ray
50700	Revision of ureter
50715	Release of ureter
50722	Release of ureter
50725	Release/revise ureter
50727	Revise ureter
50728	Revise ureter
50740	Fusion of ureter & kidney
50750	Fusion of ureter & kidney

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
50760	Fusion of ureters
50770	Splicing of ureters
50780	Reimplant ureter in bladder
50782	Reimplant ureter in bladder
50783	Reimplant ureter in bladder
50785	Reimplant ureter in bladder
50800	Implant ureter in bowel
50810	Fusion of ureter & bowel
50815	Urine shunt to intestine
50820	Construct bowel bladder
50825	Construct bowel bladder
50830	Revise urine flow
50840	Replace ureter by bowel
50845	Appendico-vesicostomy
50860	Transplant ureter to skin
50900	Repair of ureter
50920	Closure ureter/skin fistula
50930	Closure ureter/bowel fistula
50940	Release of ureter
50945	Laparoscopy ureterolithotomy
50947	Laparo new ureter/bladder
50948	Laparo new ureter/bladder
50949	Laparoscope proc, ureter
50951	Endoscopy of ureter
50953	Endoscopy of ureter
50955	Ureter endoscopy & biopsy
50957	Ureter endoscopy & treatment
50959	Ureter endoscopy & tracer
50961	Ureter endoscopy & treatment
50970	Ureter endoscopy
50972	Ureter endoscopy & catheter
50974	Ureter endoscopy & biopsy
50976	Ureter endoscopy & treatment
50978	Ureter endoscopy & tracer
50980	Ureter endoscopy & treatment
52007	Cystoscopy and biopsy
52010	Cystoscopy & duct catheter
52204	Cystoscopy
52214	Cystoscopy and treatment
52224	Cystoscopy and treatment
52234	Cystoscopy and treatment
52235	Cystoscopy and treatment
52240	Cystoscopy and treatment
52265	Cystoscopy and treatment
52270	Cystoscopy & revise urethra
52275	Cystoscopy & revise urethra
52310	Cystoscopy and treatment
52315	Cystoscopy and treatment
52317	Remove bladder stone
52327	Cystoscopy, inject material
52330	Cystoscopy and treatment
52332	Cystoscopy and treatment
53040	Drainage of urethra abscess
53060	Drainage of urethra abscess
53200	Biopsy of urethra
53260	Treatment of urethra lesion
53265	Treatment of urethra lesion
53270	Removal of urethra gland
53605	Dilate urethra stricture
53665	Dilation of urethra
53850	Prostatic microwave thermotx
53852	Prostatic rf thermotx
53853	Prostatic water thermother

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
54000	Slitting of prepuce
54001	Slitting of prepuce
54056	Cryosurgery, penis lesion(s)
54057	Laser surg, penis lesion(s)
54060	Excision of penis lesion(s)
54065	Destruction, penis lesion(s)
54105	Biopsy of penis
54110	Treatment of penis lesion
54111	Treat penis lesion, graft
54112	Treat penis lesion, graft
54115	Treatment of penis lesion
54120	Partial removal of penis
54125	Removal of penis
54130	Remove penis & nodes
54135	Remove penis & nodes
54150	Circumcision
54160	Circumcision
54162	Lysis penil circumic lesion
55110	Explore scrotum
55120	Removal of scrotum lesion
55150	Removal of scrotum
55175	Revision of scrotum
55180	Revision of scrotum
55200	Incision of sperm duct
55250	Removal of sperm duct(s)
55400	Repair of sperm duct
56605	Biopsy of vulva/perineum
56700	Partial removal of hymen
56720	Incision of hymen
56740	Remove vagina gland lesion
57100	Biopsy of vagina
57105	Biopsy of vagina
57160	Insert pessary/other device
57400	Dilation of vagina
57452	Exam of cervix w/scope
57454	Bx/curett of cervix w/scope
57460	Bx of cervix w/scope, leep
57500	Biopsy of cervix
57520	Conization of cervix
57522	Conization of cervix
58555	Hysteroscopy, dx, sep proc
58558	Hysteroscopy, biopsy
58559	Hysteroscopy, lysis
58560	Hysteroscopy, resect septum
58561	Hysteroscopy, remove myoma
58562	Hysteroscopy, remove fb
58800	Drainage of ovarian cyst(s)
58823	Drain pelvic abscess, percut
59030	Fetal scalp blood sample
59140	Treat ectopic pregnancy
59320	Revision of cervix
59325	Revision of cervix
59350	Repair of uterus
59820	Care of miscarriage
59821	Treatment of miscarriage
61107	Drill skull for implantation
61210	Pierce skull, implant device
61316	Implt cran bone flap to abdo
61517	Implt brain chemotx add-on
61576	Skull base/brainstem surgery
61864	Implant neuroelectrde, add'l
61868	Implant neuroelectrde, add'l
62120	Repair skull cavity lesion

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ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
62121	Incise skull repair
62148	Retr bone flap to fix skull
62160	Neuroendoscopy add-on
62270	Spinal fluid tap, diagnostic
62272	Drain cerebro spinal fluid
62273	Treat epidural spine lesion
62280	Treat spinal cord lesion
62281	Treat spinal cord lesion
62282	Treat spinal canal lesion
62284	Injection for myelogram
62290	Inject for spine disk x-ray
62291	Inject for spine disk x-ray
62310	Inject spine c/t
62311	Inject spine l/s (cd)
62318	Inject spine w/cath, c/t
62319	Inject spine w/cath l/s (cd)
62367	Analyze spine infusion pump
62368	Analyze spine infusion pump
63048	Remove spinal lamina add-on
63057	Decompress spine cord add-on
63066	Decompress spine cord add-on
63076	Neck spine disk surgery
63078	Spine disk surgery, thorax
63082	Remove vertebral body add-on
63086	Remove vertebral body add-on
63088	Remove vertebral body add-on
63091	Remove vertebral body add-on
63103	Remove vertebral body add-on
63308	Remove vertebral body add-on
64400	N block inj, trigeminal
64402	N block inj, facial
64405	N block inj, occipital
64408	N block inj, vagus
64410	N block inj, phrenic
64412	N block inj, spinal accessor
64413	N block inj, cervical plexus
64415	N block inj, brachial plexus
64417	N block inj, axillary
64418	N block inj, suprascapular
64420	N block inj, intercost, sng
64421	N block inj, intercost, mlt
64425	N block inj ilio-ing/hypogi
64430	N block inj, pudendal
64435	N block inj, paracervical
64445	N block inj, sciatic, sng
64450	N block, other peripheral
64470	Inj paravertebral c/t
64472	Inj paravertebral c/t add-on
64475	Inj paravertebral l/s
64476	Inj paravertebral l/s add-on
64479	Inj foramen epidural c/t
64480	Inj foramen epidural add-on
64483	Inj foramen epidural l/s
64484	Inj foramen epidural add-on
64505	N block, spenopalatine gangl
64508	N block, carotid sinus s/p
64510	N block, stellate ganglion
64520	N block, lumbar/thoracic
64530	N block inj, celiac pelus
64561	Implant neuroelectrodes
64600	Injection treatment of nerve
64605	Injection treatment of nerve
64610	Injection treatment of nerve

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
64612	Destroy nerve, face muscle
64613	Destroy nerve, spine muscle
64614	Destroy nerve, extrem musc
64620	Injection treatment of nerve
64622	Destr paravertebrl nerve l/s
64623	Destr paravertebral n add-on
64626	Destr paravertebrl nerve c/t
64627	Destr paravertebral n add-on
64630	Injection treatment of nerve
64640	Injection treatment of nerve
64680	Injection treatment of nerve
64716	Revision of cranial nerve
64740	Incision of tongue nerve
64778	Digit nerve surgery add-on
64864	Repair of facial nerve
64865	Repair of facial nerve
64866	Fusion of facial/other nerve
64868	Fusion of facial/other nerve
64885	Nerve graft, head or neck
64886	Nerve graft, head or neck
65125	Revise ocular implant
65205	Remove foreign body from eye
65210	Remove foreign body from eye
65220	Remove foreign body from eye
65222	Remove foreign body from eye
65270	Repair of eye wound
65272	Repair of eye wound
65273	Repair of eye wound
65275	Repair of eye wound
65280	Repair of eye wound
65285	Repair of eye wound
65286	Repair of eye wound
65290	Repair of eye socket wound
65400	Removal of eye lesion
65410	Biopsy of cornea
65420	Removal of eye lesion
65426	Removal of eye lesion
65430	Corneal smear
65435	Curette/treat cornea
65436	Curette/treat cornea
65450	Treatment of corneal lesion
65600	Revision of cornea
65771	Radial keratotomy
65772	Correction of astigmatism
65800	Drainage of eye
65805	Drainage of eye
65810	Drainage of eye
65815	Drainage of eye
65855	Laser surgery of eye
65860	Incise inner eye adhesions
66020	Injection treatment of eye
66030	Injection treatment of eye
66130	Remove eye lesion
66250	Follow-up surgery of eye
66625	Removal of iris
66630	Removal of iris
66635	Removal of iris
66990	Ophthalmic endoscope add-on
67025	Replace eye fluid
67027	Implant eye drug system
67028	Injection eye drug
67031	Laser surgery, eye strands
67101	Repair detached retina

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
67105	Repair detached retina
67107	Repair detached retina
67108	Repair detached retina
67110	Repair detached retina
67112	Rerepair detached retina
67115	Release encircling material
67120	Remove eye implant material
67121	Remove eye implant material
67141	Treatment of retina
67145	Treatment of retina
67345	Destroy nerve of eye muscle
67500	Inject/treat eye socket
67505	Inject/treat eye socket
67515	Inject/treat eye socket
67700	Drainage of eyelid abscess
67710	Incision of eyelid
67715	Incision of eyelid fold
67800	Remove eyelid lesion
67801	Remove eyelid lesions
67805	Remove eyelid lesions
67808	Remove eyelid lesion(s)
67820	Revise eyelashes
67825	Revise eyelashes
67830	Revise eyelashes
67840	Remove eyelid lesion
67850	Treat eyelid lesion
67875	Closure of eyelid by suture
67880	Revision of eyelid
67882	Revision of eyelid
67900	Repair brow defect
67901	Repair eyelid defect
67902	Repair eyelid defect
67903	Repair eyelid defect
67904	Repair eyelid defect
67906	Repair eyelid defect
67908	Repair eyelid defect
67909	Repair eyelid defect
67911	Repair eyelid defect
67914	Repair eyelid defect
67915	Repair eyelid defect
67916	Repair eyelid defect
67917	Repair eyelid defect
67921	Repair eyelid defect
67922	Repair eyelid defect
67923	Repair eyelid defect
67924	Repair eyelid defect
67930	Repair eyelid wound
67935	Repair eyelid wound
67938	Remove eyelid foreign body
67950	Revision of eyelid
67961	Revision of eyelid
67966	Revision of eyelid
67971	Reconstruction of eyelid
67973	Reconstruction of eyelid
67974	Reconstruction of eyelid
67975	Reconstruction of eyelid
68020	Incise/drain eyelid lining
68040	Treatment of eyelid lesions
68100	Biopsy of eyelid lining
68110	Remove eyelid lining lesion
68115	Remove eyelid lining lesion
68130	Remove eyelid lining lesion
68135	Remove eyelid lining lesion

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ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
68200	Treat eyelid by injection
68320	Revise/graft eyelid lining
68325	Revise/graft eyelid lining
68326	Revise/graft eyelid lining
68328	Revise/graft eyelid lining
68330	Revise eyelid lining
68335	Revise/graft eyelid lining
68340	Separate eyelid adhesions
68360	Revise eyelid lining
68362	Revise eyelid lining
68440	Incise tear duct opening
68700	Repair tear ducts
68705	Revise tear duct opening
68760	Close tear duct opening
68761	Close tear duct opening
68770	Close tear duct opening
68801	Dilate tear duct opening
68810	Probe nasolacrimal duct
68811	Probe nasolacrimal duct
68815	Probe nasolacrimal duct
68840	Explore/irrigate tear ducts
68850	Injection for tear sac x-ray
69110	Remove external ear, partial
69120	Removal of external ear
69140	Remove ear canal lesion(s)
69145	Remove ear canal lesion(s)
69150	Extensive ear canal surgery
69155	Extensive ear/neck surgery
69310	Rebuild outer ear canal
69320	Rebuild outer ear canal
69440	Exploration of middle ear
69450	Eardrum revision
69501	Mastoidectomy
69502	Mastoidectomy
69505	Remove mastoid structures
69511	Extensive mastoid surgery
69530	Extensive mastoid surgery
69535	Remove part of temporal bone
69550	Remove ear lesion
69552	Remove ear lesion
69554	Remove ear lesion
69601	Mastoid surgery revision
69602	Mastoid surgery revision
69603	Mastoid surgery revision
69604	Mastoid surgery revision
69605	Mastoid surgery revision
69620	Repair of eardrum
69631	Repair eardrum structures
69632	Rebuild eardrum structures
69633	Rebuild eardrum structures
69635	Repair eardrum structures
69636	Rebuild eardrum structures
69637	Rebuild eardrum structures
69641	Revise middle ear & mastoid
69642	Revise middle ear & mastoid
69643	Revise middle ear & mastoid
69644	Revise middle ear & mastoid
69645	Revise middle ear & mastoid
69646	Revise middle ear & mastoid
69650	Release middle ear bone
69660	Revise middle ear bone
69661	Revise middle ear bone
69662	Revise middle ear bone

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
69666	Repair middle ear structures
69667	Repair middle ear structures
69670	Remove mastoid air cells
69676	Remove middle ear nerve
69700	Close mastoid fistula
69711	Remove/repair hearing aid
69714	Implant temple bone w/stimul
69715	Temple bne implnt w/stimulat
69717	Temple bone implant revision
69718	Revise temple bone implant
69720	Release facial nerve
69725	Release facial nerve
69740	Repair facial nerve
69745	Repair facial nerve
69801	Incise inner ear
69802	Incise inner ear
69805	Explore inner ear
69806	Explore inner ear
69820	Establish inner ear window
69840	Revise inner ear window
69905	Remove inner ear
69910	Remove inner ear & mastoid
69915	Incise inner ear nerve
69930	Implant cochlear device
69950	Incise inner ear nerve
69955	Release facial nerve
69960	Release inner ear canal
69970	Remove inner ear lesion
69990	Microsurgery add-on
70010	Contrast x-ray of brain
70015	Contrast x-ray of brain
70030	X-ray eye for foreign body
70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70170	X-ray exam of tear duct
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70240	X-ray exam, pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70332	X-ray exam of jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation, complex
70373	Contrast x-ray of larynx
70380	X-ray exam of salivary gland
70390	X-ray exam of salivary duct
70450	Ct head/brain w/o dye

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/ dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w dye
70552	Mri brain w/ dye
70553	Mri brain w/o & w/ dye
70557	Mri brain w/o dye
70558	Mri brain w/ dye
70559	Mri brain w/o & w/ dye
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray
71040	Contrast x-ray of bronchi
71060	Contrast x-ray of bronchi
71090	X-ray & pacemaker insertion
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/ chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone
71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/ dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye

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All anesthesia codes were reviewed with the exception of 00104 abd 00124.

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72142	Mri neck spine w/dye
72147	Mri chest spine w/dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72159	Mr angio spine w/o&w/dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
72240	Contrast x-ray of neck spine
72255	Contrast x-ray, thorax spine
72270	Contrast x-ray, spine
72275	Epidurography
72285	X-ray c/t spine disk
72295	X-ray of lower spine disk
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73040	Contrast x-ray of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73085	Contrast x-ray of elbow
73090	X-ray exam of forearm
73092	X-ray exam of arm, infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73115	Contrast x-ray of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73225	Mr angio upr extr w/o&w/dye
73500	X-ray exam of hip
73510	X-ray exam of hip
73520	X-ray exam of hips
73525	Contrast x-ray of hip
73530	X-ray exam of hip
73540	X-ray exam of pelvis & hips
73542	X-ray exam, sacroiliac joint
73550	X-ray exam of thigh
73560	X-ray exam of knee, 1 or 2
73562	X-ray exam of knee, 3

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
73564	X-ray exam, knee, 4 or more
73565	X-ray exam of knees
73580	Contrast x-ray of knee joint
73590	X-ray exam of lower leg
73592	X-ray exam of leg, infant
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73615	Contrast x-ray of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen
74022	X-ray exam series, abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o &w /dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w orw/o dye
74190	X-ray exam of peritoneum
74210	Contrst x-ray exam of throat
74220	Contrast x-ray, esophagus
74230	Cine/vid x-ray, throat/esoph
74235	Remove esophagus obstruction
74240	X-ray exam, upper gi tract
74241	X-ray exam, upper gi tract
74245	X-ray exam, upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract
74251	X-ray exam of small bowel
74260	X-ray exam of small bowel
74270	Contrast x-ray exam of colon
74280	Contrast x-ray exam of colon
74283	Contrast x-ray exam of colon
74290	Contrast x-ray, gallbladder
74291	Contrast x-rays, gallbladder
74300	X-ray bile ducts/pancreas
74305	X-ray bile ducts/pancreas
74320	Contrast x-ray of bile ducts
74327	X-ray bile stone removal
74328	X-ray bile duct endoscopy
74329	X-ray for pancreas endoscopy
74330	X-ray bile/panc endoscopy
74340	X-ray guide for GI tube
74350	X-ray guide, stomach tube
74355	X-ray guide, intestinal tube
74360	X-ray guide, GI dilation
74363	X-ray, bile duct dilation
74420	Contrst x-ray, urinary tract
74425	Contrst x-ray, urinary tract
74440	X-ray, male genital tract

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
74445	X-ray exam of penis
74450	X-ray, urethra/bladder
74470	X-ray exam of kidney lesion
74475	X-ray control, cath insert
74480	X-ray control, cath insert
74485	X-ray guide, GU dilation
74710	X-ray measurement of pelvis
74742	X-ray, fallopian tube
74775	X-ray exam of perineum
75553	Heart mri for morph w/dye
75556	Cardiac MRI/flow mapping
75600	Contrast x-ray exam of aorta
75605	Contrast x-ray exam of aorta
75625	Contrast x-ray exam of aorta
75630	X-ray aorta, leg arteries
75650	Artery x-rays, head & neck
75658	Artery x-rays, arm
75660	Artery x-rays, head & neck
75662	Artery x-rays, head & neck
75665	Artery x-rays, head & neck
75671	Artery x-rays, head & neck
75676	Artery x-rays, neck
75680	Artery x-rays, neck
75685	Artery x-rays, spine
75705	Artery x-rays, spine
74250	X-ray exam of small bowel
75710	Artery x-rays, arm/leg
75716	Artery x-rays, arms/legs
75722	Artery x-rays, kidney
75724	Artery x-rays, kidneys
75726	Artery x-rays, abdomen
75731	Artery x-rays, adrenal gland
75733	Artery x-rays, adrenals
75736	Artery x-rays, pelvis
75741	Artery x-rays, lung
75743	Artery x-rays, lungs
75746	Artery x-rays, lung
75756	Artery x-rays, chest
75774	Artery x-ray, each vessel
75790	Visualize A-V shunt
75801	Lymph vessel x-ray, arm/leg
75803	Lymph vessel x-ray,arms/legs
75805	Lymph vessel x-ray, trunk
75807	Lymph vessel x-ray, trunk
75809	Nonvascular shunt, x-ray
75810	Vein x-ray, spleen/liver
75820	Vein x-ray, arm/leg
75822	Vein x-ray, arms/legs
75825	Vein x-ray, trunk
75827	Vein x-ray, chest
75831	Vein x-ray, kidney
75833	Vein x-ray, kidneys
75840	Vein x-ray, adrenal gland
75842	Vein x-ray, adrenal glands
75860	Vein x-ray, neck
75870	Vein x-ray, skull
75872	Vein x-ray, skull
75880	Vein x-ray, eye socket
75885	Vein x-ray, liver
75887	Vein x-ray, liver
75889	Vein x-ray, liver
75891	Vein x-ray, liver
75893	Venous sampling by catheter

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ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
75894	X-rays, transcath therapy
75896	X-rays, transcath therapy
75898	Follow-up angiography
75900	Arterial catheter exchange
75940	X-ray placement, vein filter
75952	Endovasc repair abdom aorta
75953	Abdom aneurysm endovas rpr
75954	Iliac aneurysm endovas rpr
75960	Transcatheter intro, stent
75961	Retrieval, broken catheter
75962	Repair arterial blockage
75964	Repair artery blockage, each
75966	Repair arterial blockage
75968	Repair artery blockage, each
75970	Vascular biopsy
75978	Repair venous blockage
75980	Contrast xray exam bile duct
75982	Contrast xray exam bile duct
75984	Xray control catheter change
75989	Abscess drainage under x-ray
75992	Atherectomy, x-ray exam
75993	Atherectomy, x-ray exam
75994	Atherectomy, x-ray exam
75995	Atherectomy, x-ray exam
75996	Atherectomy, x-ray exam
76001	Fluoroscope exam, extensive
76003	Needle localization by x-ray
76005	Fluoroguide for spine inject
76006	X-ray stress view
76010	X-ray, nose to rectum
76012	Percut vertebroplasty fluor
76013	Percut vertebroplasty, ct
76020	X-rays for bone age
76040	X-rays, bone evaluation
76061	X-rays, bone survey
76062	X-rays, bone survey
76065	X-rays, bone evaluation
76066	Joint survey, single view
76070	Ct bone density, axial
76075	Dexa, axial skeleton study
76076	Dexa, peripheral study
76078	Radiographic absorptiometry
76080	X-ray exam of fistula
76086	X-ray of mammary duct
76088	X-ray of mammary ducts
76090	Mammogram, one breast
76091	Mammogram, both breasts
76092	Mammogram, screening
76093	Magnetic image, breast
76094	Magnetic image, both breasts
76095	Stereotactic breast biopsy
76096	X-ray of needle wire, breast
76096	X-ray of needle wire, breast
76098	X-ray exam, breast specimen
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays
76350	Special x-ray contrast study
76355	Ct scan for localization
76360	Ct scan for needle biopsy
76362	Ct guide for tissue ablation
76362	Ct guide for tissue ablation
76370	Ct scan for therapy guide

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
76375	3d/holograph reconstr add-on
76380	CAT scan follow-up study
76390	Mr spectroscopy
76394	Mri for tissue ablation
76394	Mri for tissue ablation
76604	Us exam, chest, b-scan
76645	Us exam, breast(s)
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76775	Us exam abdo back wall, lim
76800	Us exam, spinal canal
76886	Us exam infant hips, static
76932	Echo guide for heart biopsy
76936	Echo guide for artery repair
76941	Us guide, tissue ablation
76941	Echo guide for transfusion
76945	Echo guide for transfusion
76946	Echo guide, villus sampling
76948	Echo guide for amniocentesis
76950	Echo guide, ova aspiration
76965	Echo guidance radiotherapy
76970	Echo guidance radiotherapy
76977	Ultrasound exam follow-up
76986	Us bone density measure
77295	Ultrasound guide intraoper
77326	Set radiation therapy field
77327	Brachytx isodose calc simp
77328	Brachytx isodose calc interm
77427	Brachytx isodose plan compl
77431	Radiation tx management, x5
77470	Stereotactic radiation trmt
77600	Special radiation treatment
77605	Hyperthermia treatment
77610	Hyperthermia treatment
77615	Hyperthermia treatment
77620	Hyperthermia treatment
77750	Hyperthermia treatment
77761	Infuse radioactive materials
77762	Apply intrcav radiat simple
77763	Apply intrcav radiat interm
77776	Apply intrcav radiat compl
77777	Apply interstit radiat simpl
77778	Apply interstit radiat inter
77790	Apply surface radiation
78000	Radiation handling
78001	Thyroid, single uptake
78003	Thyroid, multiple uptakes
78006	Thyroid suppress/stimul
78007	Thyroid imaging with uptake
78010	Thyroid image, mult uptakes
78011	Thyroid imaging
78015	Thyroid imaging with flow
78016	Thyroid met imaging
78018	Thyroid met imaging/studies
78020	Thyroid met imaging, body
78070	Thyroid met uptake
78075	Parathyroid nuclear imaging
78102	Adrenal nuclear imaging
78103	Bone marrow imaging, ltd
78104	Bone marrow imaging, mult
78110	Bone marrow imaging, body
78111	Plasma volume, single
78120	Plasma volume, multiple

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
78121	Red cell mass, single
78122	Red cell mass, multiple
78130	Blood volume
78135	Red cell survival study
78140	Red cell survival kinetics
78185	Total body iron estimation
78190	Spleen imaging
78191	Platelet survival, kinetics
78195	Platelet survival
78201	Lymph system imaging
78202	Liver imaging
78205	Liver imaging with flow
78215	Liver image (3d) with flow
78216	Liver and spleen imaging
78220	Liver & spleen image/flow
78223	Liver function study
78230	Hepatobiliary imaging
78231	Salivary gland imaging
78232	Serial salivary imaging
78258	Salivary gland function exam
78261	Esophageal motility study
78262	Gastric mucosa imaging
78264	Gastroesophageal reflux exam
78270	Gastric emptying study
78271	Vit B-12 absorption exam
78272	Vit b-12 absrp exam, int fac
78278	Vit B-12 absorp, combined
78290	GI protein loss exam
78291	Meckel's divert exam
78300	Leveen/shunt patency exam
78305	Bone imaging, limited area
78306	Bone imaging, multiple areas
78315	Bone imaging, whole body
78320	Bone imaging, 3 phase
78428	Bone mineral, dual photon
78445	Cardiac shunt imaging
78456	Venous thrombosis study
78457	Acute venous thrombus image
78458	Venous thrombosis imaging
78460	Ven thrombosis images, bilat
78461	Heart muscle blood, single
78464	Heart muscle blood, multiple
78466	Heart image (3d), single
78468	Heart infarct image
78469	Heart infarct image (ef)
78472	Heart infarct image (3D)
78473	Gated heart, planar, single
78478	Gated heart, multiple
78480	Heart wall motion add-on
78481	Heart function add-on
78483	Heart first pass, single
78494	Heart first pass, multiple
78496	Heart image, spect
78580	Heart first pass add-on
78584	Lung perfusion imaging
78585	Lung V/Q image single breath
78586	Lung V/Q imaging
78587	Aerosol lung image, single
78588	Aerosol lung image, multiple
78591	Perfusion lung image
78593	Vent image, 1 breath, 1 proj
78594	Vent image, 1 proj, gas
78596	Vent image, mult proj, gas

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ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
78601	Brain imaging, ltd static
78605	Brain imaging, ltd w/flow
78606	Brain imaging, complete
78610	Brain imaging (3D)
78615	Brain flow imaging only
78630	Cerebral vascular flow image
78635	Cerebrospinal fluid scan
78645	CSF ventriculography
78650	Cerebrospinal fluid scan
78660	CSF leakage imaging
78700	Nuclear exam of tear flow
78701	Kidney imaging, static
78704	Kidney imaging with flow
78707	Imaging renogram
78708	Kidney flow/function image
78709	Kidney flow/function image
78710	Kidney flow/function image
78715	Kidney imaging (3D)
78725	Renal vascular flow exam
78730	Kidney function study
78740	Urinary bladder retention
78760	Ureteral reflux study
78761	Testicular imaging
78800	Testicular imaging/flow
78801	Tumor imaging, limited area
78802	Tumor imaging, mult areas
78804	Tumor imaging (3D)
78805	Tumor imaging, whole body
78806	Abscess imaging, ltd area
78890	Nuclear localization/abscess
78891	Nuclear medicine data proc
85396	Nuclear joint therapy
88125	TB tine test
88141	Forensic cytopathology
88348	Cytopath, c/v, interpret
88349	Electron microscopy
90865	Sample stomach contents
90870	Narcosynthesis
90875	Electroconvulsive therapy
90876	Psychophysiological therapy
90885	Hypnotherapy
91000	Psy evaluation of records
91010	Esophageal intubation
91011	Esophagus motility study
91012	Esophagus motility study
91020	Esophagus motility study
91030	Gastric motility
91052	Prolonged acid reflux test
91055	Gastric analysis test
91060	Gastric intubation for smear
91065	Gastric saline load test
91100	Breath hydrogen test
91105	Pass intestine bleeding tube
91122	Gastric intubation treatment
91123	Anal pressure record
91132	Irrigate fecal impaction
91133	Electrogastrography
92325	Prescription of contact lens
92326	Modification of contact lens
92354	Fitting of artificial eye
92355	Special spectacles fitting
92358	Special spectacles fitting
92371	Eye prosthesis service

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
92392	Repair & adjust spectacles
92393	Supply of low vision aids
92395	Supply of artificial eye
92512	Supply of contact lenses
92516	Nasal function studies
92547	Facial nerve function test
92548	Supplemental electrical test
92565	Posturography
92571	Stenger test, pure tone
92572	Filtered speech hearing test
92573	Staggered spondaic word test
92575	Lombard test
92576	Sensorineural acuity test
92577	Synthetic sentence test
92579	Stenger test, speech
92582	Visual audiometry (vra)
92583	Conditioning play audiometry
92584	Select picture audiometry
92585	Electrocochleography
92586	Auditor evoke potent, compre
92587	Auditor evoke potent, limit
92588	Evoked auditory test
92596	Evoked auditory test
92950	Oral speech device eval
92975	Cardioassist, external
93012	Dissolve clot, heart vessel
93014	Transmission of ecg
93224	Cardiac drug stress test
93225	ECG monitor/report, 24 hrs
93226	ECG monitor/record, 24 hrs
93227	ECG monitor/report, 24 hrs
93230	ECG monitor/review, 24 hrs
93231	ECG monitor/report, 24 hrs
93232	Ecg monitor/record, 24 hrs
93235	ECG monitor/report, 24 hrs
93236	ECG monitor/report, 24 hrs
93237	ECG monitor/report, 24 hrs
93268	ECG monitor/review, 24 hrs
93270	ECG record/review
93271	ECG recording
93272	Ecg/monitoring and analysis
93278	Ecg/review, interpret only
93318	Echo transesophageal
93501	Echo transesophageal intraop
93505	Right heart catheterization
93508	Biopsy of heart lining
93510	Cath placement, angiography
93526	Left heart catheterization
93555	R & l heart cath, congenital
93556	Imaging, cardiac cath
93609	Heart flow reserve measure
93613	Map tachycardia, add-on
93660	Electrophys map 3d, add-on
93721	Tilt table evaluation
93724	Plethysmography tracing
93727	Analyze pacemaker system
93731	Analyze ilr system
93732	Analyze pacemaker system
93734	Analyze pacemaker system
93735	Analyze pacemaker system
93741	Analyze pacemaker system
93742	Analyze ht pace device sngl
93743	Analyze ht pace device sngl

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
93744	Analyze ht pace device dual
93798	Cardiac rehab
93980	Cardiac rehab/monitor
93981	Penile vascular study
94070	Review patient spirometry
94450	CO2 breathing response curve
94770	Pulmonary compliance study
95044	Breath recording, infant
95052	Allergy patch tests
95056	Photo patch test
95070	Photosensitivity tests
95180	Ingestion challenge test
95250	Rapid desensitization
95806	Multiple sleep latency test
95819	Sleep study, attended
95824	Eeg, awake and asleep
95824	Eeg, cerebral death only
95827	Eeg, cerebral death only
95858	Tensilon test
95869	Tensilon test & myogram
95872	Muscle test, thor paraspinal
95920	Limb exercise test
95925	Intraop nerve test add-on
95926	Somatosensory testing
95927	Somatosensory testing
95930	Somatosensory testing
95936	Visual evoked potential test
95957	Eeg monitoring, cable/radio
95958	EEG digital analysis
95961	EEG monitoring/function test
95962	Electrode stimulation, brain
95970	Meg, evoked, each add'l
95971	Analyze neurostim, no prog
95972	Analyze neurostim, simple
95973	Analyze neurostim, complex
95974	Analyze neurostim, complex
95975	Cranial neurostim, complex
96902	Ultraviolet light therapy
99026	Wound(s) care, selective
99027	In-hospital on call service
99170	Out-of-hosp on call service
99175	Anogenital exam, child
99183	Induction of vomiting
99217	Total body hypothermia
99218	Observation care discharge
99219	Observation care
99220	Observation care
99221	Observation care
99222	Initial hospital care
99223	Initial hospital care
99231	Initial hospital care
99232	Subsequent hospital care
99233	Subsequent hospital care
99234	Subsequent hospital care
99235	Observ/hosp same date
99236	Observ/hosp same date
99238	Observ/hosp same date
99239	Hospital discharge day
99251	Office consultation
99252	Initial inpatient consult
99253	Initial inpatient consult
99254	Initial inpatient consult
99255	Initial inpatient consult

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ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
99261	Initial inpatient consult
99262	Follow-up inpatient consult
99263	Follow-up inpatient consult
99271	Follow-up inpatient consult
99272	Confirmatory consultation
99273	Confirmatory consultation
99274	Confirmatory consultation
99275	Confirmatory consultation
99281	Confirmatory consultation
99282	Emergency dept visit
99283	Emergency dept visit
99284	Emergency dept visit
99285	Emergency dept visit
99288	Emergency dept visit
99289	Direct advanced life support
99290	Ped crit care transport
99291	Ped crit care transport addl
99292	Critical care, first hour
99293	Critical care, add'l 30 min
99294	Ped critical care, initial
99295	Ped critical care, subseq
99296	Neonate crit care, initial
99298	Neonate critical care subseq
99299	Ic for lbw infant < 1500 gm
99301	Ic, lbw infant 1500-2500 gm
99302	Nursing facility care
99303	Nursing facility care
99311	Nursing facility care
99312	Nursing fac care, subseq
99313	Nursing fac care, subseq
99315	Nursing fac care, subseq
99316	Nursing fac discharge day
99321	Nursing fac discharge day
99322	Rest home visit, new patient

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
99323	Rest home visit, new patient
99331	Rest home visit, new patient
99332	Rest home visit, est pat
99333	Rest home visit, est pat
99341	Rest home visit, est pat
99342	Home visit, new patient
99343	Home visit, new patient
99344	Home visit, new patient
99345	Home visit, new patient
99347	Home visit, new patient
99348	Home visit, est patient
99349	Home visit, est patient
99350	Home visit, est patient
99354	Home visit, est patient
99355	Prolonged service, office
99356	Prolonged service, office
99357	Prolonged service, inpatient
99358	Prolonged service, inpatient
99359	Prolonged serv, w/o contact
99360	Prolonged serv, w/o contact
99361	Physician standby services
99362	Physician/team conference
99371	Physician/team conference
99372	Physician phone consultation
99373	Physician phone consultation
99374	Physician phone consultation
99375	Home health care supervision
99377	Home health care supervision
99378	Hospice care supervision
99379	Hospice care supervision
99380	Nursing fac care supervision
99381	Nursing fac care supervision
99382	Prev visit, new, infant
99383	Prev visit, new, age 1-4

ADDENDUM C.—CODES FOR WHICH WE RECEIVED PEAC RECOMMENDATIONS ON PRACTICE EXPENSE DIRECT COST INPUTS—Continued

CPT code	Short descriptors
99384	Prev visit, new, age 5-11
99385	Prev visit, new, age 12-17
99386	Prev visit, new, age 18-39
99387	Prev visit, new, age 40-64
99391	Prev visit, new, 65 & over
99392	Prev visit, est, infant
99393	Prev visit, est, age 1-4
99394	Prev visit, est, age 5-11
99395	Prev visit, est, age 12-17
99396	Prev visit, est, age 18-39
99397	Prev visit, est, age 40-64
99401	Prev visit, est, 65 & over
99402	Preventive counseling, indiv
99403	Preventive counseling, indiv
99404	Preventive counseling, indiv
99411	Preventive counseling, indiv
99412	Preventive counseling, group
99420	Preventive counseling, group
99431	Health risk assessment test
99432	Initial care, normal newborn
99433	Newborn care, not in hosp
99435	Normal newborn care/hospital
99436	Newborn discharge day hosp
99440	Attendance, birth
99450	Newborn resuscitation
99455	Life/disability evaluation
99456	Disability examination

Some of these codes have previously been refined and additional refinements were made by the PEAC.

All anesthesia codes were reviewed with the exception of 00104 abd 00124.

ADDENDUM D.—PROPOSED CHANGES TO PRACTICE EXPENSE EQUIPMENT DESCRIPTION, LIFE, AND PRICING

Equip code	2004 practice expense equipment details			2005 practice expense supply details (proposed)			
	Description	Life	Price	Description	Life	Price	Equipment category
E54006	22 channel EEG (split to separate systems)	7.0	$44,310.00	EEG, digital, prolonged testing system (computer w-remote camera).	7	$46,750.00	Other Equipment
E54006	22 channel EEG (split to separate systems)	7.0	$44,310.00	EEG, digital, standard testing system (computer hardware & software).	7	$21,000.00	Other Equipment
E54004 +	22 channel EMG-EP machine	7.0	$66,650.00	EMG-NCV-EP system, 8 channel	10	$59,500.00	Other Equipment
E51028	2-D Scanning Densitometer	5.0	$6,000.00	Deleted through PEAC refinement.			No Details
E55002	3 Channel ECG machine	5.0	$4,800.00	ECG, 3-channel	7	$1,845.42	Other Equipment
E55005	3 channel ECG/BP monitor	5.0	$3,895.00	ECG, 3-channel (with SpO2, NIBP, temp, resp).	7	$4,322.50	Other Equipment
E51034	30 cm Water Phantom w/ Manual positioner	5.0	$2,850.00	Deleted through PEAC refinement.			No Details
E50002	35mm camera	5.0	$1,150.00	camera, 35mm system (medical grade)	5	$1,106.50	Documentation
E13623	37*, 60*, 90* degree oven	10.0	$682.00	oven, convection (lab)	10	$640.73	Laboratory
	3-D Phantom	5.0	$1,084.00	phantom, 3-D	10	$1,084.00	Radiology
E51032	3-D Water Scanning Phantom	5.0	$56,000.00	Deleted through PEAC refinement.			No Details
E71025	ABR machine, (Mikolay or Biologic)	7.0	$23,000.00	ABR-auditory brainstem response system	7	$27,000.00	Other Equipment
	Accelerator, 4 MV	5.0	$1,600,000.00	accelerator, 4-6 MV	7	$1,408,491.00	Radiology
	Accelerator, 6 MV	5.0	$1,770,708.00	accelerator, 4-6 MV	7	$1,408,491.00	Radiology
	Accelerator, 18 MV	5.0	$1,741,018.00	accelerator, 6-18 MV	7	$1,832,941.00	Radiology
	Accelerator, 20 MV	5.0					
	accelerator, 6-18 MV	7	$1,832,941.00	Radiology.			
E52020	Acusonic Sequoia C0256	5.0	$250,000.00	ultrasound, echocardiography w-4 transducers (Sequoia C256).	5	$248,000.00	Other Equipment
	Adjustable computer table	7.0	$895.00	table, motorized (for instruments-equipment)	15	$895.00	Furniture
	ADL kit	7.0	$587.00	kit, ADL	10	$586.50	Other Equipment
	ADL kit	10.0	$586.00	kit, ADL	10	$586.50	Other Equipment
	aerosol machine	5.0		Deleted (less than $500)			No Details
	air compressor, safety	10.0	$575.00	air compressor, safety	12	$575.00	Other Equipment
E30026	Albarran bridge	7.5	$975.00	Albarran deflecting bridge, single channel	3	$988.00	Scope
	alternans system, CH2000	8.0	$29,400.00	cardiac monitor w-treadmill (microvolt, CH2000).	10	$32,600.00	Other Equipment
	ambulation kit (canes, walker, mirror, balance board, crutches, safety belt).	10.0	$750.00	kit, ambulation	10	$763.70	Other Equipment
E52015	a-mode ultrasonic biometry unit	5.0	$6,950.00	ultrasonic biometry, A-scan	5	$5,247.50	Other Equipment
	aneroid barometer	5.0	$550.00	barometer, aneroid	7	$587.50	Radiology
E30025	anesthesia machine	7.0	$49,035.00	anesthesia machine (w-vaporizers)	7	$60,000.00	Other Equipment
E51084	angiographic room	5.0	$1,580,000.00	room, angiography	5	$1,386,816.00	Room - Lane
E71010	anomaloscopes - diagnostic	5.0	$10,500.00	anomaloscope, diagnostic (HMC)	10	$6,146.00	Other Equipment
E13116	anoscope & light source	3.0	$550.00	anoscope with light source	3	$657.62	Scope
E51038	Anthropomorphic Phantom	5.0	$8,250.00	Deleted through PEAC refinement.			No Details
E51066	Applicator sets for HDR	5.0	$3,333.00	Deleted through PEAC refinement.			No Details
E51068	Applicator sets for LDR	5.0	$2,723.00	Deleted through PEAC refinement.			No Details
E72001	argon laser	5.0	$45,000.00	laser, argon (w-slit lamp adapter)	5	$32,900.00	Other Equipment
E72002	argon-krypton laser	5.0	$65,000.00	laser, argon-kripton	5	$85,000.00	Other Equipment
E55035	ART signal averaging machine	7.5	$8,250.00	ECG signal averaging system	5	$8,250.00	Other Equipment
	audio system, MRI	10.0	$16,000.00	intercom (incl. master, pt substation, power, wiring).	10	$1,630.00	Other Equipment
E71029	audiometer	7.0	$5,495.00	audiometer, clinical-diagnostic	10	$6,250.00	Other Equipment
E71011	auto lensometer	5.0	$2,095.00	lensometer, auto	7	$2,995.00	Other Equipment
E71026	Autoacustic Emission Equipment	7.0	$7,995.00	OAE-otoacoustic emission system	7	$7,780.00	Other Equipment
E55024	Autobox V6200	8.0	$22,985.00	Vmax 62j (body plethysmograph autobox)	8	$21,055.00	Other Equipment
	automated radio frequency generator	5.0	$30,000.00	radiofrequency generator, TUNA procedure	5	$16,500.00	Other Equipment
E52016	b scan ultrasonography	5.0	$24,975.00	ultrasonic biometry, B-scan	5	$12,500.00	Other Equipment
E13604	balance	7.0	$2,400.00	balance, analytic	10	$4,001.67	Laboratory

ADDENDUM D.—PROPOSED CHANGES TO PRACTICE EXPENSE EQUIPMENT DESCRIPTION, LIFE, AND PRICING—Continued

Equip code	2004 practice expense equipment details			2005 practice expense supply details (proposed)			
	Description	Life	Price	Description	Life	Price	Equipment category
	balance board	10.0	$600.00	balance board	15	$509.66	Other Equipment
	balance master	10.0	$12,500.00	balance assessment-retraining system (Balance Master).	5	$13,500.00	Other Equipment
	balance scales	10.0	$995.00	balance, scale	7	$768.50	Laboratory
	balance, analytic	7.0	$5,570.00	balance, analytic	10	$4,001.67	Laboratory
E51004	basic radiology room	5.0	$150,000.00	room, basic radiology	5	$150,000.00	Room - Lane
E92002	bath tub	10.0	$1,224.00	bath tub	10	$1,150.00	Furniture
	bath, paraffin, institutional	10.0	$3,349.00	paraffin bath, hand-foot (institutional)	7	$2,406.50	Other Equipment
	beat-to-beat bp unit	7.0	$14,900.00	arterial tonometry monitor (Colin Pilot)	7	$14,900.00	Other Equipment
E50005	Bio Impedance Body Weight Analysis Machine.	7.0	$4,490.00	body analysis machine, bioimpedence	10	$2,151.32	Other Equipment
	biohazard hood	10.0	$7,612.00	hood, biohazard	10	$6,884.25	Laboratory
	bladder scanner with cart	5.0	$11,445.00	ultrasound, noninvasive bladder scanner w-cart.	5	$11,450.00	Other Equipment
E72005	Blepharoplasty Tray	4.0	$1,949.53	instrument pack, medium ($1500 and up)	4	$1,500.00	Other Equipment
	body analysis machine, bioimpedence	7.0	$2,700.00	body analysis machine, bioimpedence	10	$2,151.32	Other Equipment
	Body Plethysmography Unit	8.0	$45,000.00	Vmax 22d and 62j (PFT equip, autobox, computer system).	8	$47,930.00	Other Equipment
	bone drill system, surgical, small bone (Stryker).	4.0	$8,979.00	drill system, surgical, small-micro (Stryker)	3	$8,979.00	Other Equipment
	bone saw, electric (Stryker)	7.5	$6,080.00	saw, surgical, electric (Stryker)	10	$6,080.00	Other Equipment
	BTE primus	10.0	$45,820.00	rehab and testing system (BTE primus)	5	$45,820.00	Other Equipment
	CAD processor unit	8.0	$210,000.00	CAD processor unit (mammography)	5	$210,000.00	Documentation
	Calibrated Chamber	5.0	$500.00	calibration (AAPM ADCL), ion chamber	5	$500.00	Radiology
	Calibration Computer with Software	5.0	$5,500.00	electrometer, PC-based, dual channel	5	$5,675.00	Radiology
	calibration equipment	5.0	$5,000.00	electrometer, PC-based, dual channel	5	$5,675.00	Radiology
	caloric irrigator	7.0	$4,875.00	caloric stimulator, air or water	7	$5,950.00	Other Equipment
E55017	camera (autoswitching) with 16X zoom lens	5.0	$6,300.00	camera, remote-autoswitching	5	$5,250.00	Documentation
	camera, retinal topcon	5.0	$78,000.00	camera, retinal (TRC 50IX, w-ICG, filters, motor drives).	5	$37,000.00	Documentation
E13611	carbon coater	7.5	$6,200.00	Deleted (part of new system)			No Details
	cardiac gating device	5.0	$40,000.00	ECG R-wave trigger (gating) device	7	$5,671.00	Other Equipment
E55016	cardiac monitor - 12 lead- stress test monitor and treadmill.	5.0	$18,726.00	cardiac monitor w-treadmill (12-lead PC-based ECG).	10	$14,271.03	Other Equipment
E53005	Cardiac Nuclear Camera System	7.5	$675,000.00	camera system, cardiac, nuclear	5	$675,000.00	Documentation
E55018	cardiac output monitor	7.5	$22,790.00	ICG monitoring system (impedance cardiography).	5	$28,625.00	Other Equipment
E53003	Cardiac Phantom	7.5	$3,990.00	phantom, SPECT with cardiac insert	10	$3,042.00	Radiology
E53026	Cardiofocal Collimators (1Set)	5.0	$29,990.00	collimator, cardiofocal set	7	$29,990.00	Radiology
	cardio-pulmonary stress testing system	8.0	$58,751.00	Vmax 29c (cardio-pulm stress test equip, treadmill, computer system).	8	$58,751.00	Other Equipment
	cardio-respiratory monitor	5.0	$12,000.00	ECG, 3-channel (with SpO2, NIBP, temp, resp).	7	$4,322.50	Other Equipment
	cart heating pan, Splint-Form 2000	10.0	$790.00	water bath, thermoplastic softener (20in x 12in).	7	$722.36	Radiology
	cart, laboratory	10.0	$585.00	cart, laboratory	10	$677.83	Furniture
	cast cart	10.0	$5,000.00	cast cart	10	$3,808.00	Other Equipment
E30022	cast cutter	7.0	$1,295.00	cast cutter	10	$1,160.62	Other Equipment
	cast table	10.0	$25,000.00	casting table attachment, hip-spica cast	10	$4,099.00	Furniture
	cast vacuum	7.0	$1,476.00	cast vacuum	8	$1,475.50	Other Equipment
	casting frame	10.0	$12,500.00	casting table attachment, Risser	10	$2,538.00	Furniture
E72007	Cataract Tray	4.0	$11,261.33	Deleted through PEAC refinement.			No Details

E71112	Central (Pod) Equipment Lane	7.0	$30,442.01	lane, central pod (oph)	7	$23,029.00	Room - Lane
E13656	centrifuge	7.0	$3,250.00	centrifuge (with rotor)	7	$4,291.65	Laboratory
	Cerrobend melting pots	7.0	$1,500.00	alloy melter, digital, 3 gallon	7	$1,393.00	Radiology
E53046	Cesium 137 sources (6-10mg, 6-15mg, 6-20 mg, 2-25mg, 2-5mg) 3m.	7.0	$43,580.00	Deleted through PEAC refinement.	.....	.....	No Details
	chair, medical recliner (chemo, phlebotomy)	10.0	$829.03	chair, medical recliner	10	$829.03	Furniture
	chair, phlebotomy-injection	10	1200	chair, medical recliner	10	$829.03	Furniture
E91004	Chemo couch	10.0	$895.00	chair, medical recliner	10	$829.03	Furniture
E51086	chest room	5.0	$200,000.00	Deleted through PEAC refinement.	.....	.....	No Details
E30007	CO2 laser	5.0	$42,500.00	laser, CO2 (Star X)	5	$7,795.00	Other Equipment
E55025	CO2 monitor	7.0	$7,495.00	CO2 respiratory profile monitor	7	$7,995.00	Other Equipment
E53002	Colbalt-57 sheet flood source	0.5	$2,790.00	Cobalt-57 Flood Source (47cm dia) (10 mCi)	5	$2,243.00	Radiology
E53002	Colbalt-57 sheet flood source	7.5	$2,790.00	Cobalt-57 Flood Source (47cm dia) (10 mCi)	5	$2,243.00	Radiology
E53002	Colbalt-57 sheet flood source	8.0	$2,790.00	Cobalt-57 Flood Source (47cm dia) (10 mCi)	5	$2,243.00	Radiology
E13110	colonoscope, video (SPLIT: scope and video system).	3.0	$54,590.00	videoscope, colonoscopy	3	$23,650.00	Scope
E13401	colposcope	3.0	$4,550.00	colposcope	8	$3,946.67	Scope
E71013	computer and VDT and software	5.0	$9,000.00	computer and VDT and software	5	$9,000.00	Documentation
E92013	computerized spinal range of motion device	10.0	$9,995.00	range of motion (spinal) device and software (Myo-Logic).	5	$7,995.00	Other Equipment
E71014	corneal topography unit	5.0	$17,950.00	topography unit, corneal (Magellan)	7	$13,495.00	Other Equipment
	CPAP/BiPAP remote clinical unit	7.0	.....	CPAP/BiPAP remote clinical unit	7	.....	Other Equipment
E13609	critical point dryer	10.0	$8,000.00	Deleted through PEAC refinement.	.....	.....	No Details
E30015	cryostat	7.0	$13,950.00	cryostat	7	$17,197.50	Other Equipment
E30014	cryostat knife sharpener	7.0	$6,234.00	microtome sharpener	10	$6,400.00	Radiology
	cryosurgery equipment package	7.5	$2,750.00	cryosurgery equipment (for liquid nitrogen) ...	10	$2,394.30	Other Equipment
	cryosurgery system, non-ophthalmic	7.5	$1,608.00	cryosurgery system, non-ophthalmic	10	$1,607.50	Other Equipment
	cryosurgery system, ophthalmic	7.5	$5,245.00	cryosurgery system, ophthalmic	7	$5,245.00	Other Equipment
	cryo-thermal unit	7.5	.....	cryo-thermal unit	10	.....	Other Equipment
	csf shunt reprogramming device (hand-held)	5.0	$1,500.00	CSF shunt programmer unit	7	$2,392.00	Other Equipment
E51082	CT Room	5.0	$1,000,000.00	room, CT	5	$981,045.00	Room - Lane
E51018	CT-Based Virtual Simulator	5.0	$900,000.00	IMRT CT-based simulator	5	$975,000.00	Radiology
E13657	cytology thin prep processor	7.5	$35,000.00	cytology thinlayer processor (ThinPrep)	7	$54,000.00	Laboratory
E51054	Daily Output QA Device, RMI (RBA-5)	5.0	$5,795.00	Deleted through PEAC refinement.	.....	.....	No Details
E13658	dark field microscope	7.0	$4,500.00	microscope, polarized (dark field)	7	$5,374.50	Laboratory
	data acquisition beat-to-beat analysis system	7.0	$14,496.00	arterial tonometry acquisition system (WR Testworks).	7	$14,500.00	Other Equipment
	data acquisition/q-sart recording system	7.0	$22,228.00	QSART acquisition system (Q-Sweat)	5	$28,000.00	Other Equipment
	decloaking chamber	7.5	$875.00	decloaking chamber (DC2002)	7	$1,249.00	Laboratory
	decloaking chamber (DC2002)	7.5	$1,249.00	decloaking chamber (DC2002)	7	$1,249.00	Laboratory
E71001	dedicated slit lamp for argon laser	10.0	$6,561.00	slit lamp (Haag-Streit), dedicated to laser use.	10	$7,435.00	Other Equipment
	defibrillator	5.0	.....	defibrillator	5	$2,853.33	Other Equipment
	DELETED	.....	.....	Deleted through PEAC refinement.	.....	.....	No Details
E51078	Dental X-ray	5.0	$80,000.00	Deleted through PEAC refinement.	.....	.....	No Details
	dermatome	5.0	$4,030.00	dermatome, electric	10	$4,399.00	Other Equipment
E71102	Designed for Vision loupes	7.0	$600.00	loupes, standard, up to 3.5x	7	$836.67	Other Equipment
E53036	Detector (Probe)	5.0	$14,000.00	Detector (Probe)	5	$14,000.00	Radiology
E51010	DEXA Unit Dual Energy X-ray Absorptiometry.	5.0	$49,500.00	densitometry unit, whole body, DXA	5	$41,000.00	Radiology
	dialysis access flow monitor	5.0	$10,000.00	dialysis access flow monitor	5	$10,000.00	Other Equipment
E13659	diamond knife	10.0	$3,100.00	diamond knife (4.0-4.4mm) (electron microscopy).	7	$3,400.00	Laboratory
E13660	diamond knife resharpener	7.0	$1,795.00	Deleted through PEAC refinement.	.....	.....	No Details
E52002	diasonic software	5.0	$35,000.00	fetal monitor software	5	$35,000.00	Other Equipment
E71015	diathermy machine	5.0	$3,120.00	diathermy, short wave (AutoTherm 395)	10	$8,185.00	Other Equipment
E71015	diathermy machine	5.0	$10,000.00	diathermy, short wave (AutoTherm 395)	10	$8,185.00	Other Equipment
	differential analyzer	7.0	$38,500.00	differential analyzer, hematology	7	$37,216.67	Laboratory
	differential counter, hematology	7.0	$1,238.00	differential tally counter, 12-channel	5	$672.73	Laboratory

ADDENDUM D.—PROPOSED CHANGES TO PRACTICE EXPENSE EQUIPMENT DESCRIPTION, LIFE, AND PRICING—Continued

Equip code	2004 practice expense equipment details			2005 practice expense supply details (proposed)			
	Description	Life	Price	Description	Life	Price	Equipment category
E52007	Digital Aquisition Unit (Nova Microsonics Image Vue DCR or TomTec Freeland P90).	5.0	$29,900.00	ultrasound, echocardiography digital acquisition (Novo Microsonics, TomTec).	5	$29,900.00	Other Equipment
	digital camera	5.0	$800.00	camera, digital (6 mexapixel)	5	$946.16	Documentation
E51020	Digital Camera	5.0	$300,000.00	Deleted through PEAC refinement.	.....	.....	No Details
	digital camera package	5.0	$3,060.00	camera, digital system, 12 megapixel (medical grade).	5	$3,570.98	Documentation
E13113	digitrapper (24-hr ambulatory pH monitor by Cynectics).	10.0	$9,685.00	pH recorder, 24-hr ambulatory (Digitrapper)	5	$6,900.00	Other Equipment
	discogram pressure monitor	7.0	.....	discogram pressure monitor	7	$600.00	Other Equipment
	dissecting instrument kit	5.0	$596.00	instrument pack, basic ($500-$1499)	4	$500.00	Other Equipment
	DNA image analyzer (ACIS)	7.0	$200,000.00	DNA image analyzer (ACIS)	7	$200,000.00	Laboratory
	DNA image analyzer (ACIS)	7.5	$200,000.00	DNA image analyzer (ACIS)	7	$200,000.00	Laboratory
E30016	doppler	5.0	$1,350.00	doppler (fetal or vascular)	5	$708.22	Other Equipment
	dose calibration source vial set (Cs137, Co57, and Ba137).	5.0	$1,159.00	dose calibration source vial set (Cs137, Co57, and Ba137).	5	$1,159.00	Radiology
E51064	Dose Callibrator w/ Lead Glass Sheild & Ce-137 Standard.	5.0	$6,000.00	dose calibrator (Atomlab)	5	$5,496.67	Radiology
	Dosimetry software	5.0	$21,000.00	radiation therapy dosimetry software (Argus QC).	5	$21,000.00	Radiology
E53034	Dual Photon Densitometer/Computer	5.0	$65,000.00	densitometry unit, whole body, DPA	5	$65,000.00	Radiology
	dust extractor	10.0	$1,982.00	dust extractor	8	$500.00	Other Equipment
	Dynavox/Dynamyte Wireless Backup and computer backup.	7.0	$549.00	augmentative communication - DynaBeam access w-memory backup.	7	$604.00	Other Equipment
	Dynovox 3100	7.0	$6,995.00	augmentative communication - DynaVox 3100.	7	$7,295.00	Other Equipment
E55009	ECG Burdick EK-10	7.0	$1,985.50	ECG, 1-channel (Burdick)	7	$1,506.00	Other Equipment
	EECP system	5.0	$180,000.00	EECP, external counterpulsation system	7	$150,000.00	Other Equipment
E11015	electric bed	12.0	$2,024.00	bed, hospital, electric	12	$1,746.52	Furniture
E11010	electric table	15.0	$935.71	table, motorized (for instruments-equipment).doc.	15	$895.00	Furniture
E30005	electrocautery	7.0	$995.00	electrocautery-hyfrecator, up to 45 watts	10	$975.08	Other Equipment
	electrogastrography machine system	10.0	$20,750.00	EGG monitoring system	7	$32,900.00	Other Equipment
	electro-oculography machine	10.0	$50,000.00	EOG, ERG, VEP electrodiagnostic unit	7	$33,500.00	Other Equipment
	electro-retinography machine	10.0	$50,000.00	EOG, ERG, VEP electrodiagnostic unit	7	$33,500.00	Other Equipment
E30008	electro-surgical device	7.0	$1,225.00	electrosurgical generator, up to 120 watts	7	$1,838.42	Other Equipment
E13641	embedding station	8.0	$8,200.00	tissue embedding center	8	$9,096.67	Laboratory
	EMG biofeedback continence training system (Pathway CTS2000).	5.0	$11,750.00	EMG biofeedback continence training system (Pathway CTS2000).	8	$11,750.00	Other Equipment
E54012	EMG botox	7.0	$1,500.00	EMG botox	7	$1,500.00	Other Equipment
E54007	EMG Machine	7.0	$21,157.50	EMG-NCV-EP system, 2-4 channel	10	$18,288.63	Other Equipment
	EMG, surface system (OT, PT, clinician) (Therapist System).	7.0	$10,995.00	EMG, surface system (OT, PT, clinician) (Therapist System).	8	$9,995.00	Other Equipment
E13118	endoscope, rigid, cystoscopy	3.0	$3,365.00	endoscope, rigid, cystoscopy	3	$3,394.00	Scope
E13402	endoscope, rigid, hysteroscopy	3.0	$8,878.00	endoscope, rigid, hysteroscopy	3	$4,990.50	Scope
	endoscope, rigid, laryngoscopy	3.0	$5,080.00	endoscope, rigid, laryngoscopy	3	$3,095.67	Scope
	endoscope, rigid, otology	3.0	$2,456.88	endoscope, rigid, otology	7	$2,456.88	Scope
	endoscope, rigid, sigmoidoscopy	3.0	$841.00	endoscope, rigid, sigmoidoscopy	3	$841.38	Scope
E13126	endoscope, rigid, sinoscopy	3.0	$5,080.00	endoscope, rigid, sinoscopy	7	$2,414.17	Scope
	endoscope, rigid, sinoscopy	3.0	$5,080.00	endoscope, rigid, sinoscopy	7	$2,414.17	Scope
E11005	endoscopy stretcher	10.0	$1,010.00	stretcher, endoscopy	10	$2,414.00	Furniture
E71027	ENG Recorder	7.0	$19,900.00	ENG recording system	5	$19,900.00	Other Equipment

	environmental module - car	10.0	$30,000.00	environmental module - car	15	$33,750.00	Room - Lane
	environmental module - kitchen	10.0	$50,000.00	environmental module - kitchen	15	$56,250.00	Room - Lane
	environmental module - the workshop	10.0	$20,000.00	environmental module - the workshop	15	$22,500.00	Room - Lane
	ergonomic kit	10.0	$2,285.00	kit, ergonomic (office)	10	$2,285.48	Other Equipment
E13114	esophogeal motility monitor (physiograph)	10.0	$22,865.00	Deleted through PEAC refinement.	.....	.....	No Details
	evaluation system for upper extremity/hand	10.0	$16,500.00	evaluation system for upper extremity-hand (Greenleaf).	5	$17,495.00	Other Equipment
	exam chair, reclining	15.0	$1,000.00	chair, medical recliner	10	$829.03	Furniture
E30006	exam lamp	10.0	$1,850.00	light, exam	10	$1,630.12	Other Equipment
E71109	Exam Lane	7.0	$31,046.15	lane, exam (oph)	7	$30,453.33	Room - Lane
E11001	exam table	15.0	$1,360.00	table, exam	15	$1,338.17	Furniture
	exercise kit aquatic (boots, fins, gloves,weights, cuffs, spine safety board).	5.0	$500.00	kit, aquatic exercise	10	$500.00	Other Equipment
	exercise staircase	10.0	$870.00	stairs, ambulation training	15	$793.67	Other Equipment
	exercise staircase	15.0	$870.00	stairs, ambulation training	15	$793.67	Other Equipment
E71016	external 35 mm camera with medical lenses	5.0	$10,795.00	camera, 35mm system (medical grade)	5	$1,106.50	Documentation
E51062	External Microwave Applicators (set of 5), BSD.	10.0	$7,250.00	Deleted through PEAC refinement.	.....	.....	No Details
	Farmer Chamber	5.0	$1,500.00	chamber, Farmer-type	7	$1,169.38	Radiology
E71002	Farnsworth-Munsell 100-Hue Test or Nagel anomoscoope, McBeth light.	7.5	$556.00	Farnsworth-Munsell 100-Hue color vision test w/software.	7	$626.50	Other Equipment
E13404	fetal monitor	5.0	$9,435.00	fetal monitor	5	$5,415.95	Other Equipment
E11006	fiberoptic exam light (combine with source)	10.0	$608.75	light, fiberoptic headlight w-source	5	$1,992.92	Other Equipment
E13123	fiberscope, flexible, bronchoscopy	3.0	$9,700.00	fiberscope, flexible, bronchoscopy	3	$14,175.00	Scope
	fiberscope, flexible, bronchoscopy	3.0	$14,175.00	fiberscope, flexible, bronchoscopy	3	$14,175.00	Scope
	fiberscope, flexible, bronchoscopy w-forceps (SPLIT: Scope/Forceps).	3.0	$10,943.33	fiberscope, flexible, bronchoscopy	3	$14,175.00	Scope
	fiberscope, flexible, cystoscopy	3.0	$7,410.00	fiberscope, flexible, cystoscopy	3	$7,408.33	Scope
E13117	fiberscope, flexible, cystoscopy, with light source.	3.0	$7,760.00	fiberscope, flexible, cystoscopy, with light source.	3	$9,082.50	Scope
E13124	fiberscope, flexible, rhinolaryngoscopy	3.0	$5,080.00	fiberscope, flexible, rhinolaryngoscopy	3	$6,301.93	Scope
	fiberscope, flexible, rhinolaryngoscopy	3.0	$5,080.00	fiberscope, flexible, rhinolaryngoscopy	3	$6,301.93	Scope
E13101	fiberscope, flexible, sigmoidoscopy	3.0	$5,803.00	fiberscope, flexible, sigmoidoscopy	3	$5,803.33	Scope
	fiberscope, flexible, sigmoidoscopy	3.0	$5,803.00	fiberscope, flexible, sigmoidoscopy	3	$5,803.33	Scope
E13121	fiberscope, flexible, ureteroscopy	3.0	$12,920.00	fiberscope, flexible, ureteroscopy	3	$12,595.00	Scope
	film alternator	10.0	$30,000.00	film alternator (motorized film viewbox)	10	$27,500.00	Radiology
	Film Densitometer	5.0	$1,580.00	densitometer, film	5	$1,435.00	Radiology
	film dosimetry equipment for IMRT	5.0	$28,500.00	film dosimetry equipment-software (RIT)	5	$30,840.00	Radiology
	film printer, laser	5.0	$45,000.00	film processor, dry, laser	8	$69,950.00	Documentation
	film processor, precision calibrated	8.0	$25,000.00	film processor, wet	8	$26,325.00	Documentation
	fistula probes, set of 4	5.0	$560.00	Deleted (less than $500)	.....	.....	No Details
E13616	flow cytometer	5.0	$11,000.00	flow cytometer	5	$119,850.00	Laboratory
E13639	fluorescence microscope	7.0	$12,000.00	microscope, fluorescence	7	$9,468.48	Laboratory
E51070	Fluroscopic unit, Mobile C-Arm	5.0	$205,000.00	fluoroscopic system, mobile C-Arm	8	$73,000.00	Radiology
	food models	5.0	$700.00	food models	4	$700.00	Other Equipment
E30021	foot & ankle surgery instrument pack	4.0	$1,530.40	instrument pack, medium ($1500 and up)	4	$1,500.00	Other Equipment
	forceps, biopsy	4.0	$1,310.00	endoscope forceps, biopsy	3	$1,243.33	Scope
	forceps, grasping	4.0	$735.00	endoscope forceps, grasping	3	$745.67	Scope
E71103	full diameter trial lens set	7.5	$1,180.00	lens set, trial, full diameter, w-frame	10	$904.93	Other Equipment
E13613	fume hood	10.0	$6,500.00	hood, fume	15	$4,778.46	Laboratory
	gamma counter, automatic	7.5	$17,900.00	gamma counter, automatic	7	$17,665.00	Radiology
E71003	Ganzfeld stimulator	10.0	$45,000.00	Ganzfeld stimulator	7	$8,750.00	Other Equipment
	gas cylinders	5.0	$8,000.00	laser gas cylinder (for excimer)	5	$1,140.00	Other Equipment
E13104	gastro cautery unit	7.0	$5,450.00	electrosurgical generator, gastrocautery	7	$11,375.00	Other Equipment
E13106	gastroscope video (SPLIT: scope and video system).	3.0	$52,990.00	videoscope, gastroscopy	3	$21,598.33	Scope
E55022	Gating Device	5.0	$3,625.00	ECG R-wave trigger (gating) device	7	$5,671.00	Other Equipment
	generator, constant current	3.0	$950.00	generator, constant current	20	$950.00	Other Equipment

ADDENDUM D.—PROPOSED CHANGES TO PRACTICE EXPENSE EQUIPMENT DESCRIPTION, LIFE, AND PRICING—Continued

Equip code	2004 practice expense equipment details			2005 practice expense supply details (proposed)			
	Description	Life	Price	Description	Life	Price	Equipment category
	glucose monitor continuous (incl.accessories).	5.0	$2,613.00	glucose continuous monitoring system	5	$2,465.00	Other Equipment
E13666	GLX linear stainer	7.5	$6,995.00	slide stainer, automated, standard throughput.	7	$8,265.64	Laboratory
E13637	grossing station	10.0	$23,391.00	grossing station w-heavy duty disposal	20	$20,175.50	Laboratory
	halogen light (Edit light type)	5.0	$5,080.00	light source, xenon	5	$6,723.33	Other Equipment
	halogen light cable	5.0		Deleted (part of new system)			No Details
	hand dexterity/sensory/strength kit	7.0	$1,407.00	kit, hand dexterity, sensory, strength	10	$1,561.40	Other Equipment
	Hand Held Voice	7.0	$645.00	augmentative communication - Hand Held Voice.	7	$695.00	Other Equipment
	Hand Measurement Kit (dynamometers, goniometers, etc).	7.0	$600.00	kit, hand evaluation	10	$617.65	Other Equipment
	hand-case instrument set	4.0	$2,000.00	instrument pack, medium ($1500 and up)	4	$1,500.00	Other Equipment
E51072	HDR Afterload System, Nucletron - Oldelft	5.0	$375,000.00	HDR Afterload System, Nucletron - Oldelft	7	$375,000.00	Radiology
	headmaster adapters (Accessibility)	5.0	$1,675.00	augmentative communication - HeadMaster w-adapters.	7	$1,695.00	Other Equipment
E53006	Heavy Duty Imaging Table	7.5	$4,550.00	table, imaging	15	$5,188.33	Furniture
	heavy-duty disposer	5.0	$1,506.00	Deleted (part of new system)			No Details
E71037	hilger nerve stimulator	7.5	$1,805.00	Deleted through PEAC refinement.			No Details
E55008	Holter Monitor	7.0	$2,590.00	holter monitor	7	$1,413.43	Other Equipment
E55015	Holter monitor reader	7.0	$14,995.00	holter analysys system	7	$8,815.58	Other Equipment
E55015	Holter monitor reader	7.0	$14,995.00	holter system with one recorder	7	$11,303.90	Other Equipment
	hood, biohazard	10.0	$7,612.00	hood, biohazard	10	$6,884.25	Laboratory
	hot wire cutter, Heustis	7.0	$28,600.00	Huestis block cutting machine w-attachments	15	$22,030.00	Radiology
E92016	Hubbard tank	15.0	$17,000.00	whirlpool (Hubbard tank)	10	$15,195.00	Furniture
E71005	Humphrey field analyzer (or octopus)	7.5	$27,950.00	Humphrey field analyzer	7	$27,000.00	Other Equipment
E92006	hydroculator, cold	10.0	$1,675.00	hydrocollator, cold	10	$1,910.50	Other Equipment
E92007	hydroculator, hot	10.0	$1,265.00	hydrocollator, hot	10	$1,090.17	Other Equipment
E55033	Hydrogen gas analyzer	7.5	$6,117.00	breath hydrogen analyzer (MicroLyzer)	8	$4,895.00	Other Equipment
	hyperbaric chamber	10.0	$125,000.00	hyperbaric chamber	15	$125,000.00	Other Equipment
E13652	image analyzer (CAS system)	5.0	$92,000.00	image analyzer (CAS system)	5	$92,000.00	Laboratory
	Immittance bridge	7.0	$6,900.00	immittance, middle-ear analyzer	10	$4,995.00	Other Equipment
	impedance meter	7.0	$1,312.00	impedance meter, 32-channel	7	$1,120.00	Other Equipment
	IMRT physics tools	5.0	$55,485.00	IMRT physics tools	5	$55,485.00	Radiology
E92012	inclinometer	10.0	$520.00	Deleted (less than $500)			No Details
	incubator	10.0	$795.00	incubator	10	$837.30	Laboratory
E13631	incubator (CO_2)	10.0	$6,000.00	incubator, CO_2 (dry-wall)	10	$5,842.99	Laboratory
	infrared ceiling lamps/temperature control	3.0	$2,000.00	light, infra-red, ceiling mount	10	$555.00	Other Equipment
E30023	infrared coagulator	7.0	$3,550.00	infrared coagulator (with hand applicator)	10	$3,087.50	Other Equipment
	infrared illuminator	7.0	$1,050.00	Deleted (part of new system)			No Details
E91001	infusion pump	10.0	$4,150.00	IV infusion pump	10	$2,384.45	Other Equipment
	INR monitor, home	4.0	$2,000.00	INR monitor, home	5	$2,000.00	Other Equipment
	instrument pack, basic (auricle)	4.0	$500.00	instrument pack, basic ($500-$1499)	4	$500.00	Other Equipment
	instrument pack, basic (EPF)	4.0	$1,200.00	instrument pack, medium ($1500 and up)	4	$1,500.00	Other Equipment
	instrument pack, basic (surgery)	4.0	$500.00	instrument pack, basic ($500-$1499)	4	$500.00	Other Equipment
	instrument pack, medium (ear)	4.0	$1,500.00	instrument pack, medium ($1500 and up)	4	$1,500.00	Other Equipment
	instrument pack, medium (intraoral biopsy)	4.0	$1,500.00	instrument pack, medium ($1500 and up)	4	$1,500.00	Other Equipment
	instrument pack, medium (nasal endoscopy)	4.0	$1,500.00	instrument pack, medium ($1500 and up)	4	$1,500.00	Other Equipment
	instrument pack, medium (nasal)	4.0	$1,500.00	instrument pack, medium ($1500 and up)	4	$1,500.00	Other Equipment
	instrument pack, medium (otology POV)	4.0	$1,500.00	instrument pack, medium ($1500 and up)	4	$1,500.00	Other Equipment
	instrument pack, medium (surgery)	4.0	$1,500.00	instrument pack, medium ($1500 and up)	4	$1,500.00	Other Equipment
E92009	Intellect High Voltage electrical stimulator	10.0	$1,395.00	electrotherapy stimulator, high volt, 2 channel.	7	$1,923.00	Other Equipment

	Intellikeys	7.0	$525.00	augmentative communication - IntelliKeys, Overlay, ClickIt.	7	$560.00	Other Equipment
E92020	Intercom	10.0	$10,000.00	intercom (incl. master, pt substation, power, wiring).	10	$1,630.00	Other Equipment
	intestinal imaging workstation	7.0	$25,400.00	intestinal imaging workstation	5		
	Other Equipment.						
E51042	Ion Chamber Array	5.0	$6,445.00	Deleted through PEAC refinement.			No Details
E71030	iontophoresis machine	7.5	$1,500.00	iontophoresis machine	8	$995.00	Other Equipment
	isoalign device	5.0	$950.00	isocentric beam alignment device	5	$995.00	Radiology
E92014	isokinetic strenghthening equipment	10.0	$29,823.00	exercise equipment (treadmill, bike, stepper, UBE, pulleys, balance board).	15	$12,710.00	Other Equipment
	isokinetic testing equipment	7.0	$45,820.00	rehab and testing system (BTE primus)	5	$45,820.00	Other Equipment
E50003	isokinetometer	10.0	$11,995.00	isokinetic evaluation system (Cybex NORM)	5	$39,900.00	Other Equipment
E91008	IVAC Injection Automatic Pump	5.0	$2,500.00	IVAC Injection Automatic Pump	10	$2,500.00	Other Equipment
E55010	King of Hearts-20 (Instromedix)	7.0	$1,750.00	Deleted through PEAC refinement.			No Details
	kit, capsule endoscopy recorder		$6,950.00	kit, capsule endoscopy recorder	10	$6,950.00	Other Equipment
	lacrimal probes	4.0		Deleted (less than $500)			No Details
	laryngeal injector	4.0	$1,032.00	kit, laryngeal injector	3	$1,032.00	Other Equipment
E13405	laser	5.0	$23,500.00	laser (gs, uro, obg, ge) (Indigo Optima)	5	$59,890.00	Other Equipment
	laser generator	5.0	$54,890.00	laser (gs, uro, obg, ge) (Indigo Optima)	5	$59,890.00	Other Equipment
	laser printer for CT angiography	5.0	$71,400.00	film processor, dry, laser	8	$69,950.00	Documentation
	Laser Targeting System	5.0	$11,625.00	laser targeting system (4 diodes)	5	$10,350.00	Radiology
	laser, ablation (gs, uro, obg, ge) (Indigo Optima).	5.0	$59,890.00	laser (gs, uro, obg, ge) (Indigo Optima)	5	$59,890.00	Other Equipment
	laser, diode, for patient positioning (Probe)	5.0	$7,678.00	laser, diode, for patient positioning (Probe)	5	$7,678.00	Radiology
	laser, excimer	5.0	$155,000.00	laser, excimer	5	$160,000.00	Other Equipment
E53001	lead safe	20.0	$3,375.00	safe, storage, lead-lined	15	$3,850.00	Radiology
E13403	LEEP system	7.0	$4,670.00	electrosurgical system (w-smoke evac) (LEEP, Quantum).	7	$4,283.00	Other Equipment
E55014	life signs receiving center	7.0	$3,800.00	pacemaker receiving software (GEMS Lite)	5	$3,995.00	Other Equipment
	lift, chair and sling	10.0	$3,000.00	lift, hydraulic, chair	10	$4,848.65	Furniture
	lift, hydraulic	10.0	$4,730.00	lift, hydraulic, chair	10	$4,848.65	Furniture
	light for photodynamic therapy, 400MW (BLU-U).	5.0	$15,759.00	light, external PDT, w-probe set (LumaCare)	5	$8,810.00	Other Equipment
E13122	light source (combine with headlight)	3.0	$1,700.00	light, fiberoptic headlight w-source	5	$1,992.92	Other Equipment
	light, infrared	3.0	$500.00	light, infra-red, pole mount	10	$512.50	Other Equipment
	light, ultraviolet	3.0	$630.00	light, ultra-violet	10	$618.22	Other Equipment
E51056	Linear Accelerator - Cliniac-2100	5.0	$1,600,000.00	accelerator, 6-18 MV	7	$1,832,941.00	Radiology
E30010	Liquid Nitro Tank w/ Cryac	10.0	$1,529.00	cryosurgery system, non-ophthalmic	10	$1,607.50	Other Equipment
E30024	lithotriptor	5.0	$1,375,000.00	lithotriptor, with C-arm (ESWL)	5	$440,000.00	Other Equipment
E11001	low mat table	10.0	$5,000.00	table, mat, hi-lo, 6 x 8 platform	15	$4,521.67	Furniture
	low mat table	10.0	$5,000.00	table, mat, hi-lo, 6 x 8 platform	15	$4,521.67	Furniture
	mammatome driver	5.0	$27,750.00	breast biopsy device w-system (Mammotome).	5	$29,862.00	Other Equipment
	mammography cassettes (4)	5.0		Deleted (less than $500)			No Details
E51016	Mammography Room	5.0	$130,000.00	room, mammography	5	$130,000.00	Room - Lane
	mayo stand	7.0	$585.00	mayo stand	15	$530.76	Furniture
E30019	McGrowan ligator/Bander	7.0	$625.00	Deleted through PEAC refinement.			No Details
E92010	mechanical traction	10.0	$2,090.00	traction system (hi-low table, digital unit, accessories).	10	$5,654.83	Other Equipment
	medium energy collimator (siemens 05232868).	5.0	$14,000.00	collimator, medium energy (set of 2)	7	$14,000.00	Radiology
E13608	microprobe EDS x-ray analysis	7.0	$42,500.00	Deleted (part of new system)			No Details
E13662	Microscope camera Konan SP 9000	5.0	$6,995.00	camera system, specular microscope	5	$26,100.00	Laboratory
E13601	microscope, compound	7.0	$11,600.00	microscope, compound	7	$11,621.35	Laboratory
E13606	microscope, dissecting	7.0	$1,700.00	microscope, binocular - dissecting	7	$956.00	Laboratory
E13618	microtome	7.0	$31,500.00	microtome	7	$13,369.00	Radiology
E13619	microtome knife sharpener	7.0	$7,200.00	microtome sharpener	10	$6,400.00	Radiology
	microwave	10.0		diathermy, microwave	10		Other Equipment

ADDENDUM D.—PROPOSED CHANGES TO PRACTICE EXPENSE EQUIPMENT DESCRIPTION, LIFE, AND PRICING—Continued

Equip code	2004 practice expense equipment details			2005 practice expense supply details (proposed)			
	Description	Life	Price	Description	Life	Price	Equipment category
E51060	Microwave Hypothermia System, BSD	10.0	$550,000.00	Deleted through PEAC refinement.			No Details
	mimic/controllers/crane	5.0	$448,680.00	collimator, multileaf system w-autocrane (MIMiC).	7	$355,030.00	Radiology
E72004	Minor Equipment Pack	4.0	$1,082.95	instrument pack, basic ($500-$1499)	4	$500.00	Other Equipment
E72006	Minor Surgical Pack	4.0	$1,596.88	instrument pack, medium ($1500 and up)	4	$1,500.00	Other Equipment
E30020	minor surgical tray	4.0	$572.20	instrument pack, basic ($500-$1499)	4	$500.00	Other Equipment
E53008	Mobile Source Storage Safes	20.0	$3,650.00	Deleted through PEAC refinement.			No Details
E92017	mobolization/manipulation table	10.0	$9,315.00	table, mobolization-manipulation (Lloyd's)	15	$8,195.00	Furniture
	motor coordination kit	10.0	$643.00	kit, motor coordination	10	$643.75	Other Equipment
	Mount/wheel chair	7.0	$830.00	augmentative communication - DynaVox wheelchair mount.doc.	7	$765.00	Other Equipment
E51058	MR Room	5.0	$3,140,000.00	room, MR	5	$1,961,375.00	Room - Lane
	nasal pressure transducer	7.0	$525.00	transducer, pressure, airflow sensor	7	$582.50	Other Equipment
	naturally speaking software, dragon (Accessibility).	5.0	$696.00	augmentative communication - Dragon Naturally-Speaking.	7	$699.95	Other Equipment
E91010	Negative Flow Hood	10.0	$2,000.00	hood, negative flow	15	$2,400.00	Laboratory
E30028	nerve stimulator	7.5	$523.80	nerve stimulator (eg, for nerve block)	7	$572.30	Other Equipment
E12002	neurobehavioral status instrument-average	7.5	$717.00	neurobehavioral status instrument-average	5	$717.00	Other Equipment
	new item			biofeedback equipment	8		Other Equipment
	new item			blood warmer	7	$3,840.00	Other Equipment
	new item			breast biopsy imaging system, stereotactic (imager, table, software).	5	$234,000.00	Other Equipment
	new item			camera, digital system, for electron microscopy.	5	$41,000.00	Documentation
	new item			cell separator system	6	$59,320.00	Other Equipment
	new item			chair, thyroid imaging	10	$2,200.00	Furniture
	new item			CO2 infrared analyzer (COSMO)	7	$4,500.00	Other Equipment
	new item			computer workstation, 3D hyperthermia treatment planning.	5	$98,000.00	Documentation
	new item			computer workstation, 3D radiation treatment planning.	5	$130,216.50	Documentation
	new item			computer workstation, 3D reconstruction CT-MR.	5	$45,926.00	Documentation
	new item			computer workstation, brachytherapy treatment planning.	5	$105,403.00	Documentation
	new item			computer workstation, cardiac cath monitoring.	5	$94,000.00	Documentation
	new item			computer workstation, MRA post processing	5		Documentation
	new item			contrast media warmer	7	$552.00	Other Equipment
	new item			cortical bipolar-biphasic stimulating equipment.	7		Other Equipment
	new item			crash cart (unstocked)	10	$868.50	Furniture
	new item			cryosurgical probe, retina	7	$1,984.00	Other Equipment
	new item			defibrillator w-ECG monitor	5	$3,150.67	Other Equipment
	new item			densitometry unit, peripheral, SXA	5	$22,096.00	Radiology
	new item			densitometry unit, peripheral, ultrasound	5	$13,225.00	Radiology
	new item			dermabrader (Osada)	10	$1,590.00	Other Equipment
	new item			drill, ophthalmology	3		Other Equipment
	new item			EEG analysis software	5	$82,000.00	Other Equipment
	new item			EEG monitor, digital, portable	7		Other Equipment
	new item			electroconvulsive therapy machine	5		Other Equipment

	new item	.....	.....	external fixation, craniofacial halo (BlueDevice).	4	$5,146.00	Other Equipment
	new item	.....	.....	external fixation, mandible (Joe Hall Morris)	4	$4,508.00	Other Equipment
	new item	.....	.....	gamma camera system, single-dual head	5	$406,816.80	Radiology
	new item	.....	.....	hyperthermia system, RF-deep and microwave.	5	$790,353.00	Radiology
	new item	.....	.....	hyperthermia system, ultrasound, external	5	$360,000.00	Radiology
	new item	.....	.....	hyperthermia system, ultrasound, intracavitary.	5	$250,000.00	Radiology
	new item	.....	.....	intracavitary applicator set (tandem and ovoids).	4	$10,321.50	Radiology
	new item	.....	.....	intra-compartmental pressure monitor device	7	$1,737.00	Other Equipment
	new item	.....	.....	lens set, fitting, low vision	10	$4,750.00	Other Equipment
	new item	.....	.....	liposorber system	7	$7,800.00	Other Equipment
	new item	.....	.....	mammography reporting software	5	.....	Documentation
	new item	.....	.....	manometry system (computer, transducers, catheter).	5	$39,400.00	Other Equipment
	new item	.....	.....	micropigmentation (tattoo) system	7	$2,550.00	Other Equipment
	new item	.....	.....	microscope, electron, transmission (TEM)	7	$319,290.00	Laboratory
	new item	.....	.....	microtome, ultra	7	$25,950.00	Radiology
	new item	.....	.....	nuclide rod source set	5	$1,395.00	Radiology
	new item	.....	.....	oximeter, whole blood	5	$6,950.00	Other Equipment
	new item	.....	.....	oxygen system, portable	8	$569.89	Other Equipment
	new item	.....	.....	phantom, mammography-accreditation	10	$674.00	Radiology
	new item	.....	.....	phantom, QCT densitometry	10	$5,464.00	Radiology
	new item	.....	.....	pump, water perfusion (for manometry)	7	$7,307.00	Other Equipment
	new item	.....	.....	radiation L-block tabletop shield	10	$725.00	Radiology
	new item	.....	.....	radiusgauge	7	$1,234.00	Other Equipment
	new item	.....	.....	resectoscope, continuous flow	3	$1,200.00	Scope
	new item	.....	.....	RGP lens modification unit	7	$540.00	Other Equipment
	new item	.....	.....	rhinomanometer system (w-transducers and software).	7	$10,800.00	Other Equipment
	new item	.....	.....	sleep screening system, ambulatory (incl. hardware, software).	5	$14,877.25	Other Equipment
	new item	.....	.....	stepper, stabilizer, template (for brachytherapy treatment).	7	$18,550.00	Radiology
	new item	.....	.....	stirrups (for brachytherapy table)	10	$3,876.00	Radiology
	new item	.....	.....	stretcher chair	10	$3,133.00	Furniture
	new item	.....	.....	table, brachytherapy treatment	15	$28,900.00	Furniture
	new item	.....	.....	table, cystoscopy	15	.....	Furniture
	new item	.....	.....	thyroid uptake system	5	$13,995.00	Radiology
	new item	.....	.....	urethrotome, optical	3	$1,881.00	Scope
	new item	.....	.....	vacuum deposition system (Auto306)	7	$38,070.00	Laboratory
	new item	.....	.....	x-ray, dental, intra-oral	5	$3,869.00	Radiology
	new item	.....	.....	x-ray, dental, panoramic	5	$24,405.00	Radiology
	Non-amplified auditory trainer	7.0	$1,295.00	augmentative communication - auditory trainer.	7	$1,096.00	Other Equipment
E13406	NST, Non Stress Test	5.0	$8,878.00	fetal monitor	5	$5,415.95	Other Equipment
	nuclear pharmacy management software (w-computer and printer) (NMIS).	5.0	$13,400.00	computer workstation, nuclear pharmacy management (hardware and software).	5	$13,400.00	Documentation
	Nucleus Crystal Integrity Testing System	7.0	$9,450.00	cochlear implant testing system	10	$9,500.00	Other Equipment
	Nucleus PCI	7.0	$8,000.00	cochlear implant programming system	7	$9,000.00	Other Equipment
	nutrition therapy software	5.0	$500.00	nutrition therapy software (Nutritionist Pro)	5	$595.00	Other Equipment
E13102	Olympus halogen light	3.0	$950.00	Deleted (part of new system)	.....	.....	No Details
E30013	operating microscope	7.0	$5,400.00	microscope, operating	7	$7,047.50	Other Equipment
E71019	ophthalmic telebinocular	7.5	$1,025.00	telebinocular, ophthalmic	7	$1,014.33	Other Equipment
	optical coherence biometer	5.0	$25,950.00	Deleted through PEAC refinement.	.....	.....	No Details
	optical disk reader	5.0	$4,000.00	optical drive (MO), external	5	$2,050.00	Documentation
	optical fibers	5.0	$3,236.00	laser optical delivery system (for excimer)	5	$1,500.00	Other Equipment

ADDENDUM D.—PROPOSED CHANGES TO PRACTICE EXPENSE EQUIPMENT DESCRIPTION, LIFE, AND PRICING—Continued

Equip code	2004 practice expense equipment details			2005 practice expense supply details (proposed)			
	Description	Life	Price	Description	Life	Price	Equipment category
	Orthovoltage Machine	5.0	$140,000.00	orthovoltage radiotherapy system	5	$140,000.00	Radiology
	OSHA ventilated hood	10.0	$5,000.00	OSHA ventilated hood	15	$5,000.00	Radiology
E13602	osmometer	7.0	$4,595.00	Deleted through PEAC refinement.			No Details
	otoscope-ophthalmoscope	3.0	$505.00	otoscope-ophthalmoscope (wall unit)	10	$694.00	Other Equipment
E54008	Oxford PT recorder	7.0	$6,940.00	EEG recorder, ambulatory	7	$6,940.00	Other Equipment
E54009	Oxford review station	7.0	$44,950.00	EEG review station, ambulatory	5	$44,950.00	Other Equipment
	Oximetry Recorder, overnight/software	5.0	$3,660.00	pulse oxymetry recording software (prolonged monitoring).	5	$3,660.00	Other Equipment
	oxygen concentrator	15.0	$3,806.00	oxygen concentrator (5-6 lpm)	8	$1,035.83	Other Equipment
	oxygen tank	10.0		Deleted (less than $500)			No Details
E55027	Oxygen uptake expired gas analyzer	7.0	$46,000.00	Vmax 229 (PFT equip, computer system)	8	$44,681.00	Other Equipment
	pacemaker follow-up system (e.g. paceart)	7.0	$22,000.00	pacemaker follow-up system (incl software and hardware) (Paceart).	7	$23,507.00	Other Equipment
E71020	pachometer	5.0	$3,650.00	ultrasonic biometry, pachymeter	5	$3,945.00	Other Equipment
E13638	paraffin dispenser	7.5	$995.00	paraffin dispenser (two-gallon)	10	$1,520.00	Laboratory
	paraffin dispenser, 5 gal.	7.0	$1,995.00	paraffin dispenser (five-gallon)	10	$2,222.50	Laboratory
E92011	parallel bars	15.0	$1,755.00	parallel bars, platform mounted	15	$1,670.67	Other Equipment
	PC server	5.0	$25,000.00	computer, server	5	$25,000.00	Documentation
E52003	Pentium computer	5.0	$2,800.00	computer, desktop, w-monitor	5	$2,501.00	Documentation
	percutaneous neuro test stimulator	4.0	$795.00	percutaneous neuro test stimulator	7	$795.00	Other Equipment
	peripheral QCT scanner	5.0	$55,000.00	densitometry unit, peripheral, QCT	5	$79,000.00	Radiology
	pessary stock kit	10.0	$1,824.00	Deleted (less than $500)			No Details
E13603	pH meter	7.0	$1,000.00	pH conductivity meter	10	$1,028.00	Laboratory
	photochemotherapy unit & lamps (200 ea/yr)	5.0	$32,000.00	phototherapy unit, whole body, UVA-UVB	10	$12,975.00	Other Equipment
	photochemotherapy unit, hand/foot combo	5.0	$1,525.00	phototherapy unit, hand-foot, UVA-UVB	10	$1,675.00	Other Equipment
E13620	photographic enlarger	10.0	$15,000.00	photographic enlarger	5	$3,195.00	Documentation
E13621	photographic film processor	10.0	$6,000.00	film processor (electron microscopy)	8	$4,400.00	Laboratory
	physician analysis and viewing station	7.5	$35,000.00	computer workstation, nuclear medicine analysis-viewing.	5	$55,097.00	Documentation
	physician analysis/viewing station	10.0	$35,000.00	computer workstation, nuclear medicine analysis-viewing.	5	$55,097.00	Documentation
	physics support package for intensity modulated radiotherapy.	5.0	$12,500.00	Deleted (weekly training cost)			No Details
E91011	Plasma pheresis machine w/UV light source	7.5	$37,900.00	plasma pheresis machine w/UV light source	6	$37,900.00	Other Equipment
E11009	pneumatic chairs	15.0	$697.60	Deleted (less than $500)			No Details
	pneumatic tourniquet device	5.0		tourniquet system (Zimmer1200)	7	$10,220.00	Other Equipment
	pool cleaner	10.0	$1,500.00	pool cleaner	15	$1,372.15	Other Equipment
E11003	Power Table	7.5	$6,939.00	table, power	10	$6,153.63	Furniture
E11003	Power Table	10.0	$6,939.00	table, power	10	$6,153.63	Furniture
E11003	Power Table	15.0	$6,939.00	table, power	10	$6,153.63	Furniture
E13622	print washer	10.0	$670.00	Deleted through PEAC refinement.			No Details
	Printer (HP)	5.0	$1,200.00	printer, laser, paper	5	$1,199.00	Documentation
	printer, dye, sublimated	5.0	$15,000.00	printer, dye sublimation (photo, color)	5	$2,322.50	Documentation
	printer, laser for CT	5.0	$75,000.00	film processor, dry, laser	8	$69,950.00	Documentation
	printer, laser for CT angiography	5.0	$71,400.00	film processor, dry, laser	8	$69,950.00	Documentation
E51080	Processor (wet or dry)	8.0	$55,000.00	film processor, wet	8	$26,325.00	Documentation
E55011	Programmer: Intermedics	7.0	$10,000.00	Deleted through PEAC refinement.			No Details
E55013	Programmers for Pacemakers	7.0	$10,000.00	programmer, pacemaker	7	$10,000.00	Other Equipment
E55012	Programmers: Medtronic, CPI, Ventritex	7.0	$11,000.00	programmer, for implanted medication pump (spine).	7	$1,975.00	Other Equipment
E55012	Programmers: Medtronic, CPI, Ventritex	7.0	$11,000.00	programmer, neurostimulator (w-printer)	7	$1,975.00	Other Equipment
E54011	Pt. Bedroom Furniture	12.0	$1,824.00	bedroom furniture (hospital bed, table, reclining chair).	12	$2,416.99	Furniture

E30011	pulse dye laser	5.0	$125,000.00	laser, pulse dye	5	$78,500.00	Other Equipment
E55003	pulse oximeter	5.0	$885.00	pulse oximeter w-printer	7	$1,207.18	Other Equipment
	Radiation Source Meter	7.0	$600.00	Deleted through PEAC refinement.			No Details
	Radiation Survey Meter	7.0	$1,117.00	radiation survey meter	8	$756.25	Radiology
	radiofrequency generator (NEURO)	7.0	$32,900.00	radiofrequency generator (NEURO)	5	$32,900.00	Other Equipment
E51005	Radiographic/ fluoroscopic room	5.0	$475,000.00	room, radiographic-fluoroscopic	5	$475,000.00	Room - Lane
E51030	Radiographic/Fluroscopic Evaluation Unit, RMI 4000.	5.0	$15,995.00	Deleted through PEAC refinement.			No Details
	radiopharmaceutical receiving area	5.0	$51,545.00	Deleted (split into separate equipment items)			No Details
E11011	reclining exam chair with headrest	10.0	$4,495.00	chair with headrest, exam, reclining	15	$4,836.33	Furniture
E51022	Record and verify Computer (Varian)	5.0	$60,000.00	computer system, record and verify	5	$60,000.00	Documentation
	remote monitoring service	7.0	$9,500.00	remote monitoring service (neurodiagnostics)	5	$9,500.00	Other Equipment
	respiratory plethysmograph	7.0		Deleted (part of new system)			No Details
	retractor, hand	4.0	$1,566.20	instrument pack, medium ($1500 and up)	4	$1,500.00	Other Equipment
E54010	review master	7.0	$23,500.00	review master	5	$23,500.00	Other Equipment
	review software (e.g. Prosolve)	5.0	$8,000.00	ultrasound, echocardiography analyzer software (ProSolv).	5	$8,000.00	Other Equipment
E52013	Review Station: AG7300 SVHS,17in.	5.0	$899.99	video SVHS VCR (medical grade)	5	$1,250.00	Documentation
E71036	Rhinomenometer	7.5	$3,150.00	Deleted through PEAC refinement.			No Details
E72010	Rigid Bone fixation system	7.5	$20,000.00	Deleted through PEAC refinement.			No Details
E52014	Rigiscan	7.5	$12,500.00	nocturnal penile tumescence monitor (Rigiscan Plus).	7	$9,000.00	Other Equipment
E13642	robotic cover slipper	7.5	$32,288.00	slide coverslipper, robotic	7	$30,143.00	Laboratory
E51087	Roesenthal dosimeter	5.0	$1,995.00	dosimeter, aerosol provocation	10	$1,795.00	Other Equipment
	rotation chair	7.0	$91,059.00	CDP-computerized dynamic posturography system.	7	$86,957.50	Other Equipment
E13643	routine pap stainer	7.0	$20,000.00	slide stainer, automated, high-volume throughput.	7	$14,085.68	Laboratory
	RVS System	7.0	$54,000.00	radiation virtual simulation system	5	$54,000.00	Radiology
E50006	scale, high capacity	10.0	$1,995.00	scale, high capacity (800 lb)	10	$1,726.33	Furniture
	scale, new born electronic	7.0	$1,276.00	scale, new born, digital	15	$1,279.41	Furniture
E13607	scanning electron microscope	7.0	$120,000.00	microscope, electron, scanning (SEM) (with microprobe and x-ray microanalyzer).	7	$178,725.00	Laboratory
	Scanning Laser Device	5.0	$60,000.00	tomographic device, optical coherence (OCT).	7	$49,950.00	Other Equipment
	scope washer	7.0		endoscope disinfector, rigid or fiberoptic, w-cart.	7	$18,802.00	Scope
E71111	Screening Lane	7.0	$28,234.95	lane, screening (oph)	7	$28,463.33	Room - Lane
E54003	Seizure Detection Device	7.0	$21,000.00	EEG, digital, prolonged testing system (computer w-remote camera).	7	$46,750.00	Other Equipment
	sensitometer	5.0	$2,500.00	sensitometer, film	10	$1,050.00	Radiology
	sensory integration equipment	8.0	$3,600.00	sensory integration equip (eg, ball pit, glider, trampoline, ramp).	15	$3,600.00	Other Equipment
	sensory kit	10.0	$677.00	kit, sensory	10	$677.35	Other Equipment
E72008	septoplasty tray	4.0	$725.76	Deleted through PEAC refinement.			No Details
	shock wave machine	5.0	$450,000.00	shock wave system	5	$350,000.00	Other Equipment
E13103	sigmoidoscopic equipment cart	10.0	$3,340.00	cart, endoscopy imaging equipment	10	$2,793.00	Scope
	simple ear instrument pack	4.0		instrument pack, medium ($1500 and up)	4	$1,500.00	Other Equipment
	simple ear instrumentation pack	4.0		instrument pack, medium ($1500 and up)	4	$1,500.00	Other Equipment
	Simulator, Varian	5.0	$595,000.00	IMRT x-ray-fluoroscopic-based simulator	5	$598,120.00	Radiology
E51024	Simulator, Ximatron CF w/last Image hold	5.0	$450,000.00	Deleted through PEAC refinement.			No Details
E53018	Single Head Anger Scintillation Camera	5.0	$300,000.00	gamma camera system, single-dual head	5	$406,816.80	Radiology
E53020	Single Head or Dual Head Camera	5.0	$575,000.00	gamma camera system, single-dual head	5	$406,816.80	Radiology
E53032	Single Photon Densitometer/Computer	5.0	$22,500.00	densitometry unit, whole body, SPA	5	$22,500.00	Radiology
E71028	Sinusoidal Harmonic Acceleration Chair	7.0	$70,080.00	CDP-computerized dynamic posturography system.	7	$86,957.50	Other Equipment
	sleep kit (includes snore sensor & leg kit)	7.0	$630.00	Deleted (less than $500)			No Details
E13644	slide dryer oven	10.0	$695.00	slide dryer	10	$962.50	Laboratory
E13645	slide etcher	7.5	$9,400.00	slide etcher-labeler	7	$15,836.67	Laboratory

ADDENDUM D.—PROPOSED CHANGES TO PRACTICE EXPENSE EQUIPMENT DESCRIPTION, LIFE, AND PRICING—Continued

Equip code	2004 practice expense equipment details			2005 practice expense supply details (proposed)			
	Description	Life	Price	Description	Life	Price	Equipment category
E13617	slide stainer	7.0	$13,000.00	slide stainer, automated, high-volume throughput.	7	$14,085.68	Laboratory
	smoke evacuation system	10.0		Deleted (part of new system)			No Details
	soft tissue procedure pack	4.0	$539.00	instrument pack, basic ($500-$1499)	4	$500.00	Other Equipment
E30003	soft tissue tray	4.0	$1,559.40	instrument pack, medium ($1500 and up)	4	$1,500.00	Other Equipment
E52009	Software (Paceart)	5.0	$6,000.00	pacemaker follow-up system (incl software and hardware) (Paceart).	7	$23,507.00	Other Equipment
	software, MR/PET/CT fusion	5.0	$60,000.00	computer software, MR/PET/CT fusion	5	$60,000.00	Documentation
	software-woodcock johnson test/cognitive abilities.	5.0	$728.00	cognitive abilities testing software (Woodcock Johnson).	5	$558.00	Other Equipment
E51046	Solid Water Calibration Phantom	5.0	$2,000.00	phantom, solid water calibration check	10	$2,109.50	Radiology
E13646	solvent recycling system	7.5	$22,000.00	solvent recycling system	7	$13,995.00	Laboratory
E13614	sonicator	7.5	$600.00	Deleted through PEAC refinement.			No Details
E52010	Sony Color Video Printer	5.0	$10,500.00	Deleted (part of new system)			No Details
E52010	Sony Color Video Printer (combine with system).	5.0	$10,500.00	video printer, color (Sony medical grade)	4	$2,295.00	Documentation
E71031	sound proof booth- double walled	7.5	$11,900.00	audiometric soundproof booth (exam and control rooms).	15	$33,518.00	Other Equipment
	sounds and followers set, leforte, 12-24 french.	4.0	$508.00	instrument pack, basic ($500-$1499)	4	$500.00	Other Equipment
	sounds, female (set)	4.0	$1,736.00	instrument pack, medium ($1500 and up)	4	$1,500.00	Other Equipment
	sounds, male (set)	4.0	$1,104.00	instrument pack, basic ($500-$1499)	4	$500.00	Other Equipment
	sounds, VanBurden	4.0	$1,104.00	instrument pack, basic ($500-$1499)	4	$500.00	Other Equipment
	source, 10 Ci Ir 192	3.0	$22,000.00	source, 10 Ci Ir 192	5	$22,000.00	Radiology
E53028	SPECT Three head Camera	5.0	$565,000.00	gamma camera system, single-dual head	5	$406,816.80	Radiology
	spirometry instrument	8.0	$37,974.00	Vmax 29s (spirometry testing equip, computer system).	8	$26,875.00	Other Equipment
E13610	sputter coater	7.5	$6,000.00	Deleted (part of new system)			No Details
	stainer, automated hematology	7.0	$8,253.00	slide stainer, automated, standard throughput.	7	$8,265.64	Laboratory
	stairs, exercise	10.0	$870.00	stairs, ambulation training	15	$793.67	Other Equipment
	stereotactic frame /tongs	5.0		cranial-skull tongs (Gardner-Wells)	5	$542.00	Other Equipment
	stimulator with probe	8.0		Deleted (less than $500)			No Details
E11002	stretcher	5.0	$2,664.00	stretcher	10	$1,915.00	Furniture
E11002	stretcher	10.0	$2,664.00	stretcher	10	$1,915.00	Furniture
	strontium-90 applicator	4.0	$8,599.00	strontium-90 applicator	5	$8,599.00	Other Equipment
	suction and pressure cabinet, ENT (SMR)	15.0	$3,195.00	suction and pressure cabinet, ENT (SMR)	10	$3,495.00	Other Equipment
E30001	suction machine, Gomco	10.0	$732.20	suction machine (Gomco)	10	$743.21	Other Equipment
E72009	surgical drill system	7.5	$19,800.00	drill system, surgical, large (Stryker)	10	$15,933.00	Other Equipment
E30009	surgical lamp	10.0	$3,650.00	light, surgical	10	$4,489.13	Furniture
E30018	surgical loupes	10.0	$1,300.00	loupes, surgical, prism, up to 8.0x	7	$1,398.33	Other Equipment
E53004	Survey Meter	7.5	$650.00	radiation survey meter	8	$756.25	Radiology
	suspension system for sensory integration equipment.	8.0	$2,500.00	sensory integration equipment, suspension system.	10	$2,500.00	Other Equipment
E52012	SVHS video recorder	5.0	$599.00	Deleted (part of new system)			No Details
E52012	SVHS video recorder	5.0	$599.00	video SVHS VCR (medical grade)	5	$1,250.00	Documentation
	swimming pool for aquatic therapy	10.0	$37,500.00	aquatic therapy pool	15	$36,000.00	Other Equipment
	switch kit	5.0	$1,910.00	augmentative communication - AT switches (eg, arm, tongue, pneumatic).	7	$1,910.00	Other Equipment
	table, back, mobile	10.0	$709.00	table, instrument, mobile	15	$634.00	Furniture
	table, fluoroscopy (Hydra Vision 64kW)	10.0	$281,600.00	table, fluoroscopy	15	$281,600.00	Furniture
	table, OR, tilt	10.0	$1,010.00	table, power	10	$6,153.63	Furniture
	table, pedestal for OT	15.0	$795.00	table, for seated OT therapy	15	$718.67	Furniture

	table, traction with leg rest	10.0	$3,770.00	Deleted (part of new system)	.....	.....	No Details
	table, treatment/work, adjustable height	10.0	$2,905.00	table, treatment, hi-lo	15	$2,361.67	Furniture
	Tech Speak	7.0	$645.00	augmentative communication - Tech Speak	7	$645.00	Other Equipment
	TEE transducer	5.0	$45,000.00	ultrasound, transducer (TEE Omniplane II)	5	$45,000.00	Other Equipment
	test, clerical comprehension (Valpar)	10.0	$2,680.00	work samples, clerical comprehension (Valpar 5).	7	$2,680.00	Other Equipment
	test, fine finger dexterity (Valpar)	10.0	$725.00	work samples, fine finger dexterity (Valpar 204).	7	$725.00	Other Equipment
	test, physical capacity and mobility (Valpar)	10.0	$725.00	work samples, physical capacity (Valpar 201)	7	$725.00	Other Equipment
E92023	Therapeutic exercise equipment set	15.0	$12,260.00	exercise equipment (treadmill, bike, stepper, UBE, pulleys, balance board).	15	$12,710.00	Other Equipment
E92001	therapeutic ultrasound unit	7.0	$1,995.00	ultrasound unit, therapeutic	7	$1,304.33	Other Equipment
	Tilt Table	10.0	$6,995.00	table, tilt (w-trendelenberg)	15	$7,695.00	Furniture
E13649	tissue processing fume hood	7.5	$6,400.00	hood, fume	15	$4,778.46	Laboratory
E13650	tissue processor	7.0	$39,500.00	tissue processor	7	$33,593.00	Laboratory
	TLD oven/annealing furnace	5.0	$1,960.00	TLD annealing furnace	7	$2,536.00	Laboratory
E51048	TLD Reader	5.0	$13,000.00	TLD Reader	7	$14,390.00	Laboratory
	Tonography Unit	5.0	$10,065.00	tonography unit	7	$6,195.00	Other Equipment
	tool set, valpar	7.0	$1,765.00	work samples, small tools (Valpar 1)	7	$1,765.00	Other Equipment
	topcon TRC 50 E	5.0	$28,790.00	camera, retinal (TRC 50IX, w-ICG, filters, motor drives).	5	$37,000.00	Documentation
	tourniquet device, pneumatic	7.0	$12,500.00	tourniquet system (Zimmer1200)	7	$10,220.00	Other Equipment
	Tracher 2000	7.0	$1,895.00	augmentative communication - Tracker 2000	7	$1,795.00	Other Equipment
	transthoracic echo probe, pediatric, 8 mHz	5.0	$15,000.00	Deleted (part of new system)	.....	.....	No Details
	treadmill	10.0	$4,700.00	treadmill	8	$4,446.11	Other Equipment
E55020	Treadmill w/ ECG Monitor	8.0	$16,000.00	cardiac monitor w-treadmill (12-lead PC-based ECG).	10	$14,271.03	Other Equipment
E51050	Treatment Planning Computer-3D (Focus)	5.0	$221,500.00	computer workstation, 3D teletherapy treatment planning.	5	$221,500.00	Documentation
	treatment planning system for intensity modulated radiotherapy.	5.0	$350,000.00	treatment planning system, IMRT (Corvus w-Peregrine 3D Monte Carlo).	5	$350,545.00	Documentation
	Treatment Vault	7.0	$550,670.00	radiation treatment vault	15	$550,670.00	Radiology
	TUMT device	5.0	$60,000.00	TUMT system control unit	7	$29,995.00	Other Equipment
E71032	tympanometer with printer	7.0	$2,700.00	tympanometer with printer	10	$2,648.53	Other Equipment
	ultrasonic biometry, pachymeter	5.0	$3,945.00	ultrasonic biometry, pachymeter	5	$3,945.00	Other Equipment
E13663	ultrasonic instrument cleaner	7.5	$945.00	Deleted (indirect)	.....	.....	No Details
E52019	Ultrasonic nebulizer	10.0	$1,000.00	Deleted (CPT action)	.....	.....	No Details
E52001	ultrasound color doppler, transducers and vaginal probe.	5.0	$155,000.00	ultrasound color doppler, transducers and vaginal probe.	5	$155,000.00	Other Equipment
E52018	Ultrasound Room	5.0	$272,000.00	room, ultrasound, general	5	$369,945.00	Room - Lane
	ultrasound table	10.0	$4,495.00	table, ultrasound	15	$5,823.33	Furniture
	Ultrasound Unit	5.0	$30,000.00	ultrasound unit, Shimadzu	5	$29,999.00	Other Equipment
E52005	ultrasound, shimatsu	5.0	$35,000.00	ultrasound unit, Shimadzu	5	$29,999.00	Other Equipment
	urethotome, otis	3.0	$1,735.00	urethrotome, Otis	4	$1,697.50	Scope
E52006	urodynamics machine, 4-channel video	5.0	$15,175.00	urodynamics system, 4-channel	5	$30,733.00	Other Equipment
	urodynamics machine, 6-channel video	5.0	$115,578.00	urodynamics system, 6-channel, w-video	5	$115,578.00	Other Equipment
	uroflowmeter, digital, w-chair (Microflo)	5.0	$2,758.00	uroflowmeter, digital, w-chair	7	$2,758.00	Other Equipment
	uterine thermal balloon ablation system (Thermachoice).	5.0	$8,500.00	uterine thermal balloon ablation system (Thermachoice).	7	$8,500.00	Other Equipment
	UV monitor/meter	5.0	$690.00	phototherapy UVB measuring device	10	$690.00	Other Equipment
	vacuum cart	10.0	.....	vacuum cart	10		
	Other Equipment.						
E13615	vacuum dissector	10.0	$635.00	Deleted through PEAC refinement.	.....	.....	No Details
E13627	vacuum evaporator	7.5	$15,000.00	Deleted (part of new system)	.....	.....	No Details
E13612	vacuum oven	10.0	$3,000.00	Deleted (part of new system)	.....	.....	No Details
E13624	vacuum pump	10.0	$1,455.00	vacuum pump	7	$1,840.00	Laboratory
E92015	Vasopneumatic device	10.0	$795.00	vasopneumatic compression system	10	$632.48	Other Equipment
E91003	ventilator hood & blower	10.0	$602.55	hood, ventilator with blower	10	$1,612.50	Laboratory

ADDENDUM D.—PROPOSED CHANGES TO PRACTICE EXPENSE EQUIPMENT DESCRIPTION, LIFE, AND PRICING—Continued

Equip code	2004 practice expense equipment details			2005 practice expense supply details (proposed)			
	Description	Life	Price	Description	Life	Price	Equipment category
	video add-on camera system w-monitor (endoscopy).	5.0	$9,495.00	video add-on camera system w-monitor (endoscopy).	5	$9,495.00	Scope
E13635	video camera	5.0	$1,000.00	Deleted (part of new system)	.....	.....	No Details
E13635	video camera (combine with system)	5.0	$1,000.00	video add-on camera system w-monitor (endoscopy).	5	$9,495.00	Scope
E13635	video camera (combine with system)	5.0	$1,000.00	video camera	5	$1,000.00	Documentation
	video system, capsule endoscopy (software, computer, monitor, printer).	.....	$17,000.00	video system, capsule endoscopy (software, computer, monitor, printer).	5	$17,000.00	Scope
	video system, capsule endoscopy, booster drive w-accessories.	.....	$2,500.00	video system, capsule endoscopy, booster drive w-accessories.	5	$2,500.00	Scope
	video system, endoscopy (processor, digital capture, monitor, printer, cart).	5.0	$33,233.00	video system, endoscopy (processor, digital capture, monitor, printer, cart).	5	$33,232.50	Scope
	video system, FEES (scope, camera, light source, image capture, monitor, printer, cart).	5.0	$21,675.00	video system, FEES (scope, camera, light source, image capture, monitor, printer, cart).	5	$21,675.00	Scope
	video system, FEESST (scope, sensory stimulator, camera, light source, image capture, monitor, printer, cart).	5.0	$29,550.00	video system, FEESST (scope, sensory stimulator, camera, light source, image capture, monitor, printer, cart).	5	$29,550.00	Scope
	video system, stroboscopy (strobing platform, camera, digital recorder, monitor, printer, cart).	5.0	$25,310.00	video system, stroboscopy (strobing platform, camera, digital recorder, monitor, printer, cart).	5	$25,310.00	Scope
E71033	visual response audiometry	7.0	$700.00	VRA-visual reinforcment audiometry system	5	$1,550.00	Other Equipment
E55023	VMax 229 (split/combine systems)	8.0	$56,551.20	Vmax 229 (spirometry testing equip, computer system).	8	$44,681.00	Other Equipment
E55023	VMax 229 (split/combine systems)	8.0	$56,551.20	Vmax 29s (spirometry testing equip, computer system).	8	$26,875.00	Other Equipment
	Voice Pal Max	7.0	$555.00	augmentative communication - VoicePal Max	7	$555.00	Other Equipment
E13648	vortex mixer	7.5	$500.00	Deleted (less than $500)	.....	.....	No Details
E54002	Voyager acquisition station	7.0	$46,850.00	sleep screening system, attended (w-resp plethysmography).	5	$22,000.00	Other Equipment
	water bath	10.0	$750.00	water bath, general purpose (lab)	7	$726.45	Laboratory
	Water Bath Phantom with Drivers	5.0	$15,000.00	phantom, water, includes remote motor drive	10	$3,070.00	Radiology
	water bath, general purpose (lab)	5.0	$726.45	water bath, general purpose (lab)	7	$726.45	Laboratory
	Water Chiller	7.0	$28,000.00	water chiller (radiation treatment)	7	$28,000.00	Radiology
E51026	Waterbath for Thermoplastic Immobilizer System.	5.0	$750.00	water bath, thermoplastic softener (20in x 12in).	7	$722.36	Radiology
	Waterbath, Medtech	5.0	$1,150.00	water bath, thermoplastic softener (20in x 12in).	7	$722.36	Radiology
E71008	Weeks dark adaptometer	5.0	$16,100.00	Weeks dark adaptometer	7	$2,950.00	Other Equipment
E51076	Well Counter	5.0	$3,955.00	well counter	7	$3,955.00	Radiology
E51074	Well Ionization Chamber, Standard Imaging	5.0	$4,641.00	Deleted through PEAC refinement.	.....	.....	No Details
E71108	wheatstone trainer	7.5	$895.00	stereo trainer (wheatstone)	7	$550.00	Other Equipment
E92005	whirlpool	10.0	$3,700.00	whirlpool, lo-boy tank (whole body)	10	$3,296.40	Furniture
	whitkit evaluation kit	5.0	$1,400.00	augmentative communication - WhitKit head support.	7	$1,400.00	Other Equipment
E53030	Whole Body or Dual Head Camera	5.0	$575,000.00	Deleted through PEAC refinement.	.....	.....	No Details
	WIT thermotherapy unit	5.0	$18,500.00	WIT system (AquaTherm)	7	$16,400.00	Other Equipment
	work bench, orthotic, mobile	10.0	$750.00	cart-workbench, orthotic, mobile	10	$752.50	Furniture
	work station, post processing for CT angiography.	10.0	$180,000.00	Deleted (part of new system)	.....	.....	No Details
E53022	Xenon Delivery System	5.0	$5,450.00	Deleted through PEAC refinement.	.....	.....	No Details
	xenon light source - cable for endoscope	3.0					

	light source, xenon	5	$6,723.33	Other Equipment.			
E53024	Xenon Monitor	5.0	$2,775.00	Deleted through PEAC refinement.			No Details
E51003	X-omat Film processor M35A	8.0	$10,900.00	film processor, x-omat (Kodak 2000A)	8	$11,500.00	Documentation
E51002	X-omat film processor M6B	8.0	$26,832.00	film processor, x-omat (M6B)	8	$34,865.00	Documentation
E55032	x-ray lift	7.5	$800.00	lift, hydraulic, table assist	10	$1,111.00	Furniture
E51001	X-ray View Box 4 panel	15.0	$909.49	x-ray view box, 4 panel	10	$889.17	Radiology
E72000	YAG laser	5.0	$40,000.00	laser, YAG	5	$29,975.00	Other Equipment
E71009	Zeiss slit lamp camera	10.0	$7,495.00	slit lamp (Haag-Streit)	10	$7,435.00	Other Equipment
	zeiss visulas 690 PDT laser	5.0	$37,900.00	laser, photodynamic therapy	5	$35,000.00	Other Equipment

ADDENDUM E.—REVISED 2005 OFFICE RENTAL INDEX VERSUS CURRENT OFFICE RENTAL INDEX BY 2004 FEE SCHEDULE AREA

Carrier No.	Loc. No.	Locality name	Current rental index	Revised 2005 rental index	Difference	Percentage difference
00510	00	ALABAMA	0.738	0.679	-0.059	-8.0
00831	01	ALASKA	1.249	1.141	-0.108	-8.6
31146	26	ANAHEIM/SANTA ANA, CA	1.422	1.586	0.164	11.5
00832	00	ARIZONA	1.000	1.034	0.034	3.4
00520	13	ARKANSAS	0.704	0.666	-0.038	-5.4
00511	01	ATLANTA, GA	1.136	1.271	0.135	11.9
00900	31	AUSTIN, TX	1.111	1.243	0.132	11.9
00901	01	BALTIMORE/SURR. CNTYS, MD	1.026	1.159	0.133	13.0
00900	20	BEAUMONT, TX	0.758	0.700	-0.058	-7.7
00900	09	BRAZORIA, TX	1.018	0.991	-0.027	-2.7
00952	16	CHICAGO, IL	1.216	1.274	0.058	4.8
00824	01	COLORADO	1.066	1.100	0.034	3.2
00591	00	CONNECTICUT	1.215	1.275	0.060	4.9
00900	11	DALLAS, TX	1.196	1.167	-0.029	-2.4
00903	01	DC + MD/VA SUBURBS	1.341	1.584	0.243	18.1
00902	01	DELAWARE	1.051	0.983	-0.068	-6.5
00953	01	DETROIT, MI	1.045	1.060	0.015	1.4
00952	12	EAST ST. LOUIS, IL	0.792	0.912	0.120	15.2
00590	03	FORT LAUDERDALE, FL	1.090	1.041	-0.049	-4.5
00900	28	FORT WORTH, TX	0.977	1.017	0.040	4.1
00900	15	GALVESTON, TX	0.924	0.901	-0.023	-2.5
00833	01	HAWAII/GUAM	1.389	1.186	-0.203	-14.6
00900	18	HOUSTON, TX	0.988	1.024	0.036	3.6
05130	00	IDAHO	0.791	0.730	-0.061	-7.7
00630	00	INDIANA	0.847	0.789	-0.058	-6.8
00826	00	IOWA	0.785	0.737	-0.048	-6.1
00650	00	KANSAS*	0.793	0.765	-0.028	-3.5
00740	04	KANSAS*	0.793	0.765	-0.028	-3.5
00660	00	KENTUCKY	0.721	0.685	-0.036	-5.0
31146	18	LOS ANGELES, CA	1.223	1.328	0.105	8.6
00803	01	MANHATTAN, NY	1.744	1.676	-0.068	-3.9
31140	03	MARIN/NAPA/SOLANO, CA	1.647	1.886	0.239	14.5
31143	01	METROPOLITAN BOSTON	1.504	1.809	0.305	20.3
00740	02	METROPOLITAN KANSAS CITY, MO	0.916	0.962	0.046	5.0
00865	01	METROPOLITAN PHILADELPHIA, PA	1.178	1.196	0.018	1.5
00523	01	METROPOLITAN ST. LOUIS, MO	0.814	0.949	0.135	16.6
00590	04	MIAMI, FL	1.139	1.117	-0.022	-1.9
00954	00	MINNESOTA	0.940	0.997	0.057	6.1
00512	00	MISSISSIPPI	0.690	0.667	-0.023	-3.3
00751	01	MONTANA	0.794	0.738	-0.056	-7.1
00655	00	NEBRASKA	0.817	0.748	-0.069	-8.4
00834	00	NEVADA	1.117	1.110	-0.007	-0.6
31144	40	NEW HAMPSHIRE	1.089	1.123	0.034	3.1
00521	05	NEW MEXICO	0.837	0.788	-0.049	-5.9
00528	01	NEW ORLEANS, LA	0.832	0.905	0.073	8.8
05535	00	NORTH CAROLINA	0.869	0.826	-0.043	-4.9
00820	01	NORTH DAKOTA	0.800	0.751	-0.049	-6.1
00805	01	NORTHERN NJ	1.399	1.421	0.022	1.6
00803	02	NYC SUBURBS/LONG I., NY	1.573	1.538	-0.035	-2.2
31140	07	OAKLAND/BERKELEY, CA	1.470	1.886	0.416	28.3
00883	00	OHIO	0.863	0.838	-0.025	-2.9
00522	00	OKLAHOMA	0.725	0.717	-0.008	-1.1
00835	01	PORTLAND, OR	1.120	1.058	-0.062	-5.5
00803	03	POUGHKPSIE/N NYC SUBURBS, NY	1.254	1.201	-0.053	-4.2
00973	20	PUERTO RICO	0.688	0.631	-0.057	-8.3
14330	04	QUEENS, NY	1.414	1.359	-0.055	-3.9
31146	99	REST OF CALIFORNIA*	1.050	1.110	0.060	5.7
31140	99	REST OF CALIFORNIA*	1.050	1.110	0.060	5.7
00590	99	REST OF FLORIDA	0.951	0.928	-0.023	-2.4
00511	99	REST OF GEORGIA	0.771	0.729	-0.042	-5.4
00952	99	REST OF ILLINOIS	0.797	0.741	-0.056	-7.0
00528	99	REST OF LOUISIANA	0.715	0.672	-0.043	-6.0
31142	99	REST OF MAINE	0.801	0.755	-0.046	-5.7
00901	99	REST OF MARYLAND	0.995	1.026	0.031	3.1
31143	99	REST OF MASSACHUSETTS	1.308	1.239	-0.069	-5.3
00953	99	REST OF MICHIGAN	0.848	0.799	-0.049	-5.8
00740	99	REST OF MISSOURI*	0.662	0.613	-0.049	-7.4
00523	99	REST OF MISSOURI*	0.662	0.613	-0.049	-7.4
00805	99	REST OF NEW JERSEY	1.312	1.256	-0.056	-4.3
00801	99	REST OF NEW YORK	0.875	0.812	-0.063	-7.2

ADDENDUM E.—REVISED 2005 OFFICE RENTAL INDEX VERSUS CURRENT OFFICE RENTAL INDEX BY 2004 FEE SCHEDULE AREA—Continued

Carrier No.	Loc. No.	Locality name	Current rental index	Revised 2005 rental index	Difference	Percentage difference
00835	99	REST OF OREGON	0.901	0.837	-0.064	-7.1
00865	99	REST OF PENNSYLVANIA	0.844	0.785	-0.059	-7.0
00900	99	REST OF TEXAS	0.795	0.759	-0.036	-4.5
00836	99	REST OF WASHINGTON	0.958	0.915	-0.043	-4.5
00870	01	RHODE ISLAND	1.098	0.931	-0.167	-15.2
31140	05	SAN FRANCISCO, CA	2.174	2.356	0.182	8.4
31140	06	SAN MATEO, CA	2.174	2.356	0.182	8.4
31140	09	SANTA CLARA, CA	1.949	2.416	0.467	24.0
00836	02	SEATTLE (KING CNTY), WA	1.232	1.234	0.002	0.2
00880	01	SOUTH CAROLINA	0.825	0.763	-0.062	-7.5
00820	02	SOUTH DAKOTA	0.853	0.801	-0.052	-6.1
31142	03	SOUTHERN MAINE	1.009	1.098	0.089	8.8
00952	15	SUBURBAN CHICAGO, IL	1.216	1.274	0.058	4.8
05440	35	TENNESSEE	0.800	0.748	-0.052	-6.5
00910	09	UTAH	0.978	0.950	-0.028	-2.9
31146	17	VENTURA, CA	1.294	1.484	0.190	14.7
31145	50	VERMONT	1.004	0.997	-0.007	-0.7
00973	50	VIRGIN ISLANDS	1.260	1.164	-0.096	-7.6
00904	00	VIRGINIA	0.892	0.933	0.041	4.6
00884	16	WEST VIRGINIA	0.685	0.634	-0.051	-7.4
00951	00	WISCONSIN	0.866	0.801	-0.065	-7.5
00825	21	WYOMING	0.799	0.751	-0.048	-6.0

Note: Revised Rental Indices Based Upon 2004 HUD FMR Data.

ADDENDUM F.—CURRENT GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier No.	Loc. No.	Locality name	Work GPCI	PE GPCI	MP GPCI
00510	00	ALABAMA	1.000	0.870	0.779
00831	01	ALASKA	1.670	1.670	1.670
00832	00	ARIZONA	1.000	0.978	1.090
00520	13	ARKANSAS	1.000	0.847	0.389
31146	26	ANAHEIM/SANTA ANA, CA	1.037	1.184	0.955
31146	18	LOS ANGELES, CA	1.056	1.139	0.955
31140	03	MARIN/NAPA/SOLANO, CA	1.015	1.248	0.669
31140	07	OAKLAND/BERKELEY, CA	1.041	1.235	0.669
31140	05	SAN FRANCISCO, CA	1.068	1.458	0.669
31140	06	SAN MATEO, CA	1.048	1.432	0.663
31140	09	SANTA CLARA, CA	1.063	1.380	0.622
31146	17	VENTURA, CA	1.028	1.125	0.763
31146	99	REST OF CALIFORNIA*	1.007	1.034	0.740
31140	99	REST OF CALIFORNIA*	1.007	1.034	0.740
00824	01	COLORADO	1.000	0.992	0.821
00591	00	CONNECTICUT	1.050	1.156	0.933
00902	01	DELAWARE	1.019	1.035	0.802
00903	01	DC + MD/VA SUBURBS	1.050	1.166	0.917
00590	03	FORT LAUDERDALE, FL	1.000	1.018	1.790
00590	04	MIAMI, FL	1.015	1.052	2.399
00590	99	REST OF FLORIDA	1.000	0.946	1.268
00511	01	ATLANTA, GA	1.006	1.059	0.951
00511	99	REST OF GEORGIA	1.000	0.892	0.951
00833	01	HAWAII/GUAM	1.000	1.124	0.817
05130	00	IDAHO	1.000	0.881	0.478
00952	16	CHICAGO, IL	1.028	1.092	1.832
00952	12	EAST ST. LOUIS, IL	1.000	0.924	1.720
00952	15	SUBURBAN CHICAGO, IL	1.006	1.071	1.648
00952	99	REST OF ILLINOIS	1.000	0.889	1.175
00630	00	INDIANA	1.000	0.922	0.459
00826	00	IOWA	1.000	0.876	0.593
00650	00	KANSAS*	1.000	0.895	0.738
00740	04	KANSAS*	1.000	0.895	0.738
00660	00	KENTUCKY	1.000	0.866	0.875
00528	01	NEW ORLEANS, LA	1.000	0.945	1.240
00528	99	REST OF LOUISIANA	1.000	0.870	1.066
31142	03	SOUTHERN MAINE	1.000	0.999	0.652
31142	99	REST OF MAINE	1.000	0.910	0.652
00901	01	BALTIMORE/SURR. CNTYS, MD	1.021	1.038	0.931
00901	99	REST OF MARYLAND	1.000	0.972	0.767

ADDENDUM F.—CURRENT GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier No.	Loc. No.	Locality name	Work GPCI	PE GPCI	MP GPCI
31143	01	METROPOLITAN BOSTON	1.041	1.239	0.803
31143	99	REST OF MASSACHUSETTS	1.010	1.129	0.803
00953	01	DETROIT, MI	1.043	1.038	2.741
00953	99	REST OF MICHIGAN	1.000	0.938	1.545
00954	00	MINNESOTA	1.000	0.974	0.431
00512	00	MISSISSIPPI	1.000	0.837	0.750
00740	02	METROPOLITAN KANSAS CITY, MO	1.000	0.967	0.896
00523	01	METROPOLITAN ST. LOUIS, MO	1.000	0.938	0.893
00740	99	REST OF MISSOURI*	1.000	0.825	0.842
00523	99	REST OF MISSOURI*	1.000	0.825	0.842
00751	01	MONTANA	1.000	0.876	0.815
00655	00	NEBRASKA	1.000	0.877	0.442
00834	00	NEVADA	1.005	1.039	1.138
31144	40	NEW HAMPSHIRE	1.000	1.030	0.883
00805	01	NORTHERN NJ	1.058	1.193	0.916
00805	99	REST OF NEW JERSEY	1.029	1.110	0.916
00521	05	NEW MEXICO	1.000	0.900	0.898
00803	01	MANHATTAN, NY	1.094	1.351	1.586
00803	02	NYC SUBURBS/LONG I., NY	1.068	1.251	1.869
00803	03	POUGHKPSIE/N NYC SUBURBS, NY	1.011	1.075	1.221
14330	04	QUEENS, NY	1.058	1.228	1.791
00801	99	REST OF NEW YORK	1.000	0.944	0.720
05535	00	NORTH CAROLINA	1.000	0.931	0.618
00820	01	NORTH DAKOTA	1.000	0.880	0.630
00883	00	OHIO	1.000	0.944	0.967
00522	00	OKLAHOMA	1.000	0.876	0.413
00835	01	PORTLAND, OR	1.000	1.049	0.438
00835	99	REST OF OREGON	1.000	0.933	0.438
00865	01	METROPOLITAN PHILADELPHIA, PA	1.023	1.092	1.400
00865	99	REST OF PENNSYLVANIA	1.000	0.929	0.790
00973	20	PUERTO RICO	1.000	0.712	0.268
00870	01	RHODE ISLAND	1.017	1.065	0.896
00880	01	SOUTH CAROLINA	1.000	0.904	0.336
00820	02	SOUTH DAKOTA	1.000	0.878	0.385
05440	35	TENNESSEE	1.000	0.900	0.612
00900	31	AUSTIN, TX	1.000	0.996	0.922
00900	20	BEAUMONT, TX	1.000	0.890	1.318
00900	09	BRAZORIA, TX	1.000	0.978	1.318
00900	11	DALLAS, TX	1.010	1.065	0.996
00900	28	FORT WORTH, TX	1.000	0.981	0.996
00900	15	GALVESTON, TX	1.000	0.969	1.318
00900	18	HOUSTON, TX	1.020	1.007	1.316
00900	99	REST OF TEXAS	1.000	0.880	1.047
00910	09	UTAH	1.000	0.941	0.653
31145	50	VERMONT	1.000	0.986	0.527
00973	50	VIRGIN ISLANDS	1.000	1.023	1.003
00904	00	VIRGINIA	1.000	0.938	0.540
00836	02	SEATTLE (KING CNTY), WA	1.005	1.100	0.803
00836	99	REST OF WASHINGTON	1.000	0.972	0.803
00884	16	WEST VIRGINIA	1.000	0.850	1.462
00951	00	WISCONSIN	1.000	0.929	0.865
00825	21	WYOMING	1.000	0.895	0.970

Note: Work GPCI is the 1/4 work GPCI required by section 1848(e)(1)(A)(iii) of the Act. 1.0 Floor on Work GPCI, 1.67 for all Alaska indices, set by MMA GPCIs are scaled by the following factors: Work= 0.9977, Practice Expense=0.9930, Malpractice Expense=1.0021.

ADDENDUM G.—PROPOSED 2005 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier No.	Loc. No.	Locality name	Work GPCI	PE GPCI	MP GPCI
00510	00	ALABAMA	1.000	0.860	0.779
00831	01	ALASKA	1.670	1.670	1.670
00832	00	ARIZONA	1.000	0.983	1.090
00520	13	ARKANSAS	1.000	0.841	0.389
31146	26	ANAHEIM/SANTA ANA, CA	1.036	1.203	0.955
31146	18	LOS ANGELES, CA	1.049	1.142	0.955
31140	03	MARIN/NAPA/SOLANO, CA	1.026	1.292	0.669
31140	07	OAKLAND/BERKELEY, CA	1.049	1.301	0.669
31140	05	SAN FRANCISCO, CA	1.066	1.498	0.669
31140	06	SAN MATEO, CA	1.062	1.482	0.663

ADDENDUM G.—PROPOSED 2005 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier No.	Loc. No.	Locality name	Work GPCI	PE GPCI	MP GPCI
31140	09	SANTA CLARA, CA	1.076	1.457	0.622
31146	17	VENTURA, CA	1.029	1.146	0.763
31146	99	REST OF CALIFORNIA*	1.007	1.039	0.740
31140	99	REST OF CALIFORNIA*	1.007	1.039	0.740
00824	01	COLORADO	1.000	1.004	0.821
00591	00	CONNECTICUT	1.044	1.161	0.933
00902	01	DELAWARE	1.016	1.027	0.802
00903	01	DC + MD/VA SUBURBS	1.051	1.202	0.917
00590	03	FORT LAUDERDALE, FL	1.000	1.005	1.790
00590	04	MIAMI, FL	1.007	1.036	2.399
00590	99	REST OF FLORIDA	1.000	0.941	1.268
00511	01	ATLANTA, GA	1.009	1.076	0.951
00511	99	REST OF GEORGIA	1.000	0.885	0.951
00833	01	HAWAII/GUAM	1.001	1.113	0.817
05130	00	IDAHO	1.000	0.874	0.478
00952	16	CHICAGO, IL	1.027	1.110	1.832
00952	12	EAST ST. LOUIS, IL	1.000	0.934	1.720
00952	15	SUBURBAN CHICAGO, IL	1.013	1.094	1.648
00952	99	REST OF ILLINOIS	1.000	0.883	1.175
00630	00	INDIANA	1.000	0.916	0.459
00826	00	IOWA	1.000	0.874	0.593
00650	00	KANSAS*	1.000	0.889	0.738
00740	04	KANSAS*	1.000	0.889	0.738
00660	00	KENTUCKY	1.000	0.862	0.875
00528	01	NEW ORLEANS, LA	1.000	0.947	1.240
00528	99	REST OF LOUISIANA	1.000	0.860	1.066
31142	03	SOUTHERN MAINE	1.000	1.006	0.652
31142	99	REST OF MAINE	1.000	0.899	0.652
00901	01	BALTIMORE/SURR. CNTYS, MD	1.017	1.054	0.931
00901	99	REST OF MARYLAND	1.000	0.974	0.767
31143	01	METROPOLITAN BOSTON	1.036	1.277	0.803
31143	99	REST OF MASSACHUSETTS	1.009	1.113	0.803
00953	01	DETROIT, MI	1.040	1.044	2.741
00953	99	REST OF MICHIGAN	1.000	0.930	1.545
00954	00	MINNESOTA	1.000	0.990	0.431
00512	00	MISSISSIPPI	1.000	0.840	0.750
00740	02	METROPOLITAN KANSAS CITY, MO	1.000	0.972	0.896
00523	01	METROPOLITAN ST. LOUIS, MO	1.000	0.949	0.893
00740	99	REST OF MISSOURI*	1.000	0.815	0.842
00523	99	REST OF MISSOURI*	1.000	0.815	0.842
00751	01	MONTANA	1.000	0.861	0.815
00655	00	NEBRASKA	1.000	0.878	0.442
00834	00	NEVADA	1.004	1.039	1.138
31144	40	NEW HAMPSHIRE	1.000	1.027	0.883
00805	01	NORTHERN NJ	1.058	1.204	0.916
00805	99	REST OF NEW JERSEY	1.036	1.114	0.916
00521	05	NEW MEXICO	1.000	0.895	0.898
00803	01	MANHATTAN, NY	1.080	1.346	1.586
00803	02	NYC SUBURBS/LONG I., NY	1.059	1.256	1.869
00803	03	POUGHKPSIE/N NYC SUBURBS, NY	1.012	1.072	1.221
14330	04	QUEENS, NY	1.045	1.210	1.791
00801	99	REST OF NEW YORK	1.000	0.934	0.720
05535	00	NORTH CAROLINA	1.000	0.928	0.618
00820	01	NORTH DAKOTA	1.000	0.871	0.630
00883	00	OHIO	1.000	0.940	0.967
00522	00	OKLAHOMA	1.000	0.867	0.413
00835	01	PORTLAND, OR	1.000	1.052	0.438
00835	99	REST OF OREGON	1.000	0.929	0.438
00865	01	METROPOLITAN PHILADELPHIA, PA	1.020	1.098	1.400
00865	99	REST OF PENNSYLVANIA	1.000	0.917	0.790
00973	20	PUERTO RICO	1.000	0.708	0.268
00870	01	RHODE ISLAND	1.030	1.028	0.896
00880	01	SOUTH CAROLINA	1.000	0.901	0.336
00820	02	SOUTH DAKOTA	1.000	0.878	0.385
05440	35	TENNESSEE	1.000	0.892	0.612
00900	31	AUSTIN, TX	1.000	1.025	0.922
00900	20	BEAUMONT, TX	1.000	0.877	1.318
00900	09	BRAZORIA, TX	1.008	0.971	1.318
00900	11	DALLAS, TX	1.011	1.064	0.996
00900	28	FORT WORTH, TX	1.000	0.985	0.996

ADDENDUM G.—PROPOSED 2005 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier No.	Loc. No.	Locality name	Work GPCI	PE GPCI	MP GPCI
00900	15	GALVESTON, TX	1.000	0.962	1.318
00900	18	HOUSTON, TX	1.020	1.012	1.316
00900	99	REST OF TEXAS	1.000	0.874	1.047
00910	09	UTAH	1.000	0.940	0.653
31145	50	VERMONT	1.000	0.979	0.527
00973	50	VIRGIN ISLANDS	1.000	1.008	1.003
00904	00	VIRGINIA	1.000	0.941	0.540
00836	02	SEATTLE (KING CNTY), WA	1.011	1.115	0.803
00836	99	REST OF WASHINGTON	1.000	0.975	0.803
00884	16	WEST VIRGINIA	1.000	0.836	1.462
00951	00	WISCONSIN	1.000	0.925	0.865
00825	21	WYOMING	1.000	0.875	0.970

Note: Work GPCI is the 1/4 work GPCI required by section 1848(e)(1)(A)(iii) of the Act. 1.0 Floor on Work GPCI, 1.67 for all Alaska indices, set by MMAMMA GPCIs are scaled by the following factors: Work= 0.9977, Practice Expense=0.9930, Malpractice Expense=1.0021.

ADDENDUM H.—PROPOSED 2006 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier No.	Loc. No.	Locality name	Work GPCI	PE GPCI	MP GPCI
00510	00	ALABAMA	1.000	0.850	0.752
00831	01	ALASKA	1.670	1.670	1.670
00832	00	ARIZONA	1.000	0.988	1.069
00520	13	ARKANSAS	1.000	0.835	0.438
31146	26	ANAHEIM/SANTA ANA, CA	1.036	1.223	0.954
31146	18	LOS ANGELES, CA	1.043	1.144	0.954
31140	03	MARIN/NAPA/SOLANO, CA	1.037	1.336	0.651
31140	07	OAKLAND/BERKELEY, CA	1.058	1.366	0.651
31140	05	SAN FRANCISCO, CA	1.064	1.539	0.651
31140	06	SAN MATEO, CA	1.076	1.531	0.639
31140	09	SANTA CLARA, CA	1.088	1.534	0.604
31146	17	VENTURA, CA	1.031	1.167	0.744
31146	99	REST OF CALIFORNIA*	1.007	1.044	0.733
31140	99	REST OF CALIFORNIA*	1.007	1.044	0.733
00824	01	COLORADO	1.000	1.016	0.803
00591	00	CONNECTICUT	1.039	1.167	0.900
00902	01	DELAWARE	1.013	1.020	0.892
00903	01	DC + MD/VA SUBURBS	1.052	1.238	0.926
00590	03	FORT LAUDERDALE, FL	1.000	0.992	1.703
00590	04	MIAMI, FL	1.000	1.020	2.269
00590	99	REST OF FLORIDA	1.000	0.936	1.272
00511	01	ATLANTA, GA	1.012	1.093	0.966
00511	99	REST OF GEORGIA	1.000	0.877	0.966
00833	01	HAWAII/GUAM	1.006	1.101	0.800
05130	00	IDAHO	1.000	0.868	0.459
00952	16	CHICAGO, IL	1.027	1.128	1.867
00952	12	EAST ST. LOUIS, IL	1.000	0.944	1.750
00952	15	SUBURBAN CHICAGO, IL	1.021	1.117	1.652
00952	99	REST OF ILLINOIS	1.000	0.877	1.193
00630	00	INDIANA	1.000	0.910	0.436
00826	00	IOWA	1.000	0.872	0.589
00650	00	KANSAS*	1.000	0.882	0.721
00740	04	KANSAS*	1.000	0.882	0.721
00660	00	KENTUCKY	1.000	0.858	0.873
00528	01	NEW ORLEANS, LA	1.000	0.950	1.197
00528	99	REST OF LOUISIANA	1.000	0.849	1.058
31142	03	SOUTHERN MAINE	1.000	1.013	0.637
31142	99	REST OF MAINE	1.000	0.888	0.637
00901	01	BALTIMORE/SURR. CNTYS, MD	1.014	1.070	0.947
00901	99	REST OF MARYLAND	1.000	0.977	0.760
31143	01	METROPOLITAN BOSTON	1.032	1.314	0.823
31143	99	REST OF MASSACHUSETTS	1.008	1.097	0.823
00953	01	DETROIT, MI	1.038	1.050	2.744
00953	99	REST OF MICHIGAN	1.000	0.923	1.518
00954	00	MINNESOTA	1.000	1.005	0.410
00512	00	MISSISSIPPI	1.000	0.843	0.722
00740	02	METROPOLITAN KANSAS CITY, MO	1.000	0.978	0.946
00523	01	METROPOLITAN ST. LOUIS, MO	1.000	0.961	0.941
00740	99	REST OF MISSOURI*	1.000	0.805	0.892

ADDENDUM H.—PROPOSED 2006 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY—Continued

Carrier No.	Loc. No.	Locality name	Work GPCI	PE GPCI	MP GPCI
00523	99	REST OF MISSOURI*	1.000	0.805	0.892
00751	01	MONTANA	1.000	0.845	0.904
00655	00	NEBRASKA	1.000	0.879	0.454
00834	00	NEVADA	1.003	1.039	1.068
31144	40	NEW HAMPSHIRE	1.000	1.023	0.942
00805	01	NORTHERN NJ	1.059	1.215	0.973
00805	99	REST OF NEW JERSEY	1.043	1.117	0.973
00521	05	NEW MEXICO	1.000	0.890	0.895
00803	01	MANHATTAN, NY	1.067	1.341	1.504
00803	02	NYC SUBURBS/LONG I., NY	1.051	1.260	1.785
00803	03	POUGHKPSIE/N NYC SUBURBS, NY	1.013	1.070	1.167
14330	04	QUEENS, NY	1.032	1.192	1.710
00801	99	REST OF NEW YORK	1.000	0.923	0.677
05535	00	NORTH CAROLINA	1.000	0.926	0.640
00820	01	NORTH DAKOTA	1.000	0.862	0.602
00883	00	OHIO	1.000	0.937	0.976
00522	00	OKLAHOMA	1.000	0.858	0.382
00835	01	PORTLAND, OR	1.004	1.055	0.441
00835	99	REST OF OREGON	1.000	0.926	0.441
00865	01	METROPOLITAN PHILADELPHIA, PA	1.018	1.105	1.386
00865	99	REST OF PENNSYLVANIA	1.000	0.906	0.806
00973	20	PUERTO RICO	1.000	0.705	0.261
00870	01	RHODE ISLAND	1.044	0.992	0.909
00880	01	SOUTH CAROLINA	1.000	0.897	0.394
00820	02	SOUTH DAKOTA	1.000	0.879	0.365
05440	35	TENNESSEE	1.000	0.884	0.631
00900	31	AUSTIN, TX	1.000	1.053	0.986
00900	20	BEAUMONT, TX	1.000	0.864	1.298
00900	09	BRAZORIA, TX	1.025	0.964	1.298
00900	11	DALLAS, TX	1.013	1.063	1.061
00900	28	FORT WORTH, TX	1.000	0.989	1.061
00900	15	GALVESTON, TX	1.000	0.956	1.298
00900	18	HOUSTON, TX	1.020	1.017	1.297
00900	99	REST OF TEXAS	1.000	0.868	1.138
00910	09	UTAH	1.000	0.939	0.662
31145	50	VERMONT	1.000	0.972	0.514
00973	50	VIRGIN ISLANDS	1.000	0.993	1.003
00904	00	VIRGINIA	1.000	0.944	0.579
00836	02	SEATTLE (KING CNTY), WA	1.018	1.131	0.819
00836	99	REST OF WASHINGTON	1.000	0.979	0.819
00884	16	WEST VIRGINIA	1.000	0.822	1.547
00951	00	WISCONSIN	1.000	0.921	0.790
00825	21	WYOMING	1.000	0.856	0.935

Note: Work GPCI is the 1/4 work GPCI required by section 1848(e)(1)(A)(iii) of the Act. 1.0 Floor on Work GPCI, 1.67 for all Alaska indices, set by MMA GPCIs are scaled by the following factors: Work= 0.9977, Practice Expense=0.9930, Malpractice Expense=1.0021.

ADDENDUM I.—COMPARISON OF CURRENT 2004 GAFS TO PROPOSED 2005GAFS

[In descending order of difference]

Carrier No.	Loc. No.	Locality name	Current 2004 GAF	Proposed 2005 GAF	Difference	Percent difference
31140	09	SANTA CLARA, CA	1.184	1.225	0.040	3.41
31140	07	OAKLAND/BERKELEY, CA	1.111	1.144	0.033	2.96
31140	06	SAN MATEO, CA	1.201	1.230	0.029	2.44
31140	03	MARIN/NAPA/SOLANO, CA	1.104	1.128	0.025	2.25
31140	05	SAN FRANCISCO, CA	1.223	1.239	0.017	1.36
00903	01	DC + MD/VA SUBURBS	1.095	1.112	0.016	1.49
31143	01	METROPOLITAN BOSTON	1.118	1.132	0.014	1.24
00952	15	SUBURBAN CHICAGO, IL	1.059	1.073	0.014	1.31
00900	31	AUSTIN, TX	0.995	1.008	0.013	1.26
00836	02	SEATTLE (KING CNTY), WA	1.038	1.048	0.010	0.96
31146	17	VENTURA, CA	1.060	1.070	0.010	0.91
00511	01	ATLANTA, GA	1.027	1.036	0.009	0.88
31146	26	ANAHEIM/SANTA ANA, CA	1.098	1.106	0.008	0.72
00952	16	CHICAGO, IL	1.087	1.094	0.008	0.70
00954	00	MINNESOTA	0.967	0.974	0.007	0.70
00805	99	REST OF NEW JERSEY	1.060	1.065	0.005	0.50
00824	01	COLORADO	0.990	0.995	0.005	0.51

ADDENDUM I.—COMPARISON OF CURRENT 2004 GAFS TO PROPOSED 2005GAFS—Continued

[In descending order of difference]

Carrier No.	Loc. No.	Locality name	Current 2004 GAF	Proposed 2005 GAF	Difference	Percent difference
00805	01	NORTHERN NJ	1.111	1.116	0.005	0.45
00901	01	BALTIMORE/SURR. CNTYS, MD	1.025	1.030	0.005	0.48
00523	01	METROPOLITAN ST. LOUIS, MO	0.969	0.974	0.005	0.51
00952	12	EAST ST. LOUIS, IL	0.995	0.999	0.004	0.44
31142	03	SOUTHERN MAINE	0.986	0.989	0.003	0.31
00740	02	METROPOLITAN KANSAS CITY, MO	0.981	0.984	0.002	0.24
31146	99	REST OF CALIFORNIA*	1.008	1.011	0.002	0.22
31140	99	REST OF CALIFORNIA*	1.008	1.011	0.002	0.22
00900	18	HOUSTON, TX	1.026	1.028	0.002	0.21
00832	00	ARIZONA	0.994	0.996	0.002	0.20
00900	28	FORT WORTH, TX	0.992	0.993	0.002	0.16
00836	99	REST OF WASHINGTON	0.980	0.981	0.002	0.16
00512	00	MISSISSIPPI	0.919	0.920	0.002	0.16
00835	01	PORTLAND, OR	1.000	1.001	0.001	0.13
00904	00	VIRGINIA	0.955	0.956	0.001	0.14
00865	01	METROPOLITAN PHILADELPHIA, PA	1.067	1.069	0.001	0.12
00953	01	DETROIT, MI	1.106	1.107	0.001	0.10
00901	99	REST OF MARYLAND	0.979	0.980	0.001	0.11
00528	01	NEW ORLEANS, LA	0.985	0.986	0.001	0.10
00900	09	BRAZORIA, TX	1.003	1.004	0.001	0.09
00655	00	NEBRASKA	0.925	0.925	0.000	0.04
00900	11	DALLAS, TX	1.033	1.034	0.000	0.02
00831	01	ALASKA	1.670	1.670	0.000	0.00
00820	02	SOUTH DAKOTA	0.923	0.923	0.000	-0.01
00910	09	UTAH	0.961	0.960	0.000	-0.03
00834	00	NEVADA	1.025	1.024	-0.001	-0.05
00803	03	POUGHKPSIE/N NYC SUBURBS, NY	1.047	1.046	-0.001	-0.06
00591	00	CONNECTICUT	1.092	1.091	-0.001	-0.08
00826	00	IOWA	0.930	0.929	-0.001	-0.11
05535	00	NORTH CAROLINA	0.955	0.954	-0.001	-0.13
00880	01	SOUTH CAROLINA	0.932	0.931	-0.001	-0.14
31144	40	NEW HAMPSHIRE	1.009	1.007	-0.001	-0.13
00883	00	OHIO	0.974	0.973	-0.002	-0.17
00835	99	REST OF OREGON	0.949	0.947	-0.002	-0.18
00951	00	WISCONSIN	0.964	0.962	-0.002	-0.17
00973	20	PUERTO RICO	0.846	0.844	-0.002	-0.21
00660	00	KENTUCKY	0.937	0.935	-0.002	-0.20
00590	99	REST OF FLORIDA	0.987	0.985	-0.002	-0.21
00521	05	NEW MEXICO	0.952	0.950	-0.002	-0.23
31146	18	LOS ANGELES, CA	1.088	1.086	-0.002	-0.22
00630	00	INDIANA	0.945	0.942	-0.003	-0.27
00803	02	NYC SUBURBS/LONG I., NY	1.179	1.176	-0.003	-0.22
00650	00	KANSAS*	0.944	0.941	-0.003	-0.28
00740	04	KANSAS*	0.944	0.941	-0.003	-0.28
00952	99	REST OF ILLINOIS	0.958	0.956	-0.003	-0.28
00900	99	REST OF TEXAS	0.950	0.947	-0.003	-0.29
00520	13	ARKANSAS	0.910	0.907	-0.003	-0.31
00900	15	GALVESTON, TX	0.999	0.996	-0.003	-0.29
00511	99	REST OF GEORGIA	0.951	0.948	-0.003	-0.33
05130	00	IDAHO	0.928	0.925	-0.003	-0.34
31145	50	VERMONT	0.976	0.973	-0.003	-0.33
00953	99	REST OF MICHIGAN	0.994	0.990	-0.003	-0.34
05440	35	TENNESSEE	0.941	0.938	-0.004	-0.37
00820	01	NORTH DAKOTA	0.933	0.929	-0.004	-0.43
00522	00	OKLAHOMA	0.923	0.919	-0.004	-0.44
00740	99	REST OF MISSOURI*	0.917	0.913	-0.004	-0.46
00523	99	REST OF MISSOURI*	0.917	0.913	-0.004	-0.46
00801	99	REST OF NEW YORK	0.965	0.960	-0.004	-0.44
00833	01	HAWAII/GUAM	1.047	1.043	-0.004	-0.42
00510	00	ALABAMA	0.935	0.930	-0.004	-0.48
00528	99	REST OF LOUISIANA	0.946	0.941	-0.004	-0.48
31142	99	REST OF MAINE	0.947	0.942	-0.005	-0.51
00902	01	DELAWARE	1.018	1.013	-0.005	-0.49
00865	99	REST OF PENNSYLVANIA	0.961	0.956	-0.005	-0.54
00900	20	BEAUMONT, TX	0.964	0.959	-0.006	-0.59
00590	03	FORT LAUDERDALE, FL	1.038	1.033	-0.006	-0.55
00884	16	WEST VIRGINIA	0.953	0.946	-0.006	-0.66
00973	50	VIRGIN ISLANDS	1.010	1.004	-0.007	-0.65
00751	01	MONTANA	0.939	0.932	-0.007	-0.71
31143	99	REST OF MASSACHUSETTS	1.054	1.046	-0.008	-0.72

ADDENDUM I.—COMPARISON OF CURRENT 2004 GAFS TO PROPOSED 2005GAFS—Continued

[In descending order of difference]

Carrier No.	Loc. No.	Locality name	Current 2004 GAF	Proposed 2005 GAF	Difference	Percent difference
00825	21	WYOMING	0.953	0.944	-0.009	-0.92
00803	01	MANHATTAN, NY	1.225	1.216	-0.009	-0.75
00870	01	RHODE ISLAND	1.033	1.024	-0.009	-0.89
00590	04	MIAMI, FL	1.085	1.073	-0.011	-1.02
14330	04	QUEENS, NY	1.161	1.146	-0.015	-1.26

Note: GAFs based upon revised MEI weights as published in November 7, 2003 final rule; Work GPCI=52.466, Practice Expense GPCI=43.669, Malpractice GPCI=3.865

ADDENDUM J.—COMPARISON OF CURRENT 2004 GAFS TO PROPOSED 2006 GAFS

[in descending order of difference]

Carrier No.	Loc. No.	Locality name	Current 2004 GAF	Proposed 2006 GAF	Difference	Percent difference
31140	09	SANTA CLARA, CA	1.184	1.264	0.080	6.72
31140	07	OAKLAND/BERKELEY, CA	1.111	1.177	0.065	5.87
31140	06	SAN MATEO, CA	1.201	1.258	0.057	4.76
31140	03	MARIN/NAPA/SOLANO, CA	1.104	1.153	0.049	4.45
00903	01	DC + MD/VA SUBURBS	1.095	1.128	0.033	3.01
31140	05	SAN FRANCISCO, CA	1.223	1.255	0.033	2.68
31143	01	METROPOLITAN BOSTON	1.118	1.147	0.029	2.56
00952	15	SUBURBAN CHICAGO, IL	1.059	1.087	0.028	2.67
00900	31	AUSTIN, TX	0.995	1.023	0.027	2.74
00836	02	SEATTLE (KING CNTY), WA	1.038	1.060	0.021	2.04
31146	17	VENTURA, CA	1.060	1.079	0.019	1.80
00511	01	ATLANTA, GA	1.027	1.046	0.019	1.82
00952	16	CHICAGO, IL	1.087	1.104	0.017	1.54
31146	26	ANAHEIM/SANTA ANA, CA	1.098	1.114	0.017	1.51
00805	01	NORTHERN NJ	1.111	1.124	0.013	1.13
00954	00	MINNESOTA	0.967	0.979	0.013	1.29
00805	99	REST OF NEW JERSEY	1.060	1.073	0.012	1.18
00523	01	METROPOLITAN ST. LOUIS, MO	0.969	0.981	0.012	1.24
00901	01	BALTIMORE/SURR. CNTYS, MD	1.025	1.036	0.011	1.07
00952	12	EAST ST. LOUIS, IL	0.995	1.005	0.010	1.00
00824	01	COLORADO	0.990	0.999	0.010	0.97
00740	02	METROPOLITAN KANSAS CITY, MO	0.981	0.988	0.007	0.71
00900	09	BRAZORIA, TX	1.003	1.009	0.006	0.60
00900	28	FORT WORTH, TX	0.992	0.998	0.006	0.59
31142	03	SOUTHERN MAINE	0.986	0.992	0.006	0.56
00835	01	PORTLAND, OR	1.000	1.005	0.005	0.49
00904	00	VIRGINIA	0.955	0.959	0.004	0.43
31146	99	REST OF CALIFORNIA*	1.008	1.013	0.004	0.41
31140	99	REST OF CALIFORNIA*	1.008	1.013	0.004	0.41
00836	99	REST OF WASHINGTON	0.980	0.984	0.004	0.40
00900	18	HOUSTON, TX	1.026	1.029	0.004	0.35
00832	00	ARIZONA	0.994	0.997	0.003	0.34
00900	11	DALLAS, TX	1.033	1.037	0.003	0.32
00953	01	DETROIT, MI	1.106	1.109	0.003	0.25
00865	01	METROPOLITAN PHILADELPHIA, PA	1.067	1.070	0.003	0.26
00901	99	REST OF MARYLAND	0.979	0.981	0.002	0.22
00512	00	MISSISSIPPI	0.919	0.921	0.002	0.19
00655	00	NEBRASKA	0.925	0.926	0.001	0.13
00528	01	NEW ORLEANS, LA	0.985	0.986	0.001	0.07
00831	01	ALASKA	1.670	1.670	0.000	0.00
00910	09	UTAH	0.961	0.960	0.000	-0.04
00820	02	SOUTH DAKOTA	0.923	0.923	0.000	-0.05
31144	40	NEW HAMPSHIRE	1.009	1.008	-0.001	-0.08
00880	01	SOUTH CAROLINA	0.932	0.932	-0.001	-0.09
05535	00	NORTH CAROLINA	0.955	0.954	-0.001	-0.13
00900	99	REST OF TEXAS	0.950	0.948	-0.002	-0.19
00826	00	IOWA	0.930	0.928	-0.002	-0.22
00591	00	CONNECTICUT	1.092	1.090	-0.002	-0.20
00883	00	OHIO	0.974	0.972	-0.003	-0.27
00835	99	REST OF OREGON	0.949	0.946	-0.003	-0.30
00803	03	POUGHKPSIE/N NYC SUBURBS, NY	1.047	1.044	-0.003	-0.29
00973	20	PUERTO RICO	0.846	0.843	-0.003	-0.39
00520	13	ARKANSAS	0.910	0.906	-0.004	-0.39
00660	00	KENTUCKY	0.937	0.933	-0.004	-0.40
00834	00	NEVADA	1.025	1.021	-0.004	-0.36

ADDENDUM J.—COMPARISON OF CURRENT 2004 GAFS TO PROPOSED 2006 GAFS—Continued

[in descending order of difference]

Carrier No.	Loc. No.	Locality name	Current 2004 GAF	Proposed 2006 GAF	Difference	Percent difference
00590	99	REST OF FLORIDA	0.987	0.983	-0.004	-0.41
00521	05	NEW MEXICO	0.952	0.948	-0.005	-0.47
00952	99	REST OF ILLINOIS	0.958	0.954	-0.005	-0.48
31146	18	LOS ANGELES, CA	1.088	1.084	-0.005	-0.43
00511	99	REST OF GEORGIA	0.951	0.945	-0.006	-0.63
00630	00	INDIANA	0.945	0.939	-0.006	-0.64
00902	01	DELAWARE	1.018	1.011	-0.006	-0.61
00900	15	GALVESTON, TX	0.999	0.992	-0.006	-0.63
05440	35	TENNESSEE	0.941	0.935	-0.006	-0.67
00951	00	WISCONSIN	0.964	0.957	-0.006	-0.66
00650	00	KANSAS*	0.944	0.938	-0.006	-0.68
00740	04	KANSAS*	0.944	0.938	-0.006	-0.68
05130	00	IDAHO	0.928	0.921	-0.007	-0.70
00740	99	REST OF MISSOURI*	0.917	0.911	-0.007	-0.72
00523	99	REST OF MISSOURI*	0.917	0.911	-0.007	-0.72
31145	50	VERMONT	0.976	0.969	-0.007	-0.70
00953	99	REST OF MICHIGAN	0.994	0.986	-0.007	-0.75
00833	01	HAWAII/GUAM	1.047	1.040	-0.008	-0.74
00803	02	NYC SUBURBS/LONG I., NY	1.179	1.171	-0.008	-0.70
00820	01	NORTH DAKOTA	0.933	0.924	-0.009	-0.97
00884	16	WEST VIRGINIA	0.953	0.943	-0.009	-0.96
00522	00	OKLAHOMA	0.923	0.914	-0.009	-0.99
00865	99	REST OF PENNSYLVANIA	0.961	0.951	-0.009	-0.97
00528	99	REST OF LOUISIANA	0.946	0.936	-0.010	-1.02
00510	00	ALABAMA	0.935	0.925	-0.010	-1.06
31142	99	REST OF MAINE	0.947	0.937	-0.010	-1.07
00751	01	MONTANA	0.939	0.929	-0.010	-1.09
00801	99	REST OF NEW YORK	0.965	0.954	-0.011	-1.11
00900	20	BEAUMONT, TX	0.964	0.952	-0.012	-1.26
00973	50	VIRGIN ISLANDS	1.010	0.997	-0.013	-1.30
31143	99	REST OF MASSACHUSETTS	1.054	1.040	-0.014	-1.36
00590	03	FORT LAUDERDALE, FL	1.038	1.024	-0.015	-1.42
00870	01	RHODE ISLAND	1.033	1.016	-0.017	-1.65
00825	21	WYOMING	0.953	0.935	-0.018	-1.93
00803	01	MANHATTAN, NY	1.225	1.204	-0.021	-1.74
00590	04	MIAMI, FL	1.085	1.058	-0.027	-2.47
14330	04	QUEENS, NY	1.161	1.128	-0.032	-2.80

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