DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405 and 419

[CMS–1206–FC and CMS–1179–F]

RIN 0938–AL19 and 0938–AK59

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

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period revises the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements and changes arising from our continuing experience with this system. In addition, it describes changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system. These changes are applicable to services furnished on or after January 1, 2003. This rule also allows the Secretary to suspend Medicare payments ''in whole or in part'' if a provider fails to file a timely and acceptable cost report.

In addition, this rule responds to public comments received on the November 2, 2001 interim final rule with comment period (66 FR 55850) that set forth the criteria the Secretary will use to establish new categories of medical devices eligible for transitional pass-through payment under the Medicare's hospital outpatient prospective payment system. Finally, this rule responds to public comments received on the August 9, 2002 proposed rule for revisions to the hospital outpatient prospective payment system and payment rates (67 FR 52092). CMS finds good cause to waive proposed rulemaking for the assignment of new codes to Ambulatory Payment Classifications and for the payment of influenza and pneumococcal vaccines under reasonable cost; justification for the waiver will follow in a subsequent **Federal Register** notice.

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

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

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

SUPPLEMENTARY INFORMATION:

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Outline of Contents

I. Background

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

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

B. Summary of Rulemaking for the Outpatient Prospective Payment System

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

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

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

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

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

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

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

• On November 30, 2001, we published a final rule (66 FR 59856) that revised the Medicare OPPS to implement applicable statutory requirements, including relevant provisions of BIPA, and changes resulting from continuing experience with this system. It addition, it described the CY 2002 payment rates for Medicare hospital outpatient services paid under the PPS. This final rule also announced a uniform reduction of 68.9 percent to be applied to each of the transitional pass-through payments for certain categories of medical devices and drugs and biologicals.

• On December 31, 2001, we published a final rule (66 FR 67494) that delayed, until no later than April 1, 2002, the effective date of CY 2002 payment rates and the uniform reduction of transitional pass-through payments that were announced in the November 30, 2001 final rule. In addition, this final rule indefinitely delayed certain related regulatory provisions.

• On March 1, 2002, we published a final rule (67 FR 9556) that corrected technical errors that affected the amounts and factors used to determine the payment rates for services paid under the Medicare OPPS and corrected the uniform reduction to be applied to transitional pass-through payments for CY 2002 as published in the November 30, 2001 final rule. These corrections and the regulatory provisions that had been delayed became effective on April 1, 2002.

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

C. Authority for Payment Suspensions for Unfiled Cost Reports

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

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

1. Changes Relating to the OPPS

On August 9, 2002, we published a proposed rule (67 FR 52092) that set forth proposed changes to the Medicare hospital OPPS and CY 2003 payment rates including changes used to determine these payment rates. The following is a summary of the major changes that we proposed and the issues we addressed in the August 9, 2002 proposed rule.

a. *Changes Required By Statute*

We proposed the following changes to implement statutory requirements:

• Add APCs, delete APCs, and modify the composition of some existing APCs.

• Recalibrate the relative payment weights of the APCs.

• Update the conversion factor and the wage index.

• Revise the APC payment amounts to reflect the APC reclassifications, the recalibration of payment weights, and the other required updates and adjustments.

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

b. *Additional Changes to OPPS*

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

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

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

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

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

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

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

C. Changes to the Regulations Text

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

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

2. Changes Relating to Payment Suspension for Unfiled Cost Reports

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

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

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

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

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

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

• *Substantial clinical improvement.* The category describes devices that demonstrate a substantial improvement in medical benefits for Medicare beneficiaries compared to the benefits obtained by devices in previously established categories or other available treatments, as described in regulations at new § 419.66(c)(1).

• *Cost.* We determine that the estimated cost to hospitals of the devices in a new category (including any candidate devices and the other devices that we believe will be included in the category) is ''not insignificant'' relative to the payment rate for the applicable procedures.

We received five timely items of correspondence on the November 2, 2001 interim final rule with comment period. Summaries of the public comments and our responses to those comments are set forth below under the appropriate section heading of this final rule with comment period.

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

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

1. OPPS

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

• Expiration of pass-through payment for most devices and drugs/biologicals.

• Extent of reduction in payments for devices compared to payments in 2002.

• Potential impact on access to care of proposed payments.

• The proposal to package drugs with a per line cost less than $150 and to pay separately for others.

• Assignment and reassignment of codes to APCs (including assignments to procedural APCs from new tech APCs).

• Quality, quantity and content of claims data used to set payment weights.

• Continuation of a list of procedures that are not paid under OPPS because we believe that they should be performed as inpatient services.

• Policy on payment for outpatient observation care.

• Creation of evaluation and management codes for OPPS use.

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

2. Payment Suspension for Unfiled Cost Reports

Comments and Responses

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

Response: We appreciate the hospital associations supporting this change.

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

Response: We believe that immediate suspension of all payments when a cost report is not filed timely may not always be the appropriate response. However, if we require a provider to file a cost report, it is important for the cost report to be filed in a timely manner regardless of the amount of payment that is determined based on the cost report. We need flexibility in determining the amount of a provider's payments to suspend if its cost report is not filed timely. This could include the potential suspension of payments that are not determined by the cost report. Thus, we will retain § 405.371 of the regulation as set forth in the proposed rule.

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

Under the OPPS, we pay for hospital outpatient services on a rate-per-service basis that varies according to the APC group to which the service is assigned. Each APC weight represents the median

hospital cost of the services included in that APC relative to the median hospital cost of the services included in APC 601, Mid-Level Clinic Visits. The APC weights are scaled to APC 601 because a mid-level clinic visit is one of the most frequently performed services in the outpatient setting.

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

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

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

For purposes of the proposed rule and for this final rule with comment period, we analyzed the APC groups within this statutory framework.

A. Recommendations of the Advisory Panel on APC Groups

1. Establishment of the Advisory Panel

Section 1833(t)(9)(A) of the Act, requires that we consult with an outside panel of experts when annually reviewing and updating the APC groups and the relative weights. The Act specifies that the panel will act in an advisory capacity. The expert panel, which is to be composed of representatives of providers, is to review and advise us about the clinical integrity of the APC groups and their weights. The panel is not restricted to using our data and may use data collected or developed by organizations outside the Department in conducting its review.

On November 21, 2000, the Secretary signed the charter establishing an ''Advisory Panel on APC Groups'' (the Panel). The Panel is technical in nature and is governed by the provisions of the Federal Advisory Committee Act (FACA) as amended (Pub. L. 92–463). To establish the Panel, we solicited members in a notice published in the **Federal Register** on December 5, 2000 (65 FR 75943). We received applications from more than 115 individuals nominating either themselves or a colleague. After carefully reviewing the applications, we chose 15 highly qualified individuals to serve on the Panel. The first APC Panel meeting was held on February 27, February 28, and March 1, 2001, to discuss the 2001 APCs in anticipation of the 2002 OPPS.

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

2. General Issues Considered by the Advisory Panel

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

Content for Future Presentations to the Panel

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

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

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

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

Inpatient Only List

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

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

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

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

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

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

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

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

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

Multiple Bills

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

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

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

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

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

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

Packaging

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

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

would be returned to the provider for correction and resubmission.

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

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

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

Add-On Codes

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

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

3. Recommendations of the Advisory Panel and Our Responses

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Panel Recommendations to Defer Changes Pending Availability of 2001 Claims Data

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

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

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

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

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

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

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

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

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

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

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

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

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

APC 115: Cannula/Access Device Procedures

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

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

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

APC 363: Otorhinolaryngologic Function Tests

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Limit on Variation of Costs of Services Classified Within a Group

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

Taking into account the APC changes discussed in relation to the APC panel recommendations in this section of this preamble and the use of 2001 claims data to calculate the median cost of procedures classified to APCs, we reviewed all APCs to determine which of them would not meet the 2 times limit. We use the following criteria when deciding whether to make exceptions to the 2 times rule for affected APCs:

- Resource homogeneity.
- Clinical homogeneity.
- Hospital concentration.
- Frequency of service (volume).
- Opportunity for upcoding and code fragmentation.

For a detailed discussion of these criteria, refer to the April 7, 2000, final rule (65 FR 18457).

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

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

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

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

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

Table 2 contains the final list of APCs that we exempt from the 2 times rule based on the criteria cited above. In cases in which compliance with the 2 times rule appeared to conflict with a recommendation of the APC Advisory Panel, we generally accepted the Panel recommendation. This was because Panel recommendations were based on explicit consideration of resource use, clinical homogeneity, hospital specialization, and the quality of the data used to determine payment rates.

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

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

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

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

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

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

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

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

In the November 30, 2001 final rule, we made final our proposal to change the period of time during which a service may be paid under a new technology APC (66 FR 59903), initially established in the April 7, 2000 final rule. That is, beginning in 2002, we will retain a service within a new technology APC group until we have acquired adequate data that allow us to assign the service to a clinically appropriate APC. This policy allows us to move a service from a new technology APC in less than 2 years if sufficient data are available, and it also allows us to retain a service in a new technology APC for more than 3 years if sufficient data upon which to base a decision for reassignment have not been collected.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

New Technology APC Issues

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

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

New Technology APC for Preview Planning Software

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HCPCS Codes Created During CY 2002

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Drug-Eluting Stents

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

The new HCPCS codes that we proposed are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

G codes for Outpatient Services Under National Clinical Trials

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

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

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

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

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

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

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

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

General comments on creation and use of G codes

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

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

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

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

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

Public Comments on Interim APC Assignments for Codes New for 2003

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

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

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

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

4. Other Public Comments on APC Assignments and Payment Rates

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

we will present this issue to the APC Advisory Panel.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

needed to support the procedure that the physician provides.

5. Procedures That Will Be Paid Only as Inpatient Procedures

Section 1833(t)(1)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. In the April 7, 2000, final rule, we identified procedures that are typically provided only in an inpatient setting and, therefore, would not be paid by Medicare under the OPPS (65 FR 18455). These procedures comprise what is referred to as the ''inpatient list.'' The inpatient list specifies those services that are only paid when provided in an inpatient setting. As we discussed in the April 7, 2000, and the November 30, 2001, final rules, we use the following criteria when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under the OPPS:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes we have already moved off the inpatient list.

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

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

- We have determined that the procedure is being performed in numerous hospitals on an outpatient basis; or
- We have determined that the procedure can be appropriately and safely performed in an ASC and is on the list of approved ASC procedures or proposed by us for addition to the ASC list.

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

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

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

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

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

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

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

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

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

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

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

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

Response: As we stated above, anyone interested in having a particular code or group of codes on the inpatient list reviewed for payment under the OPPS need only submit a request to the Director, Division of Outpatient Care, Centers for Medicare & Medicaid Services, Mailstop C4–05–17, 7500 Security Boulevard, Baltimore, MD 21244–1850. The request should include supporting information and data to demonstrate that the code meets the five criteria discussed above. We ask that evidence be submitted, including operative reports of actual cases and peer-reviewed medical literature, to demonstrate that the procedure is being performed on an outpatient basis in a safe and appropriate manner in a variety of different types of hospitals. We agree with the commenters suggestions, and encourage, in addition to medical literature, the submission of community medical standards and practice as well physician comments, outcome data, and post-procedure care data to reinforce the point.

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

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

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

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

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

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

Comment: Two commenters supported our proposal to remove CPT

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Partial Hospitalization

Payment Methodology

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

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

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

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

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

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

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

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

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

III. Recalibration of APC Weights for 2003

Section 1833(t)(9)(A) of the Act requires that the Secretary review and revise the relative payment weights for APCs at least annually, beginning in 2001 for application in 2002. In the April 7, 2000 final rule (65 FR 18482), we explained in detail how we calculated the relative payment weights that were implemented on August 1, 2000 for each APC group. Except for some reweighting due to APC changes, these relative weights continued to be in effect for 2001. (See the November 13, 2000, interim final rule (65 FR 67824 to 67827).)

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

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

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

A. Data Issues

1. Treatment of ''Multiple Procedure'' Claims

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

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

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

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

Comments and our responses are summarized below:

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

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

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

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

Recommendations for Including More Multiple Procedure Claims

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Absence of Devices on Claims

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

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

B. Description of How Weights Were Calculated for CY 2003

As discussed previously in this section, we first selected claims for services provided from April 1, 2001 through March 31, 2002. The methodology we followed to calculate the final APC relative payment weights for CY 2003 is as follows:

- We excluded from the data claims for those bill and claim types that would not be paid under the OPPS (for example, bill type 72X for dialysis services for patients with ESRD).
- We eliminated 1.6 million claims from hospitals located in Maryland, Guam, and the U. S. Virgin Islands.
- Using the most recent available cost report from each hospital, we converted billed charges to costs and aggregated them to the procedure or visit level first by identifying the cost-to-charge ratio specific to each hospital's cost centers (''cost center specific cost-to-charge ratios'' or CCRs) and then by matching the CCRs to revenue centers used on the hospital's 2001 outpatient bills. The CCRs include operating and capital costs but exclude items paid on a reasonable cost basis.
- We eliminated from the hospital CCR data 301 hospitals that we identified as having reported charges on their cost reports, which were not actual charges (for example, a uniform charge applied to all services).
- We calculated the geometric mean of the total operating CCRs of hospitals remaining in the CCR data. We removed from the CCR data 67 hospitals whose total operating CCR exceeded the geometric mean by more than 3 standard deviations.
- We excluded from our data approximately 3.6 million claims submitted by the hospitals that we removed or trimmed from the hospital CCR data.
- We matched revenue centers from the remaining universe of approximately 92.9 million claims to CCRs for remaining hospitals.
- We separated the 92.9 million claims that we had matched with a cost report into the following three distinct groups:

(1) Single-procedure claims.

(2) Multiple-procedure claims.

(3) Claims on which we could not identify at least one OPPS covered service.

Single-procedure claims are those that include only one HCPCS code (other than laboratory and incidentals such as packaged drugs and venipuncture), which could be grouped to an APC. Multiple-procedure claims include more than one HCPCS code that could be mapped to an APC. Dividing the claims in this manner yielded approximately 30.7 million single-procedure claims and 20.4 million multiple-procedure claims. Approximately 41.8 million claims without at least one covered OPPS service were set aside.

We converted 10.8 million multiple-procedure claims to single-procedure claims using the following criteria:

(1) If a multiple-procedure claim contained lines with a HCPCS code in the pathology series (that is, CPT 80000 series of codes), we treated each of those lines as a single claim.

(2) For multiple procedure claims with a packaged HCPCS code (status indicator ''N'') on the claim, we ignored line items for chest X-rays (HCPCS codes 71010 and/or 71020) and/or EKGs (HCPCS code 93005) on these claims. If only one procedure (other than HCPCS codes 71010, 71020, and 93005) existed on the claim, we treated it as a single-procedure claim.

(3) If the claim had no packaged HCPCS codes and if there were no packaged revenue centers on the claim, we treated each line with a procedure as a single claim if the line item was billed as a single unit.

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

- To calculate median costs for services within an APC, we used only single-procedure bills and those multiple procedure bills that we converted into single claims. If a claim had a single code with a zero charge (that would have been considered a single-procedure claim), we did not use it. As we discussed in section III.A.1 of this final rule, we did not use multiple-procedure claims that included more than one separately payable HCPCS code with charges for packaged items and services such as anesthesia, recovery room, or supplies that could not be reliably allocated or apportioned among the primary HCPCS codes on the claim. We have not yet developed what we regard as an acceptable method of using other multiple-procedure bills to recalibrate APC weights that minimizes the risk of improperly assigning charges to the wrong procedure or visit.
- For each single-procedure claim, we calculated a cost for every billed line item charge by multiplying each revenue center charge by the appropriate hospital-specific departmental CCR. If an appropriate cost center did not exist for a given hospital, we crosswalked the revenue center to a secondary cost center when possible, or we used the hospital's overall cost-to-charge ratio for outpatient department services. We excluded from this calculation all charges associated with HCPCS codes previously defined as not paid under the OPPS (for example, laboratory, ambulance, and therapy services). We included all charges associated with HCPCS codes that are designated as packaged services (that is, HCPCS codes with the status indicator of ''N'').
- To calculate per-service costs, we used the charges shown in revenue centers that contained items integral to performing the service. We observed the packaging provisions set forth in the April 7, 2000 final rule with comment period that were in effect during 2001 (65 FR 18484). For instance, in calculating the cost of a surgical procedure, we included charges for the operating room; treatment rooms; recovery; observation; medical and surgical supplies; pharmacy; anesthesia; casts and splints; and donor tissue, bone, and organs. To determine medical visit costs, we included charges for items such as medical and surgical supplies, drugs, and observation in those instances where they are still packaged. Table 7 lists packaged services by revenue center that we proposed to use to calculate per-service

costs for outpatient services furnished in CY 2003.

TABLE 7.—PACKAGED SERVICES BY REVENUE CODE

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

TABLE 7.—PACKAGED SERVICES BY REVENUE CODE—Continued

Revenue code	Description
	OTHER DIAGNOSTIC
254	PHARMACY INCIDENT TO OTHER DIAGNOSTIC.
280	ONCOLOGY.
289	OTHER ONCOLOGY.
372	ANESTHESIA INCIDENT TO OTHER DIAGNOSTIC.
560	MEDICAL SOCIAL SERVICES.
569	OTHER MEDICAL SOCIAL SERVICES.
622	SUPPLIES INCIDENT TO OTHER DIAGNOSTIC.
624	INVESTIGATIONAL DEVICE (IDE). .
710	RECOVERY ROOM.
719	OTHER RECOVERY ROOM.
762	OBSERVATION ROOM.
	RADIOLOGY
255	PHARMACY INCIDENT TO RADIOLOGY.
280	ONCOLOGY.
289	OTHER ONCOLOGY.
371	ANESTHESIA INCIDENT TO RADIOLOGY.
560	MEDICAL SOCIAL SERVICES.
569	OTHER MEDICAL SOCIAL SERVICES.
621	SUPPLIES INCIDENT TO RADIOLOGY.
624	INVESTIGATIONAL DEVICE (IDE).
710	RECOVERY ROOM.
719	OTHER RECOVERY ROOM.
762	OBSERVATION ROOM.
	ALL OTHER APC GROUPS
250	PHARMACY.
251	GENERIC.
252	NONGENERIC.
257	NONPRESCRIPTION DRUGS.
258	IV SOLUTIONS.
259	OTHER PHARMACY.
260	IV THERAPY, GENERAL CLASS.
262	IV THERAPY PHARMACY SERVICES.
263	IV THERAPY DRUG/SUPPLY/DELIVERY.
264	IV THERAPY SUPPLIES.
269	OTHER IV THERAPY.
270	M&S SUPPLIES.
271	NONSTERILE SUPPLIES.
272	STERILE SUPPLIES.
279	OTHER M&S SUPPLIES.
560	MEDICAL SOCIAL SERVICES.
569	OTHER MEDICAL SOCIAL SERVICES.
630	DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS.
631	SINGLE SOURCE DRUG.
632	MULTIPLE SOURCE DRUG.
633	RESTRICTIVE PRESCRIPTION.
762	OBSERVATION ROOM.
942	EDUCATION/TRAINING.

• We standardized costs for geographic wage variation by dividing the labor-related portion of the operating and capital costs for each billed item by the FY 2003 hospital inpatient prospective payment system (IPPS) wage index published in the **Federal Register** on August 1, 2002 (67 FR 49982). We used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. We have used this estimate since the inception of the OPPS and continue to believe that it is appropriate. (See the April 7, 2000 final rule (65 FR 18496) for a complete description of how we derived this percentage).

• We summed the standardized labor-related cost and the nonlabor-related cost component for each billed item to derive the total standardized cost for each procedure or medical visit.

• We removed extremely unusual costs that appeared to be errors in the data using a trimming methodology analogous to what we use in calculating the diagnosis-related group (DRG) weights for the hospital IPPS. That is, we eliminated any bills with costs outside of three standard deviations from the geometric mean.

• After trimming the procedure and visit level costs, we mapped each procedure or visit cost to its assigned APC, including the proposed APC changes described in section II.A of this final rule.

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

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

• Using these median APC costs, we calculated the relative payment weights for each APC. As in prior years, we scaled all the relative payment weights to APC 0601, mid-level clinic visit, because it is one of the most frequently performed services in the hospital outpatient setting. This approach is consistent with that used in developing RVUs for the Medicare physician fee schedule. We assigned APC 0601 a relative payment weight of 1.00 and divided the median cost for each APC by the median cost for APC 0601 to derive the relative payment weight for each APC. Using the 2001 through 2002 data, the median cost for APC 0601 is $57.56.

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

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

Changes in Payment Rates from 2002 to 2003

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TABLE 8.—BLOOD AND BLOOD PRODUCTS WITH SPECIAL LIMITS

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

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

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

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

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

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

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

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

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

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

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

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

Use of Cost-to-Charge Ratios and Charge Compression

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

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

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

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

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

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

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

Use of Means Rather Than Medians To Set Weights

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

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

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

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

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

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

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

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

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

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

Release of Crosswalk for Packaging Costs to Specific APCs

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

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

Impact of Medical Education on OPPS Payment Adequacy

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

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

Elimination of Payment for Cochlear Implants and Vagus Nerve Stimulators

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

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

Underfunding of OPPS in General

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

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

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

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

Data Issues Peculiar to Radiopharmaceuticals

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

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

Methodological Reasons That the Data for Drugs Are Flawed

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

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

Elimination of Data for Hospitals Without Actual Charges

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

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

Impact of Rounding of Relative Weights for Drugs

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

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

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

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

Need for a Special Exceptions Process

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

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

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

Claims Process

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

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

Reduced Quality of Care for Gamma Knife Services

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

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

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

IV. Transitional Pass-Through and Related Payment Issues

A. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain medical devices, drugs, and biologicals.

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

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

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

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

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

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

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

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

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

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

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

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

B. Discussion of Pro Rata Reduction

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for a given year to an ''applicable percentage'' of projected total payments under the hospital OPPS. For a year before 2004, the applicable percentage is 2.5 percent; for 2004 and subsequent years, we specify the applicable percentage up to 2.0 percent. If we estimate before the beginning of the calendar year that the total amount of pass-through payments in that year would exceed the applicable percentage, section 1833(t)(6)(E)(iii) of the Act requires a (prospective) uniform reduction in the amount of each of the transitional pass-through payments made in that year to ensure that the limit is not exceeded. We make an estimate of pass-through spending to determine not only whether pass-through payments will exceed the applicable percentage but also to determine the appropriate reduction to the conversion factor.

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

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

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

Estimates of Pass-Through Spending

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

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

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

Response: Section 1833(t)(6)(E)(i) of the Act requires that the Secretary estimate the total pass-through payments to be made for the forthcoming year (which allows us to determine the amount of the conversion factor for the forthcoming year) and to the extent the estimate exceeds the statutory limit, reduce the amount of each pass-through payment. For 2003,

the statutory limit is 2.5 percent of total estimated program payments. In the August 9, 2002 proposed rule, we provided our best estimate at that time of pass-through payments for the drugs and devices for which we expected to make pass-through payments in 2003, and we explained our methodology for determining the estimate for the final rule. We provided a list of the devices and drugs we either knew would be paid under pass-through next year or which we believed may be paid as pass-through items in 2003.

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

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

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

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

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

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

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

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

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

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

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

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

Two commercial epoetin-alpha products are currently marketed in the United States: Epogen™ (marketed by Amgen) and Procrit™ (marketed by Ortho Biotech). These products are exactly the same but are marketed under two different trade names. Both Epogen™ and Procrit™ are approved by FDA for marketing for the following conditions: (1) Treatment of anemia of chronic renal failure (including patients

on and not on dialysis), (2) treatment of Zidovudine-related anemia in HIV patients, (3) treatment of anemia in cancer patients on chemotherapy, and (4) treatment of anemia related to allogenic blood transfusions in surgery patients. Both products are given either intravenously or subcutaneously up to three times a week.

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

Because darbepoetin alpha has two additional carbohydrate side-chains, it is not structurally identical to epoetin alpha. However, the two products are functionally equivalent: In this case, both products use the same biological mechanism to produce the same clinical result, stimulation of the bone marrow to produce red blood cells. Thus, Epogen™, Procrit™, and Aranesp™ are all functionally equivalent.

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

In clinical practice, CMS recognizes that no strict method of converting an epoetin alpha dose to a darbepoetin alpha dose exists. There are general guidelines for conversion, and clinicians modify the dose based on the patient's hematopoietic response. For developing a payment policy, however, it is feasible to establish a method of converting the dose of each of these drugs to the other.

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

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

CMS's identification of a conversion ratio between the dosages of these two products, darbepoetin alpha and epoetin alpha, is solely for the purpose of developing a Medicare payment policy. It is not meant to imply or suggest what should be done for individual patients in clinical practice. In addition, by using a conversion ratio CMS is not attempting to establish a lower or upper limit on the amount of either biological a physician can prescribe to a patient. CMS expects that physicians will continue to prescribe these biologicals based on the needs of individual patients. In terms of payment, however, CMS considers these biologicals to be functionally equivalent (even if structurally different), and, therefore, will establish an equitable payment policy that relates dosage of the agents to each other.

In our review, we placed the greatest emphasis on published, high quality clinical studies and looked for the best possible estimates based on an evaluation of the dosing of each product that, on average, produced the same clinical response. Based on our own review of the evidence, our consultation with the independent contactor who also reviewed the evidence, and our discussions with Amgen and Ortho Biotech, CMS concludes that an appropriate conversion ratio for the purposes of a payment policy is to 260 International Units of epoetin alpha to one microgram of darbepoetin alpha (260:1).

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

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

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

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

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

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

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

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

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

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

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

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

Other commenters objected to our estimates for specific drugs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Expiration of Transitional Pass-Through Payments in Calendar Year 2003 for Devices

Section 1833(t)(6)(B)(iii) of the Act requires that a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3, years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category. We proposed that 95 device categories currently in effect will expire effective January 1, 2003. Our proposed payment methodology for devices that have been paid by means of pass-through categories, but for which pass-through status will expire effective January 1, 2003, is discussed in the section below.

Although the device category codes became effective on April 1, 2001, many of the item-specific C-codes for pass-through devices that were crosswalked to the new category codes were approved for pass-through payment in CY 2000, or as of January 1, 2001. (The crosswalk for item-specific C-codes to category codes was issued in Transmittals A–01–41 and A–01–97,) To establish the expiration date for the category codes listed in Table 10, we determined when item-specific devices that are described by the categories were first made effective for pass-through payment before the implementation of device categories. These dates are listed in Table 7 in the column entitled ''Date First Populated.'' We proposed to base the expiration date for a device category on the earliest effective date of pass-through status for any device that populates that category. Thus, the 95 categories for devices that will have been eligible for pass-through payments for at least 2 years as of December 31, 2002 would not be eligible for pass-through payments effective January 1, 2003.

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

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

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

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

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

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

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

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

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

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

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

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

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

General

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

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

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

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

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

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

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

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

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

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

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

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

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

Expiration of Device Categories

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

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

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

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

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

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

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

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

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

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

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

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

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

Use of Codes for Expiring Categories After January 1, 2003

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

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

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

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

New Device Categories

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

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

Stent Categories C1874 and C1875

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

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

DME Payment for Implantable Devices

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

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

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

Category C1765, Adhesion Barrier

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

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

Cochlear Implants

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

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

IOLs

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

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

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

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

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

Dialysis Access Systems

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

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

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

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

Specific Category Applications

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

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

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

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

Drugs as Packaged Supplies

As we explained in the April 7, 2000 final rule, we generally package the cost of drugs and biologicals into the APC payment rate for the primary procedure or treatment with which the drugs are usually furnished (65 FR 18450). Hospitals do not receive separate payment from Medicare for packaged items and supplies, and hospitals may not bill beneficiaries separately for any such packaged items and supplies whose costs are recognized and paid for within the national OPPS payment rate for the associated procedure or service. (Transmittal A–01–133, a Program Memorandum issued to Intermediaries on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services.) Hospitals bill for costs directly related and integral to performing a procedure or furnishing a service using a revenue center or packaged HCPCS code (status indicator ''N''). As discussed earlier in section III.A.2 of the preamble, we list the packaged services, by revenue center, that we use to calculate per-service costs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

General

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

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

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

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

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

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

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

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

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

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

Comments on this proposal and our responses are summarized below:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Packaging Issue

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

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

Orphan Drugs

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

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

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

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

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

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

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

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

Blood and Blood Products

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Vaccines Covered Under a Benefit Other Than OPPS

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

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

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

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

Higher Cost Drugs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Remote Afterloading High Intensity Brachytherapy

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

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

Prostate Brachytherapy

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

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

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

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

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

Packaging of Other Device Costs Associated With Brachytherapy

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

Brachytherapy

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

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

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

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

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

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

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

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

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

Response: We agree and will do so.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Response: We calculated payments for pass-through drugs and devices in accordance with the statute in sections 1833(t)(6)(D)(i) and (ii) of the Act.

Comment: Numerous commenters were concerned with the time required to incorporate new drugs and biologicals into the APC system. Some commenters indicated that we frequently depart from our own timeframe of 4 to 7 months from the date of submission of an application to the potential effective data for pass-through status. Thus, they urged us to follow one of the following recommendations: Expedite the processing of pass-through applications and the creation of C codes; develop C codes for products pending FDA approval, or permit retroactive dates for new codes to allow for retroactive reimbursement for hospitals. Another commenter suggested that we create a centralized on-line listing of all current pass-through drugs, biologicals, and devices along with all of the new applications under review.

Response: We understand the commenters' concerns, and we would like to clarify the operation of our quarterly deadlines. We establish deadlines for submission of transitional pass-through applications that are 4 months in advance of the next quarterly update to the claims-payment system in order to accommodate time for review and decision and for revisions to the claims-payment systems. Thus an applicant submitting by the deadline can be assured we will consider the application for possible inclusion in the next quarterly update. However, we cannot guarantee that we will be able to make a decision regarding the application within that period of time. Incomplete applications or the need to answer technical questions that arise during review may extend the period of review.

We have instructed hospitals through our fiscal intermediaries that hospitals may bill for new drugs following FDA approval using an unspecified HCPCS code until a permanent HCPCS is established for the drug and/or we have approved pass-through payment for the drug. Payment for a new drug, if determined by the fiscal intermediary to be a covered drug, would be packaged. However inclusion of the drug charges for the procedure will be considered in determining outlier payments and will be used in future rate setting for the procedure and/or the drug once its pass-through status expires. Hospitals should note that we have lowered the threshold for outlier payments for 2003, and this new threshold requirement is described in section IX of the preamble.

We intend to minimize the delays in the review process as much as possible so that we can facilitate access to new products and services for our beneficiaries, which is why we review new pass-through applications on a quarterly basis. We disagree with the commenters who suggested that we allow retroactive reimbursement for hospitals to the date of FDA approval. Moving to such a policy would greatly increase the burden on our and hospitals' computer systems in programming, testing, and implementing updates to the payment system. We do not provide for retroactive changes in reimbursement because this is a prospectively

determined payment system and because retroactive payment rate changes are administratively burdensome and confusing for beneficiaries and providers.

We appreciate the suggestion to create an on-line listing of all transitional pass-through items and applications that are under review, and will consider it for the future.

Comment: Several national trade associations and drug companies were concerned with our proposal to consider drugs and biologicals that were subject to repackaging as multisource drugs. They indicated that repackagers do not manufacture the products; instead, they purchase the products from the manufacturers, package them differently, and then sell the products. The manufacturer of the product continues to be the sole source of the product; therefore, we should regard repackaged products as sole source drugs. Also, they recommended that we utilize the ''Orange Book'' to determine whether a drug should considered single source, multisource, or generic for OPPS purposes.

Response: We acknowledge that we treat certain drugs that have only one manufacturer as a multisource drug. Our rationale behind regarding a repackaged drug as a multisource product is that, even though there may be only one manufacturer of a repackaged drug, there is more than one party selling the repackaged drug in the market. Therefore, a repackager may charge a different price to hospitals for the same product sold by its manufacturer. Our intention in the payment system is to account for the economic relationship between market prices for repackagers, multisource drugs, and sole source drugs. From our analysis, we judged the drugs sold by repackagers to be similar to drugs available from more than one manufacturer in terms of price differentials and estimated hospital acquisition costs. We also note that if we were to recategorize these drugs as single source, we would have to recalculate the average values for acquisition costs for the three categories of drugs.

Comment: Several commenters suggested that we use the October 2002 Red Book information to set the final pass-through payment rates for 2003. Also, the commenters urged us to update the pass-through payment rates quarterly since there will be significantly fewer pass-through drugs in 2003.

Response: Upon considering the commenters' suggestions in using the October 2002 Red Book to set the pass-through payment rates for drugs and biologicals, we decided to continue using the July 2002 Red Book as we proposed since it is most consistent with our publication schedule. In the future, for all of our final rules that must be published by November, we will continue to use the July edition of the Red Book for that year.

We carefully considered the proposal to update the pass-through payments on a quarterly basis and decided to continue with only annual updates of the rates. From previous experience, we know that doing a quarterly update of the prices for all the pass-through drugs and biologicals would be burdensome on our contractors and disruptive to both our computer systems and pricing software. Although we make other updates on a quarterly basis, we do not include revision of rates in these updates unless an error was made in the calculation of the rate. We see no compelling reason to update the transitional pass-through drug prices under the OPPS more frequently than the other payment rates in the outpatient system.

Comment: Several commenters indicated that in the proposed rule we appeared intent on estimating pass-through expenditures that will exceed the statutory cap and trigger a pro-rata reduction of pass-through payments in 2003.

Response: Frankly, we find it puzzling that commenters would believe we would manipulate the estimates of pass-through spending with the intention of ensuring that a pro-rata reduction would be imposed. Our estimate of transitional pass-through spending indicates that no pro-rata reduction will be necessary in 2003.

Comment: A commenter urged us to develop a process for acknowledgement and payment adjustment when it is determined that the rates published in the Red Book are incorrect.

Response: As stated elsewhere in this final rule, we update payment rates for pass-through drugs and biologicals only on an annual basis using the information published in the July edition of the Red Book. We rely on information supplied by manufacturers to the Red Book to be accurate.

V. Criteria for New Device Categories As Implemented in the November 2, 2001 Interim Final Rule With Comment

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), Public Law 106–113, amended section 1833(t) of the Act to make major changes that affected the new PPS for hospital outpatient services. Section 1833(t)(6) of the Act, which was added by section 201(b) of the BBRA, provided for temporary additional payments, referred to as ''transitional pass-through payments,'' for certain drugs, biologicals, and devices. Section 1833(t)(b) of the Act provided for payment of new medical devices, as well as new drugs and biologicals, in instances in which the item was not being paid as a hospital outpatient service as of December 31, 1996, and when the cost of the item is ''not insignificant'' in relation to the OPPS payment amount. Section 402 of BIPA, which amends section 1833(t)(6) of the Act, requires us to use categories in determining the eligibility of devices for transitional pass-through payments effective April 1, 2001. Section 1833(t)(6)(B)(ii)(IV) of the Act, as added by section 402(a) of BIPA, requires us to establish a new category for a medical device when—

- The cost of the device is not insignificant in relation to the OPPS payment amount;
- No existing or previously existing device category is appropriate for the device; and
- Payment was not being made for the device as an outpatient hospital service as of December 31, 1996. However, section 1833(t)(6)(B)(iv) of the Act, also added by section 402(a) of BIPA, provides that a medical device shall be treated as meeting the first and third requirements if either—
- The device is described by one of the initial categories established and in effect or
- The device is described by one of the additional categories we established and in effect, and—

—An application under section 515 of the Federal Food, Drug, and Cosmetic Act has been approved; or

—The device has been cleared for market under section 510(k) of the Federal Food, Drug, and Cosmetic Act; or

—The device is exempt from the requirements of section 510(k) of the Federal Food, Drug, and Cosmetic Act under section 510(l) or section 510(m) of that Act.

Thus, otherwise covered devices that are described by a currently existing category may be eligible for transitional pass-through payments even if they were paid as part of an outpatient service as of December 31, 1996. At the same time, no categories will be created on the basis of devices that were paid on or before December 31, 1996.

Section 1833(t)(6)(B)(i)(I) of the Act, as amended by BIPA, required us to establish, by April 1, 2001, an initial set of categories based on device by type in such a way that specific devices eligible

for transitional pass-through payments under sections 1833(t)(A)(ii) and (iv) of the Act as of January 1, 2001 would be included in a category. We developed this initial set of categories in consultation with groups representing hospitals, manufacturers of medical devices, and other affected parties, as required by section 1833(t)(6)(B)(i)(II) of the Act. We issued the list of initial categories on March 22, 2001, in Program Memorandum (PM) No. A–01–41. Subsequently, an additional two categories and clarifications of some of the categories' long descriptors were made. The latest PM that lists all the existing device categories (including three additional categories that became effective July 1, 2002) is Transmittal No. A–02–050, issued June 17, 2002, which can be accessed on our Web site, *http://cms.hhs.gov.*

Section 1833(t)(6)(B)(ii)(III) of the Act, as amended by BIPA, requires us to establish criteria by July 1, 2001 that will be used to create additional categories. Section 1833(t)(6)(B)(ii)(II) of the Act requires that no medical device is described by more than one category. In addition, the criteria must include a test of whether the average cost of devices that would be included in a category is ''not insignificant'' in relation to the APC payment amount for the associated service.

On November 2, 2001, we set forth in an interim final rule (66 FR 55850) the criteria for establishing new (that is, additional) categories of medical devices eligible for transitional pass-through payments under the OPPS as required by section 1833(t)(6)(B)(ii) of the Act. We received five comments regarding our criteria published in the November 2, 2001 interim final rule with comment period. We summarize and respond to these comments below.

A. Criteria for Eligibility for Pass-Through Payment of a Medical Device

As noted above, in our April 7, 2000 final rule with comment period (65 FR 18480), we defined new or innovative devices using eight criteria, three of which were revised in our August 3, 2000 interim final rule with comment period (65 FR 47673 through 47674). These criteria were set forth in regulations at § 419.43(e)(4). For the most part, these criteria remained applicable when defining a new category for devices. That is, devices to be included in a category must meet all previously established applicable criteria for a device eligible for transitional pass-through payments. The definition of an eligible device, however, needed to change to conform to the requirements of the amended section 1833(t)(6)(B)(ii) of the Act, that is, the requirement to establish additional categories, which we accomplished in our November 2, 2001 interim final rule.

In addition, we clarified our criterion that states that a device must be approved or cleared by the FDA. The approval or clearance criterion applies only if FDA approval or clearance is required for the device as specified at new § 419.66(b)(1). For example, a device that has received an FDA investigational device exemption (IDE) and has been classified as a Category B device by the FDA in accordance with § 405.203 through § 405.207 and § 405.211 through § 405.215 is exempt from this requirement. A device that has received an FDA IDE and is classified by the FDA as a Category B device is eligible for a transitional pass-through payment if all other requirements are met.

B. Criteria for Establishing Additional Device Categories

As described above, in determining the criteria for establishing additional categories, section 1833(t)(6)(B)(ii) of the Act mandates that new categories must be established for devices that were not being paid for as an outpatient hospital service as of December 31, 1996, and for which no category in effect (or previously in effect) is appropriate in such a way that no device is described by more than one category and the average cost of devices to be included in a category is not insignificant in relation to the APC payment amount for the associated service. Based on these requirements, we announced in the November 2, 2001 interim final rule that we will use the following criteria to establish a category of devices:

- *Substantial clinical improvement.* The category describes devices that demonstrate a substantial improvement in medical benefits for Medicare beneficiaries compared to the benefits obtained by devices in previously established (that is, existing or previously existing) categories or other available treatments, as described in regulations at new § 419.66(c)(1).

We stated our belief that this criterion ensures that no existing or previously existing category contains devices that are substantially similar to the devices to be included in the new category. This criterion is consistent with the statutory mandate that no device is described by more than one category.

In addition, we said that this criterion limits the number of new categories, and consequently transitional pass-through payments, to those categories containing devices that offer the prospect of substantial clinical improvement in the care of Medicare beneficiaries. Section 1833(t)(6)(E)(iii) of the Act, requires that, if the Secretary estimates before the beginning of the year that the total estimated amount of pass-through payments would exceed a specified percentage of total program payments (2.5 percent before 2004 and no more than 2 percent thereafter), we must uniformly reduce (prospectively) each pass-through payment in that year by an amount adequate to ensure that the limit is not exceeded.

We established this criterion because it is important for hospitals to receive pass-through payments for devices that offer substantial clinical improvement in the treatment of Medicare beneficiaries to facilitate access by beneficiaries to the advantages of the new technology. Conversely, the need for additional payments for devices that offer little or no clinical improvement over a previously existing device is less apparent. These devices can still be used by hospitals, and hospitals will be paid for them through the appropriate APC payment. To the extent these devices are used, the hospitals' charges for the associated procedures will reflect their use. We will use data on hospital charges to update the APC payment rates as part of the annual update cycle. Thus, the payment process will provide an avenue to reflect appropriate payments for devices that are not substantial improvements.

We are currently evaluating requests for a new category of devices against the following criteria in order to determine if it meets the substantial clinical improvement requirement:

- The device offers a treatment option for a patient population unresponsive to, or ineligible for, currently available treatments.
- The device offers the ability to diagnose a medical condition in a patient population where that medical condition is currently undetectable or offers the ability to diagnose a medical condition earlier in a patient population than allowed by currently available methods. There must also be evidence that use of the device to make a diagnosis affects the management of the patient.
- Use of the device significantly improves clinical outcomes for a patient population as compared to currently available treatments. Some examples of outcomes that are frequently evaluated in studies of medical devices are the following:

—Reduced mortality rate with use of the device.

—Reduced rate of device-related complications.

—Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process).
—Decreased number of future hospitalizations or physician visits.
—More rapid beneficial resolution of the disease process treated because of the use of the device.
—Decreased pain, bleeding, or other quantifiable symptom.
—Reduced recovery time.

As part of the application process (described in section V.B.1 of this final rule), we require the requesting party to submit evidence that the category of devices meets one or more of these criteria. We noted that the requirements set forth above will be used only for determining whether a device is eligible for a new category under section 1833(t)(6)(B) of the Act, which authorizes transitional pass-through payments for categories of devices. These criteria are not intended for use in making coverage decisions under section 1862(a)(1)(A) of the Act. We noted that adoption of these criteria is consistent with the recommendation of the Medicare Payment Advisory Commission, in its March 2001 Report to Congress, that pass-through payments for specific technologies be made only when a technology is new or substantially improved.

We stated that we determine which devices represent a substantial clinical improvement over existing devices by using a panel of Federal clinical and other experts, supplemented if appropriate by individual consultation with outside experts. These decisions are, in general, based on information submitted by the requester about the clinical benefit of the devices as described in the above criteria, including, where available, evidence from clinical trials or other clinical investigations. A panel of clinical experts from CMS has thus far made all of our decisions on eligibility for an additional device category.

As indicated in the November 2, 2001 interim final rule, we believe that almost all substantial clinical improvements in technology that are appropriately paid for under the transitional pass-through provisions result in measurable improvements in care from the perspective of the beneficiary. Nevertheless, there may be some improvements in the medical technology itself that are so significant that we may wish to recognize them for separate payment (as opposed to packaged payments) even though they do not directly result in substantial clinical improvements. For example, improvements in such factors as the strength of materials, increased battery life, miniaturization, might so improve convenience, durability, ease of operation, etc., that such an improvement in medical technology might be considered as a separate factor from ''substantial clinical improvement'' in beneficiary care.

We invited public comment on this issue and particularly asked for examples of medical technologies for which pass-through payments might be appropriate even though they would not also pass a test based on substantial improvement in beneficiary outcomes. Although we received a number of comments on this criterion, only one attempted to provide an example of new medical technology that might not also pass a test based on substantial improvement in beneficiary outcomes. This example is described in our summary of comments and responses below.

As we noted in the November 2, 2001 interim final rule, we will continue to evaluate these criteria as we gain experience in applying them, and we will consider revisions and refinements to them over time as appropriate.

Comment: Most commenters expressed concerns regarding our criterion that new device categories demonstrate substantial clinical improvement to be eligible for pass-through payment. Device manufacturers and representatives felt that evidence of clinical outcomes should not be part of the device category evaluation and eligibility process. Some maintained that we already have standards for determining clinical benefit as part of the Medicare coverage process and we should not have such requirements in payment determination. One commenter claimed that we would be unable to determine substantial clinical improvement for pass-through categories separately from national coverage decisions, since we will be reviewing the same types of evidence for both processes. This commenter held that a payment policy decision using clinical improvement criteria is a de facto coverage decision that our Coverage Analysis Group and carriers would feel compelled to go along with.

One device manufacturer was concerned that any employment of inappropriate evidentiary standards in evaluating improvement in diagnosis or treatment when applying this criterion could be a barrier to pass-through payment for some new technologies.

Yet, some manufacturers agree that pass-through payment should be limited to technologies that represent significant advancements in providing beneficial new therapy options. A number of commenters felt we should take into account improvements in devices' technology per se, for example, material, power source, size, etc., and not limit our criterion of improvement to clinical improvement. Some commenters held that only technological aspects of new medical devices should be analyzed to determine whether there are advancements over existing pass-through devices to determine whether a device should be considered for an additional category. A manufacturer stated that if we feel that a criterion based on clinical benefits is needed, we should employ a ''substantially different'' criterion to determine eligibility for a new category. Under this suggestion, any difference in therapeutic effect, indication, surgical approach, safety or side effects, mechanics or function that offers a ''new beneficial therapeutic alternative'' would be considered ''substantial.''

One manufacturer also stated that a ''substantial clinical improvement'' criterion may be unnecessary, because we already have a criterion that addresses costs that are ''not insignificant.''

Response: Although the information required for pass-through category applications is similar for coverage determinations, the information is used differently. The purpose of the ''reasonable and necessary'' condition in evaluating coverage is different than the OPPS purpose of determining appropriate pass-through payment for new technology items. We are not attempting to determine coverage under the OPPS, only whether a payment under the pass-through mechanism is warranted. We adopted the ''substantial clinical improvement'' criterion to help us identify those devices that are not adequately described by any previously established device categories.

Those who argue that we should employ a ''substantially different'' or a ''clinical benefit'' criterion rather than the ''substantial clinical improvement'' do not answer the question as to how different a new technology should be to be considered eligible for a new device category. It seems to us that many of the differences listed in the suggestion to base a criterion on ''substantial differences'' noted above may not reflect qualitatively meaningful differences and such devices could be adequately described by the existing or previously existing categories. If a new device technology were adequately described by a category of devices in terms of its clinical application and benefits, then an additional category would not seem

warranted. Still, as we have stated in the November 2, 2001 interim final rule and again above, there may be some improvements in the medical technology itself that are so significant that we may wish to recognize them for separate payment even though they do not directly result in substantial clinical improvements. We will continue to allow the flexibility in our evaluation process to consider such items for new categories.

We believe it is harder to make a determination of substantial difference than it is to make a determination as to substantial clinical benefit. Furthermore, we believe that, in general, transitional pass through payments should be made only for technologies that benefit beneficiaries beyond the technologies currently available.''

We believe it is harder to make a determination of substantial difference than it is to make a determination as to substantial clinical benefit. Furthermore, we believe that, in general, transitional pass-through payments should be made only for technologies that benefit beneficiaries beyond the technologies currently available.

The notion that a ''substantial clinical improvement'' criterion may be unnecessary, because we already have a criterion that addresses ''not insignificant cost,'' is misplaced. The cost of the new technology may or may not directly address a nominated device's clinical benefits. Payment for a costly device may be related to a number of factors, such as Medicare payment policy for a technology or the cost of raw materials or manufacturing process, irrespective of substantial clinical improvement. We established the clinical improvement criterion in addition to the cost significance criterion mandated under statute because one cannot accurately infer that a high relative cost is indicative that a device cannot be described by an existing or previous category of devices. Nor can we automatically infer that a substantially clinically improved device necessarily bears significantly higher cost than what we are currently paying for pass-through devices and procedural payments through the APC payment rates. Therefore, both criteria are needed.

Comment: In the November 2, 2001 interim final rule, we invited public comment on the issue of substantial improvement, saying we would be interested in examples of medical technologies for which pass-through payments might be appropriate even though they would not pass a test based on substantial improvement in clinical outcomes. Several commenters pointed to differences in brachytherapy devices as examples. These commenters said that differences in devices should be reflected by establishing separate device categories by: different chemical substances/radioisotope, therapeutic radiation activity levels, implantation arrays of brachytherapy devices, and mechanisms of injecting brachytherapy devices that improve safety and function.

Response: We have reviewed many applications for brachytherapy devices and believe that there is a congruence between new technologies that might be eligible for transitional pass-through payments in the absence of producing substantial clinical benefit and new technologies that do produce substantial clinical benefit.

Comment: Commenters requested that we clarify the process that is employed by Federal and external experts to evaluate substantial clinical improvement on the part of nominated devices. One commenter expressed concern that a Federal panel of experts may slow down decision-making and suggested a flexible process in reviewing category applications. The commenter suggested that we rely on our internal clinical staff to make decisions not requiring outside assistance. The commenter also suggested that our review process should be open and allow the manufacturer the opportunity to present information to the panel. The list of panelists, agendas, proceedings and decisions should be made public.

Response: Our panel consists of CMS clinical experts. We consult with outside experts as appropriate. We believe that this process results in making appropriate, timely decisions while allowing for maximum flexibility. Public meetings would inevitably slow the process. We give ample opportunity for manufacturers to provide information, and we frequently meet with manufacturers to discuss their applications.

Comment: One commenter felt that the language of the statute does not support our criterion that devices show evidence of substantial clinical improvement in order to be considered for an additional category. The commenter stated that the statutory standard that no medical device be described by more than one category does not support the substantial clinical improvement criterion.

Response: The statute explicitly requires us to establish criteria that will be used for creation of additional categories. (Section 1833(t)(6)(B)(ii)(I) of the Act) This statutory requirement permits the criteria that we have established, including demonstration of substantial clinical improvement.

We are continuing to review the issue of technological change that is not associated with substantial clinical benefit to beneficiaries. We will continue to review applications for such devices on a case by case basis and work with applicants to understand exactly what technological changes were made to a device that would make the device eligible for transitional pass through payments. We solicit further examples of such devices so that, in the future, we may establish a more definite criterion for when such changes make a device eligible for transitional pass through payments.

Comment: Associations representing manufacturers stated that our assertion in the preamble of the November 2, 2001 interim final rule that says MedPAC's recommendation that pass-through payments for specific technologies be made only when a technology is new or substantially improved is a misinterpretation. The commenters asserted that MedPAC considers the concepts of improvements in devices themselves and substantial improvement to be separate, and that either of the two should be required for a criterion related to device improvement for pass-through eligibility.

Response: While we continue to believe that, in general, new technologies without a demonstrated substantial clinical benefit to beneficiaries should not receive transitional pass-through payments, we do review nominated devices for technological changes that are not associated with substantial clinical benefit to beneficiaries.

Comment: An association representing device manufacturers stated that our substantial clinical improvement criterion would significantly increase the time between FDA approval to market the device and recognition of the device for pass-through payment. The commenter claimed that this is counter to an objective of the pass-through payment mechanism as a means to promote rapid payment in the OPPS for new technology. This commenter, therefore, recommended replacing the criterion to demonstrate substantial clinical improvement with a requirement to demonstrate ''potential improvement.''

Similarly, another manufacturers' association asserted that clinical outcomes information should not be required for eligibility for a new pass-through category. This commenter suggested that our rules should request information that is appropriate and

relevant for the product and related procedures, which should include information other than published clinical trials.

Response: We are making every effort to minimize the time lag between FDA approval and establishment of a device category. We believe that we have succeeded in making timely decisions in this regard.

We will consider other information in addition to clinical outcomes that is available when clinical trial data are not yet available.

We do not know how one can demonstrate ''potential'' clinical improvement. ''Potential'' refers to the anticipated or possible capability, belief, or expectation for clinical improvement, without the evidentiary demonstration yet.

We do not believe potential improvement is an appropriate criterion. First, it would be difficult to prove; second, we would be in the position of potentially making extra payments for technologies that actually harmed beneficiaries. Thus using ''potential'' clinical improvement would assure that all new devices would meet such a criteria if the manufacturer asserted that the device in question offers a ''potential'' clinical improvement.''

Comment: Some commenters expressed concern with our rule that devices that are described by an existing category are not eligible for new categories. Some call for flexibility in applying this criterion, claiming that some of our category descriptors are too broad and confusing. One manufacturer was particularly concerned that newer technology pacemakers, internal cardioverter-defibrillators (ICDs), and pacemaker and ICD leads would be precluded from achieving new categories because they could be described by widely defined existing categories. The commenter stated that we should revise definitions of existing categories whenever necessary in order to accommodate the creation of new categories. Revising category descriptions to make them less broadly worded was one such example provided, including categories related to pacemakers, ICDs, and pacemaker and ICD leads.

Some commenters felt that new categories would need to be created in order to track cost of newer devices, even if they are described by existing categories. These commenters asserted that device costs eventually must be placed into APCs that appropriately reflect costs for future payment. Some commenters claimed that investigational devices that attained pass-through status have low procedural volumes and therefore they are underrepresented in the cost data.

Response: We believe that broadly defined categories are appropriate. Such categories are easier for coders to understand and allow devices to immediately receive transitional pass-through payments upon being marketed (instead of going through an application process). We have applied this criterion appropriately. There are devices that have been deemed eligible for a new category because the clinical applications are substantially different than devices of existing categories.

Some category descriptions have been modified when it has been brought to our attention that the descriptor is unclear. We first revised the descriptors of device categories in Program Memorandum A–01–73, effective July 1, 2001, in order to clarify the devices covered by categories. However, we do not intend to revise descriptors solely to allow the creation of new categories. If a device or class of devices is described by the categories we initially created, we will apply the criteria we implemented to determine whether an additional category is warranted. If we determine that an additional category is needed to adequately describe and pay for new devices, we will create a category. If in the course of that determination, we find that clarification of an existing or previously existing category is needed so that only one category describes the device, as required by statute, then we will modify the description of the existing or previously existing category or categories, in order to achieve that clarification.

We are maintaining our criteria to establish a new category of devices for pass-through payment.

Cost. We determine that the estimated cost to hospitals of the devices in a new category (including any candidate devices and the other devices that we believe will be included in the category) is ''not insignificant'' relative to the payment rate for the applicable procedures. The estimated cost of devices in a category is considered ''not insignificant'' if it meets the following criteria found in regulations at new § 419.66(d):

- The estimated average reasonable cost of devices in the category exceeds 25 percent of the applicable APC payment amount for the service associated with the category of devices.
- The estimated average reasonable cost of devices in the category exceeds the cost of the device-related portion of the APC payment amount for the service associated with the category of devices by at least 25 percent.
- The difference between the estimated average reasonable cost of the devices in the category and the portion of the APC payment amount determined to be associated with the device in the associated APC exceeds 10 percent of the total APC payment.

Of these three cost criteria, the latter two remain unchanged from the existing thresholds for individual devices (however, as discussed below, their effective date was revised). The first criterion, however, represents a change in the percentage threshold.

In the April 7, 2000 final rule, we provided that a device's expected reasonable cost must exceed 25 percent of the applicable APC payment for the associated service as the criterion for determining when the cost of a specific device is ''not insignificant'' in relation to the APC payment (65 FR 18480). In the August 3, 2000 interim final rule, we lowered the threshold to 10 percent because we believed the 25 percent limit was too restrictive based on the brand specific approach at the time (65 FR 47673; § 419.43(e)(1)(iv)(C)). However, given our payment experience in 2001 using the 10 percent threshold, including our information on the estimated amount of pass-through payments in CY 2002, we determined a higher threshold was warranted. We believed that setting a higher cost threshold ensures that new categories are created only in those instances where they are most valuable to beneficiaries and hospitals, given the overall limits on pass-through payments. That is, pass-through payments will be targeted only to those devices where cost considerations might be most likely to interfere with patient access.

We found that once we lowered the threshold to 10 percent, a very small minority (less than 10 percent) of devices that met all other criteria for the pass-through payment was rejected on the basis of this criterion. Partly as a result, the list of devices qualified for pass-through payments increased to well over 1,000 devices by the end of 2000. Although the extensive number of qualified devices allowed hospitals to receive additional payment for many devices, we estimated that the overall pass-through payment amount for calendar year 2002 would exceed the 2.5 percent cap. Therefore, for that year, a substantial reduction in the amount of each pass-through payment, as required by section 1833(t)(6)(E)(iii) of the Act, was established. Thus, allowing a large number of marginally costly devices to qualify for the pass-through payment

would reduce the amount of additional payment a hospital would receive for any one device. We believe raising the threshold for this criterion benefits hospitals by focusing the pass-through payments on those devices that represent a substantial loss to the hospital. We believe this change also preserves beneficiary access to especially expensive devices.

In addition, once a category is established, devices included in the category are eligible for pass-through payments regardless of the cost of the devices. Therefore, we determined that it is reasonable to set a higher threshold than 10 percent to establish a new category. While the cost of most devices described by a category may equal or exceed the threshold we use in establishing a category, the cost of individual devices could easily fall below the threshold. Therefore, we believe that it is reasonable to use a higher threshold in establishing a category than in qualifying individual devices.

Concerning the latter two criteria for determining that the estimated cost of a category of devices is not insignificant, we intended to apply these criteria to devices for which a pass-through payment is first made on or after January 1, 2003, as we provided in the August 3, 2000 interim final rule (65 FR 47673). We stated that the delay would allow us sufficient time to gather and analyze data needed to determine the current portion of the APC payment associated with the devices.

Based on the outpatient claims data we have been using for analysis, we have been able, in many cases, to use these criteria as of the November 2, 2001 interim final rule. Although the 1996 data did not provide a level of information that allowed us to determine the portion of the APC payment that was related to the device (except in a very few cases such as pacemakers), the later data have generally provided this level of detail. Therefore we applied the second and third cost criteria for the purpose of determining eligibility of proposed new categories, as described in regulations at § 419.66(d)(2) and § 419.66(d)(3), as soon after the implementation of the November 2, 2001 interim final rule as we had data to do so rather than on January 1, 2003. Although in some instances the lack of specific data prevented the application of these criteria, we believed that should not delay our use of these criteria in those situations in which the data have been available.

In order to implement these second and third criteria for the purpose of creating new device categories, it is necessary to obtain the cost of the device-related portion of the APC payment amount. For evaluations of device category applications in 2002, we used the device-offset amounts published in our March 1, 2002 final rule (67 FR 9557 through 9558), which are used to calculate the subtractions to device pass-through payments. For 2003, we will use the device-offset amounts found in Table 11 in this rule as the device-related portion of the APC payment needed for cost criteria 2 and 3. The device-offset amounts represent the device costs that have been folded into the respective APC payment rates. In those cases where an application is received in which the service-related HCPCS codes for the device is mapped to no APC that has a device offset amount, we apply only the first cost criterion.

Comment: Some commenters wrote that while we need to limit pass-through payments for new categories to those devices that are clearly underpaid relative to the APC rates, our ''not insignificant'' cost tests set the bar too high. Some held that this is particularly the case for APCs with high relative weights and consequent payments, in which our 25 percent minimum percentage of the APC as well as the device offset represent a significant cost to the hospital in absolute terms. Commenters proposed alternate percentage thresholds with specific dollar caps (for example, 20 percent of the APC payment or $1,000, whichever is less).

Response: In the cases of APCs with high relative weights and payment rates, such payments already encompass much of the costs of devices. The thresholds in dollar terms in those cases should be set higher to test for cost significance. We have heard from many commenters to our August 9, 2002 proposed rule that many device costs consist of a large percentage of the APC cost. The ratio method (for example, 25 percent) therefore equitably accounts for APC payment differences for devices.

We do not see any compelling reason to adopt the proposed alternate percentages of the APC amount as the threshold of using as an alternative to our current cost significance threshold of 25 percent for device portions related to any respective APC. Moreover, the initial pass-through categories were based on devices that achieved pass-through status with a lower 10 percent threshold.

Comment: Another commenter claimed that the statutory language demonstrates the congressional intent that only the cost of the devices in a category be compared to the applicable APC payment. Therefore, only the first of our three prongs to test cost significance of a new device should be used. This commenter claimed that section 1833(t)(6) of the Act states that we shall provide pass-through payments only for categories of devices when ''the average cost of the category of devices is not insignificant in relation to the OPD fee schedule amount * * * .'' The commenter further advocated that our criteria be amended to reflect that a proposed category of devices be required to meet any one of the three prongs, to give some weight to the potential benefits of the second and third prongs.

Response: The statute requires that the average cost of a new device category is not insignificant in relation to the OPD fee schedule amount payable for the service or group of services involved. The statute further requires the Secretary to establish criteria for creating additional categories, including criteria for cost significance. Beyond those requirements, the statute allows the Secretary the discretion to determine how to apply the cost significant criterion.

In developing the specific criteria for meeting the statutory cost significance requirement, we established thresholds which we believe ensure that new categories are created where they are most valuable to beneficiaries and hospitals, given the overall limits on pass-through payments. Our goal is to target pass-through payments at those devices where cost considerations might be most likely to interfere with patient access.

To properly target the pass-through payments at devices that could represent a substantial loss to the hospital, it is important to both assess the incremental cost of performing the procedure using the new device as well as to compare the cost of the new device against the costs of existing devices already packaged into the APC payment for the procedure.

The first prong of our three prong criterion tests only the relationship of the new device to the cost of the entire procedure whereas the second and third prongs test for the relationship to device costs already incorporated into the payment rate for the procedure.

Comment: A hospital organization supported our two major criteria for establishing an additional device category for pass-through payment, that is, that a category of devices must demonstrate substantial clinical improvement and have costs that are ''not insignificant'' in relation to the APC payment. In particular, the

organization supported our decision to raise the threshold that device costs for a new category must exceed 25 percent of the related APC payment, as well as our re-institution of the two additional prongs of the not-insignificant cost test. However, the commenter noted that we had previously delayed the implementation of these latter two prongs of the ''not insignificant'' cost criterion until January 1, 2003, so that we could ensure reliable and accurate data to make the cost estimates. The organization would support the reinstitution of these cost prongs that establish that costs are not insignificant only when CMS has sufficiently accurate and reliable data to make such estimates. The commenter also believes that the data and methodology should be made available to the public for review.

This organization also felt that the (then) current number of initial categories is appropriate. It urged us to make application information regarding any proposed new categories public for comment before final creation of a new category.

Response: Based on the outpatient claims data we have been using for analysis, we have been able, in many cases, to use the second and third cost criteria since the November 2, 2001 interim final rule became effective. Although the 1996 data did not provide a level of information that allowed us to determine the portion of the APC payment that was related to the device (except in a very few cases such as pacemakers), the later data we have used has generally provided this level of detail. Therefore, we applied the second and third cost criteria. As noted earlier, for 2002, we have used the device offsets we calculated for subtracting the cost of existing devices in APCs as the portion of the APC payment related to the device. We feel the offsets have been appropriate as this portion of the APC payment, and we will use them for 2003 as well. We therefore feel this commenter's concerns have been addressed.

We will continue to use the three prongs of the not insignificant cost test as published in the November 2, 2001 interim final rule.

1. Application Process for Creation of a New Device Category

Device manufacturers, hospitals, or other interested parties may apply for a new device category for transitional pass-through payments. Details regarding the informational requirements, deadlines for quarterly review, and other aspects of the application process are available on our Web site, *http://cms.hhs.gov.*

We will accept applications at any time. However, we will establish new categories only at the beginning of a calendar quarter, in deference to our computer systems needs and those of our contractors and hospitals. We must receive applications in sufficient time before the beginning of the calendar quarter in which a category would be established to allow for decision-making and programming. For now, we will require that applications be received at least 4 months before the beginning of the quarter. Moreover, we have found, that, due to the complexity of the information and review process for additional categories, we cannot always complete our review within that time frame. Review of applications involving devices with new technologies often involves requesting additional information from the applicants, as well as consultation with experts in certain clinical specialties (usually here at CMS) or with other clinical personnel at CMS with expertise in Medicare coverage issues, as needed (for example, the hearing aid issue).

We may change the details of this application process in the future to reflect experience in evaluating applications and programmatic needs. If we revise these instructions, we will submit the revisions to the Office of Management and Budget under the Paperwork Reduction Act. We will also post the revisions on our Web site.

Comment: One commenter recommended that we post draft new categories and any draft changes to existing categories to our Web site for public review and comment before final publication, as a collaborative, informal process to be accomplished within the 4-month quarterly application evaluation and update time frame.

Response: Such process could not be accomplished within the 4-month time frame. We note that the greater part of the four month period is consumed in systems changes, not review of the application, so little time is available for further information. Thus, further consultation would result in longer timeframes for action. We have listened and met with many parties concerning recommendations for additional categories and heard their concerns related to our existing and new categories and will continue to do so. However, we believe that the review, evaluation, and decision process and publication process for new category applications to meet the closest feasible quarterly updates is already compact. However, we will continue to consider informal comments or feedback from hospitals, manufacturers, and other parties regarding our decisions.

Comment: An association of manufacturers of brachytherapy sources and other brachytherapy devices recommended that we establish several specific new categories.

Response: We have established a uniform method for evaluating applications for new categories, based on the application information published on our Web site. We evaluate the necessity of new categories based on the specific information we receive, such as clinical differences between items nominated for the new categories and the existing or previously existing categories. We therefore are not able to react to the specific categories recommended through public comments by this commenter without complete applications on the subject brachytherapy sources.

We are making no change to our application process at this time.

2. Announcing a New Device Category

When we determine a new category is warranted, we issue a Program Memorandum specifying a new Healthcare Common Procedure Coding System (HCPCS, formerly known as HCFA Common Procedure Coding System) code and short and long descriptors for the category. We may also include additional clarifying or definitional information to help distinguish the new category from other existing or previously existing categories. It may be necessary to redefine, or make other changes to, existing or previously existing categories to accommodate a new category and ensure that no medical device is described by more than one category, though we attempt to keep these changes to a minimum. We will post these Program Memoranda on our Web site on a quarterly basis. We may find it necessary occasionally to correct or amend the list of (and clarifying information associated with) pass-through device categories. We do not expect this step will be needed often, but if it is necessary, we will issue any changes in a Program Memorandum.

VI. Wage-Index Changes for Calendar Year 2003

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

We used the proposed Federal fiscal year (FY) 2003 hospital inpatient PPS

wage index to make wage adjustments in determining the proposed payment rates set forth in the proposed rule. We also proposed to use the final FY 2003 hospital inpatient wage index to calculate the final CY 2003 payment rates and coinsurance amounts for OPPS. We used the final Federal FY 2003 hospital inpatient PPS wage index to make wage adjustments in determining the final payment rates set forth in this final rule with comment. The final FY 2003 hospital inpatient wage index published in the August 1, 2002 **Federal Register** (67 FR 39858) is reprinted in this final rule with comment as Addendum H—Wage Index for Urban Areas; Addendum I—Wage Index for Rural Areas; and Addendum J— Wage Index for Hospitals That Are Reclassified. We use the final FY 2003 hospital inpatient wage index to calculate the payment rates and coinsurance amounts published in this final rule with comment to implement the OPPS for CY 2003. We note, however, that from time to time, there are mid-year corrections to these wage indices and that our contractors will adopt and implement the mid-year charges for OPPS in the same manner that they made mid-year changes for inpatient hospital prospective payment.

Comment: A commenter asked for an explanation of the rationale behind applying the area wage index to the device component of an APC. Also, another commenter urged us to clarify that APCs for drugs and biologicals would not be subject to geographic wage adjustment since the APC payment rates primarily reflect drug acquisition costs, not labor costs.

Response: Our rationale for applying the area wage index to the device component of an APC is that once a device cost is packaged into a procedure APC, we do not differentiate between which costs in the APC should or should not have the area wage index applied. We believe that it would be complicated and prone to error to segment out a device component of the APC and determine the appropriate portion of the APC payment amount that consists of device cost only. To address the second issue, we would like to clarify that we do not apply the area wage index to payment rates for drugs and biologicals that are assigned to the status indicator G or K.

VII. Copayment for Calendar Year 2003

Section 1833(t)(8)(C)(ii) of the Act accelerates the reduction of beneficiary copayment amounts, providing that, for services furnished on or after April 1, 2001, and before January 1, 2002, the national unadjusted coinsurance for an APC cannot exceed 57 percent of the APC payment rate. The statute provides that the national unadjusted coinsurance for an APC cannot exceed 55 percent in 2002 and 2003. The statute provides for further reductions in future years so that the national unadjusted coinsurance for an APC cannot exceed 55 percent of the APC payment rate in 2002 and 2003, 50 percent in 2004, 45 percent in 2005, and 40 percent in 2006 and thereafter.

For 2003, we determined copayment amounts for new and revised APCs using the same methodology that we implemented for 2002 (see the November 30, 2001 final at 66 FR 59888). See Addendum B for national unadjusted copayments for 2003. Our regulations at § 419.41 conform to this provision of the Act.

VIII. Conversion Factor Update for Calendar Year 2003

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

Section 1833(t)(3)(C)(iv) of the Act provides that for 2003, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act.

The most recent forecast of the hospital market basket increase for FY 2003 is 3.5 percent. To set the proposed OPPS conversion factor for 2003, we increased the 2002 conversion factor of $50.904 (the figure from the March 1, 2002 final rule (67 FR 9556)) by 3.5 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the conversion factor for 2003 to ensure that the revisions we made to update the wage index are made on a budget-neutral basis. We calculated the proposed budget-neutrality factor of .98778 for wage-index changes by comparing total payments from our simulation model using the proposed FY 2003 hospital inpatient PPS wage-index values to those payments using the current (FY 2002) wage-index values.

The increase factor of 3.5 percent for 2003 and the required wage-index budget-neutrality adjustment of .98715 resulted in a proposed conversion factor for 2003 of 52.009.

In determining the proposed conversion factor of 52.009, we projected 2.5 percent pass-through payments based on our preliminary estimates of pass-through payments for CY 2003. As described in the section IV discussion of the pro-rata provisions, our final estimate of pass-through payments in CY 2003 is 2.3 percent of the total program payments for covered OPD services. Therefore, we have increased the final conversion factor to reflect the projected change in pass-through spending from 2.5 percent to 2.3 percent. After applying this adjustment, the 3.5 percent update factor and the final budget-neutrality adjustment of .98778 to account for changes due to the final FY 2003 hospital inpatient wage-index values, we establish the final conversion factor for 2003 at $52.151 (or 52.152).

We received several comments concerning the conversion factor update for 2003, which are summarized below along with our responses.

Comment: Several commenters contended that CMS imposed excessive pro-rata reductions in 2002, which exacerbated the inadequacy of Medicare payments and urged CMS to use its statutory authority under section 1833(t)(3)(C)(iii) to adjust the 2003 conversion factor for the unexpectedly low pass-through payments made in 2002.

Response: The commenters' estimates are based on 2001 claims. We do not know yet whether there will be excessive pro-rata reductions in 2002 because at the time of this rule, we do not have more than first-quarter 2002 claims data available. Therefore, it would not be appropriate to make such an adjustment. Furthermore, we do not believe that the statute permits us to make retroactive adjustments.

Comment: One commenter stated that the statute requires the conversion factor to be updated by the full increase in the hospital inpatient market basket of 3.5 percent, but the application of a budget-neutrality factor of .987156 results in an update factor of only 2.17 percent. Another commenter indicated the belief that the amount of reduction from the 3.5 percent market basket update is excessive and beyond what is required to achieve statutory goals. The commenter recommended that the 2003 conversion factor be increased.

Response: Statute requires us to ensure that a conversion factor for covered OPD services in subsequent years is an amount equal to the conversion factor applicable to the previous year before any increases due to the market-basket increase. In order to ensure that we maintain budget neutrality (except for the market-basket increase), we must make an adjustment to account for changes in the wage index. To do so, we calculate the total payments for 2002, using the 2002 wage index and weights, and compare that result to total payments calculated by applying the new 2003 wage index to

the 2002 APC weights. For 2003, that comparison resulted in the .969 adjustment.

IX. Outlier Policy for Calendar Year 2003

For OPPS services furnished between August 1, 2000, and April 1, 2002, we calculated outlier payments in the aggregate for all OPPS services that appear on a bill in accordance with section 1833(t)(5)(D) of the Act. In the November 30, 2001 final rule (66 FR 59856, 59888), we specified that beginning with 2002, we will calculate outlier payments based on each individual OPPS service. We revised the aggregate method that we had used to calculate outlier payments and began to determine outliers on a service-by-service basis.

As explained in the April 7, 2000 final rule (65 FR 18498), we set a target for outlier payments at 2.0 percent of total payments. For purposes of simulating payments to calculate outlier thresholds, we proposed to set the target for outlier payments at 2.0 percent. The target was 2.0 percent for CY 2001 and 1.5 percent for 2002. For 2002, the outlier threshold is met when costs of furnishing a service or procedure exceed 3.5 times the APC payment amount, and the current outlier payment percentage is 50 percent of the amount of costs in excess of the threshold. Based on our simulations for 2003, we proposed to set the threshold for 2003 at 2.75 times the APC payment amounts, and the proposed 2003 payment percentage applicable to costs over the threshold at 50 percent.

In this final rule we are setting the target amount for outlier payments at 2 percent of total payments. Based on revised simulations performed for the final rule, in order to pay outlier payments at the target amount, we are adopting the proposed outlier threshold of 2.75 but decreasing the outlier payment percentage to 45 percent. Simulations using the final APC rates and projecting outlier payments for 2003 using a different set of claims than we used for the proposed rule (claims for the period April 1, 2001 through March 31, 2002 instead of claims for calendar year 2001) resulted in outlier payments that were in excess of the 2 percent outlier payment target. In order to meet, but not exceed, the target we found it necessary to either increase the proposed outlier threshold of 2.75 or reduce the proposed outlier payment percentage of 50 percent. Because we wanted to make it easier for more for high cost services to qualify for outlier payments, we chose to adopt the proposed outlier threshold but reduce the outlier payment percentage to 45 percent. For 2003, the outlier threshold will be met when costs of furnishing a service or procedure exceed 2.75 times the APC payment amount, and the outlier payment percent will be 45 percent of the amount of costs in excess of the threshold.

We received a number of comments concerning our proposed threshold and percentages for outlier payments, which are summarized below along with our responses. We also received comments concerning the changes that we proposed and finalized in 2002 with respect to the calculation of outliers on a service-by-service basis. Because we have not proposed any changes to the current policy, we do not summarize those comments in this preamble.

Comment: A number of commenters commended CMS on lowering the outlier threshold, but they urged CMS to reduce the threshold even further. The commenters also said that the outlier payment percentage of 50 percent of costs in excess of the outlier threshold was not sufficient to offset the losses hospitals incur in high-cost cases. Some of these commenters urged CMS to adopt the same marginal payment rate of 80 percent that is used for calculating outliers under the inpatient PPS.

Response: Under the OPPS, CMS must address two needs: the need to balance payment for high-cost cases with the need to ensure that appropriate payments are made for basic services for the average patient population. By setting our outlier target of 2 percent, we believe that we have struck the right balance to accomplish these goals.

Comment: According to one commenter, new technologies and drugs are expanding too rapidly for CMS to appropriately account for the costs in the APCs, which is a particular concern at larger hospitals that provide a wide scope of services and access to new technologies and drugs. The commenter said that outliers can help defray the costs of new technologies until adequately reflected in the APC payments and urged CMS to consider expanding the outlier target from 2 percent to 2.5 percent. Another commenter contended that the transition of expiring pass-through items into APCs will result in dramatic payment reductions and urged CMS to reduce the outlier threshold to 2.5 times the APC payment amount for 2003 and increase the outlier target as close as possible to the statutory maximum of 2.5 percent of total payments.

Response: As described elsewhere in this final rule, the recalibration of weights based on newer data and the additional steps that we have taken to limit the payment reductions should decrease the need for outliers. Also, the pass-through provisions for new drugs and devices and our payment mechanism for new technology procedures provide hospitals with an additional mechanism to defray costs for emerging technologies.

Comment: A number of commenters said that CMS does not provide sufficient data to support how outlier payments and thresholds are determined and to ensure that outlier payments are being made in the range of 2 percent to 2.5 percent. Additional outlier data that the commenters requested include information such as the actual outlays as compared to forecasted outlays 2001, estimated outlays for 2002, the historical outlier percentage of total OPPS payments, and information on the types of cases that are qualifying for outlier payments. The commenters wanted CMS to provide supporting information in the final rule, just as it does for the inpatient PPS.

Response: We agree with the commenters that we should provide this data. However, due to the time constraints in producing this final rule, we are unable to add this information to this preamble. Nonetheless, we will post this information to our Web site shortly after publication of the rule. We will notify the public through the CMS listserv when the information is available. To subscribe to this listserv, please go to the following Web site: *www.cms.hhs.gov/medlearn/listserv.* Follow the directions for subscribing to the OPPS listserv to get the most up-to-date information on OPPS directly from CMS.

Comment: One commenter expressed concern that CMS has made significant changes to the outlier target and eligibility thresholds in 2002 and 2003, in opposite directions, without sufficiently supporting the changes with experiential data. The commenter maintained that, in aggregate, outlier payments as a percentage of total payments should remain relatively predictable and, therefore, questions whether the experience in 2001 and 2002 would support the significant swings in funding and thresholds.

Response: It is too early for us to tell what the 2002 experience has been like in order to compare it to the 2001 experience. Nevertheless, as indicated in the previous response, we will also notify the public and share the 2001 data on our Web site.

Comment: One commenter urged CMS to provide clarification regarding the rationale to decrease the cost threshold that permits more items to qualify for outlier payments, rather than

to increase the payment percentage from its current level of 50 percent, which would provide more payments for high-cost cases.

Response: We apply an iterative process in which we try different combinations of thresholds and payment percentages until an appropriate combination results in outlier payments under our simulation that is equal to the target percentage of total OPPS payments. While some fluctuation is expected each year due to the use of newer and better data and policy changes, we attempt both to strike a balance and to prevent (to the extent possible) large changes in the outlier payments to hospitals. A significant increase in the threshold would limit the number of services and hospitals that qualify for outlier services.

Comment: One commenter expressed concern that without correcting for the significant reductions proposed for a number of high-cost APCs, those services may unnecessarily qualify for outlier payments because the costs that go into the outlier calculation are calculated using a hospital's overall cost-to-charge ratio (CCR), which may be higher than the departmental CCRs used to determine costs for payment-rate calculations. The commenter contends that, if this occurs, it will result in outlier payments that are higher than anticipated, which could unduly raise thresholds in the future and affect the integrity of the outlier policy.

Response: As described elsewhere in this rule, we believe that the adjustments we have made to many APC rates for this final rule will address the commenter's concerns about services unnecessarily qualifying for outlier payments.

X. Other Policy Decisions and Changes

A. Hospital Coding for Evaluation and Management (E/M) Services

Background

Currently, facilities code clinic and emergency department visits using the same current procedural terminology (CPT) codes as physicians. For both clinic and emergency department visits, there are five levels of care. While there is only one set of codes for emergency visits, clinic visits are differentiated by new patient, established patient, and consultation visits. CPT codes 99201 through 99205 are used for new patients, CPT codes 99211 through 99215 are used for established patients, and CPT codes 99281 through 99285 for emergency patients.

Physicians determine the proper code for reporting their services by referring to CPT descriptors and our documentation guidelines. The descriptors and guidelines are helpful to physicians because they reference taking a history, performing an examination, and making medical decisions. The lower levels of service (for example, CPT codes 99201, 99211, and 99281) are used for shorter visits and for patients with uncomplicated problems, and the higher levels of service (for example, CPT codes 99205, 99215, and 99285) are used for longer visits and patients with complex problems.

These codes were defined to reflect the activities of physicians. It is generally agreed, however, that they do not describe well the range and mix of services provided by facilities to clinic and emergency patients (for example, ongoing nursing care, preparation for diagnostic tests, and patient education).

Before the implementation of the OPPS, facilities were paid on the basis of charges reduced to costs. In that system, because use of a correct HCPCS code did not influence payment, there was little incentive to correctly report the level of service. In fact, many facilities reported all clinic and emergency visits with the lowest level of service (for example, CPT codes 99211, 99201, and 99281) simply to minimize administrative burden (for example, charge-masters might include only one level of service).

This situation changed with the implementation of the OPPS. The OPPS requires correct reporting of services using HCPCS codes as a prerequisite to payment. For emergency and clinic visits, the OPPS distinguishes three levels of service for payment purposes. These are referred to as ''low-level,'' ''mid-level,'' and ''high-level'' emergency or clinic visits. Payment rates for low-level visits are less than for mid-level visits, which are less than rates for high-level visits.

In the April 7, 2000 final rule (65 FR 18434), we stated that to pay hospitals properly, it was important that emergency and clinic visits be coded properly. To facilitate proper coding, we required each hospital to create an internal set of guidelines to determine what level of visit to report for each patient. We stated in the rule, that if hospitals set up these guidelines and follow them, they would be in compliance with OPPS coding requirements for the visits. Furthermore, we announced that we would be reviewing this issue and planned to set national guidelines for coding clinic and emergency visits in the future. In the August 24, 2001 proposed rule (66 FR 44672), we asked for public comments regarding national guidelines for hospital coding of emergency and clinic visits. We also announced that we would compile these comments and present them to our APC Panel at the January 2002 meeting. We also announced that we planned to propose uniform national facility coding guidelines in the proposed rule for the 2003 OPPS.

During its January 2002 meeting, the APC Panel reviewed written comments, heard oral testimony, discussed the issue, and made recommendations concerning establishment of facility coding guidelines for emergency and clinic visits. Among those who submitted oral and written comments to us and to the Panel were national hospital organizations, national physician organizations, hospital systems, individual hospitals, coding organizations, and consultants.

APC Panel Recommendations

The APC Panel reviewed the comments that we received, reviewed background material we prepared, and heard oral testimony. Most commenters recommended that we adopt the ACEP guidelines. However, one organization representing cancer centers stated that the most appropriate proxy for facility resource consumption in cancer care is staff time and asked that we consider basing our guidelines on staff time. Commenters agreed that we needed to address this problem in the proposed rule for CY 2003. They also agreed that to address potential HIPAA compliance issues, we should develop new HCPCS codes for facility visits; and that we should maintain five levels of service for emergency and clinic visits until data are available to show that only three levels of service are required to ensure accurate payments. Commenters also agreed that, for the same level of service, clinic resource consumption should be similar for new, established, and consultation patients. Therefore, we need only create a single set of five codes for clinic visits.

After a thorough discussion, the APC technical panel made the following recommendations:

1. Propose and make final facility coding guidelines for E/M services for calendar year 2003.

2. Create a series of G codes with appropriate descriptors for facility E/M services.

3. Maintain a single set of codes, with five levels of service, for emergency department visits.

4. Develop a single set of codes, with five levels of service, for clinic visits.

The Panel specifically recommended that we not differentiate among visit types (for example, new, established, and consultation visits) for the purposes of facility coding of clinic visits.

5. Adopt the ACEP facility coding guidelines as the national guidelines for facility coding of emergency department visits.

6. Develop guidelines for clinic visits that are modeled on the ACEP guidelines but are appropriate for clinic visits.

7. Implement these guidelines as interim and continue to work with appropriate organizations and stakeholders to develop final guidelines.

Proposed Rule

We reviewed the written comments, the oral testimony before the APC Panel, and the Panel's recommendations; we agreed that facility-coding guidelines should be implemented as soon as possible. We were particularly concerned that facilities be able to comply with HIPAA requirements. We announced that we have worked, and will continue to work, on this issue with hospitals, organizations representing hospitals, physicians, and organizations representing physicians. We noted that the AMA CPT Editorial Panel is not currently considering the issue of facility coding guidelines for clinic visits and that the earliest any CPT guidelines could be implemented would be in January 2004. Additionally, consistent with the intent of the outpatient prospective payment system, we wanted to ensure that reporting of hospital emergency and clinic visits is resource based.

After careful review and consideration of written comments, oral testimony and the APC Panel's recommendations, we proposed the following (for implementation no earlier than January 2004):

1. To develop five G codes to describe emergency department services: GXXX1—Level 1 Facility Emergency Services, GXXX2—Level 2 Facility Emergency Services, GXXX3—Level 3 Facility Emergency Services, GXXX4—Level 4 Facility Emergency Services, and GXXX5—Level 5 Facility Emergency Services.

2. To develop five G codes to describe clinic visits: GXXX6—Level 1 Facility Clinic Services, GXXX7—Level 2 Facility Clinic Services, GXXX8—Level 3 Facility Clinic Services, GXXX9—Level 4 Facility Clinic Services, and GXXX10—Level 5 Facility Clinic Services.

3. To replace CPT Visit Codes with the 10 new G codes for OPPS payment purposes.

4. To establish separate documentation guidelines for emergency visits and clinic visits.

With regard to the documentation guidelines, our primary concerns were to make appropriate payment for medically necessary care, to minimize the information collection and reporting burden on facilities, and to minimize any incentive to provide unnecessary or low quality care. We realized that many facilities use complaint or diagnosis driven care protocols and that current documentation standards do not include documentation of staff time or the complexity of diagnostic and therapeutic services provided. Therefore, in the interest of facilitating the delivery of medically necessary care in a clinically appropriate way, we believed that the potential drawbacks of each of the recommended sets of guidelines outweighed the potential benefits of creating uniformity and reproducibility. For example, any documentation system requiring counting or quantification of resource use has the potential to be burdensome, require clinically unnecessary documentation, and be susceptible to upcoding and gaming. Documentation systems using coding grids or a series of clinical examples for each level of service are subject to interpretation, may induce variability, may be overly complex and burdensome, and may result in disagreements with medical reviewers. We were also concerned that all the proposed guidelines allow counting of separately paid services (for example, intravenous infusion, x-ray, EKG, lab tests, and so forth) as ''interventions'' or ''staff time'' in determining a level of service. We believe that, within the constraints of clinical care and management protocols, the level of service for emergency and clinic visits should be determined by resource consumption that is not otherwise separately payable.

To address these concerns, in addition to reviewing written comments, oral comments, and the APC Panel recommendations, we also reviewed, for the proposed rule, the current distribution of paid emergency and clinic visit codes in the OPPS. With regard to emergency visits, we observed that well over 50 percent of the visits were considered ''multiple procedure claims'' because the claim includes services such as diagnostic tests (for example, EKGs and x-rays) or therapeutic interventions (for example, intravenous infusions). The distribution of all emergency services was in a bell-shaped curve with a slight left shift because there were more claims for CPT codes 99281 and 99282 than for CPT codes 99284 and 99285. This pattern of coding is significantly different from physician billing for emergency services, which is skewed and peaks at CPT code 99284. We also noted that the median costs for successive levels of emergency visits show an expected increase across APCs.

With regard to clinic visits, we observed that more than 50 percent of the services were considered ''single claims'' meaning that they were billed without any other significant procedures such as diagnostic tests or therapeutic interventions. We also noted that the distribution of clinic visits is skewed with the majority being low-level clinic visits. This distribution was consistent with pre-OPPS billing patterns where many facilities billed all clinic visits as low level visits. However, the median costs for different levels of clinic services, while similar within an APC, did not show the expected increase across the clinic visit APCs.

Based on our review, on the current distribution of coding for emergency and clinic visits, and on our understanding that hospitals set charges for services based on the resources used to provide those services, we believed that an incremental approach to developing and implementing documentation guidelines for emergency and clinic visits was appropriate. For example, as hospitals became more familiar with the OPPS and with the need to differentiate emergency and clinic visits based on resource consumption, we would continue to review the advantages and disadvantages of detailed, uniform documentation guidelines. We planned to begin the development of uniform guidelines over the next year. If we were ready, we would propose the guidelines for comments in our **Federal Register** document for the CY 2004 update. For CY 2003, we proposed the following new codes:

Emergency Visits

Because, our data indicated that, in general, hospitals under the OPPS were reporting emergency visits appropriately, we believed that insofar as hospitals have existing guidelines for determining the level of emergency service, those guidelines reflected facility resource consumption. Therefore, we proposed that GXXX1—Level 1 Facility Emergency Services be reported when facilities deliver, and document, basic emergency department services. These services included registration, triage, initial nursing assessment, minimal monitoring in the emergency department (for example,

one additional set of vital signs), minimal diagnostic and therapeutic services (for example, rapid strep test, urine dipstick), nursing discharge (including brief home instructions), and exam room set up/clean up. We expected that these services would be delivered to patients who present with minor problems of low acuity.

With regard to GXXX2 through GXXX5, we proposed to require that facilities develop internal documentation guidelines based on hospital resource consumption (for example, staff time). These guidelines would be appropriate for the type of services provided in the hospital and also clearly differentiate the relative resource consumption for each level of service so that a medical reviewer could easily infer the type, complexity, and medical necessity of the services provided and validate the level of service reported. Because of the great variability in available facility resources, staff, and clinical protocols among facilities, we did not believe that it is advisable to require a single set of guidelines for all facilities. Instead, we believed it is appropriate for each facility to develop its own documentation guidelines that took into account the facility's clinical protocols, available facility resources, and staff types. As stated above, we did not propose any specific requirements with regard to the basis of these guidelines. However, the guidelines were to be tied to actual resource consumption in the emergency department such as number and type of staff interventions, staff time, clinical examples, or patient acuity. We also proposed to require that facilities have documentation guidelines available for review upon request. The guidelines had to emphasize relative resource consumption and not, to the extent possible, set minimal requirements as a basis for determining the level of service (for example, require 30 minutes of staff time or five staff interventions to bill a level three emergency visit).

We proposed that these requirements, if made final, would be interim. We proposed to work with interested parties to revise these requirements and to propose any revision to these requirements in a future proposed rule.

Clinic Visits

We believed that the current distribution of codes for clinic visits were due to a facility's continued use of pre-OPPS coding policies for clinic visits. We believed that over time facilities would become as experienced differentiating levels of clinic visits as they were at differentiating levels of emergency visits. Therefore, we proposed a set of guidelines for clinic visits that paralleled the requirements for emergency visits. We proposed that GXXX6—Level 1 Facility Clinic Services, be reported when facilities deliver, and document, basic clinic services. These services included registration, triage, initial nursing assessment, minimal monitoring in the clinic (for example, one additional set of vital signs), minimal diagnostic and therapeutic services (for example, rapid strep test, urine dipstick), nursing discharge (including brief home instructions), and exam room set up/clean up. Our proposal for GXXX7 through GXXX10 was the same as for GXXX2 through GXXX5 except that the facility-specific guidelines were tied to actual resource consumption in the clinic such as number and type of staff intervention, staff time, clinical examples, or patient acuity. The guidelines had to differentiate the relative resource consumption in the clinic for each level of service sufficiently so that a medical reviewer could easily infer the type, complexity, and medical necessity of the services provided to validate the level of service provided.

We proposed that, if made final, these requirements would be interim. Any changes would be proposed in a future proposed rule.

We proposed to make final, in the 2003 OPPS final rule, changes in coding for clinic and emergency department visits and requirements related to the development of documentation guidelines for the new codes. However, we proposed to implement the new codes and documentation guidelines no earlier than January 1, 2004. This would have given hospitals time to develop documentation guidelines for the new codes and prepare their internal billing systems to accommodate the changes. We proposed to continue to work with hospitals throughout CY 2003 as they developed the documentation guidelines. In the proposed rule, we solicited comments on this proposal overall as well as the specific components of the proposal.

Comment: Many commenters recommended that CMS should keep the current E/M coding system until national coding guidelines with standard definitions can be established. Commenters also recommended that CMS convene a panel of experts to develop standard code definitions and guidelines that are simple to understand and implement and that allow for compliance with HIPAA requirements. Commenters generally recommended that code definitions and guidelines be established and implemented in 2003.

Response: We agree with many of the commenters concerns. While we agree that standard code definitions and guidelines should be implemented as soon as possible, we want to ensure that those definitions and guidelines are developed using an open process involving a variety of experts (for example, clinicians, coders, and compliance officers) in the field. Furthermore, the process should include adequate time for the education of clinicians and coders and for hospitals to make the necessary changes in their systems to accommodate the codes and guidelines.

In view of the comments received we believe that the most appropriate forum for development of code definitions and guidelines is an independent expert panel that makes recommendations to CMS in time for CMS to propose specific code definitions in the next year's proposed rule. Organizations such as the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA) have such expertise and are particularly well equipped to provide the ongoing education of providers. We believe it is critically important to the development, acceptance, and implementation of code definitions and guidelines for the organizations that develop the guidelines to also maintain them, update them, and provide ongoing education to providers concerning them. We would be happy to work with such an expert panel as code definitions and guidelines are developed.

We encourage any independent expert panel sending recommendations to CMS concerning guidelines to carefully review the principles and requirements for codes and guidelines that we announced in the proposed rule. We still believe that any set of national guidelines must adhere to those principles and requirements (for example, guidelines must be resource-based). Moreover, we encourage any such panel to address our concerns about existing guidelines (for example, potential for upcoding) in its recommendations to CMS. For example, our Advisory Panel on APC Groups recommended that CMS adopt the facility coding guidelines developed by the American College of Emergency Physicians (ACEP). While we understand that those guidelines have widespread support in the hospital community and that an independent panel may review them while developing guidelines, we would encourage such a panel to review the

ACEP guidelines in light of the principles, requirements, and concerns we enunciated in the proposed rule.

CMS hopes to receive recommendations on code definitions in time to include them in the notice of proposed rulemaking for 2004. We agree with the commenters who were concerned about implementing code definitions without national guidelines, and we will not propose or finalize code definitions until national guidelines for them have been developed.

Comment: Several commenters believed that use of G codes to describe facility visits would cause problems with payment by non-Medicare payers for these services. They believed this problem would worsen if the G codes were not accompanied by guidelines.

Response: G codes are national codes and must be recognized by other payers, though other payers do not need to use these codes for payment. We are unsure if the commenters' assertions are true. However, as stated in the previous response, we do not plan to finalize new codes for these services until guidelines for their use have been developed. Moreover, we will work with CPT, as appropriate, to develop CPT codes for these services once we have finalized and implemented them.

Comment: One commenter asked that CMS provide protection for hospitals against fraud and abuse allegations stemming from the current ambiguous guidelines.

Response: We are unsure if the commenter is referring to the CPT guidelines as being ambiguous for facilities or if the concern is over allowing facilities to develop and implement facility-specific guidelines until national codes and guidelines are implemented. In any case, we believe that written facility guidelines-developed in accordance with the principles (which we enunciated in the proposed rule and reaffirmed in this final rule) and which are widely disseminated in the facility, accompanied by appropriate education of clinicians and coders, and made available to reviewers-should address the concerns of the commenters.

Comment: Several commenters voiced concerns about what activities should be described in possible guidelines (*e.g.*, use of time as a criterion for selecting a level of service), the burden on facilities of having to adapt to a new set of codes for visits, and any requirements for facilities to develop their own guidelines. One commenter listed several principles for the development of facility codes and descriptors (that is, codes and guidelines should: focus on resource use, be supported by medical record documentation, support code assignment by the chargemaster, and provide a means for benchmarking medical-visit data across the industry).

Response: We believe that having an independent panel develop guidelines and make recommendations to CMS will address the concerns of these commenters. With regard to requiring facilities to develop internal guidelines for visit services, we believe that development of internal guidelines is critical for ensuring appropriate medical review and for enabling facilities to prove that billing for services were actually rendered.

Comment: One commenter asked CMS to clarify the terms ''nursing assessment'' and ''nursing discharge'' when assigning a level of service to a visit.

Response: Because we expect to receive recommendations from an independent panel regarding coding guidelines, we will not finalize the proposal describing what constitutes a level one emergency or clinic visit. Instead, we will continue to allow hospitals to develop their own internal guidelines for such visits until we finalize codes and guidelines.

Comment: One commenter asked that we create five payment rates for emergency and clinic visits, one for each level of service—instead of the three payment rates that we currently use.

Response: We review the relative weights of each APC on a yearly basis, and we would consider such a change if our claims data indicated such a change is appropriate.

Comment: One commenter asked that we craft a surgical global package for facilities to provide guidance for facility billing of surgical procedures and visits.

Response: The current APC structure and coding edits already do this. Payment for surgical procedures includes payment for all services related to the procedure (for example, postoperative care, preoperative valuation). Facilities may bill for visits in addition to surgical procedures when the visit is a separately identifiable service unrelated to the procedure. In such cases, the facilities attest to this by appending the –25 modifier to the line item for the visit.

Comment: One commenter said that CMS should provide guidance as to when it is appropriate to add together levels of service from two visits, and bill one visit at a higher level. Another commenter requested that CMS stop using the GO condition code in favor of the –27 modifier.

Response: We disagree. Each clinic visit should be coded separately. It is important to track utilization and for each clinic visit to be reported separately. This is critical for determining proper payment rates in the OPPS. Clinic visits should never be added together and billed as a single service with a higher level of service. We plan to continue using the GO modifier as it specifically addresses coding issues arising in the OPPS.

Comment: One commenter asked us to reconsider our G code descriptors for clinic and emergency visits.

Response: We will propose and finalize G code descriptors after we receive recommendations from an independent expert panel.

Comment: Several commenters asked us to develop guidelines based on a point or acuity system.

Response: The divergence of opinion in the hospital community makes it imperative that an independent expert panel be convened and that such a panel should make recommendations to CMS on these issues.

Comment: Several commenters were concerned about disparities between physician and facility coding for the same service. One commenter asked that hospitals be allowed to code a different level of service than the physicians.

Response: We do not believe that facilities and physicians would be expected to bill similar levels of service for the same encounter. The resources used by a facility for a visit may be quite different from the resources used by a physician for the same visit. Facilities should code a level of service based on facility resource consumption, not physician resource consumption. This includes situations where patients may see a physician only briefly, or not at all.

However, if a visit and another service is also billed (that is, chemotherapy, diagnostic test, surgical procedure) the visit must be separately identifiable from the other service because the resources used to provide non-visit services including staff time, equipment, supplies, and so forth, are captured in the line item for that service. Billing a visit in addition to another service merely because the patient interacted with hospital staff or spent time in a room for that service is inappropriate.

Comment: One commenter asked CMS to clarify proper billing for E/M services when a visit and another service, such as chemotherapy, have been provided.

Response: If a visit and another service is also billed (that is, chemotherapy, diagnostic test, or surgical procedure) the visit must be separately identifiable from the other

service. This is because the resources used to provide non-visit services (including staff time, equipment, supplies and so forth) are captured in the line item for that particular service. However, billing a visit in addition to another service—merely because the patient interacted with hospital staff or spent time in a room for that service—is inappropriate.

B. Observation Services

Coding and Billing Instructions

On November 30, 2001, we published a final rule updating changes to the OPPS for 2002. We implemented provisions that allow separate payment for observation services under certain conditions. That is, a hospital may bill for a separate APC payment (APC 0339) for observation services for patients with diagnoses of chest pain, asthma, or congestive heart failure when certain criteria are met. The criteria discussed in the November 30, 2001 final rule and as corrected in the March 1, 2002 final rule are also explained in detail in section XI of a Program Memorandum to intermediaries issued on March 28, 2002 (Transmittal A–02–026). Payment for HCPCS code G0244, observation care provided by a facility to a patient with congestive heart failure, chest pain or asthma, minimum eight hours, maximum 48 hours, was effective for services furnished on or after April 1, 2002.

Section XI of Transmittal A–02–026 that was issued on March 28, 2002, provides additional billing and coding instructions and requirements that flow from the basic criteria that we implemented in the November 30, 2001 and the March 1, 2002 final rules. Although we do not address them explicitly in the final rules, the additional instructions and requirements in Transmittal A–02–026 were developed to implement the basic observation criteria within the programming logic of the outpatient code editor (OCE), which is used to process claims submitted by hospitals for payment under the OPPS. For example, in the November 30, 2001 final rule, we state that an emergency department visit (APC 0610, 0611, or 0612) or a clinic visit (APC 0600, 0601, or 0602) must be billed in conjunction with each bill for observation services (66 FR 59879). In section XI of Transmittal A–02–026, we state that an E/M code (referred to, incorrectly, in Transmittal A–02–026 as an ''Emergency Management'' code), for the emergency room, clinic visit, or critical care is required to be billed on the day before or the day that the patient is admitted to observation. That is, unless one of the CPT codes assigned to APCs 0600, 0601, 0602, 0610, 0611, 0612, or 0620 is billed on the day before or the day that the patient is admitted to observation, separate payment for G0244 is not allowed. The codes assigned to these APCs are categorized by CPT as E/M codes. Although we did not include APC 0620, Critical Care, among the APCs that must be billed in order to receive separate payment for observation services, we added it in the program memorandum because critical care is an E/M service that can be furnished in a clinic or an emergency department. Critical care may appropriately precede admission to observation for chest pain, asthma, or congestive heart failure. We clarify in Transmittal A–02–026 that both the associated E/M code and G0244 are paid separately if the observation criteria are met. We also specify that the E/M code associated with observation must be billed on the same claim as the observation service.

Similarly, in the November 30, 2001 and the March 1, 2002 final rules, we require that certain diagnostic tests be performed in order to bill for separate payment for observation services. In Transmittal A–02–026, in section XI.B.2, we list the diagnostic tests that the OCE looks for on a bill for G0244. This list, which amplifies what we published in the November 30, 2001 and March 1, 2002 final rules, is incomplete and should read as follows to reflect the current OCE logic that is applied to claims for G0244:

- For chest pain, at least two sets of cardiac enzymes [either two CPK (82550, 82552, or 82553), or two troponin (84484 or 84512)], and two sequential electrocardiograms (93005);
- For asthma, a peak expiratory flow rate (94010) or pulse oximetry (94760, 94761, or 94762);
- For congestive heart failure, a chest x-ray (71010, 71020, or 71030) and an electrocardiogram (93005) and pulse oximetry (94760, 94761, or 94762).
- Note: Pulse oximetry codes 94760, 94761, and 94762 are treated as packaged services under the OPPS. Although no separate payment is made for packaged codes, hospitals must separately report the HCPCS code and a charge for pulse oximetry in order to establish that observation services for congestive heart failure and asthma diagnoses meet the criteria for separate payment.

Transmittal A–02–026 also provides specific coding instructions that hospitals must use when billing for observation services that do not meet the criteria for separate payment under APC 0339. In addition, Transmittal A–02–026 addresses the use of modifier –25 with the E/M code billed with G0244.

Comment: A few commenters requested clarification of the requirement that CPT 94010 (peak flow) be billed to establish a diagnosis of asthma. The commenter noted that CPT 94010 is the code for spirometry with recording and that it would be erroneous to bill peak flow, which is all that is relevant for asthma, as a spirometry, which requires a record and should include such elements as vital capacity and flow-volume loops. The commenter is concerned that we are instructing hospitals to bill incorrectly if our intention is solely to require peak flow.

Response: We are reviewing this comment and if we determine that a modification of the current requirement for peak flow is appropriate, we will revise the requirement in the program memorandum that implements the 2003 OPPS update effective January 1, 2003.

Comment: One commenter asked whether bedside services other than infusion, such as CVP placement, arterial punctures, and IV injections, can be billed when furnished to observation patients or whether these services are considered to be packaged into the observation payment.

Response: We would not expect that placement of a CVP line would be billed for a patient in observation. However, in general, any service that is separately payable under the OPPS, that is, procedures with status indicators S, X, K, G, V, or H, can be billed with G0244 and paid separately, although services with status indicator ''T'' (with the exception of Q0081), as we explain below, are *not* separately payable with G0244.

Direct Admissions to Observation

Since implementation of the provision for separate payment for observation services under APC 0339, a number of hospitals, hospital associations, and other interested parties have asked if separate payment for observation services would be allowed for a patient with chest pain, asthma, or congestive heart failure who is admitted directly into observation by order of the patient's physician but without having received critical care or E/M services in a hospital clinic or the emergency department on the day before or the day of admission to observation. We have responded during monthly CMS hospital open forum calls that, consistent with the criteria in the November 30, 2001 final rule, effective for services furnished on or after April

1, 2002, separate payment for observation services requires that an admission to observation be made by order of a physician in a hospital clinic or in a hospital emergency department. If a patient is directly admitted to observation but without an associated E/M service (including critical care) shown on the same bill, the hospital should bill observation services using revenue code 762 alone or revenue code 762 with one of the HCPCS codes for packaged observation services (CPT codes 99218, 99219, 99220, 99234, 99235, or 99236).

A related question has arisen in connection with a policy interpretation that was posted as a response to a ''Frequently Asked Question'' (FAQ) on our Web site on September 12, 2000. The FAQ follows:

''Q.97: If a patient is admitted from the physician's office to the observation room, will there be no reimbursement?

''A.97: Since observation is a packaged service, payment cannot be made if it is the only OPPS service on a claim. However, we believe that the ''admission'' of a patient to observation involves a low-level visit billed by the hospital, as well as whatever office visit the physician who arranged for the admission billed. Thus, when a patient arrives for observation arranged for by a physician in the community (that is, ''direct admit to observation''), and is not seen or assessed by a hospital-based physician, the hospital may bill a low-level visit code. This low-level visit code will capture the baseline nursing assessment, the creation of a medical record, the recording and initiation of telephone orders, and so forth. This visit may be coded only once during the period of observation. The observation charges should be shown in revenue code 762. The number of hours the patient was in observation status should be shown in the units field. Payment for those services is packaged into the APC for the visit. Other services performed in connection with observation, such as lab, radiology, and so forth, should be billed for as well. * * *''

We have been asked to clarify whether or not the low-level visit code suggested in the FAQ for patients directly admitted for observation services would satisfy the requirement that a line item for a hospital emergency visit, hospital clinic visit, or critical care appear on the same bill as HCPCS code G0244. Our response is that when we established the final criteria effective for services furnished on or after April 1, 2002, we did not contemplate that the low-level visit described in the FAQ would satisfy the requirement for the E/M code that a hospital must bill to show a hospital clinic visit or hospital emergency department visit was performed before observation services for asthma, congestive heart failure, or chest pain to bill and receive payment for G0244 under APC 0339.

In light of these questions, we have reviewed the criteria for separate payment for observation services under APC 0339, and we proposed to modify the criteria and coding for observation services furnished on or after January 1, 2003. Specifically, we proposed to create two new codes. These additional codes would allow us to collect data on the extent to which patients are directly admitted to hospital observation services without an associated hospital clinic visit or emergency department visit. The proposed codes were as follows:

G0LLL-Initial nursing assessment of patient directly admitted to observation with diagnosis of congestive heart failure, chest pain, or asthma.

G0MMM-Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma.

If a hospital directly admits to observation from a physician's office a patient with a diagnosis of congestive heart failure, asthma, or chest pain, we proposed to require that G0LLL be billed with G0244. The current requirement that the hospital bill an emergency department visit (APC 0600, 0601, or 0602) or a clinic visit (APC 0610, 0611, or 0612) or a critical care service (APC 0620) in order to receive separate payment for observation services for patients not admitted directly from a physician's office would remain in effect. However, because the initial nursing assessment is part of any observation service, we proposed not to make separate payment for G0LLL. Rather, we proposed to assign status indicator ''N'' to G0LLL, to designate that charges submitted with G0LLL would be packaged into the costs associated with APC 0339. If G0LLL is billed, we would require that the medical record show that the patient was admitted directly from a physician's office for purposes of evaluating and treating chest pain, asthma, or congestive heart failure.

G0MMM describes the initial nursing assessment of a patient directly admitted to observation with a diagnosis other than chest pain, asthma, or congestive heart failure. We proposed to assign G0MMM for payment under APC 0706, New Technology—Level I. We proposed to require hospitals to bill G0MMM instead of the low level clinic visit referred to in the FAQ above to describe the initial nursing assessment of a patient directly admitted to observation with a diagnosis other than chest pain, asthma, or congestive heart failure. Separate payment would not be made for observation services billed with G0MMM. Rather, when billing G0MMM, hospitals would be required to use revenue code 762 alone or revenue code 762 with one of the HCPCS codes for packaged observation services (99218, 99219, 99220, 99234, 992335, or 99236). We proposed to create G0MMM to establish a separately payable code into which costs for observation care for patients directly admitted for diagnoses other than asthma, chest pain, or congestive heart failure can be packaged and recognized.

We would use billing data for G0LLL and G0MMM in reviewing the provisions for payment of observation services in future updates of the OPPS. In the proposed rule, we invited comment on the extent to which these codes address the concerns that have been raised in connection with patients who are directly admitted to observation services.

Comment: Everyone who commented on our proposed refinements of the requirements to enable separate payment for observation services supported the proposal to allow separate payment for patients admitted to observation directly from physicians' offices. However, the majority of commenters opposed the coding and payment methodology that we proposed to implement this change.

Commenters stated that having to use G0LLL and G0MMM, combined with the other requirements that have to be met in order to receive separate payment for observation of patients with asthma, congestive heart failure, and chest pain, would be burdensome and confusing, and would create operational inconsistencies and problems for hospitals. Several commenters urged CMS to simplify, the observation rules in order to reduce their complexity and lessen the burden they currently impose on hospitals. Some commenters were concerned that other payors might not accept the proposed new codes and that the codes would not be HIPAA compliant.

A number of commenters recommended alternatives to the establishment of G0LLL and G0MMM that would utilize information already being reported by hospitals on the UB–92 within the existing coding system for revenue centers, diagnoses, and source and type of admission. One commenter suggested a single G code for ''Intake into observation after outside evaluation'' supported by appropriate diagnosis coding and claims edits. One

commenter recommended instituting a ''per visit'' payment logic in the OCE and PRICER similar to that used for mental health and PHP services. Several commenters suggested returning observation to a time-based charging and coding methodology based on hours. Several commenters supported using existing E/M codes instead of creating new codes.

Response: We agree with many of the commenters that our proposal for direct admissions to observation seems administratively burdensome. However, we believe that the importance of creating a payment mechanism for direct admissions to observation outweighs the administrative burden at this time. We also believe it is vital that we be able to track the utilization of these services so we will have data upon which to base policy decisions in the future.

A number of the alternatives suggested by commenters are promising and merit further analysis and review. However, our preliminary inquiries revealed that most of the suggested alternatives would require systems changes that could take six months or longer to develop and install, and that such changes could not be implemented effective January 1, 2003. Therefore, we have decided to implement the proposed G codes as follows:

G0263, Direct admission of patient with diagnosis of congestive heart failure, chest pain or asthma for observation.

G0264, Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma.

These codes would be HIPPA compliant. Other payers would make their own decisions about whether to use these codes for their own payment purposes.

Comment: One commenter asked that we instruct Fiscal Intermediaries to accept another revenue code in the 76X range for G0263 and G0264 because RC 762 may only be used to report observation charges.

Response: We are reviewing with our coding and claims processing experts to determine if there is a more appropriate revenue code to use when billing G0263 and G0264. We will provide specific instructions in the program memorandum issued to implement the January 2003 OPPS update.

Comment: Cancer centers urged CMS to expand the conditions for which we would make separate payment for observation to include febrile neutropenia, electrolyte disorders, chemotherapy hypersensitivity reaction, pulmonary embolisms, acute GI hemorrhage, and seizures presented by cancer patients under treatment at Cancer Centers. Other commenters suggested psychiatric conditions, acute abdominal pain, post-transplant threat of rejection, and pneumonia as appropriate for separate payment for observation.

Response: As we indicate in the November 30, 2001 final rule, we will review the indications for separately payable observation after we have acquired sufficient experience under the current system to make an informed decision as to whether an expansion is appropriate.

Comment: Most commenters asserted that our proposed payment for G0MMM for initial nursing assessment of a patient directly admitted to observation with a diagnosis other than chest pain, asthma, or congestive heart failure (APC 706) is too low and does not recognize the substantial type, level, and quality of the initial nursing services being provided. Commenters urged CMS either to set a higher payment rate for G0MMM or to allow an E/M code to be billed with G0MMM. Another commenter suggested assigning G0MMM to APC 0600 to be consistent with what CMS says in the FAQ 97. One commenter noted that it is inappropriate to assign G0MMM to a new technology APC because the code describes an E/M service, not a new technology service.

Response: We agree. We have therefore assigned G0264 for payment in APC 600, Low Level Clinic Visits.

Comment: One commenter wanted to know if G0LLL and G0MMM could be used for patients admitted from their homes, either (1) based solely upon a telephone call from the patient to the community physician and that physician's call to the hospital to order a direct admission for observation management, or (2) when directly admitted by the physician after going home following a visit to the physician's office, the patient's condition having deteriorated after seeing the physician.

Response: As long as the physician notifies the hospital that he/she is ordering the direct admission of the patient for observation and supports that order with the appropriate suspected diagnosis, we believe this would constitute a direct admission. Either G0263 or G0264 would be billed, depending on the final diagnosis supporting the direct admission observation services.

C. Billing Intravenous Infusions With Observation

Based on questions and concerns raised by hospitals since implementation of payment for APC 0339 effective April 1, 2002, we have also reviewed the current status of billing intravenous infusions with observation. Several hospitals have noted that claims for G0244 when billed with intravenous infusion services reported with HCPCS code Q0081 are denied because of the ''T'' status indicator assigned to HCPCS code Q0081. Our current payment rules for G0244 require that G0244 be denied if a service with status indicator ''T'' is performed the day before, the day of, or the day after observation care. Because patients in observation may require intravenous infusions of fluid, we proposed to create code G0EEE, Intravenous infusion during separately payable observation stay, per observation, payable under APC 0340 with status indicator ''X.'' When observation services that otherwise meet the billing requirements for separate payment under APC 0339 include an intravenous infusion administered as part of the observation care, G0EEE would be used to report the infusion service. We included instructions on the use of G0258 in the program memorandum issued to implement OPPS coding changes for the October 1, 2002 OCE. In the proposed rule, we solicited comment on the use of this code.

Comment: While appreciative of our recognizing the need for a mechanism that permits hospitals to bill for infusion therapy during observation, most commenters did not support our proposal to introduce a new code for the service. One commenter recommended terminating G0258 effective 12/31/02 because it creates operational burdens for the hospital and does not accurately reflect the resources used. Several commenters urged CMS to change the SI for APC 120 to which Q0081 is assigned to S. This would solve the problem and permit payment of Q0081 with G0244 and would also align the status indicators for the infusion of non-chemotherapy drugs with the infusion of chemotherapy drugs.

Commenters asked if CMS intends hospital to use G0258 instead of Q0081 when the infusion therapy is provided to the patient in the emergency department or clinic prior to patient's placement in observation when the observation stay ultimately qualifies for separate payment. The commenters pointed out that the hospital may not know when the patient is in the emergency department or clinic and the infusion therapy is initiated that the patient will subsequently be placed in an observation stay that qualifies for payment under G0244. Commenters

asked CMS to clarify how G0258 is to be used.

One commenter recommended, that we install an OCE edit to ignore Q0081 when checking for the presence of a procedure with SI=T.

Many commenters stated that the payment for G0248 should be the same as the payment for Q0081 because the resources expended for infusion therapy performed during a packaged observation stay are the same as those required for Q0081 furnished. These commenters disagreed with CMS's assertion that payment for G0258 should be discounted to equal 50 percent of the payment for Q0081 because Q0081 is invariably billed with a higher-paying procedure and is, therefore, discounted. Another commenter advocated adjusting the payment for G0244 to include the cost of infusion and eliminating a separate new code. The same commenter supported payment at 50 percent of the rate set for Q0081 because Q0081 would always be discounted because it is always billed with another procedure.

Response: Having reviewed the numerous concerns raised by commenters in connection with the use of HCPCS code G0258, Intravenous infusion during separately payable observation stay, per observation stay (must be reported with G0244), and our proposed payment for G0258, we agree with commenters that requiring the use of this code is problematic. We have determined that the OCE logic can be modified to allow payment for G0244, even though Q0081 is assigned to an APC with status indicator T. Therefore, effective for services furnished on or after January 1, 2003, we are withdrawing G0258. Instead hospitals may submit claims for G0244 with Q0081 when infusion therapy is provided, and the claim will be paid if all other requirements and conditions are met. The status indicator for G0081 will not change.

Annual Update of ICD–9 Diagnosis Codes

To receive payment for G0244, we require hospitals to bill specified ICD–9–CM diagnosis code(s). Because ICD–9–CM codes are updated effective October 1 of each year, we proposed to issue by Program Memorandum any changes in the diagnosis codes required for payment of G0244 resulting from the ICD–9–CM annual update.

In the March 1, 2002 final rule (67 FR 9559) and in Transmittal A–02–026 issued on March 28, 2002, we listed the diagnosis codes required in order for separate payment of observation services under APC 0339 to be made for patients with congestive heart failure. We added by program memorandum the following new ICD–9–CM codes to the list of allowed diagnosis codes for separate payment for observation of patients with congestive heart failure, effective for services furnished on or after October 1, 2002:

428.20 Unspecified systolic heart failure
428.21 Acute systolic heart failure
428.22 Chronic systolic heart failure
428.23 Acute on chronic systolic heart failure
428.30 Unspecified diastolic heart failure
428.31 Acute diastolic heart failure
428.32 Chronic diastolic heart failure
428.33 Acute on chronic diastolic heart failure
428.40 Unspecified combined systolic and diastolic heart failure
428.41 Acute combined systolic and diastolic heart failure
428.42 Chronic combined systolic and diastolic heart failure
428.43 Acute on chronic combined systolic and diastolic heart failure

In the August 9, 2002 proposed rule, we invited comment on the addition of these diagnosis codes to the criteria for separate payment for observation services under APC 0339.

Comment: One commenter recommended adding the following codes to the list of diagnoses for asthma: 493.00, 493.10, 493.20, and 493.90

Response: We are not including these diagnoses because they would not be appropriate for use with patients requiring observation services because they are experiencing acute exacerbations of asthma.

- Effective for services furnished on or after January 1, 2003, hospitals may bill for patients directly admitted for observation services using the following codes:

G0263, Direct admission of patient with diagnosis of congestive heart failure, chest pain or asthma for observation.

G0264, Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma.

- Payment for G0264 will be made under APC 600.
- Payment for G0263 will be packaged into the payment for APC 339
- Payment for G0244 will be allowed when billed with Q0081, Infusion therapy other than chemotherapy, when furnished to patients with asthma, congestive heart failure, or chest pain, subject to all other conditions for payment having been met.

C. Payment Policy When a Surgical Procedure on the Inpatient List Is Performed on an Emergency Basis

As we state in section II.B.5 of this preamble, the inpatient list specifies those services that are only paid when provided in an inpatient setting. The inpatient list proposed for 2003 is printed as Addendum E. In Addendum B, status indicator C designates a HCPCS code that is on the inpatient list.

Over the past year, some hospitals and hospital associations have asked how a hospital could receive Medicare payment for a procedure on the inpatient list that had to be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition who was transferred or died before being admitted as an inpatient. We reviewed within the context of our current policy the cases brought to our attention for which payment under the OPPS was denied because a procedure with status indicator C was on the bill. Based on that review, we proposed to clarify our policy regarding Medicare payment when a procedure with status indicator C is performed under certain life-threatening, emergent conditions. In the proposed rule, we solicited comments on the extent to which the payment policy described below addresses hospitals' concerns. We stated it would be most helpful if commenters provided specific examples of cases when hospitals have, in these instances, submitted bills for a procedure with OPPS status indicator C that were not paid.

1. Current Policy

In the April 7, 2000 final rule (65 FR 18451), in response to comments about the appropriate level of payment for patients who die in the emergency department, we set forth the following guidelines for fiscal intermediaries to use in determining how to make payment when a patient dies in the emergency department or is sent directly to surgery and dies there.

- If the patient dies in the emergency department, make payment under the outpatient PPS for services furnished.
- If the emergency department or other physician orders the patient to the operating room for a surgical procedure, and the patient dies in surgery, payment will be made based on the status of the patient. If the patient had been admitted as an inpatient, pay under the hospital inpatient PPS (a DRG-based payment).
- If the patient was not admitted as an inpatient, pay under the outpatient PPS (an APC-based payment).
- If the patient was not admitted as an inpatient and the procedure is

designated as an inpatient-only procedure (payment status indicator C), no Medicare payment will be made for the procedure, but payment will be made for emergency department services.

The OPPS outpatient code editor (OCE) currently has an edit in place that generates a ''line item denial'' for a line on a claim that has a status indicator C. A line item denial means that the claim can be processed for payment but with some line items denied for payment. A line item denial can be appealed under the provisions of section 1869 of the Act. The OCE includes another edit that denies all other line items furnished on the same day as a line item with a status indicator C. The rationale for this edit is that all line items for services furnished on the same date as the procedure with status indicator C would be considered inpatient services and paid under the appropriate DRG.

As part of the definition of line item denial in the program memorandum that we issue quarterly to update the OCE specifications (for example, see Program Memorandum/Intermediaries, Transmittal A–02–052, June 18, 2002, which is available on our Web site at *http://cms.hhs.gov/manuals/pm_trans/A02052.pdf*), we state that a line item denial cannot be resubmitted except for an emergency room visit in which a patient dies during a procedure that is categorized as an inpatient procedure: ''Under such circumstances, the claim can be resubmitted as an inpatient claim.''

In Addendum D of the March 1, 2002 final rule, we designate payment status indicator ''C'' as follows: ''Admit patient; bill as inpatient.''

2. Hospital Concerns

Hospitals have requested clarification regarding billing and payment in certain situations that our current policy does not seem to explicitly address. The following scenarios synthesize cases described by hospitals for which they have encountered problems when billing for a procedure with status indicator C.

Scenario A: A procedure assigned status indicator C under the OPPS is performed to resuscitate or stabilize a beneficiary who appears with or suddenly develops a life-threatening condition. The patient dies during surgery or postoperatively before being admitted.

Scenario B: An elective or emergent surgical procedure payable under the OPPS is being performed. Because of sudden, unexpected intra-operative complications, the physician must alter the surgical procedure and perform a procedure with OPPS status indicator C. The patient dies during the operation before he or she is admitted as an inpatient.

Scenario C: A procedure with status indicator C is performed to resuscitate or stabilize a beneficiary who appears with or suddenly develops a life-threatening condition. After the procedure, the patient is transferred to another facility for postoperative care.

3. Clarification of Payment Policy

We proposed the following policy for fiscal intermediaries and providers to use in determining the appropriate Medicare payment in cases such as those described in the section above.

A procedure assigned status indicator C under the OPPS is never payable under the OPPS. Therefore, for a hospital to receive payment when a procedure with OPPS status indicator C is performed and: (1) The patient dies during or after the procedure, before being admitted, or (2) the patient survives the procedure and is transferred following the procedure, the patient's medical record must contain all of the following information:

- Either orders to admit written by the physician responsible for the patient's care at the hospital to which the patient was to be admitted following the procedure for the purpose of receiving inpatient hospital services and occupying an inpatient bed, or written orders to admit and transfer the patient to another hospital following the procedure.
- Documentation that the reported HCPCS code for the surgical procedure with OPPS payment status indicator C (such as CPT code 61345) was actually performed.
- Documentation that the reported surgical procedure with status indicator C was medically necessary.
- If the patient is admitted and subsequently transferred to another facility, documentation that the transfer was medically necessary, such as the patient requiring postoperative treatment unavailable at the transferring facility.

In the case of a patient who dies during performance of a procedure with OPPS status indicator C before being admitted, the hospital would submit a claim for all services provided, including a line item for the status indicator C procedure. The claim would be rejected for payment under the OPPS and returned to the hospital. The hospital would resubmit the claim for payment as an inpatient stay under the appropriate DRG.

In the case of a patient who is admitted and transferred, the transferring hospital would be paid a per diem DRG rate if all the above conditions are met. (We proposed to revise § 3610.5 of the Medicare Intermediary Manual accordingly.) Because these services would be paid according to the appropriate DRG or per diem (see below), all services that were furnished before admission that would otherwise be payable under the OPPS would be paid in accordance with the provisions of § 3610.3 of the Medicare Intermediary Manual (''3-day rule'') and § 415.6 of the Medicare Hospital Manual.

Note that a physician's order to admit a patient to an observation bed following a procedure designated with OPPS status indicator C would not constitute an inpatient admission and, therefore, would not qualify the procedure with status indicator C for payment. In this instance, the only allowable Medicare payment would be for a code payable under APC 0610, 0611, or 0612 if those services were provided. Payment would not be allowed for either the procedure with status indicator C or for any ancillary services furnished on the same date.

Comment: Commenters agreed that the current policy on billing and payment when procedures on the inpatient list are performed on an outpatient basis requires clarification and modification. However, commenters stated that our proposals, if implemented, would be burdensome and create extra work for hospitals. Commenters opposed our proposal that an outpatient claim be submitted for rejection and then resubmitted as an inpatient claim. Commenters asserted that this would be unwieldy and create an unacceptable delay in payment. Many commenters were concerned that it would be difficult to expect a physician to write an order to admit a patient who expired during emergency surgery, and that asking physicians to do so to satisfy a billing requirement would not be appropriate. Some commenters were concerned that submitting an inpatient claim that is inconsistent with medical records documentation could create problems with medical review. However, commenters did not provide illustrations of actual cases when hospitals have submitted outpatient bills for a procedure with status indicator C that was performed in an emergency situation and not paid which would have added specificity to the general comments.

Commenters offered several alternatives to our proposal. Several commenters suggested that these cases be initially billed as inpatient stays,

supported by documentation that the procedure was performed and was medically necessary, and that a presumption of admission be made for payment purposes. Several commenters suggested that a reduced DRG-related amount be established as payment in these special cases. Several commenters suggested the use of a condition code that would allow submission of an outpatient claim when procedures on the inpatient list are performed in emergency situations.

Response: We appreciate commenters' reactions and suggestions of ways to make payment under the OPPS in emergency situations when procedures on the inpatient list are performed on a beneficiary who is not admitted as an inpatient. After careful review and consideration of the comments and recommendations, we have decided to modify certain aspects of our proposed policy, while retaining certain others. We are also taking steps to ensure that OCE edits are consistent with our policy.

The underlying principle is our policy that procedures on the inpatient list performed on patients whose status is that of outpatient are not payable as outpatient services.

However, we recognize that there are occasions when a procedure on the inpatient list must be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient. To receive payment in those cases, hospitals admit the patient and submit an inpatient claim.

In cases where a procedure on the inpatient list must be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient, the patient may be admitted and transferred to another hospital. In these cases, the transferring hospital is paid a per diem DRG rate. We shall revise section 3610.5 of the Medicare Intermediary Manual to reflect this policy.

On rare occasions, a procedure on the inpatient list must be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient and the patient dies before being admitted as an inpatient. For those rare and unusual cases, we are instructing hospitals to submit an outpatient claim for all services furnished, including the procedure code with status indicator C to which a new modifier is attached. The exact modifier that is to be used in these cases had not been issued by the HCPCS alpha-numeric workgroup in time for publication in this final rule. The modifier and instructions for its use will be included in the program memorandum for the January 2003 update. We believe that such patients would typically receive services such as those provided during a high-level emergency visit, appropriate diagnostic testing (X-ray, CT scan, EKG, and so forth), and administration of intravenous fluids and medication prior to the surgical procedure. Because these combined services constitute an episode of care, we will pay claims with a procedure code on the inpatient list that are billed with the new modifier under new technology APC 977. Separate payment will not be allowed for other services furnished on the same date. This approach allows hospitals to submit an outpatient claim and receive payment without additional paperwork, it results in consistency between the medical record and patient status, and it allows us to collect data on the costs associated with these very unusual and infrequent cases for future use in updating the OPPS.

Procedures with status indicator C but without the new modifier that are submitted on an outpatient bill will receive a line item denial, and no other services furnished on the same date are payable.

If an outpatient has a procedure that is on the inpatient list performed, and is subsequently admitted to an observation bed, the procedure with status indicator C submitted on an outpatient bill will receive a line item denial. Further, we have decided not to make final our proposal to make payment for APC 610, 611 or 612 under such circumstances. Rather, in such cases no other services furnished on the same date are payable.

We did not receive any comments on the documentation that we proposed to require in the patient's medical record when a procedure with status indicator C is performed and: (1) The patient dies before being admitted as an inpatient, or (2) the patient survives the procedure and is admitted and transferred. Therefore, we are making those requirements final.

4. Orders To Admit

Some hospitals have raised questions about the timing of a physician's order to admit a patient. The requirements for authenticating physician orders and the standards for medical record keeping fall outside the scope of this rule and OPPS payment policy. The payment provisions that we are making final in this rule are to assist hospitals and contractors in determining how to bill and pay for services appropriately under Medicare. The patient's admission status, as documented by the medical records, determines what Medicare payment is appropriate. Medical record keeping and documentation requirements are addressed in the Medicare hospital conditions of participation at § 482.24, and are governed by applicable State law and State licensing rules and hospital accreditation standards.

Comment: A few commenters requested clarification on what is meant by ''admit'' and the documentation that CMS would expect to see in order to substantiate that a patient was admitted as an inpatient. One commenter expressed concern about the variability in fiscal intermediaries' policies regarding the changing of an admission status after the service has been provided.

Response: As we have indicated, these issues are addressed in the Medicare hospital conditions of participation at § 482.24, and are governed by applicable State licensing rules and hospital accreditation standards. Questions and concerns related to these issues should be addressed to the parties who are responsible for these rules, regulations, and standards.

When a procedure on the inpatient list must be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient and the patient dies before being admitted as an inpatient, the hospital should submit an outpatient claim for all services furnished, including the procedure with status indicator C to which a new modifier, which will be announced by program memorandum is attached. Claims with a procedure code on the inpatient list that are billed with the new modifier will be paid under APC 977.

We are making final the requirement that information specified in the proposed rule be included in the medical record to support payment when a procedure with status indicator C is performed on an outpatient and the patient dies or is admitted and transferred.

D. Status Indicators

The status indicators we assign to HCPCS codes and APCs under the OPPS have an important role in payment for services under the OPPS because they indicate if a service represented by a HCPCS code is payable under the OPPS or another payment system and also if particular OPPS policies apply to the code. We are providing our status indicator assignments for APCs in Addendum A, HCPCS codes in

Addendum B, and definitions of the status indicators in Addendum D.

The OPPS is based on HCPCS codes for medical and other health services. These codes are used for a wide variety of payment systems under Medicare, including, but not limited to, the Medicare fee schedule for physician services, the Medicare fee schedule for durable medical equipment and prosthetic devices, and the Medicare clinical laboratory fee schedule. For purposes of making payment under the OPPS, we need a way to signal the claims processing system which HCPCS codes are paid under the OPPS and those codes to which particular OPPS payment policies apply. We accomplish this identification in the OPPS through the establishment of a system of status indicators with specific meanings. Addendum D defines the meaning of each status indicator for purposes of the OPPS.

We assign one and only one status indicator to each APC and to each HCPCS code. Each HCPCS code that is assigned to an APC has the same status indicator as the APC to which it is assigned.

Specifically, in 2003, we proposed to use the status indicators in the following manner:

- ''A'' to indicate services that are paid under some payment method other than OPPS, such as the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule or the physician fee schedule. Some but not all—of these other payment systems are identified in Addendum D.
- ''C'' to indicate inpatient services that are not payable under the OPPS.
- ''D'' to indicate a code that was deleted effective with the beginning of the calendar year.
- ''E'' to indicate services for which payment is not allowed under the OPPS or that are not covered by Medicare.
- ''F'' to indicate acquisition of corneal tissue, which is paid at reasonable cost.
- ''G'' to indicate drugs and biologicals that are paid under OPPS transitional pass-through rules.
- ''H'' to indicate devices that are paid under OPPS transitional pass-through rules.
- ''K'' to indicate drugs and biologicals (including blood and blood products) and certain brachytherapy seeds that are paid in separate APCs under the OPPS, but that are not paid under OPPS transitional pass-through rules.
- ''N'' to indicate services that are paid under the OPPS for which payment is packaged into another service or APC group.
- ''P'' to indicate services that are paid under the OPPS but only in partial hospitalization programs.
- ''S'' to indicate significant procedures that are paid under OPPS but to which the multiple procedure reduction does not apply.
- ''T'' to indicate significant services that are paid under the OPPS and to which the multiple procedure payment discount under OPPS applies.
- ''V'' to indicate medical visits (including clinic or emergency department visits) that are paid under the OPPS.
- ''X'' to indicate ancillary services that are paid under the OPPS.

The software that controls Medicare payment looks to the status indicators attached to the HCPCS codes and APCs for direction in the processing of the claim. Therefore, the assignment of the status indicators has significance for the payment of services. We sometimes change these indicators in the course of a year through program memoranda. Moreover, indicators are established for new codes that we establish in the middle of the year, either as a result of a national coverage decision or otherwise. A status indicator, as well as an APC, must be assigned so that payment can be made for the service identified by the new code.

Our proposed status indicators identified for each HCPCS code and each APC appear in Addenda A and B of the proposed rule. We requested comments on the appropriateness of the indicators we have assigned.

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

Comment: Some commenters said that our proposed payment for influenza and pneumococceal pneumonia vaccines and orphan drugs were inadequate to ensure the provision of these drugs and biologicals.

Response: As discussed in section III.B, we will pay reasonable cost for these drugs and biologicals in 2003. Therefore, we have assigned orphan drugs a status indicator of F and have redefined the status indicator F to mean that the item or service is paid on a reasonable cost basis. Until now, only corneal tissue acquisition has been paid as reasonable cost under OPPS and, therefore, the status indicator was specific to corneal tissue. However, beginning January 1, 2003, the ''F'' status indicator will apply to any item or service paid at reasonable cost.

With regard to influenza and pneumococcal pneumonia vaccine, which we will also pay on a reasonable cost basis, effective January 1, 2003, we have created a new status indicator ''L'' ''Influenza vaccine; pneumococcal pneumonia vaccine'' to indicate that these vaccines are paid on a reasonable cost basis but deductible and coinsurance do not apply to the payment. We show the new status indicator in Addendum D and we show it for these services in Addendum B. We are doing the following:

- Redefining status F to indicate an item or service that is paid on a reasonable-cost basis.
- Changing the status indicator for influenza and pneumococceal pneumonia vaccines to status indicator L and change orphan drugs to status indicator F.
- Changing the status indicator for APC 225 to S.

E. Other Policy Issues Relating to Pass-Through Device Categories

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

In the November 30, 2001 final rule, we explained the methodology we used to estimate the portion of each APC rate that could reasonably be attributed to the cost of associated devices that are eligible for pass-through payments (66 FR 59904). Effective with implementation of the 2002 OPPS update on April 1, 2002, we deduct from the pass-through payments for those devices an amount that offsets the portion of the otherwise applicable APC payment amount that we determined is associated with the device, as required by section 1833(t)(6)(D)(ii) of the Act. In the March 1, 2002 final rule, we published the applicable offset amounts for 2002, which we had recalculated to reflect certain device cost assignments that were corrected in the same final rule (67 FR 9557).

For the 2003 OPPS update, we proposed to estimate the portion of each APC rate that could reasonably be attributed to the cost of an associated pass-through device that is eligible for pass-through payment using claims data for services furnished between July 1, 2001, through December 31, 2001. We proposed to use only the last 6 months of 2001 claims data because bills for pass-through devices submitted during this time period would use only device category codes, allowing a more consistent analysis than would result were we to include pre-July 1 claims that might still show item-specific codes for pass-through devices. Using these claims, we would calculate a median cost for every APC without packaging the costs of associated C-codes for device categories that were billed with the APC. We would then calculate a median cost for every APC with the

costs of associated C-codes for device categories that were billed with the APC packaged into the median. Dividing the median APC cost minus device packaging by the median APC cost including device packaging would allow us to determine the percentage of the median APC cost that is attributable to associated pass-through devices. By applying these percentages to the APC payment amount, we would determine the applicable offset amount. Table 11 shows the offsets that we applied in 2003 to each APC that contains device costs. APCs were included for offsets if their device costs comprised at least 1 percent of the APC's costs. (However, if any APC's calculated offset had been less than 1 dollar, that APC and offset would not have been included.)

For this final rule, we used the device data for the 12 months ended March 31, 2002 to calculate the device and non-device portions of APCs median costs. We began with the same APCs that were listed on Table 9 of our proposed rule, with two additions. We added APCs 0648 and 0651, because they showed appreciable device percentages using our methodology. We again applied these percentages to the APC payment amounts and excluded any APC's percentage of device costs less than one percent and calculated offset amounts less than one dollar.

We received some comments on this proposal, which are summarized below:

Comment. A commenting party contended that our list of device offsets in our proposed rule is incorrect since it includes many computed offsets to APC payments for devices that will no longer receive pass-through payments. The commenter recommended that we exclude the offsets of all devices in categories that are bundled, since there is no separate pass-through payment to be offset.

Response. The offset list is a list of potential offsets. We, of course, do not know in advance which procedures and APCs will be mapped into new categories as the new categories are created and become effective. Yet, we are required to subtract the amount of similar devices in pass-through payment under section 1833(t)(6)(D)(ii) of the Act. Therefore, for the proposed rule, we calculate the device costs in each APC and include APCs on the offset list if their device costs were at least 1 percent of the APC's cost. We use a similar list for this final rule.

Comment. One commenter expressed concern about the difference in offset amounts proposed for APC 0107, Insertion of Cardioverter-Defibrilator, and APC 0108, Insertion/Replacement/Repair of Cardioverter-Defibrilator Leads. The commenter wondered why, when the cost of the cardioverter-defibrilator is 2 to 3 times the cost of the leads, the offset amount for APC 0107 is less than the offset amount for APC 0108.

Response. The commenter is incorrect that we proposed an offset amount for 0107 (83.18 percent) that is less than for 0108 (82.18 percent). Moreover, the commenter mistakenly believes that APC 0107 is for insertion/replacement/repair of cardioverter-defibrilator leads when, in fact, the definition of CPT code 33249 (the only CPT code in APC 0108) is ''Insertion or repositioning of electroleads for single or dual chamber pacing cardioverter-defibrilator and insertion of pulse generator.'' Hence, CPT code 33249 is for the insertion of a pulse generator and insertion or repositioning of leads. It is not, as the commenter indicates, for insertion or repositioning of leads alone. As shown in Table 11, the offset percent for APC 0107 is 93.29 and the offset percent for APC 0108 is 92.99.

Comment. A commenting party contended that the offsets appear to be computed using departmental cost-to-charge ratios (CCRs), yet pass-through payments for devices were computed using an overall hospital CCR. The party contended that in cases in which the hospital CCR is higher than the departmental CCR, there is effectively a zero pass-through payment for devices. Therefore, the party recommended that the offsets should be calculated using the same CCRs used to compute pass-through payments.

Response: Although the commenter states that calculating a device pass-through payment using a hospital CCR that is higher than the departmental CCR used to determine the applicable offset amount results in effectively no payment for a device, it appears to us that the opposite result would occur. That is, in the situation described, a lower offset amount would be applied to a higher calculated device cost, resulting in a higher net device payment. Offset amounts represent device costs that are included in the median costs of a procedure. The median cost of the procedure is determined, as we determine median costs for all services, by totaling all the procedure's component costs calculated using department-specific CCRs. We use department-specific CCRs to calculate the cost of the procedure, which includes devices, and because offsets are intended to represent the cost of devices that are included in the cost of the procedure, we believe the same departmental-CCR method must be applied in calculating offsets.

TABLE 11.—OFFSETS TO BE APPLIED FOR EACH APC THAT CONTAINS DEVICE COSTS

APC	Description	APC percent attributed to devices	Device related costs to be subtracted from pass-through payment
0032	Insertion of Central Venous/Arterial Catheter	31.96	$191.22
0048	Arthroplasty with Prosthesis	29.92	633.96
0051	Level III Musculoskeletal Procedures Except Hand and Foot	1.31	22.48
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	3.08	65.48
0080	Diagnostic Cardiac Catheterization	10.63	195.69
0081	Non-Coronary Angioplasty or Atherectomy	31.45	713.58
0082	Coronary Atherectomy	48.25	2,174.88
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	29.59	802.06
0085	Level II Electrophysiologic Evaluation	37.00	805.10
0086	Ablate Heart Dysrhythm Focus	41.96	1,156.01
0087	Cardiac Electrophysiologic Recording/Mapping	51.40	1,056.10
0088	Thrombectomy	3.80	64.56
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	77.40	4,543.29
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	77.14	4,942.78
0090	Insertion/Replacement of Pacemaker Pulse Generator	79.61	3,782.34
0654	Insertion/Replacement of a permanent dual chamber pacemaker	78.27	3,749.52

TABLE 11.—OFFSETS TO BE APPLIED FOR EACH APC THAT CONTAINS DEVICE COSTS—Continued

APC	Description	APC percent attributed to devices	Device related costs to be subtracted from pass-through payment
0091	Level II Vascular Ligation	1.08	15.04
0653	Vascular Reconstruction/Fistula Repair with Device	10.83	169.60
0104	Transcatheter Placement of Intracoronary Stents	46.65	1,862.31
0105	Revision/Removal of Pacemakers, AICD, or Vascular	4.60	44.61
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	50.46	1,442.72
0107	Insertion of Cardioverter-Defibrillator	93.29	15,871.30
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	92.99	21,509.86
0109	Removal of Implanted Devices	1.61	6.27
0115	Cannula/Access Device Procedures	25.85	327.87
0119	Implantation of Devices	74.37	3,463.86
0122	Level II Tube Changes and Repositioning	40.26	225.62
0124	Revision of Implanted Infusion Pump	52.73	1,377.33
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	2.87	26.21
0152	Percutaneous Abdominal and Biliary Procedures	31.57	165.11
0652	Insertion of Intraperitoneal Catheters	10.91	160.05
0154	Hernia/Hydrocele Procedures	2.73	36.63
0167	Level III Urethral Procedures	43.96	649.32
0168	Level II Urethral Procedures	1.15	14.67
0179	Urinary Incontinence Procedures	56.34	3,066.24
0182	Insertion of Penile Prosthesis	58.45	2,908.45
0202	Level VIII Female Reproductive Proc	38.35	911.22
0222	Implantation of Neurological Device	88.08	10,461.01
0223	Implantation of Pain Management Device	52.96	1,133.11
0225	Implantation of Neurostimulator Electrodes	81.03	5,888.13
0226	Implantation of Drug Infusion Reservoir	82.74	6,228.55
0227	Implantation of Drug Infusion Device	81.57	6,147.49
0229	Transcatheter Placement of Intravascular Shunts	63.65	1,907.33
0246	Cataract Procedures with IOL Insert	1.38	16.00
0259	Level VI ENT Procedures	84.07	16,118.86
0279	Level II Angiography and Venography except Extremity	2.18	9.83
0280	Level III Angiography and Venography except Extremity	4.89	38.80
0297	Level II Therapeutic Radiologic Procedures	1.35	5.41
0651	Complex Interstitial Radiation Source Application	85.13	2,429.25
0670	Intravenous and Intracardiac Ultrasound	53.75	847.71
0680	Insertion of Patient Activated Event Recorders	77.72	2,275.14
0681	Knee Arthroplasty	64.16	4,945.63
0686	Level III Skin Repair	37.79	280.72
0687	Revision/Removal of Neurostimulator Electrodes	35.06	472.51
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	69.42	2,699.74
0648	Breast Reconstruction with Prosthesis	31.69	740.32

2. Devices Paid With Multiple Procedures

As explained above, under section 1833(t)(6)(D)(ii) of the Act, the amount of additional payment for a device eligible for pass-through payment is the amount by which the hospital's cost exceeds the portion of the otherwise applicable APC payment amount that the Secretary determines is associated with the device. Thus, for devices eligible for pass-through payment, we reduce the pass-through payment amount by the cost attributable to the device that is already packaged into the APC payment for an associated procedure. For 2002, we developed offset amounts for 59 APCs (March 1, 2002 final rule, 67 FR 9556 through 9557, Table 1).

In our November 30, 2001 final rule (66 FR 59856), we articulated a policy regarding the calculation of the offsets for device costs already reflected in APCs in cases where the payment for the associated APC is reduced due to the multiple procedure discount. The policy was in response to several commenting parties that recommended that we apply the multiple procedure discount only to the non-device-related portion of the APC payment amount (66 FR 59906).

We agreed with the commenters that the full pass-through offset should not be applied when the APC payment is subject to the multiple procedure discount of 50 percent.

The purpose of the offset is to ensure that the OPPS is not making double payments for any portion of the cost associated with the use of the pass-through item. We stated in the November 30, 2001 rule that the offset should reflect that portion of the cost for the pass-through device actually reflected in the payment that is received for the associated APC. We consequently ruled that the most straightforward methodology for applying this principle is to reduce the amount of the offset amount by 50 percent whenever the multiple procedure discount applies to the associated APC. This discounting of the offset is applied in 2002 to bills subject to multiple procedure discounting that also include devices eligible for pass-through payment.

The significant number of device categories that are expiring in 2003 combined with our proposal to package 100 percent of device costs into their associated APCs has prompted us to revisit the current policy of reducing offsets for pass-through devices in instances when multiple procedure discounts are applied to procedures

associated with pass-through device categories. In order to determine the impact of multiple procedure discounting on APCs with full packaging of device costs, we reviewed the median costs of all APCs after incorporation of device costs and arrayed them in order of descending median cost. We also determined the contribution (in absolute dollars and as a percentage) of device costs to the median costs of each APC.

We then determined which APCs containing devices would be billed together. We next determined, based on median cost data, which device containing APCs would be subject to the 50 percent multiple procedure reduction. After identifying these APCs, we applied a 50 percent reduction to arrive at a discounted payment amount. We then reviewed the contribution of device costs to the discounted APC both as a percentage and in absolute dollars to determine if applying the 50 percent reduction would result in underpayment for the service. We determined that the reduced payment was adequate to pay both for the devices incorporated into the APC and for the procedure cost in the context of performing multiple procedures. We obtained the same results even when we overstated device costs in our model by 5 or 10 percent to offset concerns expressed by some manufacturers and physicians that hospital charges for transitional pass-through devices may be understated.

We noted that almost all APCs with high device costs (such as insertion of pacemakers, insertion of cardioverter-defibrillators, insertion of infusion pumps and neurostimulator electrodes) would never be subject to a multiple procedure discount. They have the highest relative weights in the OPPS, and we would not expect these procedures to be performed during the same operative session with a higher paying procedure with status indicator ''T.'' Therefore, we proposed to continue our current policy of multiple procedure discounting. That is, when two or more APCS with status indicator ''T'' are billed together we proposed to pay 100 percent for the highest cost APC and 50 percent for all other APCs with status indicator ''T.'' We proposed not to adjust these payments to account for device costs in the APCs.

We received a large number of comments on this proposal, which are summarized below:

Comment: Many commenters asked that the status indicator be changed from ''T'' to ''S'' for APCs for which a large amount of the cost of the APC is cost for a device that is packaged into the APC. They said that it is not appropriate to apply the multiple procedure discount that is applied to services with status indicator ''T'' to APCs for which the cost of a device is the majority of the cost of the APC because there is no efficiency in the provision of multiple devices. They said that the multiple procedure discount should only apply to the nondevice portion of the APC payment.

Response: We reviewed the data for combinations of APCs billed on the same claim and determined that it would not be typical for an APC, which is predominantly device cost, to be the second or subsequent APC on the same claim. Hence, it would not be typical that the predominantly device APC would be reduced (because a predominantly device APC would generally be the highest cost APC on the claim).

In the case of APC 225, however, we did change the status indicator to ''S'' because we were convinced that it must be performed when APC 222 also performed and that, therefore, a status indicator of ''T'' would not result in appropriate payment for 225.

Comment: A number of commenters took issue with our claim that almost all APCs with high device costs (such as insertion of pacemakers, insertion of cardioverter-defibrillators, insertion of infusion pumps, and neurostimulator electrodes) would never be subject to a multiple procedure discount. They asserted that some high cost APCs do incur multiple procedure discounting. The example most provided is the implantation of a neurostimulator (APC 0222) with neurostimulator electrodes or leads (APC 0225). They said that the multiple procedure discount along with proposed payment cuts to these APCs even more significantly impact the payment of these services and warrant extensive review, analysis, and consideration of outside data. They also recommended that we change the status indicators for these procedures to ''S'' (significant procedure), which are not reduced when performed as a multiple procedure in the same session. Other examples cited were: bilateral neurostimulator implants for patients with Parkinson's disease (APC 0222) and implantation of a spinal infusion pump, which involves implantation of a catheter (APC 0223) and infusion pump (APC 0227) and dual implantation of an artificial urinary sphincter and a penile prosthesis in prostate cancer survivors. One commenter recommended that all device-related APCs have a status indicator of ''S'' to reflect significant resources.

Response: We continue to believe that most procedures with significant device costs packaged in will, if provided on the same day and billed in conjunction with another procedure, be the most expensive procedure on the claim and thus not subject to discounting. We are concerned that, if we were to discontinue our policy of reducing payment for multiple procedures, we would overpay some lower valued procedures. We received many thoughtful comments on the multiple procedure discounting of certain APCs and we intend to take these comments under advisement and study this issue further.

Comment: One commenter objected to our proposal to stop applying the 50 percent discount to offsets to pass-through payments when there are multiple procedures involving a claim of a pass-through device also.

Response: As discussed above, the discount to offsets to pass-through payments will become a much less significant aspect beginning January 1, 2003, when we will retire 95 of 97 existing categories and add a limited number of new categories.

F. Outpatient Billing for Dialysis

Currently, Medicare does not pay for dialysis treatments furnished to End-Stage Renal Disease (ESRD) patients on an outpatient basis, unless the hospital also has a certified hospital-based ESRD facility. As a result of this policy, ESRD patients in need of emergency dialysis have been admitted to the hospital. These admissions have been found to be inappropriate by the Quality Improvement Organizations, and payment has been denied.

When ESRD patients come to the hospital for a medical emergency or for problems with their access sites, they typically miss their regularly scheduled dialysis appointments. If the ESRD patient's usual facility is unable to reschedule the dialysis treatment, the ESRD patient has to wait until the next scheduled dialysis appointment. We are concerned that by maintaining this policy, ESRD patients may be receiving interrupted care because there will be unnecessary lapses in treatment. The ESRD patient should not be prevented from receiving her or his normal dialysis because he or she experienced another unrelated medical situation. Therefore, we proposed to allow payment for dialysis treatments for ESRD patients in the outpatient department of a hospital in specific situations. Payment would be limited to unscheduled dialysis for ESRD patients in exceptional circumstances. Outpatient dialysis for acute patients

would not be included in this payment mechanism.

In certain instances, it is appropriate to dialyze ESRD patients on an outpatient basis. We proposed to allow payment for these nonroutine dialysis treatments in medical situations in which the ESRD patient cannot obtain her or his regularly scheduled dialysis treatment at a certified ESRD facility. The circumstances in which we proposed to allow payment are limited to:

- Dialysis performed following or in connection with a vascular access procedure;
- Dialysis performed following treatment for an unrelated medical emergency; for example, if a patient goes to the emergency room for chest pains and misses a regularly scheduled dialysis treatment that cannot be rescheduled, we would allow the hospital to provide and bill Medicare for the dialysis treatment; and
- Emergency dialysis—Currently, the only mechanism available for payment in this situation is through an inpatient admission. We will maintain our policy that routine treatments in non-ESRD certified hospitals would not be payable under OPPS.

We believe it is important to make this change in the policy for two reasons:

- To ensure that hospital outpatient departments are paid for providing this much needed service; and
- To prevent dialysis patients from receiving interrupted care. Non-ESRD certified hospital outpatient facilities would bill Medicare using a new G code, G0GGG, ''Unscheduled or emergency treatment for dialysis for ESRD patient in the outpatient department of a hospital that does not have a certified ESRD facility.'' We proposed that this new code will have status indicator ''S'' and be assigned to APC 0170. Payment would be roughly equivalent to the reimbursement rate for acute dialysis. We proposed to implement this change effective January 1, 2003. Effective January 1, 2003, this would be the only way for non-ESRD certified hospital outpatient facilities to bill Medicare and be paid for providing nonroutine outpatient dialysis to ESRD patients.

We will be monitoring the use of this new code to ensure the following:

- Certified dialysis facilities are not incorrectly using this code.
- The same dialysis patient is not repeatedly using this code, which would indicate routine dialysis treatment.

When ESRD patients receive outpatient dialysis in non-ESRD certified hospital outpatient facilities, the patient's home facility would be responsible for obtaining and reviewing the patient's medical records to ensure that appropriate care was provided in the hospital and that modifications are made, if necessary, to the patient's plan of care upon her or his return to the facility. This ensures continuity of care for the patient.

We received eight comments on our proposal to allow payment for dialysis treatments for ESRD patients in the outpatient department of a hospital. Although all of the comments support our proposed changes, some commenters asked for clarification on issues pertaining to this provision.

Comment: One commenter requested that we provide clarification on how the payment rate would be determined for this service.

Response: In the August 9, 2002 proposed rule, we provided the payment rate for providing dialysis treatments for ESRD patients in the outpatient department of a hospital. The proposed rule stated that this service would be assigned Ambulatory Payment Classification (APC) 0170, and Addendum A provides the payment rate for this APC. Effective January 1, 2003, the payment national unadjusted rate for this service will be $252.16.

Comment: One commenter wanted clarification on how services typically associated with outpatient dialysis such as covered pharmaceuticals and laboratory testing will be accounted for under the proposed policy.

Response: We would pay separately for laboratory tests based on the laboratory fee schedule. Drugs may or may not be paid separately from the payment for the dialysis treatment. The drugs that would be paid separately would have a separate APC. If there is not a separate APC, then the drugs would be packaged into the APC paid for the dialysis treatment.

Comment: One commenter expressed concern that the proposal to require the ESRD patient's home facility to obtain and review the patient's medical records from the hospital would create an additional information collection burden for dialysis facilities. The commenter requested that we include language in the final rule that specifically outlines the hospital's responsibilities in providing the patient's medical records to the home facility.

Response: There should be a regular exchange of information between a patient's home facility and any treating facilities to verify the care that has been provided and to ensure that patients are not receiving inappropriate or incorrect treatment. The dialysis facility is, however, ultimately responsible for effectively coordinating the care of its patients, including the inclusion of all information in the patient's medical record, and we believe obtaining and reviewing information from other treating facilities is part of this responsibility. The medical record indicates what care has actually been provided, and it also provides the data for evaluation and documentation of the quality and appropriateness of the care delivered. We believe subsequent dialysis treatment at the patient's home facility should not be provided without information from another treatment facility because the home facility may need to make adjustments to the plan of care when the patient returns to the facility, so the facility should obtain this information from the hospital to implement any new strategies, etc. Furthermore, since dialysis facilities should already be collecting medical records for home dialysis patients and for traveling patients, we do not view this as an additional information collection burden. We view this as a responsibility within the facilities scope of practice.

Comment: One commenter cautioned us about the potential for abuse with this proposal and recommended that we develop clear guidelines governing the use of this new code.

Response: We agree with the commenter, and we plan to issue instructions for the use of the code as well as develop code edits to monitor the use of this code to prevent potential fraud and abuse. The instructions will be issued at a later date.

Comment: Another commenter requested clarification of the word ''routine,'' and what criteria that we will apply to establish whether a patient is receiving ''routine'' dialysis treatment. The commenter also requested documentation requirements (for example, diagnoses, other procedures, etc.) for meeting these ''exceptional circumstances'' defined in the August 9, 2002 proposed rule.

Response: We define ''routine'' dialysis as the three times per week maintenance treatment the same patient would normally receive at his or her home facility. We would consider a patient to be receiving routine dialysis if the claims received from the outpatient department indicated that the same patient received dialysis treatment more than once a week in this setting.

The August 9, 2002 proposed rule states that we would allow payment for this unscheduled dialysis under exceptional circumstances, and these circumstances would be (1) dialysis

performed following or in connection with a vascular access procedure; (2) dialysis performed following treatment for an unrelated medical emergency; and (3) emergency dialysis. These are the only situations in which payment would be made for dialysis provided in the outpatient department of a hospital without a certified dialysis facility. As stated above, we plan on issuing instructions governing the specific use of this code at a later date.

Comment: The commenter requested clarification as to whether an emergency department that is part of a larger hospital that contains a certified dialysis unit is already considered an ESRD certified location. Specifically, is this proposed payment change only for those providers that do not have a certified dialysis unit on their premises, making them a non-ESRD certified outpatient facility? If the answer is yes, then would the emergency department that is part of the hospital that has an ESRD-certified location bill the new dialysis G code if dialysis is given on an emergency basis while the ESRD certified location is closed?

Response: The proposed G code is specifically designated for an outpatient department of a hospital that does not have a certified ESRD facility. Therefore, a hospital's emergency department cannot use the code just because the certified dialysis facility is closed. The basis for this decision is to prevent potential fraud and abuse. We do not want dialysis facilities to use this as a means of circumventing the current requirements to receive a higher reimbursement rate for providing dialysis treatment. As stated above, we plan on issuing instructions governing the specific use of this code at a later date.

XI. Summary and Responses of Public Comments to CMS's Response to MedPAC Recommendations

In the August 9, 2002 proposed rule, we responded to the Medicare Payment Advisory Commission (MedPAC) March 2002 Report to the Congress: ''Medicare Payment Policy,'' recommendations relating to the OPPS (67 FR 52141 through 52143). We received no comments on our responses to MedPAC's recommendations. Therefore, we will not discuss that response further here. We did receive comments from MedPAC on other issues in the proposed rule. For convenience we group those comments and our responses here:

Comment: MedPAC endorsed our proposal to create APCs for procedures involving drug-eluting stents and noted, ''This step illustrates that CMS can respond rapidly to ensure adequate payment for technologies that are thought to be of a breakthrough nature.'' The Commission noted that our reliance on data from other countries to set the payment rate for this new technology appeared adequate in this instance. However, it expressed some reservation about the long-term issues that might attend more general use of such data. MedPAC has begun to consider these issues in more depth and urges us to do so as well.

Response: We appreciate the Commission's views. We have adopted our proposal for drug-eluting stents, including our method of setting the payment rate. We will give further consideration to the issues involved in use of foreign data.

Comment: MedPAC discussed the possibility that a pro rata reduction to payments for transitional pass-through drugs and devices would be needed this year, though we had not reached a conclusion on this question in the August 9, 2002 proposed rule. The Commission commented that even if a modest pro rata reduction is needed, it does not anticipate serious consequences for access to new technology services for several reasons. First, the methods for calculating transitional pass-through payments may overcompensate for these services. Second, hospitals are still likely to use these items to improve care and maintain reputations for excellence. Third, little evidence is available that indicates access problems resulting from the large pro rata reduction in 2002. Fourth, asking hospitals to share in the costs of new technologies gives them incentives to assess their value before adopting them.

Response: We have concluded that no pro rata reduction will be necessary for 2003. We appreciate and agree with the Commission's analysis of the possible effects of a pro rata reduction.

Comment: Regarding payment for medical devices no longer eligible for transitional pass-through payments, MedPAC urged us to work with stakeholders in instances where creditable evidence is available that coding issues may have led to inaccurate payment rates. The Commission does not believe that an extension of transitional pass-through eligibility is warranted or that data other than hospital cost data should be used where reliable hospital cost data are available. It also urged us to monitor beneficiary access to procedures that include such devices if payments are cut significantly.

Response: We agree that extension of transitional pass-through eligibility is not warranted, and we do not believe that the statute contemplates that it could be continued. We also agree that stakeholders may have valuable input, and as we describe elsewhere in this final rule, we have received a great deal of helpful information that has informed the policies adopted in this rule designed to moderate payment reductions that may be associated with use of devices (and of drugs) previously in transitional pass-through status. We also agree that monitoring access by beneficiaries to these procedures is important, and we expect to do so to the extent feasible.

Comment: MedPAC expressed concern that our proposal to pay separately for high-cost drugs but not for other drugs has the potential to distort the payment system. Where drugs may substitute for one another, hospitals may face incentives to use those paid separately. The Commission urged us to limit the amount of time this policy is followed and to work to move more drugs into the procedure APCs.

Response: We agree that this policy may have distorting effects on incentives, and we do not intend to use it longer than necessary. In future years, we hope to propose additional changes to this policy, and in particular to package drugs into procedure APCs where this approach appears reasonable. We hope further improvements in our data and further attention to the structure of APCs involving the use of drugs, such as those for infusion and injection, will provide the foundation for future policy development in this area.

Comment: MedPAC commented that hospital cost data are preferable to AWPs set by manufacturers. The Commission indicated the need to give careful consideration to stakeholder comments on payment for drugs and the importance of monitoring beneficiary access.

Response: We agree.

Comment: MedPAC commented that the reductions in payments for drugs that may no longer be eligible for transitional pass-through payments based on 95 percent of average wholesale price (AWP) will result in lower payments for these drugs than in other settings, such as physicians' offices. These differences may lead to shifts in the site of care based on financial considerations. MedPAC commented that this effect is not sufficient reason to change payments for these drugs in the hospital outpatient setting, but that it indicates the need for a new approach to paying for Part B drugs.

Response: The possibility of inappropriate shifts in site of service is a source of concern. We note, however, that payment rates for these drugs only shifted to 95 percent of AWP at the inception of the OPPS; before that time, Medicare paid for drugs in outpatient departments at reasonable cost, subject to statutory reductions. Medicare payment for drugs in physicians' offices has been set at 95 percent of AWP throughout this period. It is not clear that the increase in drug payments in outpatient departments from August 2000 to the present has led to substantial shifts in site of service, and the response to the forthcoming reductions may be muted as well. Nonetheless, we believe that Medicare should attempt to align payments across settings to the greatest extent possible in order to avoid inappropriate incentives to shift the site of service. In particular, we agree that a new approach to paying for Part B drugs would be desirable.

Comment: MedPAC noted that we have the statutory authority to modify updates to correct for unnecessary increases in the volume of services or for ''upcoding'' by hospitals. The Commission urged us to carefully track the volume of services and increases in coding intensity.

Response: We have not proposed any adjustment to the update for either of these reasons, and we will not adopt any such adjustment for 2003. We continue to monitor the progress of the OPPS system to discern whether we should make any such adjustment in the future.

Comment: MedPAC noted that small rural hospitals will continue to be held harmless for losses under the OPPS in 2003. The Commission urged us to study the performance of small rural hospitals and evaluate the impact of the end of their hold-harmless status.

Response: We agree that small rural hospitals warrant special attention. We expect to study the effect of the transitional corridor provision, including the protection it affords these hospitals, in the period since the implementation of the OPPS so that we can help evaluate what provision would be appropriate for 2004 and beyond.

XII. Provisions of the Final Rule With Comment for 2003

A. OPPS

The provisions of this final rule with comment restate changes to the Medicare hospital OPPS and CY 2003 payment rates including changes used to determine these payment rates set forth in the August 9, 2002 proposed rule, except as noted elsewhere in the preamble. The following is a highlight of provisions implemented in this final rule, which are discussed in detail above.

1. Statutory and Discretionary Changes

- We revised the methodology for calculating relative weights to dampen the difference in the median costs for all APCs for which the median costs fell more than 15 percent from 2002 to 2003; used only claims on which devices were reported to set the median for APCs for which the device was either essential or frequently used in the procedures in the APC; split some APCs for which devices were an issue to achieve more accurate pricing; limited the reduction in median costs for blood and certain blood products to 11 percent, which limited the reduction in payment from 2002 to 2003 to about 15 percent; used acquisition costs from external sources as a factor together with claims data in setting adjusted medians for four APCs.
- We reviewed and revised the composition of APCs to comply with the limitation on variation in procedure medians and to achieve more accurate reflections of the costs.
- We removed from pass-through status those drugs and devices that will have been on pass-through status for at least 2 years on January 1, 2003. We packaged the costs of the expiring devices into the payments for the APCs with which the devices were billed. We packaged the costs of the expiring drugs into the APCs with which the drugs were billed if the per encounter drug cost was less than $150; we established APCs for those drugs for which the per encounter drug cost was more than $150 and for blood and certain blood products. We paid for influenza and pneumococcal pneumonia vaccines and orphan drugs on a reasonable cost basis.
- We estimated the amount of payment that would be made under the pass through provisions and compared it to 2.5 percent of the projected program expenditures; we determined that no pro rata reduction would be needed for 2003, and we adjusted the conversion factor accordingly.
- We established the percentages by which pass-through devices would be reduced to remove the part of the payment that is packaged into the APC when it is billed with the device.
- We finalized the regulations that describe the criteria that must be met for a device to get a pass-through code.
- We issued the 2003 wage index and conversion factor that would be applied to the relative weights to determine the amount of payment for a particular hospital.

2. Changes to the Regulations Text

- We amended § 419.21(d)(3) to delete influenza and pneumococcal pneumonia vaccines from the list of items that are paid to CORFs, HHAs, and hospices under OPPS.
- We amended § 419.66(c)(1) to specify that we must establish a new category for a medical device if it is not described by any category previously in effect as well as an existing category. We received no comments concerning this technical correction to our regulations text. We are making this proposal final in this final rule.

B. Payment Suspension for Unfiled Cost Reports

We are adopting the provisions set forth in the proposed rule without change.

C. Partial Hospitalization Services

In the August 9, 2002 proposed rule, we indicated we would be addressing comments received on our proposal to establish a new payment amount for partial hospitalization services and remove clinical social worker services from the partial hospitalization benefit. Upon further review we have determined that we will not include this issue in this final rule, but will address it in future rulemaking.

D. Pneumococcal and Influenza Vaccines

Section 419.21(d)(3) states that ''Pneumococcal vaccine, influenza vaccine, and hepatitis B vaccine'' are paid under the OPPS for comprehensive outpatient rehabilitation facilities, home health agencies, and hospices. There is no specific inclusion of hospitals, but we have paid hospitals for them under the OPPS since the OPPS began. We are removing the pneumococcal vaccine and influenza vaccine from this paragraph and want to pay for it under reasonable cost. We are requesting public comment on this change.

XIII. Response to Public Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to comments in the preamble to that document.

XIV. Collection of Information Requirements

This rule does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

XV. Regulatory Impact Analysis

The regulatory impact analysis for this final rule consists of an impact analysis for the OPPS provisions and a regulatory impact statement for the provision for payment suspension for unfiled cost reports.

A. OPPS

1. General

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We estimate the effects of the provisions that will be implemented by this final rule will result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from changes in the final rule as well as enrollment, utilization, and case mix changes) in expenditures under the OPPS for CY 2003 compared to CY 2002 to be approximately $1.372 billion. Therefore, this final rule is an economically significant rule under Executive Order 12866, and a major rule under 5 U.S.C. 804(2).

The RFA requires agencies to determine whether a rule will have a significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year (see 65 FR 69432).

For purposes of the RFA, we have determined that approximately 37 percent of hospitals will be considered small entities according to the Small Business Administration (SBA) size standards. We do not have data available to calculate the percentages of entities in the pharmaceutical preparation manufacturing, biological products, or medical instrument industries that would be considered to be small entities according to the SBA size standards. For the pharmaceutical preparation manufacturing industry (NAICS 325412), the size standard is 750 or fewer employees and $67.6 billion in annual sales (1997 business census). For biological products (except diagnostic) (NAICS 325414), with $5.7 billion in annual sales, and medical instruments (NAICS 339112), with $18.5 billion in annual sales, the standard is 50 or fewer employees (see the standards Web site at *http://www.sba.gov/regulations/siccodes/*). Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area (MSA) and has fewer than 100 beds (or New England County Metropolitan Area (NECMA)). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the OPPS, we classify these hospitals as urban hospitals. We believe that the changes in this final rule will affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. Therefore, we conclude that this final rule has a significant impact on a substantial number of small entities. However, the statute provides for small rural hospitals (of fewer than 100 beds) to be held harmless by the law and to continue to be paid at cost; therefore this final rule has no impact on them.

Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule will not mandate any requirements for State, local, or tribal governments. This final rule imposes no unfunded mandates on the private sector.

Federalism

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

We have examined this final rule in accordance with Executive Order 13132, Federalism, and have determined that it will not have an impact on the rights, roles, and responsibilities of State, local or tribal governments. The impact analysis (see Table 10) shows that payments to governmental hospitals (including State, local, and tribal governmental hospitals) will increase by 5 percent under the final rule.

2. Changes in this Final Rule

We are making several changes to the OPPS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We are also required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this final rule, we are updating the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2003 as we discuss in sections VIII and VI, respectively, of this preamble. We are also revising the relative APC payment weights based on claims data from January 1, 2001 through December 31, 2001. Finally, we are removing 95 devices and more than 200 drugs and biologicals from pass-through payment status.

Under this final rule, the change to the conversion factor as provided by statute will increase total OPPS payments by 3.7 percent in 2003. The changes to the wage index and to the APC weights (which incorporate the cessation of pass-through payments for many drugs and devices) do not increase OPPS payments because the OPPS is budget neutral. However, the

wage index and APC weight changes do change the distribution of payments within the budget neutral system as shown in Table 10 and described in more detail in this section.

Alternatives Considered

Alternatives to the changes we are making and the reasons that we are choosing not to make them are discussed throughout this final rule. Below we discuss options we considered when analyzing methodologies to appropriately recognize the costs of former pass-through items. For a more detailed discussion, see section IV.C regarding the expiration of pass-through payment for devices and section IV.D regarding the expiration of pass-through payment for drugs and biologicals.

Payment for Categories of Devices

We considered establishing separate APCs for categories of devices and paying for them separately. We are not choosing this option because we believe that to the extent possible, hospital payment for procedures and visits should include all of the costs required to provide the procedures and visits.

A second option we considered involved (1) packaging some categories of devices into the procedures with which they were billed in 2001 and (2) paying the rest through separate APCs (as discussed in section IV of this final rule.). We are not choosing this option because we believe that devices are routinely used in the services for which they are needed and therefore are consistently paid at the cost of providing the service. Furthermore, criteria that will provide a basis for some devices to be packaged and for others to be paid separately must be developed and approved, thereby further complicating an already complex payment system.

Payment for Drugs and Biologicals

We considered continuing to make separate payment for all drugs and biologicals through separate APCs. We are not choosing to pay separately for all drugs through separate APCs because we believe that, to the extent possible, hospital payment for services should include all of the costs of the services. We believe that drugs should be packaged with the services in which they are furnished except when we determine that there is a valid reason to do otherwise. However, we recognize that (unlike the stability that exists with device usage with the applicable procedures) the use of drugs may vary widely depending upon patient and disease characteristics. Therefore, packaging payment for all drugs may, in some cases, provide inadequate payment for the services furnished. Where a hospital has a disproportionate share of patients who need greater amounts of expensive drugs, underpayment for the drugs needed by these patients could result in cessation of needed services. For the first year that we are ceasing transitional pass-through payment for drugs, we decided to proceed cautiously by paying separately for drugs when the cost per encounter was more than $150 or when special characteristics existed (for example, orphan drugs, blood products).

We also considered packaging the costs of all drugs into the cost of the associated procedures with which they were billed in 2001. We did not package all payment for drugs into the payment for the procedures because, while this packaging is ultimately our goal, we believe, for the reasons indicated above, that we need to proceed cautiously to ensure that we do not inadvertently threaten access to needed care.

Conclusion

It is clear that the changes in this final rule will affect both a substantial number of rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this final rule, constitutes a regulatory impact analysis.

The OPPS rates for CY 2003 will have, overall, a positive effect for every category of hospital with the exception of children's hospitals, which are held harmless under the OPPS. These changes in the OPPS for 2003 will result in an overall 3.7 percent increase in Medicare payments to hospitals, exclusive of outlier and transitional pass-through payments and transitional corridor payments. As described in the preamble, budget neutrality adjustments are made to the conversion factor and the weights to ensure that the revisions in the wage index, APC groups, and relative weights do not affect aggregate payments. The impact of the wage and recalibration changes does vary somewhat by hospital group. Estimates of these impacts are displayed on Table 10.

The overall projected increase in payments for urban hospitals is slightly lower (3.1 percent) than the average increase for all hospitals (3.7 percent) while the increase for rural hospitals is significantly greater (6.2 percent) than the average increase. Rural hospitals gain 2.2 percent from the wage index change, and also gain 0.1 percent from APC changes. A discussion of the distribution of outlier payments that we project under this final rule can be found under section XV.A.4 below. Table 11 presents the outlier distribution that we expect to see under this final rule.

3. Limitations of Our Analysis

The distributional impacts represent the projected effects of the policy changes, as well as statutory changes effective for 2003, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per service while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our policy changes. In addition, we do not make adjustments for future changes in variables such as service volume, service mix, or number of encounters.

4. Estimated Impacts of This Final Rule on Hospitals

The OPPS is a budget neutral payment system under which the increase to the total payments made under OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The impact tables show the redistributive effects of the wage index and APC changes. In some cases, under this final rule, hospitals will receive more total payment than in 2002 while in other cases they will receive less total payment than they received in 2002. The impact of this final rule will depend on a number of factors, most significant of which are the mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services will change) and the impact of the wage index changes on the hospital.

Column 4 in Table 12 represents the full impact on each hospital group of all the changes for 2003. Columns 2 and 3 in the table reflect the independent effects of the change in the wage index and the APC reclassification and recalibration changes, respectively. We excluded critical access hospitals (CAHs) from the analysis of the impact of the 2003 OPPS rates that is summarized in Table 12. For that reason, the total number of hospitals included in Table 10 (4,551) is lower than in previous years. CAHs are excluded from the OPPS.

In general, the wage index changes favor rural hospitals, particularly the largest in bed size and volume. The only rural hospitals that will experience a negative impact due to wage index changes are those in Puerto Rico, a decrease of 3.2 percent. Conversely, the urban hospitals are generally negatively

affected by wage index changes, with the largest decreases occurring in those with 300 to 499 beds (−0.7 percent) and those in the Middle Atlantic (−1.0 percent), Pacific (−1.2 percent), and Puerto Rico Regions (−1.6 percent). However, this effect is somewhat lessened by the distribution of outlier payments as discussed in more detail below.

The APC reclassification and recalibration changes also favor rural hospitals and have a negative effect on urban hospitals in excess of 200 beds. Specifically, urban hospitals with 300 to 499 beds (−0.6 percent decrease) and urban hospitals in excess of 500 beds (a −0.8 percent decrease) all show a decrease attributed to APC recalibration. However, this decrease is much less than what would have occurred under the proposed rule.

In urban areas, hospitals that provide a lower volume of outpatient services are projected to receive a larger increase in payments than higher volume hospitals. In rural areas, hospitals with higher volumes are expected to receive higher increases in payments. In rural areas, hospitals with volumes greater than 42,999 services are projected to experience a significant increase in payments (7.7 percent). The less favorable impact for the high volume urban hospitals is attributable to both wage index and APC changes. For example, urban hospitals providing more than 42,999 services are projected to gain a combined 2.8 percent due to these changes.

Major teaching hospitals are projected to experience a smaller increase in payments (2.7 percent) than the aggregate for all hospitals (3.7 percent) due to negative impacts of the wage index (−0.3 percent) and recalibration (−0.8 percent). Hospitals with less intensive teaching programs are projected to experience an overall increase (3.2 percent) that is smaller than the average for all hospitals.

TABLE 12.—IMPACT OF CHANGES FOR CY 2003 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

[Percent change in total payments to hospitals (program and beneficiary); does not include hold harmless, corridor, outlier or transitional pass-through payments]

	Number of Hospitals[1] (1)	New Wage Index[2] (2)	APC Changes[3] (3)	All CY 2003 Changes[4] (4)
ALL HOSPITALS	4,519	0	0	3.7
NON-TEFRA HOSPITALS	3,989	0	−0.1	3.6
URBAN HOSPS	2,420	−0.5	−0.1	3.1
LARGE URBAN (GT 1 MILL.)	1,397	−0.6	−0.1	3.1
OTHER URBAN (LE 1 MILL.)	1,023	−0.5	−0.1	3.1
RURAL HOSPS	1,569	2.2	0.1	6.2
BEDS (URBAN):				
0–99 BEDS	550	−0.4	0.7	4.0
100–199 BEDS	877	−0.6	0.6	3.7
200–299 BEDS	488	−0.6	0.1	3.3
300–499 BEDS	364	−0.7	−0.6	2.4
500+ BEDS	141	−0.1	−0.8	2.8
BEDS (RURAL):				
0–49 BEDS	752	0.2	0	4.0
50–99 BEDS	478	1.4	−0.3	4.9
100–149 BEDS	200	2.4	0.3	6.6
150–199 BEDS	73	5.4	−0.5	8.9
200+ BEDS	66	3.1	0.8	8.0
VOLUME (URBAN):				
LT 5,000	182	0.9	3.4	8.0
5,000–10,999	293	−0.8	2.2	5.2
11,000–20,999	476	−0.7	1.1	4.2
21,000–42,999	667	−0.7	0.2	3.2
GT 42,999	802	−0.5	−0.4	2.8
VOLUME (RURAL):				
LT 5,000	334	0	1.1	4.9
5,000–10,999	419	0.3	1.2	5.4
11,000–20,999	387	1.2	0	5.0
21,000–42,999	295	1.9	0	5.8
GT 42,999	134	4.1	−0.3	7.7
REGION (URBAN):				
NEW ENGLAND	127	−0.6	0.4	3.4
MIDDLE ATLANTIC	372	−1	0.1	2.7
SOUTH ATLANTIC	367	−0.3	0.5	3.9
EAST NORTH CENT.	411	−0.7	−0.9	2.1
EAST SOUTH CENT.	153	−0.8	−0.1	2.8
WEST NORTH CENT.	170	−0.6	−1.1	2.0
WEST SOUTH CENT.	292	1	0	4.8
MOUNTAIN	122	0.2	−0.8	3.0
PACIFIC	367	−1.2	0.8	3.3
PUERTO RICO	39	−1.6	2.1	4.1
REGION (RURAL):				
NEW ENGLAND	40	1.7	−0.2	5.3
MIDDLE ATLANTIC	63	1.9	−0.5	5.3
SOUTH ATLANTIC	224	2.4	0.9	7.2
EAST NORTH CENT.	212	1.1	−1.7	3.2
EAST SOUTH CENT.	232	2.2	1.2	7.3
WEST NORTH CENT.	271	1.8	−0.6	5.0

TABLE 12.—IMPACT OF CHANGES FOR CY 2003 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent change in total payments to hospitals (program and beneficiary); does not include hold harmless, corridor, outlier or transitional pass-through payments]

	Number of Hospitals[1] (1)	New Wage Index[2] (2)	APC Changes[3] (3)	All CY 2003 Changes[4] (4)
WEST SOUTH CENT.	278	1.9	1.4	7.2
MOUNTAIN	141	4.6	−0.6	7.9
PACIFIC	103	4.9	1	10.0
PUERTO RICO	5	−3.2	7.2	7.6
TEACHING STATUS:				
NON-TEACHING	2,922	0.3	0.3	4.4
MINOR	782	−0.3	−0.2	3.2
MAJOR	284	−0.3	−0.8	2.7
DSH PATIENT PERCENT:				
0	11	5.3	5.5	15.3
GT 0–0.10	975	−0.2	−0.6	2.9
0.10–0.16	872	0.6	−0.6	3.7
0.16–0.23	766	−0.6	0	3.1
0.23–0.35	755	−0.1	0.4	4.1
GE 0.35	610	0.1	1.6	5.5
URBAN IME/DSH:				
IME & DSH	982	−0.6	−0.4	2.7
IME/NO DSH	0	0	0	0.0
NO IME/DSH	1,432	−0.5	0.4	3.6
NO IME/NO DSH	6	6.1	5.1	15.7
RURAL HOSP. TYPES:				
NO SPECIAL STATUS	607	0.5	0.3	4.6
RRC	167	4.2	0.2	8.4
SCH/EACH	507	1.4	−0.1	5.1
MDH	199	0.5	−0.7	3.6
SCH AND RRC	75	3.8	0.1	7.9
TYPE OF OWNERSHIP:				
VOLUNTARY	2,434	−0.1	−0.2	3.5
PROPRIETARY	703	−0.5	0.5	3.7
GOVERNMENT	852	0.6	0	4.4
SPECIALTY HOSPITALS:				
EYE AND EAR	13	−1.3	9.1	11.7
TRAUMA	153	−0.3	−0.6	2.9
CANCER	10	1	−4.5	0.4
TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES):				
REHAB	163	10.1	0.8	14.7
PSYCH	191	0	7.4	11.4
LTC	135	4.3	15.1	23.0
CHILDREN	41	−1.4	−1	1.3

[1] Some data necessary to classify hospitals by category were missing; thus, the total number of hospitals in each category may not equal the national total.

[2] This column shows the impact of updating the wage index used to calculate payment by applying the FY 2003 hospital inpatient wage index after geographic reclassification by the Medicare Geographic Classification Review Board. The hospital inpatient final rule for FY 2003 was published in the **Federal Register** on May 9, 2002.

[3] This column shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on 2001 hospital claims data.

[4] This column shows changes in total payment from CY 2002 to CY 2003, excluding outlier and pass-through payments. It incorporates all of the changes reflected in columns 2 and 3. In addition, it shows the impact of the FY 2003 payment update. The sum of the columns may be different from the percentage changes shown here due to rounding.

Note: For CY 2003, under the OPPS transitional corridor policy, the following categories of hospitals are held harmless compared to their 1996 payment margin for these services: cancer and children's hospitals and rural hospitals with 100 or fewer beds.

As stated elsewhere in this preamble, we have allocated 2 percent of the estimated 2003 expenditures to outlier payments. In Table 13 below, we provide a distribution by percentage of the total projected outlier payments for the categories of hospitals that we show in the impact table (Table 10).

We project, based on the mix of services for the hospitals that will be paid under the OPPS in 2003, that most hospitals will receive outlier payments.

The anticipated outlier payments for urban hospitals can be expected to ameliorate the impact of the wage index and APC changes on payments to urban hospitals.

TABLE 13.—DISTRIBUTION OF OUTLIER PAYMENTS FOR CY 2003 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	Number of Hospitals	Percent of Total Hospitals	Number of Hospitals with Outliers	Percent of Total Outlier Payments
ALL HOSPITALS	4,519	100.00	4,298	100.00
NON-TEFRA HOSPITALS	3,989	88.20	3,977	99.40
URBAN HOSPS	2,420	53.60	2,413	83.20
LARGE URBAN (GT 1 MILL.)	1,397	31.00	1,394	56.00
OTHER URBAN (LE 1 MILL.)	1,023	22.60	1,019	27.20
RURAL HOSPS	1,569	34.80	1,564	16.20
BEDS (URBAN):				
0–99 BEDS	550	12.20	545	7.20
100–199 BEDS	877	19.40	875	18.20
200–299 BEDS	488	10.80	488	16.80
300–499 BEDS	364	8.00	364	21.00
500 + BEDS	141	3.20	141	19.80
BEDS (RURAL):				
0–49 BEDS	752	16.60	749	4.40
50–99 BEDS	478	10.60	477	5.00
100–149 BEDS	200	4.40	199	2.40
150–199 BEDS	73	1.60	73	2.00
200 + BEDS	66	1.40	66	2.20
VOLUME (URBAN):				
LT 5,000	182	4.00	176	1.00
5,000–10,999	293	6.40	292	2.80
11,000–20,999	476	10.60	476	6.80
21,000–42,999	667	14.80	667	17.60
GT 42,999	802	17.80	802	55.00
VOLUME (RURAL):				
LT 5,000	334	7.40	330	1.00
5,000–10,999	419	9.20	418	2.40
11,000–20,999	387	8.60	387	4.00
21,000–42,999	295	6.60	295	4.20
GT 42,999	134	3.00	134	4.40
REGION (URBAN):				
NEW ENGLAND	127	2.80	126	5.60
MIDDLE ATLANTIC	372	8.20	371	24.20
SOUTH ATLANTIC	367	8.20	366	11.40
EAST NORTH CENT	411	9.00	408	14.80
EAST SOUTH CENT	153	3.40	153	3.20
WEST NORTH CENT	170	3.80	170	4.20
WEST SOUTH CENT	292	6.40	292	8.00
MOUNTAIN	122	2.60	122	3.00
PACIFIC	367	8.20	366	8.80
PUERTO RICO	39	0.80	39	0.00
REGION (RURAL):				
NEW ENGLAND	40	0.80	40	1.00
MIDDLE ATLANTIC	63	1.40	63	1.00
SOUTH ATLANTIC	224	5.00	222	3.00
EAST NORTH CENT	212	4.60	211	3.00
EAST SOUTH CENT	232	5.20	232	1.60
WEST NORTH CENT	271	6.00	270	2.40
WEST SOUTH CENT	278	6.20	278	1.60
MOUNTAIN	141	3.20	141	1.40
PACIFIC	103	2.20	102	1.20
PUERTO RICO	5	0.20	5	0.00
TEACHING STATUS:				
NON-TEACHING	2,922	64.60	2,910	40.40
MINOR	782	17.40	782	27.00
MAJOR	284	6.20	284	31.80
DSH PATIENT PERCENT:				
0	11	0.20	11	0.00
GT 0–0.10	975	21.60	973	24.60
0.10–0.16	872	19.20	872	19.20
0.16–0.23	766	17.00	764	17.60
0.23–0.35	755	16.80	752	19.40
GE 0.35	610	13.40	605	18.40
URBAN IME/DSH:				
IME & DSH	982	21.80	982	56.60
IME/NO DSH	0	0.00	0	0.00
NO IME/DSH	1,432	31.60	1,425	26.40
NO IME/NO DSH	6	0.20	6	0.00
RURAL HOSP. TYPES:				
NO SPECIAL STATUS	607	13.40	605	5.00

TABLE 13.—DISTRIBUTION OF OUTLIER PAYMENTS FOR CY 2003 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

	Number of Hospitals	Percent of Total Hospitals	Number of Hospitals with Outliers	Percent of Total Outlier Payments
RRC	167	3.60	166	4.00
SCH/EACH	507	11.20	507	4.40
MDH	199	4.40	198	1.20
SCH AND RRC	75	1.60	75	1.60
TYPE OF OWNERSHIP:				
VOLUNTARY	2,434	53.80	2,431	73.60
PROPRIETARY	703	15.60	699	10.60
GOVERNMENT	852	18.80	847	15.20
SPECIALTY HOSPITALS:				
EYE AND EAR	13	0.20	13	0.20
TRAUMA	153	3.40	153	15.00
CANCER	10	0.20	10	3.60
TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES):				
REHAB	163	3.60	115	0.20
PSYCH	191	4.20	67	0.00
LTC	135	3.00	99	0.20
CHILDREN	41	1.00	40	0.20

5. Estimated Impacts of This Final Rule on Beneficiaries

For services for which the beneficiary pays a coinsurance of 20 percent of the payment rate, the beneficiary share of payment will increase for services for which OPPS payments will rise and will decrease for services for which OPPS payments will fall. For example for a mid level office visit (APC 0601), the minimum unadjusted copayment in 2002 was $9.67; under this final rule, the minimum unadjusted copayment for APC 601 is $10.11 because the OPPS payment for the service will increase under this final rule. For some services (those services for which a national unadjusted copayment amount is shown in Addendum B), however, the beneficiary copayment is frozen based on historic data and will not change, therefore not presenting any potential impact on beneficiaries.

However, in all cases, the statute limits beneficiary liability for copayment for a service to the inpatient hospital deductible for the applicable year. This amount was $812 for 2002, and is $840 for 2003. In general, the impact of this final rule on beneficiaries will vary based on the service the beneficiary receives and whether the copayment for the service is one that is frozen under the OPPS.

B. Payment Suspension for Unfiled Cost Reports

Overall Impact

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Public Law 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132. (A description of each of these requirements is stated above in section XV.A.1.)

We have determined that the payment suspension provision does not have an economic impact on Medicare payments or other payments to providers. We are allowing the Secretary flexibility in payment suspensions, but we are not altering the final payment determination in any way. With the implementation of the various prospective payment systems, the majority of the payment to providers is based on the PPS methodology and not on the cost report. Suspending all payments because the cost report is not timely filed negatively affects providers. Providing the Secretary with flexibility in payment suspension can lessen the financial impact on providers. For these reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals. Under the requirement for Unfunded Mandates, this final rule will not have an economic effect on State, local, or tribal governments, in the aggregate, or on the private sector.

Anticipated Effects

1. Effects on Providers That File Cost Reports

The majority of providers that file cost reports comply with the timeliness provisions and will be unaffected by this regulation. In FY 2000, collectively 16 percent of hospitals, skilled nursing facilities, and home health agencies filed late cost reports. Of this 16 percent, 65 percent of those were only 1 day late. Currently, when a provider fails to file an acceptable cost report, the provider is placed on a complete payment suspension. Under this provision, for those providers who do not file timely, an immediate payment suspension less than the total suspension currently required might be imposed if the Secretary deemed it appropriate, which will allow the provider to more easily continue operations while completing and submitting the acceptable cost report.

2. Effects on Other Providers

The payment suspension provision does not affect other providers.

3. Effects on the Medicare Program

The provision will allow the Secretary to more effectively manage the Medicare program by imposing other than complete payment suspension when it is appropriate to do so. The Medicare program benefits because immediate complete payment suspension can be disruptive to providers and may negatively affect the care of Medicare patients. There are no costs to the Medicare program to doing so, because when the cost report is submitted, the suspended payments are returned to the provider.

4. Effects on Beneficiaries

We have determined that this provision has a potentially positive impact on beneficiaries. Under this provision, the Secretary will have the

discretion to impose less than 100 percent payment suspension when a provider fails to timely file an acceptable cost report. Doing so will lessen the financial burden on the provider and thereby allow it to provide adequate services to its patient population as it works to complete and file an acceptable cost report.

Alternatives Considered

We considered not revising existing § 405.371(c) to provide that payment suspension could be ''in whole or in part.'' However, we did not choose this option because we believe the Secretary should have the discretion to impose partial payment suspensions when circumstances warrant in order to more effectively manage the Medicare program.

Conclusion

In conclusion, we have determined that the payment suspension provision does not have an economic impact on Medicare payments.

C. Federalism

Since this regulation does not impose any costs on State or local governments, it will not have an effect on State or local governments. State or local governments will have no roles or responsibilities associated with this provision.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Subpart C—Suspension of Payment, Recovery of Overpayments, and Repayment of Scholarships and Loans

1. The authority citation for subpart C of part 405 continues to read as follows:

Authority: Secs. 1102, 1815, 1833, 1842, 1866, 1870, 1871, 1879, and 1892 of the Social Security Act (42 U.S.C. 1302, 1395g, 1395l, 1395u, 1395cc, 1395gg, 1395hh, 1395pp, and 1395ccc) and 31 U.S.C. 3711.

2. Section 405.371(c) is revised to read as follows:

§ 405.371 Suspension, offset and recoupment of Medicare payments to providers and suppliers of services.

* * * * *

(c) Suspension of payment in the case of unfiled cost reports. If a provider has failed to timely file an acceptable cost report, payment to the provider is immediately suspended in whole or in part until a cost report is filed and determined by the intermediary to be acceptable. In the case of an unfiled cost report, the provisions of § 405.372 do not apply. (See § 405.372(a)(2) concerning failure to furnish other information.)

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

1. The authority citation for part 419 continues to read as follows:

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

2. In § 419.21, paragraph (d)(3) is revised to read as follows:

§ 419.21 Hospital outpatient services subject to the outpatient prospective payment system.

* * * * *

(d) * * *

(3) Hepatitis B vaccine.

§ 419.66 [Amended]

3. In § 419.66, paragraph (c)(1) is amended by adding the phrase ''or by any category previously in effect'' after ''categories'' and before ''and''.

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

Dated: October 23, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare and Medicaid Services.

Approved: October 23, 2002.

Tommy G. Thompson,

Secretary.

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

[Calendar Year 2003]

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0001	Level I Photochemotherapy	S	0.3779	$19.71	$7.09	$3.94
0002	Fine needle Biopsy/Aspiration	T	0.5911	$30.83	.....	$6.17
0003	Bone Marrow Biopsy/Aspiration	T	1.2306	$64.18	.....	$12.84
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	1.7441	$90.96	$23.47	$18.19
0005	Level II Needle Biopsy /Aspiration Except Bone Marrow	T	3.1201	$162.72	$71.59	$32.54
0006	Level I Incision & Drainage	T	1.7926	$93.49	$24.12	$18.70
0007	Level II Incision & Drainage	T	10.0191	$522.51	$108.89	$104.50
0008	Level III Incision and Drainage	T	16.1430	$841.87	.....	$168.37
0009	Nail Procedures	T	0.6298	$32.84	$8.34	$6.57
0010	Level I Destruction of Lesion	T	0.6589	$34.36	$10.08	$6.87
0011	Level II Destruction of Lesion	T	1.8507	$96.52	$27.88	$19.30
0012	Level I Debridement & Destruction	T	0.7849	$40.93	$11.18	$8.19
0013	Level II Debridement & Destruction	T	1.0756	$56.09	$14.20	$11.22
0015	Level III Debridement & Destruction	T	1.5407	$80.35	$20.35	$16.07
0016	Level IV Debridement & Destruction	T	2.6162	$136.44	$57.31	$27.29
0017	Level VI Debridement & Destruction	T	15.8233	$825.20	$227.84	$165.04
0018	Biopsy of Skin/Puncture of Lesion	T	0.9399	$49.02	$16.04	$9.80
0019	Level I Excision/ Biopsy	T	3.7693	$196.57	$71.87	$39.31
0020	Level II Excision/ Biopsy	T	7.1898	$374.96	$113.25	$74.99
0021	Level III Excision/ Biopsy	T	13.9338	$726.66	$219.48	$145.33
0022	Level IV Excision/ Biopsy	T	17.3930	$907.06	$354.45	$181.41
0023	Exploration Penetrating Wound	T	2.5193	$131.38	$40.37	$26.28
0024	Level I Skin Repair	T	1.8507	$96.52	$34.75	$19.30
0025	Level II Skin Repair	T	5.8623	$305.72	$115.49	$61.14
0027	Level IV Skin Repair	T	15.2225	$793.87	$329.72	$158.77
0028	Level I Breast Surgery	T	16.8698	$879.78	$303.74	$175.96
0029	Level II Breast Surgery	T	28.7881	$1,501.33	$632.64	$300.27
0030	Level III Breast Surgery	T	37.5185	$1,956.63	$763.55	$391.33
0032	Insertion of Central Venous/Arterial Catheter	T	11.4726	$598.31	.....	$119.66
0033	Partial Hospitalization	P	4.6026	$240.03	$48.17	$48.01
0035	Placement of Arterial or Central Venous Catheter	T	0.2229	$11.62	$3.51	$2.32
0041	Level I Arthroscopy	T	26.1234	$1,362.36	.....	$272.47
0042	Level II Arthroscopy	T	40.9680	$2,136.52	$804.74	$427.30
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	2.4999	$130.37	.....	$26.07
0045	Bone/Joint Manipulation Under Anesthesia	T	12.9357	$674.61	$268.47	$134.92
0046	Open/Percutaneous Treatment Fracture or Dislocation	T	29.2920	$1,527.61	$535.76	$305.52
0047	Arthroplasty without Prosthesis	T	28.2842	$1,475.05	$537.03	$295.01
0048	Arthroplasty with Prosthesis	T	40.6289	$2,118.84	$695.60	$423.77
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	18.6042	$970.23	$197.14	$194.05
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	23.3037	$1,215.31	.....	$243.06
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	32.9062	$1,716.09	.....	$343.22
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	40.7646	$2,125.91	.....	$425.18
0053	Level I Hand Musculoskeletal Procedures	T	14.1760	$739.29	$253.49	$147.86
0054	Level II Hand Musculoskeletal Procedures	T	22.7223	$1,184.99	.....	$237.00
0055	Level I Foot Musculoskeletal Procedures	T	17.6740	$921.72	$355.34	$184.34
0056	Level II Foot Musculoskeletal Procedures	T	22.1700	$1,156.19	$405.81	$231.24
0057	Bunion Procedures	T	22.9064	$1,194.59	$475.91	$238.92
0058	Level I Strapping and Cast Application	S	1.0368	$54.07	.....	$10.81
0060	Manipulation Therapy	S	0.3294	$17.18	.....	$3.44
0068	CPAP Initiation	S	2.0736	$108.14	$59.48	$21.63
0069	Thoracoscopy	T	27.5575	$1,437.15	$591.64	$287.43
0070	Thoracentesis/Lavage Procedures	T	3.3623	$175.35	.....	$35.07
0071	Level I Endoscopy Upper Airway	T	0.9205	$48.00	$12.89	$9.60
0072	Level II Endoscopy Upper Airway	T	1.1628	$60.64	$26.68	$12.13
0073	Level III Endoscopy Upper Airway	T	3.1976	$166.76	$73.38	$33.35
0074	Level IV Endoscopy Upper Airway	T	12.8582	$670.57	$295.70	$134.11
0075	Level V Endoscopy Upper Airway	T	19.6604	$1,025.31	$445.92	$205.06
0076	Endoscopy Lower Airway	T	8.9533	$466.92	$189.82	$93.38
0077	Level I Pulmonary Treatment	S	0.2907	$15.16	$8.34	$3.03
0078	Level II Pulmonary Treatment	S	0.6492	$33.86	$14.55	$6.77
0079	Ventilation Initiation and Management	S	1.6376	$85.40	.....	$17.08
0080	Diagnostic Cardiac Catheterization	T	35.2996	$1,840.91	$838.92	$368.18
0081	Non-Coronary Angioplasty or Atherectomy	T	43.5067	$2,268.92	.....	$453.78
0082	Coronary Atherectomy	T	86.4321	$4,507.52	$1,293.59	$901.50
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T	51.9755	$2,710.57	.....	$542.11
0084	Level I Electrophysiologic Evaluation	S	9.3312	$486.63	.....	$97.33
0085	Level II Electrophysiologic Evaluation	T	41.7238	$2,175.94	$480.03	$435.19
0086	Ablate Heart Dysrhythm Focus	T	52.8282	$2,755.04	$936.35	$551.01

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

[Calendar Year 2003]

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0087	Cardiac Electrophysiologic Recording/Mapping	T	39.3983	$2,054.66	.....	$410.93
0088	Thrombectomy	T	32.5768	$1,698.91	$655.22	$339.78
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	112.5555	$5,869.88	$1,722.59	$1,173.98
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	87.9631	$4,587.36	$1,651.45	$917.47
0091	Level II Vascular Ligation	T	26.7048	$1,392.68	$348.23	$278.54
0092	Level I Vascular Ligation	T	23.7882	$1,240.58	$505.37	$248.12
0093	Vascular Reconstruction/Fistula Repair without Device	T	20.6294	$1,075.84	$277.34	$215.17
0094	Level I Resuscitation and Cardioversion	S	3.8371	$200.11	$67.63	$40.02
0095	Cardiac Rehabilitation	S	0.6105	$31.84	$16.73	$6.37
0096	Non-Invasive Vascular Studies	S	1.7054	$88.94	$48.15	$17.79
0097	Cardiac and Ambulatory Blood Pressure Monitoring	X	1.0077	$52.55	$23.80	$10.51
0098	Injection of Sclerosing Solution	T	1.6666	$86.91	$20.88	$17.38
0099	Electrocardiograms	S	0.3682	$19.20	.....	$3.84
0100	Cardiac Stress Tests	X	1.6085	$83.88	$41.44	$16.78
0101	Tilt Table Evaluation	S	4.2247	$220.32	$105.27	$44.06
0103	Miscellaneous Vascular Procedures	T	11.8408	$617.51	$223.63	$123.50
0104	Transcatheter Placement of Intracoronary Stents	T	76.5486	$3,992.09	.....	$798.42
0105	Revision/Removal of Pacemakers, AICD, or Vascular	T	18.5945	$969.72	$370.40	$193.94
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T	54.8243	$2,859.14	.....	$571.83
0107	Insertion of Cardioverter-Defibrillator	T	326.2231	$17,012.86	$3,699.14	$3,402.57
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	443.5460	$23,131.37	.....	$4,626.27
0109	Removal of Implanted Devices	T	7.4708	$389.61	$131.49	$77.92
0110	Transfusion	S	4.0309	$210.22	.....	$42.04
0111	Blood Product Exchange	S	14.9803	$781.24	$217.61	$156.25
0112	Apheresis, Photopheresis, and Plasmapheresis	S	36.4236	$1,899.53	$612.47	$379.91
0113	Excision Lymphatic System	T	18.7496	$977.81	.....	$195.56
0114	Thyroid/Lymphadenectomy Procedures	T	36.1135	$1,883.36	$485.91	$376.67
0115	Cannula/Access Device Procedures	T	24.3211	$1,268.37	$459.35	$253.67
0116	Chemotherapy Administration by Other Technique Except Infusion	S	0.7752	$40.43	.....	$8.09
0117	Chemotherapy Administration by Infusion Only	S	3.6046	$187.98	$48.28	$37.60
0118	Chemotherapy Administration by Both Infusion and Other Technique.	S	5.4844	$286.02	$72.03	$57.20
0119	Implantation of Devices	T	89.3100	$4,657.61	.....	$931.52
0120	Infusion Therapy Except Chemotherapy	T	2.1802	$113.70	$30.75	$22.74
0121	Level I Tube changes and Repositioning	T	2.0833	$108.65	$43.80	$21.73
0122	Level II Tube changes and Repositioning	T	10.7459	$560.41	$114.93	$112.08
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant	S	6.4049	$334.02	.....	$66.80
0124	Revision of Implanted Infusion Pump	T	50.0861	$2,612.04	.....	$522.41
0125	Refilling of Infusion Pump	T	2.0639	$107.63	.....	$21.53
0130	Level I Laparoscopy	T	30.4644	$1,588.75	$659.53	$317.75
0131	Level II Laparoscopy	T	40.2026	$2,096.61	$1,001.89	$419.32
0132	Level III Laparoscopy	T	56.9948	$2,972.34	$1,239.22	$594.47
0140	Esophageal Dilation without Endoscopy	T	6.0948	$317.85	$107.24	$63.57
0141	Upper GI Procedures	T	7.4126	$386.57	$143.38	$77.31
0142	Small Intestine Endoscopy	T	8.1393	$424.47	$152.78	$84.89
0143	Lower GI Endoscopy	T	7.9165	$412.85	$186.06	$82.57
0146	Level I Sigmoidoscopy	T	3.4302	$178.89	$64.40	$35.78
0147	Level II Sigmoidoscopy	T	7.0153	$365.85	$79.46	$73.17
0148	Level I Anal/Rectal Procedure	T	3.4205	$178.38	$63.38	$35.68
0149	Level III Anal/Rectal Procedure	T	16.3756	$854.00	$293.06	$170.80
0150	Level IV Anal/Rectal Procedure	T	21.2398	$1,107.68	$437.12	$221.54
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	17.5093	$913.13	$245.46	$182.63
0152	Percutaneous Abdominal and Biliary Procedures	T	10.0288	$523.01	$131.28	$104.60
0153	Peritoneal and Abdominal Procedures	T	19.5441	$1,019.24	$410.87	$203.85
0154	Hernia/Hydrocele Procedures	T	25.7262	$1,341.65	$464.85	$268.33
0155	Level II Anal/Rectal Procedure	T	10.1936	$531.61	$188.89	$106.32
0156	Level II Urinary and Anal Procedures	T	2.9747	$155.13	$46.55	$31.03
0157	Colorectal Cancer Screening: Barium Enema	S	2.5387	$132.40	.....	$26.48
0158	Colorectal Cancer Screening: Colonoscopy	T	7.0638	$368.38	.....	$92.10
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	2.3255	$121.28	.....	$30.32
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	6.3080	$328.97	$105.06	$65.79
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	15.7070	$819.14	$249.36	$163.83
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	20.5906	$1,073.82	.....	$214.76
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	28.3714	$1,479.60	.....	$295.92
0164	Level I Urinary and Anal Procedures	T	1.1240	$58.62	$17.59	$11.72
0165	Level III Urinary and Anal Procedures	T	12.2672	$639.75	.....	$127.95
0166	Level I Urethral Procedures	T	15.4163	$803.98	$218.73	$160.80
0167	Level III Urethral Procedures	T	28.3230	$1,477.07	$555.84	$295.41

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

[Calendar Year 2003]

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0168	Level II Urethral Procedures	T	24.4665	$1,275.95	$405.60	$255.19
0169	Lithotripsy	T	44.0978	$2,299.74	$1,115.69	$459.95
0170	Dialysis	S	4.8352	$252.16	.....	$50.43
0179	Urinary Incontinence Procedures	T	104.3581	$5,442.38	$2,340.22	$1,088.48
0180	Circumcision	T	18.1004	$943.95	$304.87	$188.79
0181	Penile Procedures	T	29.2435	$1,525.08	$621.82	$305.02
0182	Insertion of Penile Prosthesis	T	95.4145	$4,975.96	.....	$995.19
0183	Testes/Epididymis Procedures	T	21.2592	$1,108.69	.....	$221.74
0184	Prostate Biopsy	T	3.6918	$192.53	$96.27	$38.51
0187	Miscellaneous Placement/Repositioning	X	3.9534	$206.17	$90.71	$41.23
0188	Level II Female Reproductive Proc	T	1.0465	$54.58	$11.95	$10.92
0189	Level III Female Reproductive Proc	T	1.5310	$79.84	$18.60	$15.97
0190	Surgical Hysteroscopy	T	19.0596	$993.98	$424.28	$198.80
0191	Level I Female Reproductive Proc	T	0.2035	$10.61	$3.08	$2.12
0192	Level IV Female Reproductive Proc	T	2.7228	$142.00	$39.11	$28.40
0193	Level V Female Reproductive Proc	T	14.4764	$754.96	$171.13	$150.99
0194	Level VI Female Reproductive Proc	T	18.0228	$939.91	$397.84	$187.98
0195	Level VII Female Reproductive Proc	T	23.7301	$1,237.55	$483.80	$247.51
0196	Dilation and Curettage	T	15.5035	$808.52	$338.23	$161.70
0197	Infertility Procedures	T	1.5697	$81.86	$33.06	$16.37
0198	Pregnancy and Neonatal Care Procedures	T	1.2597	$65.69	$32.19	$13.14
0199	Obstetrical Care Service	T	3.9146	$204.15	$57.16	$40.83
0200	Therapeutic Abortion	T	15.1838	$791.85	$307.83	$158.37
0201	Spontaneous Abortion	T	15.3097	$798.42	$329.65	$159.68
0202	Level VIII Female Reproductive Proc	T	45.5610	$2,376.05	$1,164.26	$475.21
0203	Level IV Nerve Injections	T	11.7924	$614.99	$276.76	$123.00
0204	Level I Nerve Injections	T	2.0251	$105.61	$40.13	$21.12
0206	Level II Nerve Injections	T	4.7867	$249.63	$75.55	$49.93
0207	Level III Nerve Injections	T	5.7654	$300.67	$123.69	$60.13
0208	Laminotomies and Laminectomies	T	38.4487	$2,005.14	.....	$401.03
0209	Extended EEG Studies and Sleep Studies, Level II	S	11.3369	$591.23	$280.58	$118.25
0212	Nervous System Injections	T	3.3139	$172.82	$79.53	$34.56
0213	Extended EEG Studies and Sleep Studies, Level I	S	3.2557	$169.79	$70.41	$33.96
0214	Electroencephalogram	S	2.2286	$116.22	$58.12	$23.24
0215	Level I Nerve and Muscle Tests	S	0.5814	$30.32	$15.76	$6.06
0216	Level III Nerve and Muscle Tests	S	2.8972	$151.09	$67.98	$30.22
0218	Level II Nerve and Muscle Tests	S	1.0077	$52.55	.....	$10.51
0220	Level I Nerve Procedures	T	15.8136	$824.70	.....	$164.94
0221	Level II Nerve Procedures	T	21.5208	$1,122.33	$463.62	$224.47
0222	Implantation of Neurological Device	T	227.7370	$11,876.71	.....	$2,375.34
0223	Implantation of Pain Management Device	T	41.0262	$2,139.56	.....	$427.91
0224	Implantation of Reservoir/Pump/Shunt	T	34.0302	$1,774.71	$453.41	$354.94
0225	Implantation of Neurostimulator Electrodes	S	139.3379	$7,266.61	.....	$1,453.32
0226	Implantation of Drug Infusion Reservoir	T	144.3474	$7,527.86	.....	$1,505.57
0227	Implantation of Drug Infusion Device	T	144.5122	$7,536.46	.....	$1,507.29
0228	Creation of Lumbar Subarachnoid Shunt	T	59.6207	$3,109.28	$696.46	$621.86
0229	Transcatherter Placement of Intravascular Shunts	T	57.4599	$2,996.59	$771.23	$599.32
0230	Level I Eye Tests & Treatments	S	0.7364	$38.40	$14.97	$7.68
0231	Level III Eye Tests & Treatments	S	2.1705	$113.19	$50.94	$22.64
0232	Level I Anterior Segment Eye Procedures	T	4.4960	$234.47	$103.17	$46.89
0233	Level II Anterior Segment Eye Procedures	T	13.4202	$699.88	$266.33	$139.98
0234	Level III Anterior Segment Eye Procedures	T	20.4259	$1,065.23	$511.31	$213.05
0235	Level I Posterior Segment Eye Procedures	T	5.0871	$265.30	$73.44	$53.06
0236	Level II Posterior Segment Eye Procedures	T	19.4278	$1,013.18	.....	$202.64
0237	Level III Posterior Segment Eye Procedures	T	33.2647	$1,734.79	$818.54	$346.96
0238	Level I Repair and Plastic Eye Procedures	T	2.9747	$155.13	$58.96	$31.03
0239	Level II Repair and Plastic Eye Procedures	T	6.8119	$355.25	$115.94	$71.05
0240	Level III Repair and Plastic Eye Procedures	T	16.3078	$850.47	$315.31	$170.09
0241	Level IV Repair and Plastic Eye Procedures	T	20.6294	$1,075.84	$384.47	$215.17
0242	Level V Repair and Plastic Eye Procedures	T	28.0517	$1,462.92	$597.36	$292.58
0243	Strabismus/Muscle Procedures	T	19.9705	$1,041.48	$431.39	$208.30
0244	Corneal Transplant	T	35.6290	$1,858.09	$803.26	$371.62
0245	Level I Cataract Procedures without IOL Insert	T	14.5442	$758.49	$251.21	$151.70
0246	Cataract Procedures with IOL Insert	T	22.2379	$1,159.73	$495.96	$231.95
0247	Laser Eye Procedures Except Retinal	T	4.7092	$245.59	$104.31	$49.12
0248	Laser Retinal Procedures	T	4.2925	$223.86	$95.08	$44.77
0249	Level II Cataract Procedures without IOL Insert	T	26.7242	$1,393.69	$524.67	$278.74
0250	Nasal Cauterization/Packing	T	1.6376	$85.40	$29.89	$17.08

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

[Calendar Year 2003]

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0251	Level I ENT Procedures	T	1.9089	$99.55	.....	$19.91
0252	Level II ENT Procedures	T	5.8041	$302.69	$113.41	$60.54
0253	Level III ENT Procedures	T	14.4473	$753.44	$282.29	$150.69
0254	Level IV ENT Procedures	T	20.1158	$1,049.06	$321.35	$209.81
0256	Level V ENT Procedures	T	34.0302	$1,774.71	.....	$354.94
0258	Tonsil and Adenoid Procedures	T	19.8736	$1,036.43	$437.25	$207.29
0259	Level VI ENT Procedures	T	367.6466	$19,173.14	$9,394.83	$3,834.63
0260	Level I Plain Film Except Teeth	X	0.7655	$39.92	$21.95	$7.98
0261	Level II Plain Film Except Teeth Including Bone Density Measurement.	X	1.2887	$67.21	.....	$13.44
0262	Plain Film of Teeth	X	0.5717	$29.81	$9.82	$5.96
0263	Level I Miscellaneous Radiology Procedures	X	1.8992	$99.05	$43.58	$19.81
0264	Level II Miscellaneous Radiology Procedures	X	2.8197	$147.05	$79.41	$29.41
0265	Level I Diagnostic Ultrasound Except Vascular	S	0.9787	$51.04	$28.07	$10.21
0266	Level II Diagnostic Ultrasound Except Vascular	S	1.5988	$83.38	$45.86	$16.68
0267	Level III Diagnostic Ultrasound Except Vascular	S	2.4418	$127.34	$65.52	$25.47
0268	Ultrasound Guidance Procedures	S	1.3856	$72.26	.....	$14.45
0269	Level III Echocardiogram Except Transesophageal	S	3.2170	$167.77	$87.24	$33.55
0270	Transesophageal Echocardiogram	S	5.3003	$276.42	$146.79	$55.28
0271	Mammography	S	0.6492	$33.86	$16.80	$6.77
0272	Level I Fluoroscopy	X	1.3372	$69.74	$38.36	$13.95
0274	Myelography	S	3.8759	$202.13	$96.54	$40.43
0275	Arthrography	S	2.9747	$155.13	$69.09	$31.03
0276	Level I Digestive Radiology	S	1.5891	$82.87	$41.72	$16.57
0277	Level II Digestive Radiology	S	2.3546	$122.79	$60.47	$24.56
0278	Diagnostic Urography	S	2.5290	$131.89	$66.07	$26.38
0279	Level II Angiography and Venography except Extremity	S	8.6432	$450.75	$174.57	$90.15
0280	Level III Angiography and Venography except Extremity	S	15.2128	$793.36	$353.85	$158.67
0281	Venography of Extremity	S	5.2227	$272.37	$115.16	$54.47
0282	Miscellaneous Computerized Axial Tomography	S	1.6763	$87.42	$44.51	$17.48
0283	Computerized Axial Tomography with Contrast Material	S	4.5057	$234.98	$126.27	$47.00
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast Material.	S	7.2382	$377.48	$201.02	$75.50
0285	Myocardial Positron Emission Tomography (PET)	S	18.1294	$945.47	$409.56	$189.09
0286	Myocardial Scans	S	6.5309	$340.59	$187.32	$68.12
0287	Complex Venography	S	6.9863	$364.34	$114.51	$72.87
0288	Bone Density:Axial Skeleton	S	1.2984	$67.71	.....	$13.54
0289	Needle Localization for Breast Biopsy	X	1.8992	$99.05	$44.80	$19.81
0290	Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	2.0251	$105.61	$53.17	$21.12
0291	Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	3.9825	$207.69	$104.55	$41.54
0292	Level III Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	4.2925	$223.86	$112.69	$44.77
0294	Level II Therapeutic Nuclear Medicine	S	4.0794	$212.74	$117.01	$42.55
0296	Level I Therapeutic Radiologic Procedures	S	2.4127	$125.82	$69.20	$25.16
0297	Level II Therapeutic Radiologic Procedures	S	7.6839	$400.72	$172.51	$80.14
0299	Miscellaneous Radiation Treatment	S	5.9785	$311.78	.....	$62.36
0300	Level I Radiation Therapy	S	1.5794	$82.37	.....	$16.47
0301	Level II Radiation Therapy	S	3.1588	$164.73	.....	$32.95
0302	Level III Radiation Therapy	S	9.2343	$481.58	$182.43	$96.32
0303	Treatment Device Construction	X	2.8391	$148.06	$66.95	$29.61
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.6182	$84.39	$41.52	$16.88
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.6530	$190.51	$91.38	$38.10
0310	Level III Therapeutic Radiation Treatment Preparation	X	13.6625	$712.51	$325.27	$142.50
0312	Radioelement Applications	S	52.8864	$2,758.08	.....	$551.62
0313	Brachytherapy	S	21.0363	$1,097.06	.....	$219.41
0314	Hyperthermic Therapies	S	4.1763	$217.80	$101.77	$43.56
0320	Electroconvulsive Therapy	S	4.2635	$222.35	$80.06	$44.47
0321	Biofeedback and Other Training	S	1.2112	$63.17	$21.78	$12.63
0322	Brief Individual Psychotherapy	S	1.3275	$69.23	$12.40	$13.85
0323	Extended Individual Psychotherapy	S	1.8410	$96.01	$21.26	$19.20
0324	Family Psychotherapy	S	2.4612	$128.35	.....	$25.67
0325	Group Psychotherapy	S	1.4244	$74.28	$18.27	$14.86
0330	Dental Procedures	S	4.7770	$249.13	.....	$49.83
0332	Computerized Axial Tomography and Computerized Angiography without Contrast Material.	S	3.4398	$179.39	$91.27	$35.88
0333	Computerized Axial Tomography and Computerized Angio w/o Contrast Material followed by Contrast.	S	5.3681	$279.95	$146.98	$55.99
0335	Magnetic Resonance Imaging, Miscellaneous	S	6.2983	$328.46	$151.46	$65.69

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

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APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast.	S	6.5987	$344.13	$176.94	$68.83
0337	MRI and Magnetic Resonance Angiography without Contrast Material followed by Contrast Material.	S	9.2440	$482.08	$240.77	$96.42
0339	Observation	S	7.2188	$376.47	.....	$75.29
0340	Minor Ancillary Procedures	X	0.6492	$33.86	.....	$6.77
0341	Skin Tests and Miscellaneous Red Blood Cell Tests	X	0.1453	$7.58	$3.08	$1.52
0342	Level I Pathology	X	0.2132	$11.12	$5.88	$2.22
0343	Level II Pathology	X	0.4457	$23.24	$12.55	$4.65
0344	Level III Pathology	X	0.6201	$32.34	$17.46	$6.47
0345	Level I Transfusion Laboratory Procedures	X	0.1938	$10.11	$3.10	$2.02
0346	Level II Transfusion Laboratory Procedures	X	0.5136	$26.78	$6.75	$5.36
0347	Level III Transfusion Laboratory Procedures	X	1.1240	$58.62	$14.76	$11.72
0348	Fertility Laboratory Procedures	X	0.5523	$28.80	.....	$5.76
0352	Level I Injections	X	0.2229	$11.62	.....	$2.32
0353	Level II Allergy Injections	X	0.3973	$20.72	.....	$4.14
0355	Level III Immunizations	K	0.2132	$11.12	.....	$2.22
0356	Level IV Immunizations	K	0.7655	$39.92	.....	$7.98
0359	Level II Injections	X	1.1337	$59.12	.....	$11.82
0360	Level I Alimentary Tests	X	1.6279	$84.90	$42.45	$16.98
0361	Level II Alimentary Tests	X	3.3914	$176.86	$83.23	$35.37
0362	Level III Otorhinolaryngologic Function Tests	X	2.8391	$148.06	.....	$29.61
0363	Level I Otorhinolaryngologic Function Tests	X	1.0852	$56.59	$20.94	$11.32
0364	Level I Audiometry	X	0.4457	$23.24	$9.06	$4.65
0365	Level II Audiometry	X	1.2112	$63.17	$18.95	$12.63
0367	Level I Pulmonary Test	X	0.5814	$30.32	$15.16	$6.06
0368	Level II Pulmonary Tests	X	1.0562	$55.08	$27.55	$11.02
0369	Level III Pulmonary Tests	X	2.5871	$134.92	$44.18	$26.98
0370	Allergy Tests	X	0.7752	$40.43	$11.58	$8.09
0371	Level I Allergy Injections	X	0.5039	$26.28	.....	$5.26
0372	Therapeutic Phlebotomy	X	0.5329	$27.79	$10.09	$5.56
0373	Neuropsychological Testing	X	2.2577	$117.74	.....	$23.55
0374	Monitoring Psychiatric Drugs	X	1.1434	$59.63	$9.97	$11.93
0600	Low Level Clinic Visits	V	0.8430	$43.96	.....	$8.79
0601	Mid Level Clinic Visits	V	0.9690	$50.53	.....	$10.11
0602	High Level Clinic Visits	V	1.4631	$76.30	.....	$15.26
0610	Low Level Emergency Visits	V	1.4147	$73.78	$19.57	$14.76
0611	Mid Level Emergency Visits	V	2.5290	$131.89	$36.47	$26.38
0612	High Level Emergency Visits	V	4.3410	$226.39	$54.14	$45.28
0620	Critical Care	S	9.9610	$519.48	$150.55	$103.90
0648	Breast Reconstruction with Prosthesis	T	44.7955	$2,336.13	.....	$467.23
0649	Prostate Brachytherapy Palladium Seeds	T	115.0167	$5,998.24	.....	$1,199.65
0650	Intermediate/Complex Proton Beam Radiation Therapy	S	12.0152	$626.60	.....	$125.32
0651	Complex Interstitial Radiation Source Application	S	54.7177	$2,853.58	.....	$570.72
0652	Insertion of Intraperitoneal Catheters	T	28.1292	$1,466.97	.....	$293.39
0653	Vascular Reconstruction/Fistula Repair with Device	T	30.0284	$1,566.01	.....	$313.20
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	91.8583	$4,790.50	.....	$958.10
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	T	122.8654	$6,407.55	.....	$1,281.51
0656	Transcatheter Placement of Intracoronary of Drug-Eluting Stents	T	96.7516	$5,045.69	.....	$1,009.14
0657	Placement of Tissue Clips	S	1.4438	$75.30	.....	$15.06
0658	Percutaneous Breast Biopsies	T	5.2712	$274.90	.....	$54.98
0659	Hyperbaric Oxygen	S	3.2364	$168.78	.....	$33.76
0660	Level II Otorhinolaryngologic Function Tests	X	1.5891	$82.87	$30.66	$16.57
0661	Level IV Pathology	X	3.5077	$182.93	$100.61	$36.59
0662	CT Angiography	S	5.4553	$284.50	$156.47	$56.90
0664	Proton Beam Radiation Therapy	S	10.0482	$524.02	.....	$104.80
0665	Bone Density:AppendicularSkeleton	S	0.8236	$42.95	.....	$8.59
0666	Myocardial Add-on Scans	S	2.9650	$154.63	$85.05	$30.93
0668	Level I Angiography and Venography except Extremity	S	10.3292	$538.68	$237.76	$107.74
0669	Digital Mammography	S	0.8915	$46.49	.....	$9.30
0670	Intravenous and Intracardiac Ultrasound	S	30.2416	$1,577.13	$571.17	$315.43
0671	Level II Echocardiogram Except Transesophageal	S	2.3643	$123.30	$64.12	$24.66
0672	Level IV Posterior Segment Procedures	T	37.9061	$1,976.84	$988.43	$395.37
0673	Level IV Anterior Segment Eye Procedures	T	25.9490	$1,353.27	$649.56	$270.65
0674	Prostate Cryoablation	T	62.9152	$3,281.09	.....	$656.22
0675	Prostatic Thermotherapy	T	48.5648	$2,532.70	.....	$506.54
0676	Level II Transcatheter Thrombolysis	T	4.1278	$215.27	$58.21	$43.05

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

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APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0677	Level I Transcatheter Thrombolysis	T	2.6453	$137.96		$27.59
0678	External Counterpulsation	T	2.2189	$115.72		$23.14
0679	Level II Resuscitation and Cardioversion	S	5.4069	$281.98	$95.30	$56.40
0680	Insertion of Patient Activated Event Recorders	S	56.1324	$2,927.36		$585.47
0681	Knee Arthroplasty	T	147.8067	$7,708.27	$3,067.55	$1,541.65
0682	Level V Debridement & Destruction	T	7.2770	$379.50	$174.57	$75.90
0683	Level II Photochemotherapy	S	1.8992	$99.05	$35.65	$19.81
0684	Prostate Brachytherapy Iodine Seeds	T	98.8349	$5,154.34		$1,030.87
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	5.9882	$312.29	$137.40	$62.46
0686	Level III Skin Repair	T	14.2439	$742.83	$341.70	$148.57
0687	Revision/Removal of Neurostimulator Electrodes	T	25.8424	$1,347.71	$619.95	$269.54
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	74.5719	$3,889.00	$1,905.61	$777.80
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.5814	$30.32		$6.06
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	0.4263	$22.23	$10.63	$4.45
0691	Electronic Analysis of Programmable Shunts/Pumps	S	2.9166	$152.10	$83.65	$30.42
0692	Electronic Analysis of Neurostimulator Pulse Generators	S	6.2595	$326.44	$179.54	$65.29
0693	Level II Breast Reconstruction	T	37.5863	$1,960.16	$798.17	$392.03
0694	Mohs Surgery	T	3.4689	$180.91	$72.36	$36.18
0695	Level VII Debridement & Destruction	T	18.6817	$974.27	$266.59	$194.85
0697	Level I Echocardiogram Except Transesophageal	S	1.5697	$81.86	$42.57	$16.37
0698	Level II Eye Tests & Treatments	S	0.9205	$48.00	$18.72	$9.60
0699	Level IV Eye Tests & Treatments	T	3.7596	$196.07	$88.23	$39.21
0701	SR 89 chloride, per mCi	K	8.9920	$468.94		$93.79
0702	SM 153 lexidronam, 50 mCi	K	14.6218	$762.54		$152.51
0706	New Technology - Level I ($0 - $50)	S		$25.00		$5.00
0707	New Technology - Level II ($50 - $100)	S		$75.00		$15.00
0708	New Technology - Level III ($100 - $200)	S		$150.00		$30.00
0709	New Technology - Level IV ($200 - $300)	S		$250.00		$50.00
0710	New Technology - Level V ($300 - $500)	S		$400.00		$80.00
0711	New Technology - Level VI ($500 - $750)	S		$625.00		$125.00
0712	New Technology - Level VII ($750 - $1000)	S		$875.00		$175.00
0713	New Technology - Level VIII ($1000 - $1250)	S		$1,125.00		$225.00
0714	New Technology - Level IX ($1250 - $1500)	S		$1,375.00		$275.00
0715	New Technology - Level X ($1500 - $1750)	S		$1,625.00		$325.00
0716	New Technology - Level XI ($1750 - $2000)	S		$1,875.00		$375.00
0717	New Technology - Level XII ($2000 - $2500)	S		$2,250.00		$450.00
0718	New Technology - Level XIII ($2500 - $3000)	S		$2,750.00		$550.00
0719	New Technology-Level XIV ($3000 - $3500)	S		$3,250.00		$650.00
0720	New Technology - Level XV ($3500 - $5000)	S		$4,250.00		$850.00
0721	New Technology - Level XVI ($5000 - $6000)	S		$5,500.00		$1,100.00
0725	New Technology - Level XX ($19500 - $20500)	S		$20,000.00		$4,000.00
0726	Dexrazoxane hcl injection, 250 mg	K	2.2577	$117.74		$23.55
0728	Filgrastim 300 mcg injection	K	2.1027	$109.66		$21.93
0730	Pamidronate disodium , 30 mg	K	3.2654	$170.29		$34.06
0732	Mesna injection 200 mg	K	0.5039	$26.28		$5.26
0733	Non esrd epoetin alpha inj, 1000 u	K	0.1744	$9.10		$1.82
0734	Injection, darbepoetin alfa (for non-ESRD use), pre 1 mcg	K	0.0454	$2.37		$.47
0800	Leuprolide acetate, 3.75 mg	K	3.7984	$198.09		$39.62
0802	Etoposide oral 50 mg	K	0.5523	$28.80		$5.76
0807	Aldesleukin/single use vial	K	7.2867	$380.01		$76.00
0810	Goserelin acetate implant 3.6 mg	K	5.5619	$290.06		$58.01
0811	Carboplatin injection 50 mg	K	1.4922	$77.82		$15.56
0812	Carmustine, 100 mg	K	1.5310	$79.84		$15.97
0813	Cisplatin 10 mg injection	K	0.4263	$22.23		$4.45
0820	Daunorubicin 10 mg	K	1.9379	$101.06		$20.21
0821	Daunorubicin citrate liposom 10 mg	K	2.9069	$151.60		$30.32
0822	Diethylstilbestrol injection 250 mg	K	2.0251	$105.61		$21.12
0823	Docetaxel, 20 mg	K	3.8953	$203.14		$40.63
0827	Floxuridine injection 500 mg	K	2.2189	$115.72		$23.14
0828	Gemcitabine HCL 200 mg	K	1.2984	$67.71		$13.54
0830	Irinotecan injection 20 mg	K	1.7538	$91.46		$18.29
0831	Ifosfomide injection 1 gm	K	1.9186	$100.06		$20.01
0832	Idarubicin hcl injection 5 mg	K	4.8642	$253.67		$50.73
0838	Interferon gamma 1-b inj, 3 million u	K	3.0426	$158.67		$31.73
0840	Melphalan hydrochl 50 mg	K	4.5348	$236.49		$47.30
0842	Fludarabine phosphate inj 50 mg	K	3.2848	$171.31		$34.26
0843	Pegaspargase, singl dose vial	K	8.8079	$459.34		$91.87
0844	Pentostatin injection, 10 mg	K	19.8833	$1,036.93		$207.39

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

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APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0849	Rituximab, 100 mg	K	5.4941	$286.52		$57.30
0852	Topotecan, 4 mg	K	7.7130	$402.24		$80.45
0855	Vinorelbine tartrate, 10 mg	K	1.0756	$56.09		$11.22
0856	Porfimer sodium, 75 mg	K	29.6117	$1,544.28		$308.86
0857	Bleomycin sulfate injection 15 u	K	3.1879	$166.25		$33.25
0858	Cladribine, 1mg	K	0.7946	$41.44		$8.29
0861	Leuprolide acetate injection 1 mg	K	0.7752	$40.43		$8.09
0862	Mitomycin 5 mg inj	K	1.1337	$59.12		$11.82
0863	Paclitaxel injection, 30 mg	K	2.3158	$120.77		$24.15
0864	Mitoxantrone hcl, 5 mg	K	2.9263	$152.61		$30.52
0888	Cyclosporine oral 100 mg	K	0.0484	$2.52		$.50
0890	Lymphocyte immune globulin 250 mg	K	3.3429	$174.34		$34.87
0891	Tacrolimus oral per 1 mg	K	0.0291	$1.52		$.30
0902	Botulinum toxin a, per unit	K	0.0484	$2.52		$.50
0903	Cytomegalovirus imm IV/vial	K	4.7383	$247.11		$49.42
0905	Immune globulin 500 mg	K	0.8333	$43.46		$8.69
0906	RSV-ivig, 50 mg	K	0.5911	$30.83		$6.17
0909	Interferon beta-1a, 33 mcg	K	2.7906	$145.53		$29.11
0910	Interferon beta-1b /0.25 mg	K	1.9864	$103.59		$20.72
0916	Injection imiglucerase /unit	K	0.0484	$2.52		$.50
0917	Inj, Adenosine, 90 mg	K	3.1986	$166.81		$33.36
0925	Factor viii per iu	K	0.0097	$.51		$.10
0926	Factor VIII (porcine) per iu	K	0.0291	$1.52		$.30
0927	Factor viii recombinant per iu	K	0.0194	$1.01		$.20
0928	Factor ix complex per iu	K	0.0097	$.51		$.10
0929	Anti-inhibitor per iu	K	0.0194	$1.01		$.20
0930	Antithrombin iii injection per iu	K	0.0194	$1.01		$.20
0931	Factor IX non-recombinant, per iu	K	0.0097	$.51		$.10
0932	Factor IX recombinant, per iu	K	0.0194	$1.01		$.20
0949	Plasma, Pooled Multiple Donor, Solvent/Detergent T	K	2.3837	$124.31		$24.86
0950	Blood (Whole) For Transfusion	K	1.6860	$87.93		$17.59
0952	Cryoprecipitate	K	0.5620	$29.31		$5.86
0954	RBC leukocytes reduced	K	2.2868	$119.26		$23.85
0955	Plasma, Fresh Frozen	K	1.8217	$95.00		$19.00
0956	Plasma Protein Fraction	K	1.7829	$92.98		$18.60
0957	Platelet Concentrate	K	0.7946	$41.44		$8.29
0958	Platelet Rich Plasma	K	1.0271	$53.56		$10.71
0959	Red Blood Cells	K	1.6569	$86.41		$17.28
0960	Washed Red Blood Cells	K	3.0813	$160.69		$32.14
0961	Infusion, Albumin (Human) 5%, 50 ml	K	0.9980	$52.05		$10.41
0963	Albumin (human), 5%, 250 ml	K	4.9708	$259.23		$51.85
0964	Albumin (human), 25%, 20 ml	K	1.0756	$56.09		$11.22
0965	Albumin (human), 25%, 50ml	K	2.6840	$139.97		$27.99
0966	Plasmaprotein fract,5%,250ml	K	8.9145	$464.90		$92.98
0970	New Technology - Level I ($0 - $50)	T		$25.00		$5.00
0971	New Technology - Level II ($50 - $100)	T		$75.00		$15.00
0972	New Technology - Level III ($100 - $200)	T		$150.00		$30.00
0973	New Technology - Level IV ($200 - $300)	T		$250.00		$50.00
0974	New Technology - Level V ($300 - $500)	T		$400.00		$80.00
0975	New Technology - Level VI ($500 - $750)	T		$625.00		$125.00
0976	New Technology - Level VII ($750 - $1000)	T		$875.00		$175.00
0977	New Technology - Level VIII ($1000 - $1250)	T		$1,125.00		$225.00
0978	New Technology - Level IX ($1250 - $1500)	T		$1,375.00		$275.00
0979	New Technology - Level X ($1500 - $1750)	T		$1,625.00		$325.00
0980	New Technology - Level XI ($1750 - $2000)	T		$1,875.00		$375.00
0981	New Technology - Level XII ($2000 - $2500)	T		$2,250.00		$450.00
0982	New Technology - Level XIII ($2500 - $3000)	T		$2,750.00		$550.00
0983	New Technology - Level XIV ($3000 - $3500)	T		$3,250.00		$650.00
0984	New Technology - Level XV ($3500 - $5000)	T		$4,250.00		$850.00
0985	New Technology - Level XVI ($5000 - $6000)	T		$5,500.00		$1,100.00
0989	New Technology - Level XX ($19500-$20500)	T		$20,000.00		$4,000.00
1009	Cryoprecip reduced plasma	K	0.7170	$37.39		$7.48
1010	Blood, L/R, CMV-neg	K	2.3352	$121.78		$24.36
1011	Platelets, HLA-m, L/R, unit	K	9.5831	$499.77		$99.95
1013	Platelet concentrate, L/R, unit	K	0.9496	$49.52		$9.90
1016	Blood, L/R, froz/deglycerol/washed	K	5.7848	$301.68		$60.34
1017	Platelets, aph/pher, L/R, CMV-neg, unit	K	7.5386	$393.15		$78.63
1018	Blood, L/R, irradiated	K	2.5387	$132.40		$26.48

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

[Calendar Year 2003]

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1019	Platelets, aph/pher, L/R, irradiated, unit	K	7.7905	$406.28		$81.26
1020	Pit, pher,L/R,CMV,irrad	K	9.4959	$495.22		$99.04
1021	RBC, frz/deg/wsh, L/R, irrad	K	6.4436	$336.04		$67.21
1022	RBC, L/R, CMV neg, irrad	K	3.8565	$201.12		$40.22
1045	Iobenguane sulfate I-31per 0.5 mCi	K	1.5697	$81.86		$16.37
1059	Cultured chondrocytes implnt	K	114.2706	$5,959.33		$1,191.87
1084	Denileukin diftitox, 300 MCG	K	12.1315	$632.67		$126.53
1086	Temozolomide,oral 5 mg	K	0.0581	$3.03		$.61
1091	IN 111 Oxyquinoline, per .5 mCi	K	4.7092	$245.59		$49.12
1092	IN 111 Pentetate, per 0.5 mCi	K	4.4379	$231.44		$46.29
1095	Technetium TC 99M Depreotide	K	5.6006	$292.08		$58.42
1096	TC 99M Exametazime, per dose	K	4.4379	$231.44		$46.29
1122	TC 99M arcitumomab, per vial	K	11.4726	$598.31		$119.66
1167	Epirubicin hcl, 2 mg	K	0.3294	$17.18		$3.44
1178	Busulfan IV, 6 mg	K	0.4845	$25.27		$5.05
1203	Verteporfin for injection	K	16.5209	$861.58		$172.32
1207	Octreotide acetate depot 1mg	K	1.4244	$74.28		$14.86
1305	Apligraf	K	13.0520	$680.67		$136.13
1348	I-131 sol, per 1-6 mCi	K	0.9399	$49.02		$9.80
1409	Factor viia recombinant, per 1.2 mg	K	20.7844	$1,083.93		$216.79
1604	IN 111 capromab pendetide, per dose	K	16.4434	$857.54		$171.51
1605	Abciximab injection, 10 mg	K	5.8526	$305.22		$61.04
1609	Rho(D) immune globulin h, sd, 100 iu	K	0.2229	$11.62		$2.32
1611	Hylan G-F 20 injection, 16 mg	K	2.3643	$123.30		$24.66
1612	Daclizumab, parenteral, 25 mg	K	4.3991	$229.42		$45.88
1613	Trastuzumab, 10 mg	K	0.6298	$32.84		$6.57
1614	Valrubicin, 200 mg	K	3.5658	$185.96		$37.19
1615	Basiliximab, 20 mg	K	13.3621	$696.85		$139.37
1618	Vonwillebrandfactrcmplx, per iu	K	0.0194	$1.01		$.20
1620	Technetium tc99m bicisate	K	3.8759	$202.13		$40.43
1625	Indium 111-in pentetreotide	K	8.2169	$428.52		$85.70
1628	Chromic phosphate p32	K	1.5891	$82.87		$16.57
1716	Brachytx seed, Gold 198	K	0.4360	$22.74		$4.55
1718	Brachytx seed, Iodine 125	K	0.6008	$31.33		$6.27
1719	Brachytxseed, Non-HDR Ir-192	K	0.5232	$27.29		$5.46
1720	Brachytx seed, Palladium 103	K	0.8430	$43.96		$8.79
1765	Adhesion barrier	H				
1775	FDG, per dose (4-40 mCi/ml)	K	7.5289	$392.64		$78.53
1783	Ocular implant, aqueous drain device	H				
1888	Endovascular non-cardiac ablation catheter	H				
1900	Lead coronary venous	H				
2614	Probe, percutaneous lumbar disc	H				
2616	Brachytx seed, Yttrium-90	K	8.8370	$460.86		$92.17
2618	Probe, cryoablation	H				
2632	Brachytx sol, I-125, per mCi	H				
7000	Amifostine, 500 mg	K	4.5057	$234.98		$47.00
7001	Amphotericin B lipid complex, 50 mg	K	2.3449	$122.29		$24.46
7011	Oprelvekin injection, 5 mg	K	2.7325	$142.50		$28.50
7024	Corticorelin ovine triflutat	K	2.2965	$119.76		$23.95
7025	Digoxin immune FAB (ovine)	K	4.9805	$259.74		$51.95
7030	Hemin, per 1 mg	K	0.0097	$.51		$.10
7031	Octreotide acetate injection	K	1.2694	$66.20		$13.24
7034	Somatropin injection	K	0.7170	$37.39		$7.48
7035	Teniposide, 50 mg	K	1.9573	$102.08		$20.42
7038	Muromonab-CD3, 5 mg	K	6.9572	$362.82		$72.56
7041	Tirofiban hydrochloride 12.5 mg	K	4.9417	$257.71		$51.54
7042	Capecitabine, oral, 150 mg	K	0.0291	$1.52		$.30
7043	Infliximab injection 10 mg	K	0.7364	$38.40		$7.68
7045	Trimetrexate glucoronate	K	1.3081	$68.22		$13.64
7046	Doxorubicin hcl liposome inj 10 mg	K	4.3894	$228.91		$45.78
7049	Filgrastim 480 mcg injection	K	3.2267	$168.28		$33.66
7051	Leuprolide acetate implant, 65 mg	G		$5,399.80		$807.13
9000	Na chromate Cr51, per 0.25mCi	K	1.8798	$98.03		$19.61
9002	Tenecteplase, 50mg/vial	K	27.5963	$1,439.17		$287.83
9003	Palivizumab, per 50mg	K	8.5657	$446.71		$89.34
9005	Reteplase injection	K	12.6547	$659.96		$131.99
9009	Baclofen refill kit - per 2000 mcg	K	0.7267	$37.90		$7.58
9010	Baclofen refill kit - per 4000 mcg	K	0.9205	$48.00		$9.60

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

[Calendar Year 2003]

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
9012	Arsenic Trioxide	G		$31.35		$4.69
9015	Mycophenolate mofetil oral 250 mg	K	0.0291	$1.52		$.30
9016	Echocardiography contrast	G		$118.75		$17.75
9018	Botulinum toxin B, per 100 u	G		$8.79		$1.31
9019	Caspofungin acetate, 5 mg	G		$34.20		$5.11
9020	Sirolimus tablet, 1 mg	K	0.0581	$3.03		$.61
9021	Immune globulin 10 mg	K	0.0097	$.51		$.10
9022	IM inj interferon beta 1-a	K	0.9302	$48.51		$9.70
9023	Rho d immune globulin 50 mcg	K	0.0484	$2.52		$.50
9024	Amphotericin b lipid complex	K	0.4167	$21.73		$4.35
9104	Anti-thymocycte globulin rabbit	K	2.6356	$137.45		$27.49
9105	Hep B imm glob, per 1 ml	K	1.5116	$78.83		$15.77
9108	Thyrotropin alfa, per 1.1 mg	K	7.5870	$395.67		$79.13
9109	Tirofliban hcl, per 6.25 mg	K	2.1996	$114.71		$22.94
9110	Alemtuzumab, per ml	G		$511.22		$76.41
9111	Inj, bivalirudin, per 250 mg vial	G		$397.81		$56.46
9112	Perflutren lipid micro, per 2ml	G		$4.94		$.74
9113	Inj, pantoprazole sodium, vial	G		$22.80		$3.41
9114	Nesiritide, per 1.5 mg vial	G		$433.20		$64.75
9115	Inj, zoledronic acid, per 2 mg	G		$406.78		$60.80
9116	Inj, Ertapenem sodium, per 1 gm vial	G		$45.31		$6.77
9119	Inj, Pegfilgrastim, per 6 mg single dose vial	G		$2,802.50		$418.90
9120	Inj, Fulvestrant, per 50 mg	G		$87.58		$13.09
9121	Inj, Argatroban, per 5 mg	G		$14.25		$2.13
9200	Orcel, per 36 cm2	G		$1,135.25		$169.69
9201	Dermagraft, per 37.5 sq cm	G		$577.60		$86.34
9217	Leuprolide acetate suspnsion, 7.5 mg	K	6.5696	$342.61		$68.52
9500	Platelets, irradiated	K	1.4341	$74.79		$14.96
9501	Platelets, pheresis	K	7.8390	$408.81		$81.76
9502	Platelet pheresis irradiated	K	8.5076	$443.68		$88.74
9503	Fresh frozen plasma, ea unit	K	1.3372	$69.74		$13.95
9504	RBC deglycerolized	K	3.5174	$183.44		$36.69
9505	RBC irradiated	K	2.0833	$108.65		$21.73
9506	Granulocytes, pheresis	K	23.9432	$1,248.66		$249.73

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0001T	C		Endovas repr abdo ao aneurys					
0002T	C		Endovas repr abdo ao aneurys					
0003T	S		Cervicography	0706		$25.00		$5.00
0005T	C		Perc cath stent/brain cv art					
0006T	C		Perc cath stent/brain cv art					
0007T	C		Perc cath stent/brain cv art					
0008T	E		Upper gi endoscopy w/suture					
0009T	T		Endometrial cryoablation	0980		$1,875.00		$375.00
00100	N		Anesth, salivary gland					
00102	N		Anesth, repair of cleft lip					
00103	N		Anesth, blepharoplasty					
00104	N		Anesth, electroshock					
0010T	A		Tb test, gamma interferon					
00120	N		Anesth, ear surgery					
00124	N		Anesth, ear exam					
00126	N		Anesth, tympanotomy					
0012T	T		Osteochondral knee autograft	0041	26.1234	$1,362.36		$272.47
0013T	T		Osteochondral knee allograft	0041	26.1234	$1,362.36		$272.47
00140	N		Anesth, procedures on eye					
00142	N		Anesth, lens surgery					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00144	N		Anesth, corneal transplant					
00145	N		Anesth, vitreoretinal surg					
00147	N		Anesth, iridectomy					
00148	N		Anesth, eye exam					
0014T	T		Meniscal transplant, knee	0041	26.1234	$1,362.36		$272.47
00160	N		Anesth, nose/sinus surgery					
00162	N		Anesth, nose/sinus surgery					
00164	N		Anesth, biopsy of nose					
0016T	E		Thermotx choroid vasc lesion					
00170	N		Anesth, procedure on mouth					
00172	N		Anesth, cleft palate repair					
00174	C		Anesth, pharyngeal surgery					
00176	C		Anesth, pharyngeal surgery					
0017T	E		Photocoagulat macular drusen					
0018T	S		Transcranial magnetic stimul	0215	0.5814	$30.32	$15.76	$6.06
00190	N		Anesth, face/skull bone surg					
00192	C		Anesth, facial bone surgery					
0019T	A		Extracorp shock wave tx, ms					
0020T	A		Extracorp shock wave tx, ft					
00210	N		Anesth, open head surgery					
00212	N		Anesth, skull drainage					
00214	C		Anesth, skull drainage					
00215	C		Anesth, skull repair/fract					
00216	N		Anesth, head vessel surgery					
00218	N		Anesth, special head surgery					
0021T	C		Fetal oximetry, trnsvag/cerv					
00220	N		Anesth, intrcrn nerve					
00222	N		Anesth, head nerve surgery					
0023T	A		Phenotype drug test, hiv 1					
0024T	C		Transcath cardiac reduction					
0025T	S		Ultrasonic pachymetry	0230	0.7364	$38.40	$14.97	$7.68
0026T	A		Measure remnant lipoproteins					
0027T	T	NI	Endoscopic epidural lysis	0976		$875.00		$175.00
0028T	N	NI	Dexa body composition study					
0029T	N	NI	Magnetic tx for incontinence					
00300	N		Anesth, head/neck/ptrunk					
0030T	A	NI	Antiprothrombin antibody					
0031T	N	NI	Speculoscopy					
00320	N		Anesth, neck organ surgery					
00322	N		Anesth, biopsy of thyroid					
00326	N	NI	Anesth, larynx/trach, < 1 yr					
0032T	N	NI	Speculoscopy w/direct sample					
0033T	C	NI	Endovasc taa repr incl subcl					
0034T	C	NI	Endovasc taa repr w/o subcl					
00350	N		Anesth, neck vessel surgery					
00352	N		Anesth, neck vessel surgery					
0035T	C	NI	Insert endovasc prosth, taa					
0036T	C	NI	Endovasc prosth, taa, add-on					
0037T	C	NI	Artery transpose/endovas taa					
0038T	C	NI	Rad endovasc taa rpr w/cover					
0039T	C	NI	Rad s/i, endovasc taa repair					
00400	N		Anesth, skin, ext/per/atrunk					
00402	N		Anesth, surgery of breast					
00404	C		Anesth, surgery of breast					
00406	C		Anesth, surgery of breast					
0040T	C	NI	Rad s/i, endovasc taa prosth					
00410	N		Anesth, correct heart rhythm					
0041T	A	NI	Detect ur infect agnt w/cpas					
0042T	N	NI	Ct perfusion w/contrast, cbf					
0043T	A	NI	Co expired gas analysis					
0044T	N	NI	Whole body photography					
00450	N		Anesth, surgery of shoulder					
00452	C		Anesth, surgery of shoulder					
00454	N		Anesth, collar bone biopsy					
00470	N		Anesth, removal of rib					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00472	N		Anesth, chest wall repair					
00474	C		Anesth, surgery of rib(s)					
00500	N		Anesth, esophageal surgery					
00520	N		Anesth, chest procedure					
00522	N		Anesth, chest lining biopsy					
00524	C		Anesth, chest drainage					
00528	N		Anesth, chest partition view					
00530	N		Anesth, pacemaker insertion					
00532	N		Anesth, vascular access					
00534	N		Anesth, cardioverter/defib					
00537	N		Anesth, cardiac electrophys					
00539	N	NI	Anesth, trach-bronch reconst					
00540	C		Anesth, chest surgery					
00541	N	NI	Anesth, one lung ventilation					
00542	C		Anesth, release of lung					
00544	C		Anesth, chest lining removal					
00546	C		Anesth, lung,chest wall surg					
00548	N		Anesth, trachea,bronchi surg					
00550	N		Anesth, sternal debridement					
00560	C		Anesth, open heart surgery					
00562	C		Anesth, open heart surgery					
00563	N		Anesth, heart proc w/pump					
00566	N		Anesth, cabg w/o pump					
00580	C		Anesth, heart/lung transplnt					
00600	N		Anesth, spine, cord surgery					
00604	C		Anesth, sitting procedure					
00620	N		Anesth, spine, cord surgery					
00622	C		Anesth, removal of nerves					
00630	N		Anesth, spine, cord surgery					
00632	C		Anesth, removal of nerves					
00634	C		Anesth for chemonucleolysis					
00635	N		Anesth, lumbar puncture					
00640	N	NI	Anesth, spine manipulation					
00670	C		Anesth, spine, cord surgery					
00700	N		Anesth, abdominal wall surg					
00702	N		Anesth, for liver biopsy					
00730	N		Anesth, abdominal wall surg					
00740	N		Anesth, upper gi visualize					
00750	N		Anesth, repair of hernia					
00752	N		Anesth, repair of hernia					
00754	N		Anesth, repair of hernia					
00756	N		Anesth, repair of hernia					
00770	N		Anesth, blood vessel repair					
00790	N		Anesth, surg upper abdomen					
00792	C		Anesth, hemorr/excise liver					
00794	C		Anesth, pancreas removal					
00796	C		Anesth, for liver transplant					
00797	N		Anesth, surgery for obesity					
00800	N		Anesth, abdominal wall surg					
00802	C		Anesth, fat layer removal					
00810	N		Anesth, low intestine scope					
00820	N		Anesth, abdominal wall surg					
00830	N		Anesth, repair of hernia					
00832	N		Anesth, repair of hernia					
00834	N	NI	Anesth, hernia repair< 1 yr					
00836	N	NI	Anesth hernia repair preemie					
00840	N		Anesth, surg lower abdomen					
00842	N		Anesth, amniocentesis					
00844	C		Anesth, pelvis surgery					
00846	C		Anesth, hysterectomy					
00848	C		Anesth, pelvic organ surg					
00851	N		Anesth, tubal ligation					
00860	N		Anesth, surgery of abdomen					
00862	N		Anesth, kidney/ureter surg					
00864	C		Anesth, removal of bladder					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00865	C		Anesth, removal of prostate					
00866	C		Anesth, removal of adrenal					
00868	C		Anesth, kidney transplant					
00869	N	DG	Anesth, vasectomy					
00870	N		Anesth, bladder stone surg					
00872	N		Anesth kidney stone destruct					
00873	N		Anesth kidney stone destruct					
00880	N		Anesth, abdomen vessel surg					
00882	C		Anesth, major vein ligation					
00902	N		Anesth, anorectal surgery					
00904	C		Anesth, perineal surgery					
00906	N		Anesth, removal of vulva					
00908	C		Anesth, removal of prostate					
00910	N		Anesth, bladder surgery					
00912	N		Anesth, bladder tumor surg					
00914	N		Anesth, removal of prostate					
00916	N		Anesth, bleeding control					
00918	N		Anesth, stone removal					
00920	N		Anesth, genitalia surgery					
00921	N	NI	Anesth, vasectomy					
00922	N		Anesth, sperm duct surgery					
00924	N		Anesth, testis exploration					
00926	N		Anesth, removal of testis					
00928	C		Anesth, removal of testis					
00930	N		Anesth, testis suspension					
00932	C		Anesth, amputation of penis					
00934	C		Anesth, penis, nodes removal					
00936	C		Anesth, penis, nodes removal					
00938	N		Anesth, insert penis device					
00940	N		Anesth, vaginal procedures					
00942	N		Anesth, surg on vag/urethral					
00944	C		Anesth, vaginal hysterectomy					
00948	N		Anesth, repair of cervix					
00950	N		Anesth, vaginal endoscopy					
00952	N		Anesth, hysteroscope/graph					
01112	N		Anesth, bone aspirate/bx					
01120	N		Anesth, pelvis surgery					
01130	N		Anesth, body cast procedure					
01140	C		Anesth, amputation at pelvis					
01150	C		Anesth, pelvic tumor surgery					
01160	N		Anesth, pelvis procedure					
01170	N		Anesth, pelvis surgery					
01180	N		Anesth, pelvis nerve removal					
01190	C		Anesth, pelvis nerve removal					
01200	N		Anesth, hip joint procedure					
01202	N		Anesth, arthroscopy of hip					
01210	N		Anesth, hip joint surgery					
01212	C		Anesth, hip disarticulation					
01214	C		Anesth, hip arthroplasty					
01215	N		Anesth, revise hip repair					
01220	N		Anesth, procedure on femur					
01230	N		Anesth, surgery of femur					
01232	C		Anesth, amputation of femur					
01234	C		Anesth, radical femur surg					
01250	N		Anesth, upper leg surgery					
01260	N		Anesth, upper leg veins surg					
01270	N		Anesth, thigh arteries surg					
01272	C		Anesth, femoral artery surg					
01274	C		Anesth, femoral embolectomy					
01320	N		Anesth, knee area surgery					
01340	N		Anesth, knee area procedure					
01360	N		Anesth, knee area surgery					
01380	N		Anesth, knee joint procedure					
01382	N		Anesth, knee arthroscopy					
01390	N		Anesth, knee area procedure					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01392	N		Anesth, knee area surgery					
01400	N		Anesth, knee joint surgery					
01402	C		Anesth, knee arthroplasty					
01404	C		Anesth, amputation at knee					
01420	N		Anesth, knee joint casting					
01430	N		Anesth, knee veins surgery					
01432	N		Anesth, knee vessel surg					
01440	N		Anesth, knee arteries surg					
01442	C		Anesth, knee artery surg					
01444	C		Anesth, knee artery repair					
01462	N		Anesth, lower leg procedure					
01464	N		Anesth, ankle arthroscopy					
01470	N		Anesth, lower leg surgery					
01472	N		Anesth, achilles tendon surg					
01474	N		Anesth, lower leg surgery					
01480	N		Anesth, lower leg bone surg					
01482	N		Anesth, radical leg surgery					
01484	N		Anesth, lower leg revision					
01486	C		Anesth, ankle replacement					
01490	N		Anesth, lower leg casting					
01500	N		Anesth, leg arteries surg					
01502	C		Anesth, lwr leg embolectomy					
01520	N		Anesth, lower leg vein surg					
01522	N		Anesth, lower leg vein surg					
01610	N		Anesth, surgery of shoulder					
01620	N		Anesth, shoulder procedure					
01622	N		Anesth, shoulder arthroscopy					
01630	N		Anesth, surgery of shoulder					
01632	C		Anesth, surgery of shoulder					
01634	C		Anesth, shoulder joint amput					
01636	C		Anesth, forequarter amput					
01638	C		Anesth, shoulder replacement					
01650	N		Anesth, shoulder artery surg					
01652	C		Anesth, shoulder vessel surg					
01654	C		Anesth, shoulder vessel surg					
01656	C		Anesth, arm-leg vessel surg					
01670	N		Anesth, shoulder vein surg					
01680	N		Anesth, shoulder casting					
01682	N		Anesth, airplane cast					
01710	N		Anesth, elbow area surgery					
01712	N		Anesth, uppr arm tendon surg					
01714	N		Anesth, uppr arm tendon surg					
01716	N		Anesth, biceps tendon repair					
01730	N		Anesth, uppr arm procedure					
01732	N		Anesth, elbow arthroscopy					
01740	N		Anesth, upper arm surgery					
01742	N		Anesth, humerus surgery					
01744	N		Anesth, humerus repair					
01756	C		Anesth, radical humerus surg					
01758	N		Anesth, humeral lesion surg					
01760	N		Anesth, elbow replacement					
01770	N		Anesth, uppr arm artery surg					
01772	N		Anesth, uppr arm embolectomy					
01780	N		Anesth, upper arm vein surg					
01782	N		Anesth, uppr arm vein repair					
01810	N		Anesth, lower arm surgery					
01820	N		Anesth, lower arm procedure					
01829	N	NI	Anesth, dx wrist arthroscopy					
01830	N		Anesth, lower arm surgery					
01832	N		Anesth, wrist replacement					
01840	N		Anesth, lwr arm artery surg					
01842	N		Anesth, lwr arm embolectomy					
01844	N		Anesth, vascular shunt surg					
01850	N		Anesth, lower arm vein surg					
01852	N		Anesth, lwr arm vein repair					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01860	N		Anesth, lower arm casting					
01905	N		Anes, spine inject, x-ray/re					
01916	N		Anesth, dx arteriography					
01920	N		Anesth, catheterize heart					
01922	N		Anesth, cat or MRI scan					
01924	N		Anes, ther interven rad, art					
01925	N		Anes, ther interven rad, car					
01926	N		Anes, tx interv rad hrt/cran					
01930	N		Anes, ther interven rad, vei					
01931	N		Anes, ther interven rad, tip					
01932	N		Anes, tx interv rad, th vein					
01933	N		Anes, tx interv rad, cran v					
01951	N		Anesth, burn, less 4 percent					
01952	N		Anesth, burn, 4-9 percent					
01953	N		Anesth, burn, each 9 percent					
01960	N		Anesth, vaginal delivery					
01961	N		Anesth, cs delivery					
01962	N		Anesth, emer hysterectomy					
01963	N		Anesth, cs hysterectomy					
01964	N		Anesth, abortion procedures					
01967	N		Anesth/analg, vag delivery					
01968	N		Anes/analg cs deliver add-on					
01969	N		Anesth/analg cs hyst add-on					
01990	C		Support for organ donor					
01991	N	NI	Anesth, nerve block/inj					
01992	N	NI	Anesth, n block/inj, prone					
01995	N		Regional anesthesia limb					
01996	N		Manage daily drug therapy					
01999	N		Unlisted anesth procedure					
10021	T		Fna w/o image	0002	0.5911	$30.83		$6.17
10022	T		Fna w/image	0002	0.5911	$30.83		$6.17
10040	T		Acne surgery	0010	0.6589	$34.36	$10.08	$6.87
10060	T		Drainage of skin abscess	0006	1.7926	$93.49	$24.12	$18.70
10061	T		Drainage of skin abscess	0006	1.7926	$93.49	$24.12	$18.70
10080	T		Drainage of pilonidal cyst	0006	1.7926	$93.49	$24.12	$18.70
10081	T		Drainage of pilonidal cyst	0007	10.0191	$522.51	$108.89	$104.50
10120	T		Remove foreign body	0006	1.7926	$93.49	$24.12	$18.70
10121	T		Remove foreign body	0021	13.9338	$726.66	$219.48	$145.33
10140	T		Drainage of hematoma/fluid	0007	10.0191	$522.51	$108.89	$104.50
10160	T		Puncture drainage of lesion	0018	0.9399	$49.02	$16.04	$9.80
10180	T		Complex drainage, wound	0007	10.0191	$522.51	$108.89	$104.50
11000	T		Debride infected skin	0015	1.5407	$80.35	$20.35	$16.07
11001	T		Debride infected skin add-on	0013	1.0756	$56.09	$14.20	$11.22
11010	T		Debride skin, fx	0022	17.3930	$907.06	$354.45	$181.41
11011	T		Debride skin/muscle, fx	0022	17.3930	$907.06	$354.45	$181.41
11012	T		Debride skin/muscle/bone, fx	0022	17.3930	$907.06	$354.45	$181.41
11040	T		Debride skin, partial	0015	1.5407	$80.35	$20.35	$16.07
11041	T		Debride skin, full	0015	1.5407	$80.35	$20.35	$16.07
11042	T		Debride skin/tissue	0016	2.6162	$136.44	$57.31	$27.29
11043	T		Debride tissue/muscle	0016	2.6162	$136.44	$57.31	$27.29
11044	T		Debride tissue/muscle/bone	0682	7.2770	$379.50	$174.57	$75.90
11055	T		Trim skin lesion	0012	0.7849	$40.93	$11.18	$8.19
11056	T		Trim skin lesions, 2 to 4	0012	0.7849	$40.93	$11.18	$8.19
11057	T		Trim skin lesions, over 4	0012	0.7849	$40.93	$11.18	$8.19
11100	T		Biopsy of skin lesion	0018	0.9399	$49.02	$16.04	$9.80
11101	T		Biopsy, skin add-on	0018	0.9399	$49.02	$16.04	$9.80
11200	T		Removal of skin tags	0013	1.0756	$56.09	$14.20	$11.22
11201	T		Remove skin tags add-on	0015	1.5407	$80.35	$20.35	$16.07
11300	T		Shave skin lesion	0012	0.7849	$40.93	$11.18	$8.19
11301	T		Shave skin lesion	0012	0.7849	$40.93	$11.18	$8.19
11302	T		Shave skin lesion	0013	1.0756	$56.09	$14.20	$11.22
11303	T		Shave skin lesion	0015	1.5407	$80.35	$20.35	$16.07
11305	T		Shave skin lesion	0013	1.0756	$56.09	$14.20	$11.22
11306	T		Shave skin lesion	0013	1.0756	$56.09	$14.20	$11.22
11307	T		Shave skin lesion	0013	1.0756	$56.09	$14.20	$11.22

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11308	T		Shave skin lesion	0013	1.0756	$56.09	$14.20	$11.22
11310	T		Shave skin lesion	0013	1.0756	$56.09	$14.20	$11.22
11311	T		Shave skin lesion	0013	1.0756	$56.09	$14.20	$11.22
11312	T		Shave skin lesion	0013	1.0756	$56.09	$14.20	$11.22
11313	T		Shave skin lesion	0016	2.6162	$136.44	$57.31	$27.29
11400	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11401	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11402	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11403	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11404	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11406	T		Removal of skin lesion	0021	13.9338	$726.66	$219.48	$145.33
11420	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11421	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11422	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11423	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11424	T		Removal of skin lesion	0021	13.9338	$726.66	$219.48	$145.33
11426	T		Removal of skin lesion	0022	17.3930	$907.06	$354.45	$181.41
11440	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11441	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11442	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11443	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11444	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11446	T		Removal of skin lesion	0022	17.3930	$907.06	$354.45	$181.41
11450	T		Removal, sweat gland lesion	0022	17.3930	$907.06	$354.45	$181.41
11451	T		Removal, sweat gland lesion	0022	17.3930	$907.06	$354.45	$181.41
11462	T		Removal, sweat gland lesion	0022	17.3930	$907.06	$354.45	$181.41
11463	T		Removal, sweat gland lesion	0022	17.3930	$907.06	$354.45	$181.41
11470	T		Removal, sweat gland lesion	0022	17.3930	$907.06	$354.45	$181.41
11471	T		Removal, sweat gland lesion	0022	17.3930	$907.06	$354.45	$181.41
11600	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11601	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11602	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11603	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11604	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11606	T		Removal of skin lesion	0021	13.9338	$726.66	$219.48	$145.33
11620	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11621	T		Removal of skin lesion	0019	3.7693	$196.57	$71.87	$39.31
11622	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11623	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11624	T		Removal of skin lesion	0021	13.9338	$726.66	$219.48	$145.33
11626	T		Removal of skin lesion	0022	17.3930	$907.06	$354.45	$181.41
11640	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11641	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11642	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11643	T		Removal of skin lesion	0020	7.1898	$374.96	$113.25	$74.99
11644	T		Removal of skin lesion	0021	13.9338	$726.66	$219.48	$145.33
11646	T		Removal of skin lesion	0022	17.3930	$907.06	$354.45	$181.41
11719	T		Trim nail(s)	0009	0.6298	$32.84	$8.34	$6.57
11720	T		Debride nail, 1-5	0009	0.6298	$32.84	$8.34	$6.57
11721	T		Debride nail, 6 or more	0009	0.6298	$32.84	$8.34	$6.57
11730	T		Removal of nail plate	0013	1.0756	$56.09	$14.20	$11.22
11732	T		Remove nail plate, add-on	0012	0.7849	$40.93	$11.18	$8.19
11740	T		Drain blood from under nail	0009	0.6298	$32.84	$8.34	$6.57
11750	T		Removal of nail bed	0019	3.7693	$196.57	$71.87	$39.31
11752	T		Remove nail bed/finger tip	0022	17.3930	$907.06	$354.45	$181.41
11755	T		Biopsy, nail unit	0019	3.7693	$196.57	$71.87	$39.31
11760	T		Repair of nail bed	0024	1.8507	$96.52	$34.75	$19.30
11762	T		Reconstruction of nail bed	0024	1.8507	$96.52	$34.75	$19.30
11765	T		Excision of nail fold, toe	0015	1.5407	$80.35	$20.35	$16.07
11770	T		Removal of pilonidal lesion	0022	17.3930	$907.06	$354.45	$181.41
11771	T		Removal of pilonidal lesion	0022	17.3930	$907.06	$354.45	$181.41
11772	T		Removal of pilonidal lesion	0022	17.3930	$907.06	$354.45	$181.41
11900	T		Injection into skin lesions	0012	0.7849	$40.93	$11.18	$8.19
11901	T		Added skin lesions injection	0012	0.7849	$40.93	$11.18	$8.19
11920	T		Correct skin color defects	0024	1.8507	$96.52	$34.75	$19.30

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11921	T		Correct skin color defects	0024	1.8507	$96.52	$34.75	$19.30
11922	T		Correct skin color defects	0024	1.8507	$96.52	$34.75	$19.30
11950	T		Therapy for contour defects	0024	1.8507	$96.52	$34.75	$19.30
11951	T		Therapy for contour defects	0024	1.8507	$96.52	$34.75	$19.30
11952	T		Therapy for contour defects	0024	1.8507	$96.52	$34.75	$19.30
11954	T		Therapy for contour defects	0024	1.8507	$96.52	$34.75	$19.30
11960	T		Insert tissue expander(s)	0027	15.2225	$793.87	$329.72	$158.77
11970	T		Replace tissue expander	0027	15.2225	$793.87	$329.72	$158.77
11971	T		Remove tissue expander(s)	0022	17.3930	$907.06	$354.45	$181.41
11975	E		Insert contraceptive cap					
11976	T		Removal of contraceptive cap	0019	3.7693	$196.57	$71.87	$39.31
11977	E		Removal/reinsert contra cap					
11980	X		Implant hormone pellet(s)	0340	0.6492	$33.86		$6.77
11981	X		Insert drug implant device	0340	0.6492	$33.86		$6.77
11982	X		Remove drug implant device	0340	0.6492	$33.86		$6.77
11983	X		Remove/insert drug implant	0340	0.6492	$33.86		$6.77
12001	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12002	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12004	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12005	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12006	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12007	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12011	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12013	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12014	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12015	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12016	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12017	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12018	T		Repair superficial wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12020	T		Closure of split wound	0024	1.8507	$96.52	$34.75	$19.30
12021	T		Closure of split wound	0024	1.8507	$96.52	$34.75	$19.30
12031	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12032	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12034	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12035	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12036	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12037	T		Layer closure of wound(s)	0025	5.8623	$305.72	$115.49	$61.14
12041	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12042	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12044	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12045	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12046	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12047	T		Layer closure of wound(s)	0025	5.8623	$305.72	$115.49	$61.14
12051	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12052	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12053	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12054	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12055	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12056	T		Layer closure of wound(s)	0024	1.8507	$96.52	$34.75	$19.30
12057	T		Layer closure of wound(s)	0025	5.8623	$305.72	$115.49	$61.14
13100	T		Repair of wound or lesion	0025	5.8623	$305.72	$115.49	$61.14
13101	T		Repair of wound or lesion	0025	5.8623	$305.72	$115.49	$61.14
13102	T		Repair wound/lesion add-on	0024	1.8507	$96.52	$34.75	$19.30
13120	T		Repair of wound or lesion	0024	1.8507	$96.52	$34.75	$19.30
13121	T		Repair of wound or lesion	0024	1.8507	$96.52	$34.75	$19.30
13122	T		Repair wound/lesion add-on	0024	1.8507	$96.52	$34.75	$19.30
13131	T		Repair of wound or lesion	0024	1.8507	$96.52	$34.75	$19.30
13132	T		Repair of wound or lesion	0024	1.8507	$96.52	$34.75	$19.30
13133	T		Repair wound/lesion add-on	0024	1.8507	$96.52	$34.75	$19.30
13150	T		Repair of wound or lesion	0025	5.8623	$305.72	$115.49	$61.14
13151	T		Repair of wound or lesion	0024	1.8507	$96.52	$34.75	$19.30
13152	T		Repair of wound or lesion	0025	5.8623	$305.72	$115.49	$61.14
13153	T		Repair wound/lesion add-on	0024	1.8507	$96.52	$34.75	$19.30
13160	T		Late closure of wound	0027	15.2225	$793.87	$329.72	$158.77
14000	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
14001	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
14020	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
14021	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
14040	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
14041	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
14060	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
14061	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
14300	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
14350	T		Skin tissue rearrangement	0027	15.2225	$793.87	$329.72	$158.77
15000	T		Skin graft	0025	5.8623	$305.72	$115.49	$61.14
15001	T		Skin graft add-on	0025	5.8623	$305.72	$115.49	$61.14
15050	T		Skin pinch graft	0025	5.8623	$305.72	$115.49	$61.14
15100	T		Skin split graft	0027	15.2225	$793.87	$329.72	$158.77
15101	T		Skin split graft add-on	0027	15.2225	$793.87	$329.72	$158.77
15120	T		Skin split graft	0027	15.2225	$793.87	$329.72	$158.77
15121	T		Skin split graft add-on	0027	15.2225	$793.87	$329.72	$158.77
15200	T		Skin full graft	0027	15.2225	$793.87	$329.72	$158.77
15201	T		Skin full graft add-on	0025	5.8623	$305.72	$115.49	$61.14
15220	T		Skin full graft	0027	15.2225	$793.87	$329.72	$158.77
15221	T		Skin full graft add-on	0025	5.8623	$305.72	$115.49	$61.14
15240	T		Skin full graft	0027	15.2225	$793.87	$329.72	$158.77
15241	T		Skin full graft add-on	0025	5.8623	$305.72	$115.49	$61.14
15260	T		Skin full graft	0027	15.2225	$793.87	$329.72	$158.77
15261	T		Skin full graft add-on	0025	5.8623	$305.72	$115.49	$61.14
15342	T		Cultured skin graft, 25 cm	0025	5.8623	$305.72	$115.49	$61.14
15343	T		Culture skn graft addl 25 cm	0024	1.8507	$96.52	$34.75	$19.30
15350	T		Skin homograft	0686	14.2439	$742.83	$341.70	$148.57
15351	T		Skin homograft add-on	0027	15.2225	$793.87	$329.72	$158.77
15400	T		Skin heterograft	0025	5.8623	$305.72	$115.49	$61.14
15401	T		Skin heterograft add-on	0025	5.8623	$305.72	$115.49	$61.14
15570	T		Form skin pedicle flap	0027	15.2225	$793.87	$329.72	$158.77
15572	T		Form skin pedicle flap	0027	15.2225	$793.87	$329.72	$158.77
15574	T		Form skin pedicle flap	0027	15.2225	$793.87	$329.72	$158.77
15576	T		Form skin pedicle flap	0027	15.2225	$793.87	$329.72	$158.77
15600	T		Skin graft	0027	15.2225	$793.87	$329.72	$158.77
15610	T		Skin graft	0027	15.2225	$793.87	$329.72	$158.77
15620	T		Skin graft	0027	15.2225	$793.87	$329.72	$158.77
15630	T		Skin graft	0027	15.2225	$793.87	$329.72	$158.77
15650	T		Transfer skin pedicle flap	0027	15.2225	$793.87	$329.72	$158.77
15732	T		Muscle-skin graft, head/neck	0027	15.2225	$793.87	$329.72	$158.77
15734	T		Muscle-skin graft, trunk	0027	15.2225	$793.87	$329.72	$158.77
15736	T		Muscle-skin graft, arm	0027	15.2225	$793.87	$329.72	$158.77
15738	T		Muscle-skin graft, leg	0027	15.2225	$793.87	$329.72	$158.77
15740	T		Island pedicle flap graft	0027	15.2225	$793.87	$329.72	$158.77
15750	T		Neurovascular pedicle graft	0027	15.2225	$793.87	$329.72	$158.77
15756	C		Free muscle flap, microvasc					
15757	C		Free skin flap, microvasc					
15758	C		Free fascial flap, microvasc					
15760	T		Composite skin graft	0027	15.2225	$793.87	$329.72	$158.77
15770	T		Derma-fat-fascia graft	0027	15.2225	$793.87	$329.72	$158.77
15775	T		Hair transplant punch grafts	0025	5.8623	$305.72	$115.49	$61.14
15776	T		Hair transplant punch grafts	0025	5.8623	$305.72	$115.49	$61.14
15780	T		Abrasion treatment of skin	0022	17.3930	$907.06	$354.45	$181.41
15781	T		Abrasion treatment of skin	0022	17.3930	$907.06	$354.45	$181.41
15782	T		Abrasion treatment of skin	0022	17.3930	$907.06	$354.45	$181.41
15783	T		Abrasion treatment of skin	0016	2.6162	$136.44	$57.31	$27.29
15786	T		Abrasion, lesion, single	0013	1.0756	$56.09	$14.20	$11.22
15787	T		Abrasion, lesions, add-on	0013	1.0756	$56.09	$14.20	$11.22
15788	T		Chemical peel, face, epiderm	0012	0.7849	$40.93	$11.18	$8.19
15789	T		Chemical peel, face, dermal	0015	1.5407	$80.35	$20.35	$16.07
15792	T		Chemical peel, nonfacial	0012	0.7849	$40.93	$11.18	$8.19
15793	T		Chemical peel, nonfacial	0013	1.0756	$56.09	$14.20	$11.22
15810	T		Salabrasion	0016	2.6162	$136.44	$57.31	$27.29
15811	T		Salabrasion	0016	2.6162	$136.44	$57.31	$27.29
15819	T		Plastic surgery, neck	0025	5.8623	$305.72	$115.49	$61.14

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15820	T		Revision of lower eyelid	0027	15.2225	$793.87	$329.72	$158.77
15821	T		Revision of lower eyelid	0027	15.2225	$793.87	$329.72	$158.77
15822	T		Revision of upper eyelid	0027	15.2225	$793.87	$329.72	$158.77
15823	T		Revision of upper eyelid	0027	15.2225	$793.87	$329.72	$158.77
15824	T		Removal of forehead wrinkles	0027	15.2225	$793.87	$329.72	$158.77
15825	T		Removal of neck wrinkles	0027	15.2225	$793.87	$329.72	$158.77
15826	T		Removal of brow wrinkles	0027	15.2225	$793.87	$329.72	$158.77
15828	T		Removal of face wrinkles	0027	15.2225	$793.87	$329.72	$158.77
15829	T		Removal of skin wrinkles	0027	15.2225	$793.87	$329.72	$158.77
15831	T		Excise excessive skin tissue	0022	17.3930	$907.06	$354.45	$181.41
15832	T		Excise excessive skin tissue	0022	17.3930	$907.06	$354.45	$181.41
15833	T		Excise excessive skin tissue	0022	17.3930	$907.06	$354.45	$181.41
15834	T		Excise excessive skin tissue	0022	17.3930	$907.06	$354.45	$181.41
15835	T		Excise excessive skin tissue	0025	5.8623	$305.72	$115.49	$61.14
15836	T		Excise excessive skin tissue	0020	7.1898	$374.96	$113.25	$74.99
15837	T		Excise excessive skin tissue	0020	7.1898	$374.96	$113.25	$74.99
15838	T		Excise excessive skin tissue	0020	7.1898	$374.96	$113.25	$74.99
15839	T		Excise excessive skin tissue	0020	7.1898	$374.96	$113.25	$74.99
15840	T		Graft for face nerve palsy	0027	15.2225	$793.87	$329.72	$158.77
15841	T		Graft for face nerve palsy	0027	15.2225	$793.87	$329.72	$158.77
15842	T		Flap for face nerve palsy	0027	15.2225	$793.87	$329.72	$158.77
15845	T		Skin and muscle repair, face	0027	15.2225	$793.87	$329.72	$158.77
15850	T		Removal of sutures	0016	2.6162	$136.44	$57.31	$27.29
15851	T		Removal of sutures	0013	1.0756	$56.09	$14.20	$11.22
15852	X		Dressing change,not for burn	0340	0.6492	$33.86		$6.77
15860	S		Test for blood flow in graft	0706		$25.00		$5.00
15876	T		Suction assisted lipectomy	0027	15.2225	$793.87	$329.72	$158.77
15877	T		Suction assisted lipectomy	0027	15.2225	$793.87	$329.72	$158.77
15878	T		Suction assisted lipectomy	0027	15.2225	$793.87	$329.72	$158.77
15879	T		Suction assisted lipectomy	0027	15.2225	$793.87	$329.72	$158.77
15920	T		Removal of tail bone ulcer	0022	17.3930	$907.06	$354.45	$181.41
15922	T		Removal of tail bone ulcer	0027	15.2225	$793.87	$329.72	$158.77
15931	T		Remove sacrum pressure sore	0022	17.3930	$907.06	$354.45	$181.41
15933	T		Remove sacrum pressure sore	0022	17.3930	$907.06	$354.45	$181.41
15934	T		Remove sacrum pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15935	T		Remove sacrum pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15936	T		Remove sacrum pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15937	T		Remove sacrum pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15940	T		Remove hip pressure sore	0022	17.3930	$907.06	$354.45	$181.41
15941	T		Remove hip pressure sore	0022	17.3930	$907.06	$354.45	$181.41
15944	T		Remove hip pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15945	T		Remove hip pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15946	T		Remove hip pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15950	T		Remove thigh pressure sore	0022	17.3930	$907.06	$354.45	$181.41
15951	T		Remove thigh pressure sore	0022	17.3930	$907.06	$354.45	$181.41
15952	T		Remove thigh pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15953	T		Remove thigh pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15956	T		Remove thigh pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15958	T		Remove thigh pressure sore	0027	15.2225	$793.87	$329.72	$158.77
15999	T		Removal of pressure sore	0022	17.3930	$907.06	$354.45	$181.41
16000	T		Initial treatment of burn(s)	0013	1.0756	$56.09	$14.20	$11.22
16010	T		Treatment of burn(s)	0016	2.6162	$136.44	$57.31	$27.29
16015	T		Treatment of burn(s)	0017	15.8233	$825.20	$227.84	$165.04
16020	T		Treatment of burn(s)	0013	1.0756	$56.09	$14.20	$11.22
16025	T		Treatment of burn(s)	0013	1.0756	$56.09	$14.20	$11.22
16030	T		Treatment of burn(s)	0015	1.5407	$80.35	$20.35	$16.07
16035	C		Incision of burn scab, initi					
16036	C		Incise burn scab, addl incis					
17000	T		Destroy benign/premlg lesion	0010	0.6589	$34.36	$10.08	$6.87
17003	T		Destroy lesions, 2-14	0010	0.6589	$34.36	$10.08	$6.87
17004	T		Destroy lesions, 15 or more	0011	1.8507	$96.52	$27.88	$19.30
17106	T		Destruction of skin lesions	0011	1.8507	$96.52	$27.88	$19.30
17107	T		Destruction of skin lesions	0011	1.8507	$96.52	$27.88	$19.30
17108	T		Destruction of skin lesions	0011	1.8507	$96.52	$27.88	$19.30
17110	T		Destruct lesion, 1-14	0010	0.6589	$34.36	$10.08	$6.87

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
17111	T		Destruct lesion, 15 or more	0011	1.8507	$96.52	$27.88	$19.30
17250	T		Chemical cautery, tissue	0013	1.0756	$56.09	$14.20	$11.22
17260	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17261	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17262	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17263	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17264	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17266	T		Destruction of skin lesions	0016	2.6162	$136.44	$57.31	$27.29
17270	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17271	T		Destruction of skin lesions	0013	1.0756	$56.09	$14.20	$11.22
17272	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17273	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17274	T		Destruction of skin lesions	0016	2.6162	$136.44	$57.31	$27.29
17276	T		Destruction of skin lesions	0016	2.6162	$136.44	$57.31	$27.29
17280	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17281	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17282	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17283	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17284	T		Destruction of skin lesions	0016	2.6162	$136.44	$57.31	$27.29
17286	T		Destruction of skin lesions	0015	1.5407	$80.35	$20.35	$16.07
17304	T		Chemosurgery of skin lesion	0694	3.4689	$180.91	$72.36	$36.18
17305	T		2 stage mohs, up to 5 spec	0694	3.4689	$180.91	$72.36	$36.18
17306	T		3 stage mohs, up to 5 spec	0694	3.4689	$180.91	$72.36	$36.18
17307	T		Mohs addl stage up to 5 spec	0694	3.4689	$180.91	$72.36	$36.18
17310	T		Extensive skin chemosurgery	0694	3.4689	$180.91	$72.36	$36.18
17340	T		Cryotherapy of skin	0012	0.7849	$40.93	$11.18	$8.19
17360	T		Skin peel therapy	0012	0.7849	$40.93	$11.18	$8.19
17380	T		Hair removal by electrolysis	0012	0.7849	$40.93	$11.18	$8.19
17999	T		Skin tissue procedure	0006	1.7926	$93.49	$24.12	$18.70
19000	T		Drainage of breast lesion	0004	1.7441	$90.96	$23.47	$18.19
19001	T		Drain breast lesion add-on	0004	1.7441	$90.96	$23.47	$18.19
19020	T		Incision of breast lesion	0008	16.1430	$841.87		$168.37
19030	N		Injection for breast x-ray					
19100	T		Bx breast percut w/o image	0005	3.1201	$162.72	$71.59	$32.54
19101	T		Biopsy of breast, open	0028	16.8698	$879.78	$303.74	$175.96
19102	T		Bx breast percut w/image	0005	3.1201	$162.72	$71.59	$32.54
19103	T		Bx breast percut w/device	0658	5.2712	$274.90		$54.98
19110	T		Nipple exploration	0028	16.8698	$879.78	$303.74	$175.96
19112	T		Excise breast duct fistula	0028	16.8698	$879.78	$303.74	$175.96
19120	T		Removal of breast lesion	0028	16.8698	$879.78	$303.74	$175.96
19125	T		Excision, breast lesion	0028	16.8698	$879.78	$303.74	$175.96
19126	T		Excision, addl breast lesion	0028	16.8698	$879.78	$303.74	$175.96
19140	T		Removal of breast tissue	0028	16.8698	$879.78	$303.74	$175.96
19160	T		Removal of breast tissue	0028	16.8698	$879.78	$303.74	$175.96
19162	T		Remove breast tissue, nodes	0693	37.5863	$1,960.16	$798.17	$392.03
19180	T		Removal of breast	0029	28.7881	$1,501.33	$632.64	$300.27
19182	T		Removal of breast	0029	28.7881	$1,501.33	$632.64	$300.27
19200	C		Removal of breast					
19220	C		Removal of breast					
19240	T		Removal of breast	0030	37.5185	$1,956.63	$763.55	$391.33
19260	T		Removal of chest wall lesion	0021	13.9338	$726.66	$219.48	$145.33
19271	C		Revision of chest wall					
19272	C		Extensive chest wall surgery					
19290	N		Place needle wire, breast					
19291	N		Place needle wire, breast					
19295	S		Place breast clip, percut	0657	1.4438	$75.30		$15.06
19316	T		Suspension of breast	0029	28.7881	$1,501.33	$632.64	$300.27
19318	T		Reduction of large breast	0693	37.5863	$1,960.16	$798.17	$392.03
19324	T		Enlarge breast	0693	37.5863	$1,960.16	$798.17	$392.03
19325	T		Enlarge breast with implant	0648	44.7955	$2,336.13		$467.23
19328	T		Removal of breast implant	0029	28.7881	$1,501.33	$632.64	$300.27
19330	T		Removal of implant material	0029	28.7881	$1,501.33	$632.64	$300.27
19340	T		Immediate breast prosthesis	0030	37.5185	$1,956.63	$763.55	$391.33
19342	T		Delayed breast prosthesis	0648	44.7955	$2,336.13		$467.23
19350	T		Breast reconstruction	0029	28.7881	$1,501.33	$632.64	$300.27

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
19355	T		Correct inverted nipple(s)	0029	28.7881	$1,501.33	$632.64	$300.27
19357	T		Breast reconstruction	0648	44.7955	$2,336.13		$467.23
19361	C		Breast reconstruction					
19364	C		Breast reconstruction					
19366	T		Breast reconstruction	0029	28.7881	$1,501.33	$632.64	$300.27
19367	C		Breast reconstruction					
19368	C		Breast reconstruction					
19369	C		Breast reconstruction					
19370	T		Surgery of breast capsule	0029	28.7881	$1,501.33	$632.64	$300.27
19371	T		Removal of breast capsule	0029	28.7881	$1,501.33	$632.64	$300.27
19380	T		Revise breast reconstruction	0030	37.5185	$1,956.63	$763.55	$391.33
19396	T		Design custom breast implant	0029	28.7881	$1,501.33	$632.64	$300.27
19499	T		Breast surgery procedure	0028	16.8698	$879.78	$303.74	$175.96
20000	T		Incision of abscess	0006	1.7926	$93.49	$24.12	$18.70
20005	T		Incision of deep abscess	0049	18.6042	$970.23	$197.14	$194.05
20100	T		Explore wound, neck	0023	2.5193	$131.38	$40.37	$26.28
20101	T		Explore wound, chest	0027	15.2225	$793.87	$329.72	$158.77
20102	T		Explore wound, abdomen	0027	15.2225	$793.87	$329.72	$158.77
20103	T		Explore wound, extremity	0023	2.5193	$131.38	$40.37	$26.28
20150	T		Excise epiphyseal bar	0051	32.9062	$1,716.09		$343.22
20200	T		Muscle biopsy	0021	13.9338	$726.66	$219.48	$145.33
20205	T		Deep muscle biopsy	0021	13.9338	$726.66	$219.48	$145.33
20206	T		Needle biopsy, muscle	0005	3.1201	$162.72	$71.59	$32.54
20220	T		Bone biopsy, trocar/needle	0019	3.7693	$196.57	$71.87	$39.31
20225	T		Bone biopsy, trocar/needle	0019	3.7693	$196.57	$71.87	$39.31
20240	T		Bone biopsy, excisional	0022	17.3930	$907.06	$354.45	$181.41
20245	T		Bone biopsy, excisional	0022	17.3930	$907.06	$354.45	$181.41
20250	T		Open bone biopsy	0049	18.6042	$970.23	$197.14	$194.05
20251	T		Open bone biopsy	0049	18.6042	$970.23	$197.14	$194.05
20500	T		Injection of sinus tract	0251	1.9089	$99.55		$19.91
20501	N		Inject sinus tract for x-ray					
20520	T		Removal of foreign body	0019	3.7693	$196.57	$71.87	$39.31
20525	T		Removal of foreign body	0022	17.3930	$907.06	$354.45	$181.41
20526	T		Ther injection, carp tunnel	0204	2.0251	$105.61	$40.13	$21.12
20550	T		Inject tendon/ligament/cyst	0204	2.0251	$105.61	$40.13	$21.12
20551	T		Inject tendon origin/insert	0204	2.0251	$105.61	$40.13	$21.12
20552	T		Inject trigger point, 1 or 2	0204	2.0251	$105.61	$40.13	$21.12
20553	T		Inject trigger points, > 3	0204	2.0251	$105.61	$40.13	$21.12
20600	T		Drain/inject, joint/bursa	0204	2.0251	$105.61	$40.13	$21.12
20605	T		Drain/inject, joint/bursa	0204	2.0251	$105.61	$40.13	$21.12
20610	T		Drain/inject, joint/bursa	0204	2.0251	$105.61	$40.13	$21.12
20612	T	NI	Aspirate/inj ganglion cyst	0204	2.0251	$105.61	$40.13	$21.12
20615	T		Treatment of bone cyst	0004	1.7441	$90.96	$23.47	$18.19
20650	T		Insert and remove bone pin	0049	18.6042	$970.23	$197.14	$194.05
20660	C		Apply, rem fixation device					
20661	C		Application of head brace					
20662	C		Application of pelvis brace					
20663	C		Application of thigh brace					
20664	C		Halo brace application					
20665	X		Removal of fixation device	0340	0.6492	$33.86		$6.77
20670	T		Removal of support implant	0021	13.9338	$726.66	$219.48	$145.33
20680	T		Removal of support implant	0022	17.3930	$907.06	$354.45	$181.41
20690	T		Apply bone fixation device	0050	23.3037	$1,215.31		$243.06
20692	T		Apply bone fixation device	0050	23.3037	$1,215.31		$243.06
20693	T		Adjust bone fixation device	0049	18.6042	$970.23	$197.14	$194.05
20694	T		Remove bone fixation device	0049	18.6042	$970.23	$197.14	$194.05
20802	C		Replantation, arm, complete					
20805	C		Replant forearm, complete					
20808	C		Replantation hand, complete					
20816	C		Replantation digit, complete					
20822	C		Replantation digit, complete					
20824	C		Replantation thumb, complete					
20827	C		Replantation thumb, complete					
20838	C		Replantation foot, complete					
20900	T		Removal of bone for graft	0050	23.3037	$1,215.31		$243.06

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
20902	T		Removal of bone for graft	0050	23.3037	$1,215.31		$243.06
20910	T		Remove cartilage for graft	0027	15.2225	$793.87	$329.72	$158.77
20912	T		Remove cartilage for graft	0027	15.2225	$793.87	$329.72	$158.77
20920	T		Removal of fascia for graft	0027	15.2225	$793.87	$329.72	$158.77
20922	T		Removal of fascia for graft	0027	15.2225	$793.87	$329.72	$158.77
20924	T		Removal of tendon for graft	0050	23.3037	$1,215.31		$243.06
20926	T		Removal of tissue for graft	0027	15.2225	$793.87	$329.72	$158.77
20930	C		Spinal bone allograft					
20931	C		Spinal bone allograft					
20936	C		Spinal bone autograft					
20937	C		Spinal bone autograft					
20938	C		Spinal bone autograft					
20950	T		Fluid pressure, muscle	0006	1.7926	$93.49	$24.12	$18.70
20955	C		Fibula bone graft, microvasc					
20956	C		Iliac bone graft, microvasc					
20957	C		Mt bone graft, microvasc					
20962	C		Other bone graft, microvasc					
20969	C		Bone/skin graft, microvasc					
20970	C		Bone/skin graft, iliac crest					
20972	C		Bone/skin graft, metatarsal					
20973	C		Bone/skin graft, great toe					
20974	A		Electrical bone stimulation					
20975	T		Electrical bone stimulation	0049	18.6042	$970.23	$197.14	$194.05
20979	A		Us bone stimulation					
20999	T		Musculoskeletal surgery	0049	18.6042	$970.23	$197.14	$194.05
21010	T		Incision of jaw joint	0254	20.1158	$1,049.06	$321.35	$209.81
21015	T		Resection of facial tumor	0253	14.4473	$753.44	$282.29	$150.69
21025	T		Excision of bone, lower jaw	0256	34.0302	$1,774.71		$354.94
21026	T		Excision of facial bone(s)	0256	34.0302	$1,774.71		$354.94
21029	T		Contour of face bone lesion	0256	34.0302	$1,774.71		$354.94
21030	T		Removal of face bone lesion	0254	20.1158	$1,049.06	$321.35	$209.81
21031	T		Remove exostosis, mandible	0254	20.1158	$1,049.06	$321.35	$209.81
21032	T		Remove exostosis, maxilla	0254	20.1158	$1,049.06	$321.35	$209.81
21034	T		Removal of face bone lesion	0256	34.0302	$1,774.71		$354.94
21040	T		Removal of jaw bone lesion	0254	20.1158	$1,049.06	$321.35	$209.81
21041	T	DG	Removal of jaw bone lesion	0256	34.0302	$1,774.71		$354.94
21044	T		Removal of jaw bone lesion	0256	34.0302	$1,774.71		$354.94
21045	C		Extensive jaw surgery					
21046	T	NI	Remove mandible cyst complex	0256	34.0302	$1,774.71		$354.94
21047	T	NI	Excise lwr jaw cyst w/repair	0256	34.0302	$1,774.71		$354.94
21048	T	NI	Remove maxilla cyst complex	0256	34.0302	$1,774.71		$354.94
21049	T	NI	Excis uppr jaw cyst w/repair	0256	34.0302	$1,774.71		$354.94
21050	T		Removal of jaw joint	0256	34.0302	$1,774.71		$354.94
21060	T		Remove jaw joint cartilage	0256	34.0302	$1,774.71		$354.94
21070	T		Remove coronoid process	0256	34.0302	$1,774.71		$354.94
21076	T		Prepare face/oral prosthesis	0254	20.1158	$1,049.06	$321.35	$209.81
21077	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21079	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21080	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21081	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21082	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21083	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21084	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21085	T		Prepare face/oral prosthesis	0253	14.4473	$753.44	$282.29	$150.69
21086	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21087	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21088	T		Prepare face/oral prosthesis	0256	34.0302	$1,774.71		$354.94
21089	T		Prepare face/oral prosthesis	0253	14.4473	$753.44	$282.29	$150.69
21100	T		Maxillofacial fixation	0256	34.0302	$1,774.71		$354.94
21110	T		Interdental fixation	0252	5.8041	$302.69	$113.41	$60.54
21116	N		Injection, jaw joint x-ray					
21120	T		Reconstruction of chin	0254	20.1158	$1,049.06	$321.35	$209.81
21121	T		Reconstruction of chin	0254	20.1158	$1,049.06	$321.35	$209.81
21122	T		Reconstruction of chin	0254	20.1158	$1,049.06	$321.35	$209.81
21123	T		Reconstruction of chin	0254	20.1158	$1,049.06	$321.35	$209.81

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21125	T		Augmentation, lower jaw bone	0254	20.1158	$1,049.06	$321.35	$209.81
21127	T		Augmentation, lower jaw bone	0256	34.0302	$1,774.71		$354.94
21137	T		Reduction of forehead	0254	20.1158	$1,049.06	$321.35	$209.81
21138	T		Reduction of forehead	0256	34.0302	$1,774.71		$354.94
21139	T		Reduction of forehead	0256	34.0302	$1,774.71		$354.94
21141	C		Reconstruct midface, lefort					
21142	C		Reconstruct midface, lefort					
21143	C		Reconstruct midface, lefort					
21145	C		Reconstruct midface, lefort					
21146	C		Reconstruct midface, lefort					
21147	C		Reconstruct midface, lefort					
21150	C		Reconstruct midface, lefort					
21151	C		Reconstruct midface, lefort					
21154	C		Reconstruct midface, lefort					
21155	C		Reconstruct midface, lefort					
21159	C		Reconstruct midface, lefort					
21160	C		Reconstruct midface, lefort					
21172	C		Reconstruct orbit/forehead					
21175	C		Reconstruct orbit/forehead					
21179	C		Reconstruct entire forehead					
21180	C		Reconstruct entire forehead					
21181	T		Contour cranial bone lesion	0254	20.1158	$1,049.06	$321.35	$209.81
21182	C		Reconstruct cranial bone					
21183	C		Reconstruct cranial bone					
21184	C		Reconstruct cranial bone					
21188	C		Reconstruction of midface					
21193	C		Reconst lwr jaw w/o graft					
21194	C		Reconst lwr jaw w/graft					
21195	C		Reconst lwr jaw w/o fixation					
21196	C		Reconst lwr jaw w/fixation					
21198	T		Reconstr lwr jaw segment	0256	34.0302	$1,774.71		$354.94
21199	T		Reconstr lwr jaw w/advance	0256	34.0302	$1,774.71		$354.94
21206	T		Reconstruct upper jaw bone	0256	34.0302	$1,774.71		$354.94
21208	T		Augmentation of facial bones	0256	34.0302	$1,774.71		$354.94
21209	T		Reduction of facial bones	0256	34.0302	$1,774.71		$354.94
21210	T		Face bone graft	0256	34.0302	$1,774.71		$354.94
21215	T		Lower jaw bone graft	0256	34.0302	$1,774.71		$354.94
21230	T		Rib cartilage graft	0256	34.0302	$1,774.71		$354.94
21235	T		Ear cartilage graft	0254	20.1158	$1,049.06	$321.35	$209.81
21240	T		Reconstruction of jaw joint	0256	34.0302	$1,774.71		$354.94
21242	T		Reconstruction of jaw joint	0256	34.0302	$1,774.71		$354.94
21243	T		Reconstruction of jaw joint	0256	34.0302	$1,774.71		$354.94
21244	T		Reconstruction of lower jaw	0256	34.0302	$1,774.71		$354.94
21245	T		Reconstruction of jaw	0256	34.0302	$1,774.71		$354.94
21246	T		Reconstruction of jaw	0256	34.0302	$1,774.71		$354.94
21247	C		Reconstruct lower jaw bone					
21248	T		Reconstruction of jaw	0256	34.0302	$1,774.71		$354.94
21249	T		Reconstruction of jaw	0256	34.0302	$1,774.71		$354.94
21255	C		Reconstruct lower jaw bone					
21256	C		Reconstruction of orbit					
21260	T		Revise eye sockets	0256	34.0302	$1,774.71		$354.94
21261	T		Revise eye sockets	0256	34.0302	$1,774.71		$354.94
21263	T		Revise eye sockets	0256	34.0302	$1,774.71		$354.94
21267	T		Revise eye sockets	0256	34.0302	$1,774.71		$354.94
21268	C		Revise eye sockets					
21270	T		Augmentation, cheek bone	0256	34.0302	$1,774.71		$354.94
21275	T		Revision, orbitofacial bones	0256	34.0302	$1,774.71		$354.94
21280	T		Revision of eyelid	0256	34.0302	$1,774.71		$354.94
21282	T		Revision of eyelid	0253	14.4473	$753.44	$282.29	$150.69
21295	T		Revision of jaw muscle/bone	0252	5.8041	$302.69	$113.41	$60.54
21296	T		Revision of jaw muscle/bone	0254	20.1158	$1,049.06	$321.35	$209.81
21299	T		Cranio/maxillofacial surgery	0253	14.4473	$753.44	$282.29	$150.69
21300	T		Treatment of skull fracture	0253	14.4473	$753.44	$282.29	$150.69
21310	X		Treatment of nose fracture	0340	0.6492	$33.86		$6.77
21315	X		Treatment of nose fracture	0340	0.6492	$33.86		$6.77

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21320	X		Treatment of nose fracture	0340	0.6492	$33.86		$6.77
21325	T		Treatment of nose fracture	0254	20.1158	$1,049.06	$321.35	$209.81
21330	T		Treatment of nose fracture	0254	20.1158	$1,049.06	$321.35	$209.81
21335	T		Treatment of nose fracture	0254	20.1158	$1,049.06	$321.35	$209.81
21336	T		Treat nasal septal fracture	0046	29.2920	$1,527.61	$535.76	$305.52
21337	T		Treat nasal septal fracture	0253	14.4473	$753.44	$282.29	$150.69
21338	T		Treat nasoethmoid fracture	0254	20.1158	$1,049.06	$321.35	$209.81
21339	T		Treat nasoethmoid fracture	0254	20.1158	$1,049.06	$321.35	$209.81
21340	T		Treatment of nose fracture	0256	34.0302	$1,774.71		$354.94
21343	C		Treatment of sinus fracture					
21344	C		Treatment of sinus fracture					
21345	T		Treat nose/jaw fracture	0254	20.1158	$1,049.06	$321.35	$209.81
21346	C		Treat nose/jaw fracture					
21347	C		Treat nose/jaw fracture					
21348	C		Treat nose/jaw fracture					
21355	T		Treat cheek bone fracture	0256	34.0302	$1,774.71		$354.94
21356	C		Treat cheek bone fracture					
21360	C		Treat cheek bone fracture					
21365	C		Treat cheek bone fracture					
21366	C		Treat cheek bone fracture					
21385	C		Treat eye socket fracture					
21386	C		Treat eye socket fracture					
21387	C		Treat eye socket fracture					
21390	T		Treat eye socket fracture	0256	34.0302	$1,774.71		$354.94
21395	C		Treat eye socket fracture					
21400	T		Treat eye socket fracture	0252	5.8041	$302.69	$113.41	$60.54
21401	T		Treat eye socket fracture	0253	14.4473	$753.44	$282.29	$150.69
21406	T		Treat eye socket fracture	0256	34.0302	$1,774.71		$354.94
21407	T		Treat eye socket fracture	0256	34.0302	$1,774.71		$354.94
21408	C		Treat eye socket fracture					
21421	T		Treat mouth roof fracture	0254	20.1158	$1,049.06	$321.35	$209.81
21422	C		Treat mouth roof fracture					
21423	C		Treat mouth roof fracture					
21431	C		Treat craniofacial fracture					
21432	C		Treat craniofacial fracture					
21433	C		Treat craniofacial fracture					
21435	C		Treat craniofacial fracture					
21436	C		Treat craniofacial fracture					
21440	T		Treat dental ridge fracture	0254	20.1158	$1,049.06	$321.35	$209.81
21445	T		Treat dental ridge fracture	0254	20.1158	$1,049.06	$321.35	$209.81
21450	T		Treat lower jaw fracture	0251	1.9089	$99.55		$19.91
21451	T		Treat lower jaw fracture	0252	5.8041	$302.69	$113.41	$60.54
21452	T		Treat lower jaw fracture	0253	14.4473	$753.44	$282.29	$150.69
21453	T		Treat lower jaw fracture	0256	34.0302	$1,774.71		$354.94
21454	T		Treat lower jaw fracture	0254	20.1158	$1,049.06	$321.35	$209.81
21461	T		Treat lower jaw fracture	0256	34.0302	$1,774.71		$354.94
21462	T		Treat lower jaw fracture	0256	34.0302	$1,774.71		$354.94
21465	T		Treat lower jaw fracture	0256	34.0302	$1,774.71		$354.94
21470	T		Treat lower jaw fracture	0256	34.0302	$1,774.71		$354.94
21480	T		Reset dislocated jaw	0251	1.9089	$99.55		$19.91
21485	T		Reset dislocated jaw	0253	14.4473	$753.44	$282.29	$150.69
21490	T		Repair dislocated jaw	0256	34.0302	$1,774.71		$354.94
21493	T		Treat hyoid bone fracture	0252	5.8041	$302.69	$113.41	$60.54
21494	T		Treat hyoid bone fracture	0252	5.8041	$302.69	$113.41	$60.54
21495	C		Treat hyoid bone fracture					
21497	T		Interdental wiring	0253	14.4473	$753.44	$282.29	$150.69
21499	T		Head surgery procedure	0253	14.4473	$753.44	$282.29	$150.69
21501	T		Drain neck/chest lesion	0008	16.1430	$841.87		$168.37
21502	T		Drain chest lesion	0049	18.6042	$970.23	$197.14	$194.05
21510	C		Drainage of bone lesion					
21550	T		Biopsy of neck/chest	0021	13.9338	$726.66	$219.48	$145.33
21555	T		Remove lesion, neck/chest	0022	17.3930	$907.06	$354.45	$181.41
21556	T		Remove lesion, neck/chest	0022	17.3930	$907.06	$354.45	$181.41
21557	C		Remove tumor, neck/chest					
21600	T		Partial removal of rib	0050	23.3037	$1,215.31		$243.06

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21610	T		Partial removal of rib	0050	23.3037	$1,215.31		$243.06
21615	C		Removal of rib					
21616	C		Removal of rib and nerves					
21620	C		Partial removal of sternum					
21627	C		Sternal debridement					
21630	C		Extensive sternum surgery					
21632	C		Extensive sternum surgery					
21700	T		Revision of neck muscle	0049	18.6042	$970.23	$197.14	$194.05
21705	C		Revision of neck muscle/rib					
21720	T		Revision of neck muscle	0049	18.6042	$970.23	$197.14	$194.05
21725	T		Revision of neck muscle	0006	1.7926	$93.49	$24.12	$18.70
21740	C		Reconstruction of sternum					
21742	T	NI	Repair stern/nuss w/o scope	0051	32.9062	$1,716.09		$343.22
21743	T	NI	Repair sternum/nuss w/scope	0051	32.9062	$1,716.09		$343.22
21750	C		Repair of sternum separation					
21800	T		Treatment of rib fracture	0043	2.4999	$130.37		$26.07
21805	T		Treatment of rib fracture	0046	29.2920	$1,527.61	$535.76	$305.52
21810	C		Treatment of rib fracture(s)					
21820	T		Treat sternum fracture	0043	2.4999	$130.37		$26.07
21825	C		Treat sternum fracture					
21899	T		Neck/chest surgery procedure	0252	5.8041	$302.69	$113.41	$60.54
21920	T		Biopsy soft tissue of back	0020	7.1898	$374.96	$113.25	$74.99
21925	T		Biopsy soft tissue of back	0022	17.3930	$907.06	$354.45	$181.41
21930	T		Remove lesion, back or flank	0022	17.3930	$907.06	$354.45	$181.41
21935	T		Remove tumor, back	0022	17.3930	$907.06	$354.45	$181.41
22100	T		Remove part of neck vertebra	0208	38.4487	$2,005.14		$401.03
22101	T		Remove part, thorax vertebra	0208	38.4487	$2,005.14		$401.03
22102	T		Remove part, lumbar vertebra	0208	38.4487	$2,005.14		$401.03
22103	T		Remove extra spine segment	0208	38.4487	$2,005.14		$401.03
22110	C		Remove part of neck vertebra					
22112	C		Remove part, thorax vertebra					
22114	C		Remove part, lumbar vertebra					
22116	C		Remove extra spine segment					
22210	C		Revision of neck spine					
22212	C		Revision of thorax spine					
22214	C		Revision of lumbar spine					
22216	C		Revise, extra spine segment					
22220	C		Revision of neck spine					
22222	C		Revision of thorax spine					
22224	C		Revision of lumbar spine					
22226	C		Revise, extra spine segment					
22305	T		Treat spine process fracture	0043	2.4999	$130.37		$26.07
22310	T		Treat spine fracture	0043	2.4999	$130.37		$26.07
22315	T		Treat spine fracture	0043	2.4999	$130.37		$26.07
22318	C		Treat odontoid fx w/o graft					
22319	C		Treat odontoid fx w/graft					
22325	C		Treat spine fracture					
22326	C		Treat neck spine fracture					
22327	C		Treat thorax spine fracture					
22328	C		Treat each add spine fx					
22505	T		Manipulation of spine	0045	12.9357	$674.61	$268.47	$134.92
22520	T		Percut vertebroplasty thor	0050	23.3037	$1,215.31		$243.06
22521	T		Percut vertebroplasty lumb	0050	23.3037	$1,215.31		$243.06
22522	T		Percut vertebroplasty addl	0050	23.3037	$1,215.31		$243.06
22548	C		Neck spine fusion					
22554	C		Neck spine fusion					
22556	C		Thorax spine fusion					
22558	C		Lumbar spine fusion					
22585	C		Additional spinal fusion					
22590	C		Spine & skull spinal fusion					
22595	C		Neck spinal fusion					
22600	C		Neck spine fusion					
22610	C		Thorax spine fusion					
22612	T		Lumbar spine fusion	0208	38.4487	$2,005.14		$401.03
22614	T		Spine fusion, extra segment	0208	38.4487	$2,005.14		$401.03

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
22630	C	.....	Lumbar spine fusion	.....	.....	.....	.....	.....
22632	C	.....	Spine fusion, extra segment	.....	.....	.....	.....	.....
22800	C	.....	Fusion of spine	.....	.....	.....	.....	.....
22802	C	.....	Fusion of spine	.....	.....	.....	.....	.....
22804	C	.....	Fusion of spine	.....	.....	.....	.....	.....
22808	C	.....	Fusion of spine	.....	.....	.....	.....	.....
22810	C	.....	Fusion of spine	.....	.....	.....	.....	.....
22812	C	.....	Fusion of spine	.....	.....	.....	.....	.....
22818	C	.....	Kyphectomy, 1-2 segments	.....	.....	.....	.....	.....
22819	C	.....	Kyphectomy, 3 or more	.....	.....	.....	.....	.....
22830	C	.....	Exploration of spinal fusion	.....	.....	.....	.....	.....
22840	C	.....	Insert spine fixation device	.....	.....	.....	.....	.....
22841	C	.....	Insert spine fixation device	.....	.....	.....	.....	.....
22842	C	.....	Insert spine fixation device	.....	.....	.....	.....	.....
22843	C	.....	Insert spine fixation device	.....	.....	.....	.....	.....
22844	C	.....	Insert spine fixation device	.....	.....	.....	.....	.....
22845	C	.....	Insert spine fixation device	.....	.....	.....	.....	.....
22846	C	.....	Insert spine fixation device	.....	.....	.....	.....	.....
22847	C	.....	Insert spine fixation device	.....	.....	.....	.....	.....
22848	C	.....	Insert pelv fixation device	.....	.....	.....	.....	.....
22849	C	.....	Reinsert spinal fixation	.....	.....	.....	.....	.....
22850	C	.....	Remove spine fixation device	.....	.....	.....	.....	.....
22851	C	.....	Apply spine prosth device	.....	.....	.....	.....	.....
22852	C	.....	Remove spine fixation device	.....	.....	.....	.....	.....
22855	C	.....	Remove spine fixation device	.....	.....	.....	.....	.....
22899	T	.....	Spine surgery procedure	0043	2.4999	$130.37	.....	$26.07
22900	T	.....	Remove abdominal wall lesion	0022	17.3930	$907.06	$354.45	$181.41
22999	T	.....	Abdomen surgery procedure	0022	17.3930	$907.06	$354.45	$181.41
23000	T	.....	Removal of calcium deposits	0021	13.9338	$726.66	$219.48	$145.33
23020	T	.....	Release shoulder joint	0051	32.9062	$1,716.09	.....	$343.22
23030	T	.....	Drain shoulder lesion	0008	16.1430	$841.87	.....	$168.37
23031	T	.....	Drain shoulder bursa	0008	16.1430	$841.87	.....	$168.37
23035	T	.....	Drain shoulder bone lesion	0049	18.6042	$970.23	$197.14	$194.05
23040	T	.....	Exploratory shoulder surgery	0050	23.3037	$1,215.31	.....	$243.06
23044	T	.....	Exploratory shoulder surgery	0050	23.3037	$1,215.31	.....	$243.06
23065	T	.....	Biopsy shoulder tissues	0021	13.9338	$726.66	$219.48	$145.33
23066	T	.....	Biopsy shoulder tissues	0022	17.3930	$907.06	$354.45	$181.41
23075	T	.....	Removal of shoulder lesion	0021	13.9338	$726.66	$219.48	$145.33
23076	T	.....	Removal of shoulder lesion	0022	17.3930	$907.06	$354.45	$181.41
23077	T	.....	Remove tumor of shoulder	0022	17.3930	$907.06	$354.45	$181.41
23100	T	.....	Biopsy of shoulder joint	0049	18.6042	$970.23	$197.14	$194.05
23101	T	.....	Shoulder joint surgery	0050	23.3037	$1,215.31	.....	$243.06
23105	T	.....	Remove shoulder joint lining	0050	23.3037	$1,215.31	.....	$243.06
23106	T	.....	Incision of collarbone joint	0050	23.3037	$1,215.31	.....	$243.06
23107	T	.....	Explore treat shoulder joint	0050	23.3037	$1,215.31	.....	$243.06
23120	T	.....	Partial removal, collar bone	0051	32.9062	$1,716.09	.....	$343.22
23125	T	.....	Removal of collar bone	0051	32.9062	$1,716.09	.....	$343.22
23130	T	.....	Remove shoulder bone, part	0051	32.9062	$1,716.09	.....	$343.22
23140	T	.....	Removal of bone lesion	0049	18.6042	$970.23	$197.14	$194.05
23145	T	.....	Removal of bone lesion	0050	23.3037	$1,215.31	.....	$243.06
23146	T	.....	Removal of bone lesion	0050	23.3037	$1,215.31	.....	$243.06
23150	T	.....	Removal of humerus lesion	0050	23.3037	$1,215.31	.....	$243.06
23155	T	.....	Removal of humerus lesion	0050	23.3037	$1,215.31	.....	$243.06
23156	T	.....	Removal of humerus lesion	0050	23.3037	$1,215.31	.....	$243.06
23170	T	.....	Remove collar bone lesion	0050	23.3037	$1,215.31	.....	$243.06
23172	T	.....	Remove shoulder blade lesion	0050	23.3037	$1,215.31	.....	$243.06
23174	T	.....	Remove humerus lesion	0050	23.3037	$1,215.31	.....	$243.06
23180	T	.....	Remove collar bone lesion	0050	23.3037	$1,215.31	.....	$243.06
23182	T	.....	Remove shoulder blade lesion	0050	23.3037	$1,215.31	.....	$243.06
23184	T	.....	Remove humerus lesion	0050	23.3037	$1,215.31	.....	$243.06
23190	T	.....	Partial removal of scapula	0050	23.3037	$1,215.31	.....	$243.06
23195	T	.....	Removal of head of humerus	0050	23.3037	$1,215.31	.....	$243.06
23200	C	.....	Removal of collar bone	.....	.....	.....	.....	.....
23210	C	.....	Removal of shoulder blade	.....	.....	.....	.....	.....
23220	C	.....	Partial removal of humerus	.....	.....	.....	.....	.....

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23221	C	.....	Partial removal of humerus	.....	.....	.....	.....	.....
23222	C	.....	Partial removal of humerus	.....	.....	.....	.....	.....
23330	T	.....	Remove shoulder foreign body	0020	7.1898	$374.96	$113.25	$74.99
23331	T	.....	Remove shoulder foreign body	0022	17.3930	$907.06	$354.45	$181.41
23332	C	.....	Remove shoulder foreign body	.....	.....	.....	.....	.....
23350	N	.....	Injection for shoulder x-ray	.....	.....	.....	.....	.....
23395	T	.....	Muscle transfer,shoulder/arm	0051	32.9062	$1,716.09	.....	$343.22
23397	T	.....	Muscle transfers	0052	40.7646	$2,125.91	.....	$425.18
23400	T	.....	Fixation of shoulder blade	0050	23.3037	$1,215.31	.....	$243.06
23405	T	.....	Incision of tendon & muscle	0050	23.3037	$1,215.31	.....	$243.06
23406	T	.....	Incise tendon(s) & muscle(s)	0050	23.3037	$1,215.31	.....	$243.06
23410	T	.....	Repair of tendon(s)	0052	40.7646	$2,125.91	.....	$425.18
23412	T	.....	Repair rotator cuff, chronic	0052	40.7646	$2,125.91	.....	$425.18
23415	T	.....	Release of shoulder ligament	0051	32.9062	$1,716.09	.....	$343.22
23420	T	.....	Repair of shoulder	0052	40.7646	$2,125.91	.....	$425.18
23430	T	.....	Repair biceps tendon	0052	40.7646	$2,125.91	.....	$425.18
23440	T	.....	Remove/transplant tendon	0052	40.7646	$2,125.91	.....	$425.18
23450	T	.....	Repair shoulder capsule	0052	40.7646	$2,125.91	.....	$425.18
23455	T	.....	Repair shoulder capsule	0052	40.7646	$2,125.91	.....	$425.18
23460	T	.....	Repair shoulder capsule	0052	40.7646	$2,125.91	.....	$425.18
23462	T	.....	Repair shoulder capsule	0052	40.7646	$2,125.91	.....	$425.18
23465	T	.....	Repair shoulder capsule	0052	40.7646	$2,125.91	.....	$425.18
23466	T	.....	Repair shoulder capsule	0052	40.7646	$2,125.91	.....	$425.18
23470	T	.....	Reconstruct shoulder joint	0048	40.6289	$2,118.84	$695.60	$423.77
23472	C	.....	Reconstruct shoulder joint	.....	.....	.....	.....	.....
23480	T	.....	Revision of collar bone	0051	32.9062	$1,716.09	.....	$343.22
23485	T	.....	Revision of collar bone	0051	32.9062	$1,716.09	.....	$343.22
23490	T	.....	Reinforce clavicle	0051	32.9062	$1,716.09	.....	$343.22
23491	T	.....	Reinforce shoulder bones	0051	32.9062	$1,716.09	.....	$343.22
23500	T	.....	Treat clavicle fracture	0043	2.4999	$130.37	.....	$26.07
23505	T	.....	Treat clavicle fracture	0043	2.4999	$130.37	.....	$26.07
23515	T	.....	Treat clavicle fracture	0046	29.2920	$1,527.61	$535.76	$305.52
23520	T	.....	Treat clavicle dislocation	0043	2.4999	$130.37	.....	$26.07
23525	T	.....	Treat clavicle dislocation	0043	2.4999	$130.37	.....	$26.07
23530	T	.....	Treat clavicle dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
23532	T	.....	Treat clavicle dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
23540	T	.....	Treat clavicle dislocation	0043	2.4999	$130.37	.....	$26.07
23545	T	.....	Treat clavicle dislocation	0043	2.4999	$130.37	.....	$26.07
23550	T	.....	Treat clavicle dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
23552	T	.....	Treat clavicle dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
23570	T	.....	Treat shoulder blade fx	0043	2.4999	$130.37	.....	$26.07
23575	T	.....	Treat shoulder blade fx	0043	2.4999	$130.37	.....	$26.07
23585	T	.....	Treat scapula fracture	0046	29.2920	$1,527.61	$535.76	$305.52
23600	T	.....	Treat humerus fracture	0043	2.4999	$130.37	.....	$26.07
23605	T	.....	Treat humerus fracture	0043	2.4999	$130.37	.....	$26.07
23615	T	.....	Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
23616	T	.....	Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
23620	T	.....	Treat humerus fracture	0043	2.4999	$130.37	.....	$26.07
23625	T	.....	Treat humerus fracture	0043	2.4999	$130.37	.....	$26.07
23630	T	.....	Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
23650	T	.....	Treat shoulder dislocation	0043	2.4999	$130.37	.....	$26.07
23655	T	.....	Treat shoulder dislocation	0045	12.9357	$674.61	$268.47	$134.92
23660	T	.....	Treat shoulder dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
23665	T	.....	Treat dislocation/fracture	0043	2.4999	$130.37	.....	$26.07
23670	T	.....	Treat dislocation/fracture	0046	29.2920	$1,527.61	$535.76	$305.52
23675	T	.....	Treat dislocation/fracture	0043	2.4999	$130.37	.....	$26.07
23680	T	.....	Treat dislocation/fracture	0046	29.2920	$1,527.61	$535.76	$305.52
23700	T	.....	Fixation of shoulder	0045	12.9357	$674.61	$268.47	$134.92
23800	T	.....	Fusion of shoulder joint	0051	32.9062	$1,716.09	.....	$343.22
23802	T	.....	Fusion of shoulder joint	0051	32.9062	$1,716.09	.....	$343.22
23900	C	.....	Amputation of arm & girdle	.....	.....	.....	.....	.....
23920	C	.....	Amputation at shoulder joint	.....	.....	.....	.....	.....
23921	T	.....	Amputation follow-up surgery	0025	5.8623	$305.72	$115.49	$61.14
23929	T	.....	Shoulder surgery procedure	0043	2.4999	$130.37	.....	$26.07
23930	T	.....	Drainage of arm lesion	0008	16.1430	$841.87	.....	$168.37

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23931	T		Drainage of arm bursa	0006	1.7926	$93.49	$24.12	$18.70
23935	T		Drain arm/elbow bone lesion	0049	18.6042	$970.23	$197.14	$194.05
24000	T		Exploratory elbow surgery	0050	23.3037	$1,215.31		$243.06
24006	T		Release elbow joint	0050	23.3037	$1,215.31		$243.06
24065	T		Biopsy arm/elbow soft tissue	0021	13.9338	$726.66	$219.48	$145.33
24066	T		Biopsy arm/elbow soft tissue	0021	13.9338	$726.66	$219.48	$145.33
24075	T		Remove arm/elbow lesion	0021	13.9338	$726.66	$219.48	$145.33
24076	T		Remove arm/elbow lesion	0022	17.3930	$907.06	$354.45	$181.41
24077	T		Remove tumor of arm/elbow	0022	17.3930	$907.06	$354.45	$181.41
24100	T		Biopsy elbow joint lining	0049	18.6042	$970.23	$197.14	$194.05
24101	T		Explore/treat elbow joint	0050	23.3037	$1,215.31		$243.06
24102	T		Remove elbow joint lining	0050	23.3037	$1,215.31		$243.06
24105	T		Removal of elbow bursa	0049	18.6042	$970.23	$197.14	$194.05
24110	T		Remove humerus lesion	0049	18.6042	$970.23	$197.14	$194.05
24115	T		Remove/graft bone lesion	0050	23.3037	$1,215.31		$243.06
24116	T		Remove/graft bone lesion	0050	23.3037	$1,215.31		$243.06
24120	T		Remove elbow lesion	0049	18.6042	$970.23	$197.14	$194.05
24125	T		Remove/graft bone lesion	0050	23.3037	$1,215.31		$243.06
24126	T		Remove/graft bone lesion	0050	23.3037	$1,215.31		$243.06
24130	T		Removal of head of radius	0050	23.3037	$1,215.31		$243.06
24134	T		Removal of arm bone lesion	0050	23.3037	$1,215.31		$243.06
24136	T		Remove radius bone lesion	0050	23.3037	$1,215.31		$243.06
24138	T		Remove elbow bone lesion	0050	23.3037	$1,215.31		$243.06
24140	T		Partial removal of arm bone	0050	23.3037	$1,215.31		$243.06
24145	T		Partial removal of radius	0050	23.3037	$1,215.31		$243.06
24147	T		Partial removal of elbow	0050	23.3037	$1,215.31		$243.06
24149	C		Radical resection of elbow					
24150	T		Extensive humerus surgery	0052	40.7646	$2,125.91		$425.18
24151	T		Extensive humerus surgery	0052	40.7646	$2,125.91		$425.18
24152	T		Extensive radius surgery	0052	40.7646	$2,125.91		$425.18
24153	T		Extensive radius surgery	0052	40.7646	$2,125.91		$425.18
24155	T		Removal of elbow joint	0051	32.9062	$1,716.09		$343.22
24160	T		Remove elbow joint implant	0050	23.3037	$1,215.31		$243.06
24164	T		Remove radius head implant	0050	23.3037	$1,215.31		$243.06
24200	T		Removal of arm foreign body	0019	3.7693	$196.57	$71.87	$39.31
24201	T		Removal of arm foreign body	0021	13.9338	$726.66	$219.48	$145.33
24220	N		Injection for elbow x-ray					
24300	T		Manipulate elbow w/anesth	0045	12.9357	$674.61	$268.47	$134.92
24301	T		Muscle/tendon transfer	0050	23.3037	$1,215.31		$243.06
24305	T		Arm tendon lengthening	0050	23.3037	$1,215.31		$243.06
24310	T		Revision of arm tendon	0049	18.6042	$970.23	$197.14	$194.05
24320	T		Repair of arm tendon	0051	32.9062	$1,716.09		$343.22
24330	T		Revision of arm muscles	0051	32.9062	$1,716.09		$343.22
24331	T		Revision of arm muscles	0051	32.9062	$1,716.09		$343.22
24332	T		Tenolysis, triceps	0049	18.6042	$970.23	$197.14	$194.05
24340	T		Repair of biceps tendon	0051	32.9062	$1,716.09		$343.22
24341	T		Repair arm tendon/muscle	0051	32.9062	$1,716.09		$343.22
24342	T		Repair of ruptured tendon	0051	32.9062	$1,716.09		$343.22
24343	T		Repr elbow lat ligmnt w/tiss	0050	23.3037	$1,215.31		$243.06
24344	T		Reconstruct elbow lat ligmnt	0051	32.9062	$1,716.09		$343.22
24345	T		Repr elbw med ligmnt w/tissu	0050	23.3037	$1,215.31		$243.06
24346	T		Reconstruct elbow med ligmnt	0051	32.9062	$1,716.09		$343.22
24350	T		Repair of tennis elbow	0050	23.3037	$1,215.31		$243.06
24351	T		Repair of tennis elbow	0050	23.3037	$1,215.31		$243.06
24352	T		Repair of tennis elbow	0050	23.3037	$1,215.31		$243.06
24354	T		Repair of tennis elbow	0050	23.3037	$1,215.31		$243.06
24356	T		Revision of tennis elbow	0050	23.3037	$1,215.31		$243.06
24360	T		Reconstruct elbow joint	0047	28.2842	$1,475.05	$537.03	$295.01
24361	T		Reconstruct elbow joint	0048	40.6289	$2,118.84	$695.60	$423.77
24362	T		Reconstruct elbow joint	0048	40.6289	$2,118.84	$695.60	$423.77
24363	T		Replace elbow joint	0048	40.6289	$2,118.84	$695.60	$423.77
24365	T		Reconstruct head of radius	0047	28.2842	$1,475.05	$537.03	$295.01
24366	T		Reconstruct head of radius	0048	40.6289	$2,118.84	$695.60	$423.77
24400	T		Revision of humerus	0050	23.3037	$1,215.31		$243.06
24410	T		Revision of humerus	0050	23.3037	$1,215.31		$243.06

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24420	T		Revision of humerus	0051	32.9062	$1,716.09		$343.22
24430	T		Repair of humerus	0051	32.9062	$1,716.09		$343.22
24435	T		Repair humerus with graft	0051	32.9062	$1,716.09		$343.22
24470	T		Revision of elbow joint	0051	32.9062	$1,716.09		$343.22
24495	T		Decompression of forearm	0050	23.3037	$1,215.31		$243.06
24498	T		Reinforce humerus	0051	32.9062	$1,716.09		$343.22
24500	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
24505	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
24515	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24516	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24530	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
24535	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
24538	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24545	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24546	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24560	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
24565	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
24566	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24575	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24576	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
24577	T		Treat humerus fracture	0043	2.4999	$130.37		$26.07
24579	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24582	T		Treat humerus fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24586	T		Treat elbow fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24587	T		Treat elbow fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24600	T		Treat elbow dislocation	0043	2.4999	$130.37		$26.07
24605	T		Treat elbow dislocation	0045	12.9357	$674.61	$268.47	$134.92
24615	T		Treat elbow dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
24620	T		Treat elbow fracture	0043	2.4999	$130.37		$26.07
24635	T		Treat elbow fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24640	T		Treat elbow dislocation	0043	2.4999	$130.37		$26.07
24650	T		Treat radius fracture	0043	2.4999	$130.37		$26.07
24655	T		Treat radius fracture	0043	2.4999	$130.37		$26.07
24665	T		Treat radius fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24666	T		Treat radius fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24670	T		Treat ulnar fracture	0043	2.4999	$130.37		$26.07
24675	T		Treat ulnar fracture	0043	2.4999	$130.37		$26.07
24685	T		Treat ulnar fracture	0046	29.2920	$1,527.61	$535.76	$305.52
24800	T		Fusion of elbow joint	0051	32.9062	$1,716.09		$343.22
24802	T		Fusion/graft of elbow joint	0051	32.9062	$1,716.09		$343.22
24900	C		Amputation of upper arm					
24920	C		Amputation of upper arm					
24925	T		Amputation follow-up surgery	0049	18.6042	$970.23	$197.14	$194.05
24930	C		Amputation follow-up surgery					
24931	C		Amputate upper arm & implant					
24935	T		Revision of amputation	0052	40.7646	$2,125.91		$425.18
24940	C		Revision of upper arm					
24999	T		Upper arm/elbow surgery	0043	2.4999	$130.37		$26.07
25000	T		Incision of tendon sheath	0049	18.6042	$970.23	$197.14	$194.05
25001	T		Incise flexor carpi radialis	0049	18.6042	$970.23	$197.14	$194.05
25020	T		Decompress forearm 1 space	0049	18.6042	$970.23	$197.14	$194.05
25023	T		Decompress forearm 1 space	0050	23.3037	$1,215.31		$243.06
25024	T		Decompress forearm 2 spaces	0050	23.3037	$1,215.31		$243.06
25025	T		Decompress forarm 2 spaces	0050	23.3037	$1,215.31		$243.06
25028	T		Drainage of forearm lesion	0049	18.6042	$970.23	$197.14	$194.05
25031	T		Drainage of forearm bursa	0049	18.6042	$970.23	$197.14	$194.05
25035	T		Treat forearm bone lesion	0049	18.6042	$970.23	$197.14	$194.05
25040	T		Explore/treat wrist joint	0050	23.3037	$1,215.31		$243.06
25065	T		Biopsy forearm soft tissues	0021	13.9338	$726.66	$219.48	$145.33
25066	T		Biopsy forearm soft tissues	0022	17.3930	$907.06	$354.45	$181.41
25075	T		Removel forearm lesion subcu	0021	13.9338	$726.66	$219.48	$145.33
25076	T		Removel forearm lesion deep	0022	17.3930	$907.06	$354.45	$181.41
25077	T		Remove tumor, forearm/wrist	0022	17.3930	$907.06	$354.45	$181.41
25085	T		Incision of wrist capsule	0049	18.6042	$970.23	$197.14	$194.05
25100	T		Biopsy of wrist joint	0049	18.6042	$970.23	$197.14	$194.05

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25101	T		Explore/treat wrist joint	0050	23.3037	$1,215.31		$243.06
25105	T		Remove wrist joint lining	0050	23.3037	$1,215.31		$243.06
25107	T		Remove wrist joint cartilage	0050	23.3037	$1,215.31		$243.06
25110	T		Remove wrist tendon lesion	0049	18.6042	$970.23	$197.14	$194.05
25111	T		Remove wrist tendon lesion	0053	14.1760	$739.29	$253.49	$147.86
25112	T		Reremove wrist tendon lesion	0053	14.1760	$739.29	$253.49	$147.86
25115	T		Remove wrist/forearm lesion	0049	18.6042	$970.23	$197.14	$194.05
25116	T		Remove wrist/forearm lesion	0049	18.6042	$970.23	$197.14	$194.05
25118	T		Excise wrist tendon sheath	0050	23.3037	$1,215.31		$243.06
25119	T		Partial removal of ulna	0050	23.3037	$1,215.31		$243.06
25120	T		Removal of forearm lesion	0050	23.3037	$1,215.31		$243.06
25125	T		Remove/graft forearm lesion	0050	23.3037	$1,215.31		$243.06
25126	T		Remove/graft forearm lesion	0050	23.3037	$1,215.31		$243.06
25130	T		Removal of wrist lesion	0050	23.3037	$1,215.31		$243.06
25135	T		Remove & graft wrist lesion	0050	23.3037	$1,215.31		$243.06
25136	T		Remove & graft wrist lesion	0050	23.3037	$1,215.31		$243.06
25145	T		Remove forearm bone lesion	0050	23.3037	$1,215.31		$243.06
25150	T		Partial removal of ulna	0050	23.3037	$1,215.31		$243.06
25151	T		Partial removal of radius	0050	23.3037	$1,215.31		$243.06
25170	T		Extensive forearm surgery	0052	40.7646	$2,125.91		$425.18
25210	T		Removal of wrist bone	0054	22.7223	$1,184.99		$237.00
25215	T		Removal of wrist bones	0054	22.7223	$1,184.99		$237.00
25230	T		Partial removal of radius	0050	23.3037	$1,215.31		$243.06
25240	T		Partial removal of ulna	0050	23.3037	$1,215.31		$243.06
25246	N		Injection for wrist x-ray					
25248	T		Remove forearm foreign body	0049	18.6042	$970.23	$197.14	$194.05
25250	T		Removal of wrist prosthesis	0050	23.3037	$1,215.31		$243.06
25251	T		Removal of wrist prosthesis	0050	23.3037	$1,215.31		$243.06
25259	T		Manipulate wrist w/anesthes	0043	2.4999	$130.37		$26.07
25260	T		Repair forearm tendon/muscle	0050	23.3037	$1,215.31		$243.06
25263	T		Repair forearm tendon/muscle	0050	23.3037	$1,215.31		$243.06
25265	T		Repair forearm tendon/muscle	0050	23.3037	$1,215.31		$243.06
25270	T		Repair forearm tendon/muscle	0050	23.3037	$1,215.31		$243.06
25272	T		Repair forearm tendon/muscle	0050	23.3037	$1,215.31		$243.06
25274	T		Repair forearm tendon/muscle	0050	23.3037	$1,215.31		$243.06
25275	T		Repair forearm tendon sheath	0050	23.3037	$1,215.31		$243.06
25280	T		Revise wrist/forearm tendon	0050	23.3037	$1,215.31		$243.06
25290	T		Incise wrist/forearm tendon	0050	23.3037	$1,215.31		$243.06
25295	T		Release wrist/forearm tendon	0049	18.6042	$970.23	$197.14	$194.05
25300	T		Fusion of tendons at wrist	0050	23.3037	$1,215.31		$243.06
25301	T		Fusion of tendons at wrist	0050	23.3037	$1,215.31		$243.06
25310	T		Transplant forearm tendon	0051	32.9062	$1,716.09		$343.22
25312	T		Transplant forearm tendon	0051	32.9062	$1,716.09		$343.22
25315	T		Revise palsy hand tendon(s)	0051	32.9062	$1,716.09		$343.22
25316	T		Revise palsy hand tendon(s)	0051	32.9062	$1,716.09		$343.22
25320	T		Repair/revise wrist joint	0051	32.9062	$1,716.09		$343.22
25332	T		Revise wrist joint	0047	28.2842	$1,475.05	$537.03	$295.01
25335	T		Realignment of hand	0051	32.9062	$1,716.09		$343.22
25337	T		Reconstruct ulna/radioulnar	0051	32.9062	$1,716.09		$343.22
25350	T		Revision of radius	0051	32.9062	$1,716.09		$343.22
25355	T		Revision of radius	0051	32.9062	$1,716.09		$343.22
25360	T		Revision of ulna	0050	23.3037	$1,215.31		$243.06
25365	T		Revise radius & ulna	0050	23.3037	$1,215.31		$243.06
25370	T		Revise radius or ulna	0051	32.9062	$1,716.09		$343.22
25375	T		Revise radius & ulna	0051	32.9062	$1,716.09		$343.22
25390	T		Shorten radius or ulna	0050	23.3037	$1,215.31		$243.06
25391	T		Lengthen radius or ulna	0051	32.9062	$1,716.09		$343.22
25392	T		Shorten radius & ulna	0050	23.3037	$1,215.31		$243.06
25393	T		Lengthen radius & ulna	0051	32.9062	$1,716.09		$343.22
25394	T		Repair carpal bone, shorten	0053	14.1760	$739.29	$253.49	$147.86
25400	T		Repair radius or ulna	0050	23.3037	$1,215.31		$243.06
25405	T		Repair/graft radius or ulna	0050	23.3037	$1,215.31		$243.06
25415	T		Repair radius & ulna	0050	23.3037	$1,215.31		$243.06
25420	T		Repair/graft radius & ulna	0051	32.9062	$1,716.09		$343.22
25425	T		Repair/graft radius or ulna	0051	32.9062	$1,716.09		$343.22

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25426	T		Repair/graft radius & ulna	0051	32.9062	$1,716.09		$343.22
25430	T		Vasc graft into carpal bone	0054	22.7223	$1,184.99		$237.00
25431	T		Repair nonunion carpal bone	0054	22.7223	$1,184.99		$237.00
25440	T		Repair/graft wrist bone	0051	32.9062	$1,716.09		$343.22
25441	T		Reconstruct wrist joint	0048	40.6289	$2,118.84	$695.60	$423.77
25442	T		Reconstruct wrist joint	0048	40.6289	$2,118.84	$695.60	$423.77
25443	T		Reconstruct wrist joint	0048	40.6289	$2,118.84	$695.60	$423.77
25444	T		Reconstruct wrist joint	0048	40.6289	$2,118.84	$695.60	$423.77
25445	T		Reconstruct wrist joint	0048	40.6289	$2,118.84	$695.60	$423.77
25446	T		Wrist replacement	0048	40.6289	$2,118.84	$695.60	$423.77
25447	T		Repair wrist joint(s)	0047	28.2842	$1,475.05	$537.03	$295.01
25449	T		Remove wrist joint implant	0047	28.2842	$1,475.05	$537.03	$295.01
25450	T		Revision of wrist joint	0051	32.9062	$1,716.09		$343.22
25455	T		Revision of wrist joint	0051	32.9062	$1,716.09		$343.22
25490	T		Reinforce radius	0051	32.9062	$1,716.09		$343.22
25491	T		Reinforce ulna	0051	32.9062	$1,716.09		$343.22
25492	T		Reinforce radius and ulna	0051	32.9062	$1,716.09		$343.22
25500	T		Treat fracture of radius	0043	2.4999	$130.37		$26.07
25505	T		Treat fracture of radius	0043	2.4999	$130.37		$26.07
25515	T		Treat fracture of radius	0046	29.2920	$1,527.61	$535.76	$305.52
25520	T		Treat fracture of radius	0043	2.4999	$130.37		$26.07
25525	T		Treat fracture of radius	0046	29.2920	$1,527.61	$535.76	$305.52
25526	T		Treat fracture of radius	0046	29.2920	$1,527.61	$535.76	$305.52
25530	T		Treat fracture of ulna	0043	2.4999	$130.37		$26.07
25535	T		Treat fracture of ulna	0043	2.4999	$130.37		$26.07
25545	T		Treat fracture of ulna	0046	29.2920	$1,527.61	$535.76	$305.52
25560	T		Treat fracture radius & ulna	0043	2.4999	$130.37		$26.07
25565	T		Treat fracture radius & ulna	0043	2.4999	$130.37		$26.07
25574	T		Treat fracture radius & ulna	0046	29.2920	$1,527.61	$535.76	$305.52
25575	T		Treat fracture radius/ulna	0046	29.2920	$1,527.61	$535.76	$305.52
25600	T		Treat fracture radius/ulna	0043	2.4999	$130.37		$26.07
25605	T		Treat fracture radius/ulna	0043	2.4999	$130.37		$26.07
25611	T		Treat fracture radius/ulna	0046	29.2920	$1,527.61	$535.76	$305.52
25620	T		Treat fracture radius/ulna	0046	29.2920	$1,527.61	$535.76	$305.52
25622	T		Treat wrist bone fracture	0043	2.4999	$130.37		$26.07
25624	T		Treat wrist bone fracture	0043	2.4999	$130.37		$26.07
25628	T		Treat wrist bone fracture	0046	29.2920	$1,527.61	$535.76	$305.52
25630	T		Treat wrist bone fracture	0043	2.4999	$130.37		$26.07
25635	T		Treat wrist bone fracture	0043	2.4999	$130.37		$26.07
25645	T		Treat wrist bone fracture	0046	29.2920	$1,527.61	$535.76	$305.52
25650	T		Treat wrist bone fracture	0043	2.4999	$130.37		$26.07
25651	T		Pin ulnar styloid fracture	0046	29.2920	$1,527.61	$535.76	$305.52
25652	T		Treat fracture ulnar styloid	0046	29.2920	$1,527.61	$535.76	$305.52
25660	T		Treat wrist dislocation	0043	2.4999	$130.37		$26.07
25670	T		Treat wrist dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
25671	T		Pin radioulnar dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
25675	T		Treat wrist dislocation	0043	2.4999	$130.37		$26.07
25676	T		Treat wrist dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
25680	T		Treat wrist fracture	0043	2.4999	$130.37		$26.07
25685	T		Treat wrist fracture	0046	29.2920	$1,527.61	$535.76	$305.52
25690	T		Treat wrist dislocation	0043	2.4999	$130.37		$26.07
25695	T		Treat wrist dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
25800	T		Fusion of wrist joint	0051	32.9062	$1,716.09		$343.22
25805	T		Fusion/graft of wrist joint	0051	32.9062	$1,716.09		$343.22
25810	T		Fusion/graft of wrist joint	0051	32.9062	$1,716.09		$343.22
25820	T		Fusion of hand bones	0053	14.1760	$739.29	$253.49	$147.86
25825	T		Fuse hand bones with graft	0054	22.7223	$1,184.99		$237.00
25830	T		Fusion, radioulnar jnt/ulna	0051	32.9062	$1,716.09		$343.22
25900	C		Amputation of forearm					
25905	C		Amputation of forearm					
25907	T		Amputation follow-up surgery	0049	18.6042	$970.23	$197.14	$194.05
25909	C		Amputation follow-up surgery					
25915	C		Amputation of forearm					
25920	C		Amputate hand at wrist					
25922	T		Amputate hand at wrist	0049	18.6042	$970.23	$197.14	$194.05

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25924	C	.....	Amputation follow-up surgery	.....	.....	.....	.....	.....
25927	C	.....	Amputation of hand	.....	.....	.....	.....	.....
25929	T	.....	Amputation follow-up surgery	0027	15.2225	$793.87	$329.72	$158.77
25931	C	.....	Amputation follow-up surgery	.....	.....	.....	.....	.....
25999	T	.....	Forearm or wrist surgery	0043	2.4999	$130.37	.....	$26.07
26010	T	.....	Drainage of finger abscess	0006	1.7926	$93.49	$24.12	$18.70
26011	T	.....	Drainage of finger abscess	0007	10.0191	$522.51	$108.89	$104.50
26020	T	.....	Drain hand tendon sheath	0053	14.1760	$739.29	$253.49	$147.86
26025	T	.....	Drainage of palm bursa	0053	14.1760	$739.29	$253.49	$147.86
26030	T	.....	Drainage of palm bursa(s)	0053	14.1760	$739.29	$253.49	$147.86
26034	T	.....	Treat hand bone lesion	0053	14.1760	$739.29	$253.49	$147.86
26035	T	.....	Decompress fingers/hand	0053	14.1760	$739.29	$253.49	$147.86
26037	T	.....	Decompress fingers/hand	0053	14.1760	$739.29	$253.49	$147.86
26040	T	.....	Release palm contracture	0054	22.7223	$1,184.99	.....	$237.00
26045	T	.....	Release palm contracture	0054	22.7223	$1,184.99	.....	$237.00
26055	T	.....	Incise finger tendon sheath	0053	14.1760	$739.29	$253.49	$147.86
26060	T	.....	Incision of finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26070	T	.....	Explore/treat hand joint	0053	14.1760	$739.29	$253.49	$147.86
26075	T	.....	Explore/treat finger joint	0053	14.1760	$739.29	$253.49	$147.86
26080	T	.....	Explore/treat finger joint	0053	14.1760	$739.29	$253.49	$147.86
26100	T	.....	Biopsy hand joint lining	0053	14.1760	$739.29	$253.49	$147.86
26105	T	.....	Biopsy finger joint lining	0053	14.1760	$739.29	$253.49	$147.86
26110	T	.....	Biopsy finger joint lining	0053	14.1760	$739.29	$253.49	$147.86
26115	T	.....	Removel hand lesion subcut	0022	17.3930	$907.06	$354.45	$181.41
26116	T	.....	Removel hand lesion, deep	0022	17.3930	$907.06	$354.45	$181.41
26117	T	.....	Remove tumor, hand/finger	0022	17.3930	$907.06	$354.45	$181.41
26121	T	.....	Release palm contracture	0054	22.7223	$1,184.99	.....	$237.00
26123	T	.....	Release palm contracture	0054	22.7223	$1,184.99	.....	$237.00
26125	T	.....	Release palm contracture	0054	22.7223	$1,184.99	.....	$237.00
26130	T	.....	Remove wrist joint lining	0053	14.1760	$739.29	$253.49	$147.86
26135	T	.....	Revise finger joint, each	0054	22.7223	$1,184.99	.....	$237.00
26140	T	.....	Revise finger joint, each	0053	14.1760	$739.29	$253.49	$147.86
26145	T	.....	Tendon excision, palm/finger	0053	14.1760	$739.29	$253.49	$147.86
26160	T	.....	Remove tendon sheath lesion	0053	14.1760	$739.29	$253.49	$147.86
26170	T	.....	Removal of palm tendon, each	0053	14.1760	$739.29	$253.49	$147.86
26180	T	.....	Removal of finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26185	T	.....	Remove finger bone	0053	14.1760	$739.29	$253.49	$147.86
26200	T	.....	Remove hand bone lesion	0053	14.1760	$739.29	$253.49	$147.86
26205	T	.....	Remove/graft bone lesion	0054	22.7223	$1,184.99	.....	$237.00
26210	T	.....	Removal of finger lesion	0053	14.1760	$739.29	$253.49	$147.86
26215	T	.....	Remove/graft finger lesion	0053	14.1760	$739.29	$253.49	$147.86
26230	T	.....	Partial removal of hand bone	0053	14.1760	$739.29	$253.49	$147.86
26235	T	.....	Partial removal, finger bone	0053	14.1760	$739.29	$253.49	$147.86
26236	T	.....	Partial removal, finger bone	0053	14.1760	$739.29	$253.49	$147.86
26250	T	.....	Extensive hand surgery	0053	14.1760	$739.29	$253.49	$147.86
26255	T	.....	Extensive hand surgery	0054	22.7223	$1,184.99	.....	$237.00
26260	T	.....	Extensive finger surgery	0053	14.1760	$739.29	$253.49	$147.86
26261	T	.....	Extensive finger surgery	0053	14.1760	$739.29	$253.49	$147.86
26262	T	.....	Partial removal of finger	0053	14.1760	$739.29	$253.49	$147.86
26320	T	.....	Removal of implant from hand	0021	13.9338	$726.66	$219.48	$145.33
26340	T	.....	Manipulate finger w/anesth	0043	2.4999	$130.37	.....	$26.07
26350	T	.....	Repair finger/hand tendon	0054	22.7223	$1,184.99	.....	$237.00
26352	T	.....	Repair/graft hand tendon	0054	22.7223	$1,184.99	.....	$237.00
26356	T	.....	Repair finger/hand tendon	0054	22.7223	$1,184.99	.....	$237.00
26357	T	.....	Repair finger/hand tendon	0054	22.7223	$1,184.99	.....	$237.00
26358	T	.....	Repair/graft hand tendon	0054	22.7223	$1,184.99	.....	$237.00
26370	T	.....	Repair finger/hand tendon	0054	22.7223	$1,184.99	.....	$237.00
26372	T	.....	Repair/graft hand tendon	0054	22.7223	$1,184.99	.....	$237.00
26373	T	.....	Repair finger/hand tendon	0054	22.7223	$1,184.99	.....	$237.00
26390	T	.....	Revise hand/finger tendon	0054	22.7223	$1,184.99	.....	$237.00
26392	T	.....	Repair/graft hand tendon	0054	22.7223	$1,184.99	.....	$237.00
26410	T	.....	Repair hand tendon	0053	14.1760	$739.29	$253.49	$147.86
26412	T	.....	Repair/graft hand tendon	0054	22.7223	$1,184.99	.....	$237.00
26415	T	.....	Excision, hand/finger tendon	0054	22.7223	$1,184.99	.....	$237.00
26416	T	.....	Graft hand or finger tendon	0054	22.7223	$1,184.99	.....	$237.00

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26418	T		Repair finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26420	T		Repair/graft finger tendon	0054	22.7223	$1,184.99		$237.00
26426	T		Repair finger/hand tendon	0054	22.7223	$1,184.99		$237.00
26428	T		Repair/graft finger tendon	0054	22.7223	$1,184.99		$237.00
26432	T		Repair finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26433	T		Repair finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26434	T		Repair/graft finger tendon	0054	22.7223	$1,184.99		$237.00
26437	T		Realignment of tendons	0053	14.1760	$739.29	$253.49	$147.86
26440	T		Release palm/finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26442	T		Release palm & finger tendon	0054	22.7223	$1,184.99		$237.00
26445	T		Release hand/finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26449	T		Release forearm/hand tendon	0054	22.7223	$1,184.99		$237.00
26450	T		Incision of palm tendon	0053	14.1760	$739.29	$253.49	$147.86
26455	T		Incision of finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26460	T		Incise hand/finger tendon	0053	14.1760	$739.29	$253.49	$147.86
26471	T		Fusion of finger tendons	0053	14.1760	$739.29	$253.49	$147.86
26474	T		Fusion of finger tendons	0053	14.1760	$739.29	$253.49	$147.86
26476	T		Tendon lengthening	0053	14.1760	$739.29	$253.49	$147.86
26477	T		Tendon shortening	0053	14.1760	$739.29	$253.49	$147.86
26478	T		Lengthening of hand tendon	0053	14.1760	$739.29	$253.49	$147.86
26479	T		Shortening of hand tendon	0053	14.1760	$739.29	$253.49	$147.86
26480	T		Transplant hand tendon	0054	22.7223	$1,184.99		$237.00
26483	T		Transplant/graft hand tendon	0054	22.7223	$1,184.99		$237.00
26485	T		Transplant palm tendon	0054	22.7223	$1,184.99		$237.00
26489	T		Transplant/graft palm tendon	0054	22.7223	$1,184.99		$237.00
26490	T		Revise thumb tendon	0054	22.7223	$1,184.99		$237.00
26492	T		Tendon transfer with graft	0054	22.7223	$1,184.99		$237.00
26494	T		Hand tendon/muscle transfer	0054	22.7223	$1,184.99		$237.00
26496	T		Revise thumb tendon	0054	22.7223	$1,184.99		$237.00
26497	T		Finger tendon transfer	0054	22.7223	$1,184.99		$237.00
26498	T		Finger tendon transfer	0054	22.7223	$1,184.99		$237.00
26499	T		Revision of finger	0054	22.7223	$1,184.99		$237.00
26500	T		Hand tendon reconstruction	0053	14.1760	$739.29	$253.49	$147.86
26502	T		Hand tendon reconstruction	0054	22.7223	$1,184.99		$237.00
26504	T		Hand tendon reconstruction	0054	22.7223	$1,184.99		$237.00
26508	T		Release thumb contracture	0053	14.1760	$739.29	$253.49	$147.86
26510	T		Thumb tendon transfer	0054	22.7223	$1,184.99		$237.00
26516	T		Fusion of knuckle joint	0054	22.7223	$1,184.99		$237.00
26517	T		Fusion of knuckle joints	0054	22.7223	$1,184.99		$237.00
26518	T		Fusion of knuckle joints	0054	22.7223	$1,184.99		$237.00
26520	T		Release knuckle contracture	0053	14.1760	$739.29	$253.49	$147.86
26525	T		Release finger contracture	0053	14.1760	$739.29	$253.49	$147.86
26530	T		Revise knuckle joint	0047	28.2842	$1,475.05	$537.03	$295.01
26531	T		Revise knuckle with implant	0048	40.6289	$2,118.84	$695.60	$423.77
26535	T		Revise finger joint	0047	28.2842	$1,475.05	$537.03	$295.01
26536	T		Revise/implant finger joint	0048	40.6289	$2,118.84	$695.60	$423.77
26540	T		Repair hand joint	0053	14.1760	$739.29	$253.49	$147.86
26541	T		Repair hand joint with graft	0054	22.7223	$1,184.99		$237.00
26542	T		Repair hand joint with graft	0053	14.1760	$739.29	$253.49	$147.86
26545	T		Reconstruct finger joint	0054	22.7223	$1,184.99		$237.00
26546	T		Repair nonunion hand	0054	22.7223	$1,184.99		$237.00
26548	T		Reconstruct finger joint	0054	22.7223	$1,184.99		$237.00
26550	T		Construct thumb replacement	0054	22.7223	$1,184.99		$237.00
26551	C		Great toe-hand transfer					
26553	C		Single transfer, toe-hand					
26554	C		Double transfer, toe-hand					
26555	T		Positional change of finger	0054	22.7223	$1,184.99		$237.00
26556	C		Toe joint transfer					
26560	T		Repair of web finger	0053	14.1760	$739.29	$253.49	$147.86
26561	T		Repair of web finger	0054	22.7223	$1,184.99		$237.00
26562	T		Repair of web finger	0054	22.7223	$1,184.99		$237.00
26565	T		Correct metacarpal flaw	0054	22.7223	$1,184.99		$237.00
26567	T		Correct finger deformity	0054	22.7223	$1,184.99		$237.00
26568	T		Lengthen metacarpal/finger	0054	22.7223	$1,184.99		$237.00
26580	T		Repair hand deformity	0054	22.7223	$1,184.99		$237.00

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26587	T		Reconstruct extra finger	0053	14.1760	$739.29	$253.49	$147.86
26590	T		Repair finger deformity	0054	22.7223	$1,184.99		$237.00
26591	T		Repair muscles of hand	0054	22.7223	$1,184.99		$237.00
26593	T		Release muscles of hand	0053	14.1760	$739.29	$253.49	$147.86
26596	T		Excision constricting tissue	0054	22.7223	$1,184.99		$237.00
26600	T		Treat metacarpal fracture	0043	2.4999	$130.37		$26.07
26605	T		Treat metacarpal fracture	0043	2.4999	$130.37		$26.07
26607	T		Treat metacarpal fracture	0043	2.4999	$130.37		$26.07
26608	T		Treat metacarpal fracture	0046	29.2920	$1,527.61	$535.76	$305.52
26615	T		Treat metacarpal fracture	0046	29.2920	$1,527.61	$535.76	$305.52
26641	T		Treat thumb dislocation	0043	2.4999	$130.37		$26.07
26645	T		Treat thumb fracture	0043	2.4999	$130.37		$26.07
26650	T		Treat thumb fracture	0046	29.2920	$1,527.61	$535.76	$305.52
26665	T		Treat thumb fracture	0046	29.2920	$1,527.61	$535.76	$305.52
26670	T		Treat hand dislocation	0043	2.4999	$130.37		$26.07
26675	T		Treat hand dislocation	0043	2.4999	$130.37		$26.07
26676	T		Pin hand dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
26685	T		Treat hand dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
26686	T		Treat hand dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
26700	T		Treat knuckle dislocation	0043	2.4999	$130.37		$26.07
26705	T		Treat knuckle dislocation	0043	2.4999	$130.37		$26.07
26706	T		Pin knuckle dislocation	0043	2.4999	$130.37		$26.07
26715	T		Treat knuckle dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
26720	T		Treat finger fracture, each	0043	2.4999	$130.37		$26.07
26725	T		Treat finger fracture, each	0043	2.4999	$130.37		$26.07
26727	T		Treat finger fracture, each	0046	29.2920	$1,527.61	$535.76	$305.52
26735	T		Treat finger fracture, each	0046	29.2920	$1,527.61	$535.76	$305.52
26740	T		Treat finger fracture, each	0043	2.4999	$130.37		$26.07
26742	T		Treat finger fracture, each	0043	2.4999	$130.37		$26.07
26746	T		Treat finger fracture, each	0046	29.2920	$1,527.61	$535.76	$305.52
26750	T		Treat finger fracture, each	0043	2.4999	$130.37		$26.07
26755	T		Treat finger fracture, each	0043	2.4999	$130.37		$26.07
26756	T		Pin finger fracture, each	0046	29.2920	$1,527.61	$535.76	$305.52
26765	T		Treat finger fracture, each	0046	29.2920	$1,527.61	$535.76	$305.52
26770	T		Treat finger dislocation	0043	2.4999	$130.37		$26.07
26775	T		Treat finger dislocation	0045	12.9357	$674.61	$268.47	$134.92
26776	T		Pin finger dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
26785	T		Treat finger dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
26820	T		Thumb fusion with graft	0054	22.7223	$1,184.99		$237.00
26841	T		Fusion of thumb	0054	22.7223	$1,184.99		$237.00
26842	T		Thumb fusion with graft	0054	22.7223	$1,184.99		$237.00
26843	T		Fusion of hand joint	0054	22.7223	$1,184.99		$237.00
26844	T		Fusion/graft of hand joint	0054	22.7223	$1,184.99		$237.00
26850	T		Fusion of knuckle	0054	22.7223	$1,184.99		$237.00
26852	T		Fusion of knuckle with graft	0054	22.7223	$1,184.99		$237.00
26860	T		Fusion of finger joint	0054	22.7223	$1,184.99		$237.00
26861	T		Fusion of finger jnt, add-on	0054	22.7223	$1,184.99		$237.00
26862	T		Fusion/graft of finger joint	0054	22.7223	$1,184.99		$237.00
26863	T		Fuse/graft added joint	0054	22.7223	$1,184.99		$237.00
26910	T		Amputate metacarpal bone	0054	22.7223	$1,184.99		$237.00
26951	T		Amputation of finger/thumb	0053	14.1760	$739.29	$253.49	$147.86
26952	T		Amputation of finger/thumb	0053	14.1760	$739.29	$253.49	$147.86
26989	T		Hand/finger surgery	0043	2.4999	$130.37		$26.07
26990	T		Drainage of pelvis lesion	0049	18.6042	$970.23	$197.14	$194.05
26991	T		Drainage of pelvis bursa	0049	18.6042	$970.23	$197.14	$194.05
26992	C		Drainage of bone lesion					
27000	T		Incision of hip tendon	0049	18.6042	$970.23	$197.14	$194.05
27001	T		Incision of hip tendon	0050	23.3037	$1,215.31		$243.06
27003	T		Incision of hip tendon	0050	23.3037	$1,215.31		$243.06
27005	C		Incision of hip tendon					
27006	C		Incision of hip tendons					
27025	C		Incision of hip/thigh fascia					
27030	C		Drainage of hip joint					
27033	T		Exploration of hip joint	0051	32.9062	$1,716.09		$343.22
27035	T		Denervation of hip joint	0052	40.7646	$2,125.91		$425.18

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27036	C		Excision of hip joint/muscle					
27040	T		Biopsy of soft tissues	0021	13.9338	$726.66	$219.48	$145.33
27041	T		Biopsy of soft tissues	0022	17.3930	$907.06	$354.45	$181.41
27047	T		Remove hip/pelvis lesion	0022	17.3930	$907.06	$354.45	$181.41
27048	T		Remove hip/pelvis lesion	0022	17.3930	$907.06	$354.45	$181.41
27049	T		Remove tumor, hip/pelvis	0022	17.3930	$907.06	$354.45	$181.41
27050	T		Biopsy of sacroiliac joint	0049	18.6042	$970.23	$197.14	$194.05
27052	T		Biopsy of hip joint	0049	18.6042	$970.23	$197.14	$194.05
27054	C		Removal of hip joint lining					
27060	T		Removal of ischial bursa	0049	18.6042	$970.23	$197.14	$194.05
27062	T		Remove femur lesion/bursa	0049	18.6042	$970.23	$197.14	$194.05
27065	T		Removal of hip bone lesion	0049	18.6042	$970.23	$197.14	$194.05
27066	T		Removal of hip bone lesion	0050	23.3037	$1,215.31		$243.06
27067	T		Remove/graft hip bone lesion	0050	23.3037	$1,215.31		$243.06
27070	C		Partial removal of hip bone					
27071	C		Partial removal of hip bone					
27075	C		Extensive hip surgery					
27076	C		Extensive hip surgery					
27077	C		Extensive hip surgery					
27078	C		Extensive hip surgery					
27079	C		Extensive hip surgery					
27080	T		Removal of tail bone	0050	23.3037	$1,215.31		$243.06
27086	T		Remove hip foreign body	0020	7.1898	$374.96	$113.25	$74.99
27087	T		Remove hip foreign body	0049	18.6042	$970.23	$197.14	$194.05
27090	C		Removal of hip prosthesis					
27091	C		Removal of hip prosthesis					
27093	N		Injection for hip x-ray					
27095	N		Injection for hip x-ray					
27096	N		Inject sacroiliac joint					
27097	T		Revision of hip tendon	0050	23.3037	$1,215.31		$243.06
27098	T		Transfer tendon to pelvis	0050	23.3037	$1,215.31		$243.06
27100	T		Transfer of abdominal muscle	0051	32.9062	$1,716.09		$343.22
27105	T		Transfer of spinal muscle	0051	32.9062	$1,716.09		$343.22
27110	T		Transfer of iliopsoas muscle	0051	32.9062	$1,716.09		$343.22
27111	T		Transfer of iliopsoas muscle	0051	32.9062	$1,716.09		$343.22
27120	C		Reconstruction of hip socket					
27122	C		Reconstruction of hip socket					
27125	C		Partial hip replacement					
27130	C		Total hip arthroplasty					
27132	C		Total hip arthroplasty					
27134	C		Revise hip joint replacement					
27137	C		Revise hip joint replacement					
27138	C		Revise hip joint replacement					
27140	C		Transplant femur ridge					
27146	C		Incision of hip bone					
27147	C		Revision of hip bone					
27151	C		Incision of hip bones					
27156	C		Revision of hip bones					
27158	C		Revision of pelvis					
27161	C		Incision of neck of femur					
27165	C		Incision/fixation of femur					
27170	C		Repair/graft femur head/neck					
27175	C		Treat slipped epiphysis					
27176	C		Treat slipped epiphysis					
27177	C		Treat slipped epiphysis					
27178	C		Treat slipped epiphysis					
27179	C		Revise head/neck of femur					
27181	C		Treat slipped epiphysis					
27185	C		Revision of femur epiphysis					
27187	C		Reinforce hip bones					
27193	T		Treat pelvic ring fracture	0043	2.4999	$130.37		$26.07
27194	T		Treat pelvic ring fracture	0045	12.9357	$674.61	$268.47	$134.92
27200	T		Treat tail bone fracture	0043	2.4999	$130.37		$26.07
27202	T		Treat tail bone fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27215	C		Treat pelvic fracture(s)					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27216	T		Treat pelvic ring fracture	0050	23.3037	$1,215.31		$243.06
27217	C		Treat pelvic ring fracture					
27218	C		Treat pelvic ring fracture					
27220	T		Treat hip socket fracture	0043	2.4999	$130.37		$26.07
27222	C		Treat hip socket fracture					
27226	C		Treat hip wall fracture					
27227	C		Treat hip fracture(s)					
27228	C		Treat hip fracture(s)					
27230	T		Treat thigh fracture	0043	2.4999	$130.37		$26.07
27232	C		Treat thigh fracture					
27235	T		Treat thigh fracture	0050	23.3037	$1,215.31		$243.06
27236	C		Treat thigh fracture					
27238	T		Treat thigh fracture	0043	2.4999	$130.37		$26.07
27240	C		Treat thigh fracture					
27244	C		Treat thigh fracture					
27245	C		Treat thigh fracture					
27246	T		Treat thigh fracture	0043	2.4999	$130.37		$26.07
27248	C		Treat thigh fracture					
27250	T		Treat hip dislocation	0043	2.4999	$130.37		$26.07
27252	T		Treat hip dislocation	0045	12.9357	$674.61	$268.47	$134.92
27253	C		Treat hip dislocation					
27254	C		Treat hip dislocation					
27256	T		Treat hip dislocation	0043	2.4999	$130.37		$26.07
27257	T		Treat hip dislocation	0045	12.9357	$674.61	$268.47	$134.92
27258	C		Treat hip dislocation					
27259	C		Treat hip dislocation					
27265	T		Treat hip dislocation	0043	2.4999	$130.37		$26.07
27266	T		Treat hip dislocation	0045	12.9357	$674.61	$268.47	$134.92
27275	T		Manipulation of hip joint	0045	12.9357	$674.61	$268.47	$134.92
27280	C		Fusion of sacroiliac joint					
27282	C		Fusion of pubic bones					
27284	C		Fusion of hip joint					
27286	C		Fusion of hip joint					
27290	C		Amputation of leg at hip					
27295	C		Amputation of leg at hip					
27299	T		Pelvis/hip joint surgery	0043	2.4999	$130.37		$26.07
27301	T		Drain thigh/knee lesion	0008	16.1430	$841.87		$168.37
27303	C		Drainage of bone lesion					
27305	T		Incise thigh tendon & fascia	0049	18.6042	$970.23	$197.14	$194.05
27306	T		Incision of thigh tendon	0049	18.6042	$970.23	$197.14	$194.05
27307	T		Incision of thigh tendons	0049	18.6042	$970.23	$197.14	$194.05
27310	T		Exploration of knee joint	0050	23.3037	$1,215.31		$243.06
27315	T		Partial removal, thigh nerve	0220	15.8136	$824.70		$164.94
27320	T		Partial removal, thigh nerve	0220	15.8136	$824.70		$164.94
27323	T		Biopsy, thigh soft tissues	0021	13.9338	$726.66	$219.48	$145.33
27324	T		Biopsy, thigh soft tissues	0022	17.3930	$907.06	$354.45	$181.41
27327	T		Removal of thigh lesion	0022	17.3930	$907.06	$354.45	$181.41
27328	T		Removal of thigh lesion	0022	17.3930	$907.06	$354.45	$181.41
27329	T		Remove tumor, thigh/knee	0022	17.3930	$907.06	$354.45	$181.41
27330	T		Biopsy, knee joint lining	0050	23.3037	$1,215.31		$243.06
27331	T		Explore/treat knee joint	0050	23.3037	$1,215.31		$243.06
27332	T		Removal of knee cartilage	0050	23.3037	$1,215.31		$243.06
27333	T		Removal of knee cartilage	0050	23.3037	$1,215.31		$243.06
27334	T		Remove knee joint lining	0050	23.3037	$1,215.31		$243.06
27335	T		Remove knee joint lining	0050	23.3037	$1,215.31		$243.06
27340	T		Removal of kneecap bursa	0049	18.6042	$970.23	$197.14	$194.05
27345	T		Removal of knee cyst	0049	18.6042	$970.23	$197.14	$194.05
27347	T		Remove knee cyst	0049	18.6042	$970.23	$197.14	$194.05
27350	T		Removal of kneecap	0050	23.3037	$1,215.31		$243.06
27355	T		Remove femur lesion	0050	23.3037	$1,215.31		$243.06
27356	T		Remove femur lesion/graft	0050	23.3037	$1,215.31		$243.06
27357	T		Remove femur lesion/graft	0050	23.3037	$1,215.31		$243.06
27358	T		Remove femur lesion/fixation	0050	23.3037	$1,215.31		$243.06
27360	T		Partial removal, leg bone(s)	0050	23.3037	$1,215.31		$243.06
27365	C		Extensive leg surgery					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27370	N		Injection for knee x-ray					
27372	T		Removal of foreign body	0022	17.3930	$907.06	$354.45	$181.41
27380	T		Repair of kneecap tendon	0049	18.6042	$970.23	$197.14	$194.05
27381	T		Repair/graft kneecap tendon	0049	18.6042	$970.23	$197.14	$194.05
27385	T		Repair of thigh muscle	0049	18.6042	$970.23	$197.14	$194.05
27386	T		Repair/graft of thigh muscle	0049	18.6042	$970.23	$197.14	$194.05
27390	T		Incision of thigh tendon	0049	18.6042	$970.23	$197.14	$194.05
27391	T		Incision of thigh tendons	0049	18.6042	$970.23	$197.14	$194.05
27392	T		Incision of thigh tendons	0049	18.6042	$970.23	$197.14	$194.05
27393	T		Lengthening of thigh tendon	0050	23.3037	$1,215.31		$243.06
27394	T		Lengthening of thigh tendons	0050	23.3037	$1,215.31		$243.06
27395	T		Lengthening of thigh tendons	0051	32.9062	$1,716.09		$343.22
27396	T		Transplant of thigh tendon	0050	23.3037	$1,215.31		$243.06
27397	T		Transplants of thigh tendons	0051	32.9062	$1,716.09		$343.22
27400	T		Revise thigh muscles/tendons	0051	32.9062	$1,716.09		$343.22
27403	T		Repair of knee cartilage	0050	23.3037	$1,215.31		$243.06
27405	T		Repair of knee ligament	0051	32.9062	$1,716.09		$343.22
27407	T		Repair of knee ligament	0051	32.9062	$1,716.09		$343.22
27409	T		Repair of knee ligaments	0051	32.9062	$1,716.09		$343.22
27418	T		Repair degenerated kneecap	0051	32.9062	$1,716.09		$343.22
27420	T		Revision of unstable kneecap	0051	32.9062	$1,716.09		$343.22
27422	T		Revision of unstable kneecap	0051	32.9062	$1,716.09		$343.22
27424	T		Revision/removal of kneecap	0051	32.9062	$1,716.09		$343.22
27425	T		Lateral retinacular release	0050	23.3037	$1,215.31		$243.06
27427	T		Reconstruction, knee	0052	40.7646	$2,125.91		$425.18
27428	T		Reconstruction, knee	0052	40.7646	$2,125.91		$425.18
27429	T		Reconstruction, knee	0052	40.7646	$2,125.91		$425.18
27430	T		Revision of thigh muscles	0051	32.9062	$1,716.09		$343.22
27435	T		Incision of knee joint	0051	32.9062	$1,716.09		$343.22
27437	T		Revise kneecap	0047	28.2842	$1,475.05	$537.03	$295.01
27438	T		Revise kneecap with implant	0048	40.6289	$2,118.84	$695.60	$423.77
27440	T		Revision of knee joint	0047	28.2842	$1,475.05	$537.03	$295.01
27441	T		Revision of knee joint	0047	28.2842	$1,475.05	$537.03	$295.01
27442	T		Revision of knee joint	0047	28.2842	$1,475.05	$537.03	$295.01
27443	T		Revision of knee joint	0047	28.2842	$1,475.05	$537.03	$295.01
27445	C		Revision of knee joint					
27446	T		Revision of knee joint	0681	147.8067	$7,708.27	$3,067.55	$1,541.65
27447	C		Total knee arthroplasty					
27448	C		Incision of thigh					
27450	C		Incision of thigh					
27454	C		Realignment of thigh bone					
27455	C		Realignment of knee					
27457	C		Realignment of knee					
27465	C		Shortening of thigh bone					
27466	C		Lengthening of thigh bone					
27468	C		Shorten/lengthen thighs					
27470	C		Repair of thigh					
27472	C		Repair/graft of thigh					
27475	C		Surgery to stop leg growth					
27477	C		Surgery to stop leg growth					
27479	C		Surgery to stop leg growth					
27485	C		Surgery to stop leg growth					
27486	C		Revise/replace knee joint					
27487	C		Revise/replace knee joint					
27488	C		Removal of knee prosthesis					
27495	C		Reinforce thigh					
27496	T		Decompression of thigh/knee	0049	18.6042	$970.23	$197.14	$194.05
27497	T		Decompression of thigh/knee	0049	18.6042	$970.23	$197.14	$194.05
27498	T		Decompression of thigh/knee	0049	18.6042	$970.23	$197.14	$194.05
27499	T		Decompression of thigh/knee	0049	18.6042	$970.23	$197.14	$194.05
27500	T		Treatment of thigh fracture	0043	2.4999	$130.37		$26.07
27501	T		Treatment of thigh fracture	0043	2.4999	$130.37		$26.07
27502	T		Treatment of thigh fracture	0043	2.4999	$130.37		$26.07
27503	T		Treatment of thigh fracture	0043	2.4999	$130.37		$26.07
27506	C		Treatment of thigh fracture					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27507	C		Treatment of thigh fracture					
27508	T		Treatment of thigh fracture	0043	2.4999	$130.37		$26.07
27509	T		Treatment of thigh fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27510	T		Treatment of thigh fracture	0043	2.4999	$130.37		$26.07
27511	C		Treatment of thigh fracture					
27513	C		Treatment of thigh fracture					
27514	C		Treatment of thigh fracture					
27516	T		Treat thigh fx growth plate	0043	2.4999	$130.37		$26.07
27517	T		Treat thigh fx growth plate	0043	2.4999	$130.37		$26.07
27519	C		Treat thigh fx growth plate					
27520	T		Treat kneecap fracture	0043	2.4999	$130.37		$26.07
27524	T		Treat kneecap fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27530	T		Treat knee fracture	0043	2.4999	$130.37		$26.07
27532	T		Treat knee fracture	0043	2.4999	$130.37		$26.07
27535	C		Treat knee fracture					
27536	C		Treat knee fracture					
27538	T		Treat knee fracture(s)	0043	2.4999	$130.37		$26.07
27540	C		Treat knee fracture					
27550	T		Treat knee dislocation	0043	2.4999	$130.37		$26.07
27552	T		Treat knee dislocation	0045	12.9357	$674.61	$268.47	$134.92
27556	C		Treat knee dislocation					
27557	C		Treat knee dislocation					
27558	C		Treat knee dislocation					
27560	T		Treat kneecap dislocation	0043	2.4999	$130.37		$26.07
27562	T		Treat kneecap dislocation	0045	12.9357	$674.61	$268.47	$134.92
27566	T		Treat kneecap dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
27570	T		Fixation of knee joint	0045	12.9357	$674.61	$268.47	$134.92
27580	C		Fusion of knee					
27590	C		Amputate leg at thigh					
27591	C		Amputate leg at thigh					
27592	C		Amputate leg at thigh					
27594	T		Amputation follow-up surgery	0049	18.6042	$970.23	$197.14	$194.05
27596	C		Amputation follow-up surgery					
27598	C		Amputate lower leg at knee					
27599	T		Leg surgery procedure	0043	2.4999	$130.37		$26.07
27600	T		Decompression of lower leg	0049	18.6042	$970.23	$197.14	$194.05
27601	T		Decompression of lower leg	0049	18.6042	$970.23	$197.14	$194.05
27602	T		Decompression of lower leg	0049	18.6042	$970.23	$197.14	$194.05
27603	T		Drain lower leg lesion	0008	16.1430	$841.87		$168.37
27604	T		Drain lower leg bursa	0049	18.6042	$970.23	$197.14	$194.05
27605	T		Incision of achilles tendon	0055	17.6740	$921.72	$355.34	$184.34
27606	T		Incision of achilles tendon	0049	18.6042	$970.23	$197.14	$194.05
27607	T		Treat lower leg bone lesion	0049	18.6042	$970.23	$197.14	$194.05
27610	T		Explore/treat ankle joint	0050	23.3037	$1,215.31		$243.06
27612	T		Exploration of ankle joint	0050	23.3037	$1,215.31		$243.06
27613	T		Biopsy lower leg soft tissue	0020	7.1898	$374.96	$113.25	$74.99
27614	T		Biopsy lower leg soft tissue	0022	17.3930	$907.06	$354.45	$181.41
27615	T		Remove tumor, lower leg	0046	29.2920	$1,527.61	$535.76	$305.52
27618	T		Remove lower leg lesion	0021	13.9338	$726.66	$219.48	$145.33
27619	T		Remove lower leg lesion	0022	17.3930	$907.06	$354.45	$181.41
27620	T		Explore/treat ankle joint	0050	23.3037	$1,215.31		$243.06
27625	T		Remove ankle joint lining	0050	23.3037	$1,215.31		$243.06
27626	T		Remove ankle joint lining	0050	23.3037	$1,215.31		$243.06
27630	T		Removal of tendon lesion	0049	18.6042	$970.23	$197.14	$194.05
27635	T		Remove lower leg bone lesion	0050	23.3037	$1,215.31		$243.06
27637	T		Remove/graft leg bone lesion	0050	23.3037	$1,215.31		$243.06
27638	T		Remove/graft leg bone lesion	0050	23.3037	$1,215.31		$243.06
27640	T		Partial removal of tibia	0051	32.9062	$1,716.09		$343.22
27641	T		Partial removal of fibula	0050	23.3037	$1,215.31		$243.06
27645	C		Extensive lower leg surgery					
27646	C		Extensive lower leg surgery					
27647	T		Extensive ankle/heel surgery	0051	32.9062	$1,716.09		$343.22
27648	N		Injection for ankle x-ray					
27650	T		Repair achilles tendon	0051	32.9062	$1,716.09		$343.22
27652	T		Repair/graft achilles tendon	0051	32.9062	$1,716.09		$343.22

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27654	T		Repair of achilles tendon	0051	32.9062	$1,716.09		$343.22
27656	T		Repair leg fascia defect	0049	18.6042	$970.23	$197.14	$194.05
27658	T		Repair of leg tendon, each	0049	18.6042	$970.23	$197.14	$194.05
27659	T		Repair of leg tendon, each	0049	18.6042	$970.23	$197.14	$194.05
27664	T		Repair of leg tendon, each	0049	18.6042	$970.23	$197.14	$194.05
27665	T		Repair of leg tendon, each	0050	23.3037	$1,215.31		$243.06
27675	T		Repair lower leg tendons	0049	18.6042	$970.23	$197.14	$194.05
27676	T		Repair lower leg tendons	0050	23.3037	$1,215.31		$243.06
27680	T		Release of lower leg tendon	0050	23.3037	$1,215.31		$243.06
27681	T		Release of lower leg tendons	0050	23.3037	$1,215.31		$243.06
27685	T		Revision of lower leg tendon	0050	23.3037	$1,215.31		$243.06
27686	T		Revise lower leg tendons	0050	23.3037	$1,215.31		$243.06
27687	T		Revision of calf tendon	0050	23.3037	$1,215.31		$243.06
27690	T		Revise lower leg tendon	0051	32.9062	$1,716.09		$343.22
27691	T		Revise lower leg tendon	0051	32.9062	$1,716.09		$343.22
27692	T		Revise additional leg tendon	0051	32.9062	$1,716.09		$343.22
27695	T		Repair of ankle ligament	0050	23.3037	$1,215.31		$243.06
27696	T		Repair of ankle ligaments	0050	23.3037	$1,215.31		$243.06
27698	T		Repair of ankle ligament	0050	23.3037	$1,215.31		$243.06
27700	T		Revision of ankle joint	0047	28.2842	$1,475.05	$537.03	$295.01
27702	C		Reconstruct ankle joint					
27703	C		Reconstruction, ankle joint					
27704	T		Removal of ankle implant	0049	18.6042	$970.23	$197.14	$194.05
27705	T		Incision of tibia	0051	32.9062	$1,716.09		$343.22
27707	T		Incision of fibula	0049	18.6042	$970.23	$197.14	$194.05
27709	T		Incision of tibia & fibula	0050	23.3037	$1,215.31		$243.06
27712	C		Realignment of lower leg					
27715	C		Revision of lower leg					
27720	C		Repair of tibia					
27722	C		Repair/graft of tibia					
27724	C		Repair/graft of tibia					
27725	C		Repair of lower leg					
27727	C		Repair of lower leg					
27730	T		Repair of tibia epiphysis	0050	23.3037	$1,215.31		$243.06
27732	T		Repair of fibula epiphysis	0050	23.3037	$1,215.31		$243.06
27734	T		Repair lower leg epiphyses	0050	23.3037	$1,215.31		$243.06
27740	T		Repair of leg epiphyses	0050	23.3037	$1,215.31		$243.06
27742	T		Repair of leg epiphyses	0051	32.9062	$1,716.09		$343.22
27745	T		Reinforce tibia	0051	32.9062	$1,716.09		$343.22
27750	T		Treatment of tibia fracture	0043	2.4999	$130.37		$26.07
27752	T		Treatment of tibia fracture	0043	2.4999	$130.37		$26.07
27756	T		Treatment of tibia fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27758	T		Treatment of tibia fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27759	T		Treatment of tibia fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27760	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
27762	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
27766	T		Treatment of ankle fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27780	T		Treatment of fibula fracture	0043	2.4999	$130.37		$26.07
27781	T		Treatment of fibula fracture	0043	2.4999	$130.37		$26.07
27784	T		Treatment of fibula fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27786	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
27788	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
27792	T		Treatment of ankle fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27808	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
27810	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
27814	T		Treatment of ankle fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27816	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
27818	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
27822	T		Treatment of ankle fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27823	T		Treatment of ankle fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27824	T		Treat lower leg fracture	0043	2.4999	$130.37		$26.07
27825	T		Treat lower leg fracture	0043	2.4999	$130.37		$26.07
27826	T		Treat lower leg fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27827	T		Treat lower leg fracture	0046	29.2920	$1,527.61	$535.76	$305.52
27828	T		Treat lower leg fracture	0046	29.2920	$1,527.61	$535.76	$305.52

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27829	T		Treat lower leg joint	0046	29.2920	$1,527.61	$535.76	$305.52
27830	T		Treat lower leg dislocation	0043	2.4999	$130.37		$26.07
27831	T		Treat lower leg dislocation	0043	2.4999	$130.37		$26.07
27832	T		Treat lower leg dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
27840	T		Treat ankle dislocation	0043	2.4999	$130.37		$26.07
27842	T		Treat ankle dislocation	0045	12.9357	$674.61	$268.47	$134.92
27846	T		Treat ankle dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
27848	T		Treat ankle dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
27860	T		Fixation of ankle joint	0045	12.9357	$674.61	$268.47	$134.92
27870	T		Fusion of ankle joint	0051	32.9062	$1,716.09		$343.22
27871	T		Fusion of tibiofibular joint	0051	32.9062	$1,716.09		$343.22
27880	C		Amputation of lower leg					
27881	C		Amputation of lower leg					
27882	C		Amputation of lower leg					
27884	T		Amputation follow-up surgery	0049	18.6042	$970.23	$197.14	$194.05
27886	C		Amputation follow-up surgery					
27888	C		Amputation of foot at ankle					
27889	T		Amputation of foot at ankle	0050	23.3037	$1,215.31		$243.06
27892	T		Decompression of leg	0049	18.6042	$970.23	$197.14	$194.05
27893	T		Decompression of leg	0049	18.6042	$970.23	$197.14	$194.05
27894	T		Decompression of leg	0049	18.6042	$970.23	$197.14	$194.05
27899	T		Leg/ankle surgery procedure	0043	2.4999	$130.37		$26.07
28001	T		Drainage of bursa of foot	0008	16.1430	$841.87		$168.37
28002	T		Treatment of foot infection	0049	18.6042	$970.23	$197.14	$194.05
28003	T		Treatment of foot infection	0049	18.6042	$970.23	$197.14	$194.05
28005	T		Treat foot bone lesion	0055	17.6740	$921.72	$355.34	$184.34
28008	T		Incision of foot fascia	0055	17.6740	$921.72	$355.34	$184.34
28010	T		Incision of toe tendon	0055	17.6740	$921.72	$355.34	$184.34
28011	T		Incision of toe tendons	0055	17.6740	$921.72	$355.34	$184.34
28020	T		Exploration of foot joint	0055	17.6740	$921.72	$355.34	$184.34
28022	T		Exploration of foot joint	0055	17.6740	$921.72	$355.34	$184.34
28024	T		Exploration of toe joint	0055	17.6740	$921.72	$355.34	$184.34
28030	T		Removal of foot nerve	0220	15.8136	$824.70		$164.94
28035	T		Decompression of tibia nerve	0220	15.8136	$824.70		$164.94
28043	T		Excision of foot lesion	0021	13.9338	$726.66	$219.48	$145.33
28045	T		Excision of foot lesion	0055	17.6740	$921.72	$355.34	$184.34
28046	T		Resection of tumor, foot	0055	17.6740	$921.72	$355.34	$184.34
28050	T		Biopsy of foot joint lining	0055	17.6740	$921.72	$355.34	$184.34
28052	T		Biopsy of foot joint lining	0055	17.6740	$921.72	$355.34	$184.34
28054	T		Biopsy of toe joint lining	0055	17.6740	$921.72	$355.34	$184.34
28060	T		Partial removal, foot fascia	0056	22.1700	$1,156.19	$405.81	$231.24
28062	T		Removal of foot fascia	0056	22.1700	$1,156.19	$405.81	$231.24
28070	T		Removal of foot joint lining	0056	22.1700	$1,156.19	$405.81	$231.24
28072	T		Removal of foot joint lining	0056	22.1700	$1,156.19	$405.81	$231.24
28080	T		Removal of foot lesion	0055	17.6740	$921.72	$355.34	$184.34
28086	T		Excise foot tendon sheath	0055	17.6740	$921.72	$355.34	$184.34
28088	T		Excise foot tendon sheath	0055	17.6740	$921.72	$355.34	$184.34
28090	T		Removal of foot lesion	0055	17.6740	$921.72	$355.34	$184.34
28092	T		Removal of toe lesions	0055	17.6740	$921.72	$355.34	$184.34
28100	T		Removal of ankle/heel lesion	0055	17.6740	$921.72	$355.34	$184.34
28102	T		Remove/graft foot lesion	0056	22.1700	$1,156.19	$405.81	$231.24
28103	T		Remove/graft foot lesion	0056	22.1700	$1,156.19	$405.81	$231.24
28104	T		Removal of foot lesion	0055	17.6740	$921.72	$355.34	$184.34
28106	T		Remove/graft foot lesion	0056	22.1700	$1,156.19	$405.81	$231.24
28107	T		Remove/graft foot lesion	0056	22.1700	$1,156.19	$405.81	$231.24
28108	T		Removal of toe lesions	0055	17.6740	$921.72	$355.34	$184.34
28110	T		Part removal of metatarsal	0056	22.1700	$1,156.19	$405.81	$231.24
28111	T		Part removal of metatarsal	0055	17.6740	$921.72	$355.34	$184.34
28112	T		Part removal of metatarsal	0055	17.6740	$921.72	$355.34	$184.34
28113	T		Part removal of metatarsal	0055	17.6740	$921.72	$355.34	$184.34
28114	T		Removal of metatarsal heads	0055	17.6740	$921.72	$355.34	$184.34
28116	T		Revision of foot	0055	17.6740	$921.72	$355.34	$184.34
28118	T		Removal of heel bone	0055	17.6740	$921.72	$355.34	$184.34
28119	T		Removal of heel spur	0055	17.6740	$921.72	$355.34	$184.34
28120	T		Part removal of ankle/heel	0055	17.6740	$921.72	$355.34	$184.34

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28122	T		Partial removal of foot bone	0055	17.6740	$921.72	$355.34	$184.34
28124	T		Partial removal of toe	0055	17.6740	$921.72	$355.34	$184.34
28126	T		Partial removal of toe	0055	17.6740	$921.72	$355.34	$184.34
28130	T		Removal of ankle bone	0055	17.6740	$921.72	$355.34	$184.34
28140	T		Removal of metatarsal	0055	17.6740	$921.72	$355.34	$184.34
28150	T		Removal of toe	0055	17.6740	$921.72	$355.34	$184.34
28153	T		Partial removal of toe	0055	17.6740	$921.72	$355.34	$184.34
28160	T		Partial removal of toe	0055	17.6740	$921.72	$355.34	$184.34
28171	T		Extensive foot surgery	0055	17.6740	$921.72	$355.34	$184.34
28173	T		Extensive foot surgery	0055	17.6740	$921.72	$355.34	$184.34
28175	T		Extensive foot surgery	0055	17.6740	$921.72	$355.34	$184.34
28190	T		Removal of foot foreign body	0019	3.7693	$196.57	$71.87	$39.31
28192	T		Removal of foot foreign body	0021	13.9338	$726.66	$219.48	$145.33
28193	T		Removal of foot foreign body	0021	13.9338	$726.66	$219.48	$145.33
28200	T		Repair of foot tendon	0055	17.6740	$921.72	$355.34	$184.34
28202	T		Repair/graft of foot tendon	0056	22.1700	$1,156.19	$405.81	$231.24
28208	T		Repair of foot tendon	0055	17.6740	$921.72	$355.34	$184.34
28210	T		Repair/graft of foot tendon	0055	17.6740	$921.72	$355.34	$184.34
28220	T		Release of foot tendon	0055	17.6740	$921.72	$355.34	$184.34
28222	T		Release of foot tendons	0055	17.6740	$921.72	$355.34	$184.34
28225	T		Release of foot tendon	0055	17.6740	$921.72	$355.34	$184.34
28226	T		Release of foot tendons	0055	17.6740	$921.72	$355.34	$184.34
28230	T		Incision of foot tendon(s)	0055	17.6740	$921.72	$355.34	$184.34
28232	T		Incision of toe tendon	0055	17.6740	$921.72	$355.34	$184.34
28234	T		Incision of foot tendon	0055	17.6740	$921.72	$355.34	$184.34
28238	T		Revision of foot tendon	0056	22.1700	$1,156.19	$405.81	$231.24
28240	T		Release of big toe	0055	17.6740	$921.72	$355.34	$184.34
28250	T		Revision of foot fascia	0056	22.1700	$1,156.19	$405.81	$231.24
28260	T		Release of midfoot joint	0056	22.1700	$1,156.19	$405.81	$231.24
28261	T		Revision of foot tendon	0056	22.1700	$1,156.19	$405.81	$231.24
28262	T		Revision of foot and ankle	0056	22.1700	$1,156.19	$405.81	$231.24
28264	T		Release of midfoot joint	0056	22.1700	$1,156.19	$405.81	$231.24
28270	T		Release of foot contracture	0055	17.6740	$921.72	$355.34	$184.34
28272	T		Release of toe joint, each	0055	17.6740	$921.72	$355.34	$184.34
28280	T		Fusion of toes	0055	17.6740	$921.72	$355.34	$184.34
28285	T		Repair of hammertoe	0055	17.6740	$921.72	$355.34	$184.34
28286	T		Repair of hammertoe	0055	17.6740	$921.72	$355.34	$184.34
28288	T		Partial removal of foot bone	0056	22.1700	$1,156.19	$405.81	$231.24
28289	T		Repair hallux rigidus	0056	22.1700	$1,156.19	$405.81	$231.24
28290	T		Correction of bunion	0056	22.1700	$1,156.19	$405.81	$231.24
28292	T		Correction of bunion	0057	22.9064	$1,194.59	$475.91	$238.92
28293	T		Correction of bunion	0057	22.9064	$1,194.59	$475.91	$238.92
28294	T		Correction of bunion	0056	22.1700	$1,156.19	$405.81	$231.24
28296	T		Correction of bunion	0056	22.1700	$1,156.19	$405.81	$231.24
28297	T		Correction of bunion	0057	22.9064	$1,194.59	$475.91	$238.92
28298	T		Correction of bunion	0056	22.1700	$1,156.19	$405.81	$231.24
28299	T		Correction of bunion	0057	22.9064	$1,194.59	$475.91	$238.92
28300	T		Incision of heel bone	0056	22.1700	$1,156.19	$405.81	$231.24
28302	T		Incision of ankle bone	0056	22.1700	$1,156.19	$405.81	$231.24
28304	T		Incision of midfoot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28305	T		Incise/graft midfoot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28306	T		Incision of metatarsal	0056	22.1700	$1,156.19	$405.81	$231.24
28307	T		Incision of metatarsal	0056	22.1700	$1,156.19	$405.81	$231.24
28308	T		Incision of metatarsal	0056	22.1700	$1,156.19	$405.81	$231.24
28309	T		Incision of metatarsals	0056	22.1700	$1,156.19	$405.81	$231.24
28310	T		Revision of big toe	0055	17.6740	$921.72	$355.34	$184.34
28312	T		Revision of toe	0055	17.6740	$921.72	$355.34	$184.34
28313	T		Repair deformity of toe	0055	17.6740	$921.72	$355.34	$184.34
28315	T		Removal of sesamoid bone	0055	17.6740	$921.72	$355.34	$184.34
28320	T		Repair of foot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28322	T		Repair of metatarsals	0056	22.1700	$1,156.19	$405.81	$231.24
28340	T		Resect enlarged toe tissue	0055	17.6740	$921.72	$355.34	$184.34
28341	T		Resect enlarged toe	0055	17.6740	$921.72	$355.34	$184.34
28344	T		Repair extra toe(s)	0056	22.1700	$1,156.19	$405.81	$231.24
28345	T		Repair webbed toe(s)	0056	22.1700	$1,156.19	$405.81	$231.24

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28360	T		Reconstruct cleft foot	0056	22.1700	$1,156.19	$405.81	$231.24
28400	T		Treatment of heel fracture	0043	2.4999	$130.37		$26.07
28405	T		Treatment of heel fracture	0043	2.4999	$130.37		$26.07
28406	T		Treatment of heel fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28415	T		Treat heel fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28420	T		Treat/graft heel fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28430	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
28435	T		Treatment of ankle fracture	0043	2.4999	$130.37		$26.07
28436	T		Treatment of ankle fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28445	T		Treat ankle fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28450	T		Treat midfoot fracture, each	0043	2.4999	$130.37		$26.07
28455	T		Treat midfoot fracture, each	0043	2.4999	$130.37		$26.07
28456	T		Treat midfoot fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28465	T		Treat midfoot fracture, each	0046	29.2920	$1,527.61	$535.76	$305.52
28470	T		Treat metatarsal fracture	0043	2.4999	$130.37		$26.07
28475	T		Treat metatarsal fracture	0043	2.4999	$130.37		$26.07
28476	T		Treat metatarsal fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28485	T		Treat metatarsal fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28490	T		Treat big toe fracture	0043	2.4999	$130.37		$26.07
28495	T		Treat big toe fracture	0043	2.4999	$130.37		$26.07
28496	T		Treat big toe fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28505	T		Treat big toe fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28510	T		Treatment of toe fracture	0043	2.4999	$130.37		$26.07
28515	T		Treatment of toe fracture	0043	2.4999	$130.37		$26.07
28525	T		Treat toe fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28530	T		Treat sesamoid bone fracture	0043	2.4999	$130.37		$26.07
28531	T		Treat sesamoid bone fracture	0046	29.2920	$1,527.61	$535.76	$305.52
28540	T		Treat foot dislocation	0043	2.4999	$130.37		$26.07
28545	T		Treat foot dislocation	0045	12.9357	$674.61	$268.47	$134.92
28546	T		Treat foot dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28555	T		Repair foot dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28570	T		Treat foot dislocation	0043	2.4999	$130.37		$26.07
28575	T		Treat foot dislocation	0043	2.4999	$130.37		$26.07
28576	T		Treat foot dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28585	T		Repair foot dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28600	T		Treat foot dislocation	0043	2.4999	$130.37		$26.07
28605	T		Treat foot dislocation	0043	2.4999	$130.37		$26.07
28606	T		Treat foot dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28615	T		Repair foot dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28630	T		Treat toe dislocation	0043	2.4999	$130.37		$26.07
28635	T		Treat toe dislocation	0045	12.9357	$674.61	$268.47	$134.92
28636	T		Treat toe dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28645	T		Repair toe dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28660	T		Treat toe dislocation	0043	2.4999	$130.37		$26.07
28665	T		Treat toe dislocation	0045	12.9357	$674.61	$268.47	$134.92
28666	T		Treat toe dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28675	T		Repair of toe dislocation	0046	29.2920	$1,527.61	$535.76	$305.52
28705	T		Fusion of foot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28715	T		Fusion of foot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28725	T		Fusion of foot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28730	T		Fusion of foot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28735	T		Fusion of foot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28737	T		Revision of foot bones	0055	17.6740	$921.72	$355.34	$184.34
28740	T		Fusion of foot bones	0056	22.1700	$1,156.19	$405.81	$231.24
28750	T		Fusion of big toe joint	0055	17.6740	$921.72	$355.34	$184.34
28755	T		Fusion of big toe joint	0055	17.6740	$921.72	$355.34	$184.34
28760	T		Fusion of big toe joint	0056	22.1700	$1,156.19	$405.81	$231.24
28800	C		Amputation of midfoot					
28805	C		Amputation thru metatarsal					
28810	T		Amputation toe & metatarsal	0055	17.6740	$921.72	$355.34	$184.34
28820	T		Amputation of toe	0055	17.6740	$921.72	$355.34	$184.34
28825	T		Partial amputation of toe	0055	17.6740	$921.72	$355.34	$184.34
28899	T		Foot/toes surgery procedure	0043	2.4999	$130.37		$26.07
29000	S		Application of body cast	0058	1.0368	$54.07		$10.81
29010	S		Application of body cast	0058	1.0368	$54.07		$10.81

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29015	S		Application of body cast	0058	1.0368	$54.07		$10.81
29020	S		Application of body cast	0058	1.0368	$54.07		$10.81
29025	S		Application of body cast	0058	1.0368	$54.07		$10.81
29035	S		Application of body cast	0058	1.0368	$54.07		$10.81
29040	S		Application of body cast	0058	1.0368	$54.07		$10.81
29044	S		Application of body cast	0058	1.0368	$54.07		$10.81
29046	S		Application of body cast	0058	1.0368	$54.07		$10.81
29049	S		Application of figure eight	0058	1.0368	$54.07		$10.81
29055	S		Application of shoulder cast	0058	1.0368	$54.07		$10.81
29058	S		Application of shoulder cast	0058	1.0368	$54.07		$10.81
29065	S		Application of long arm cast	0058	1.0368	$54.07		$10.81
29075	S		Application of forearm cast	0058	1.0368	$54.07		$10.81
29085	S		Apply hand/wrist cast	0058	1.0368	$54.07		$10.81
29086	S		Apply finger cast	0058	1.0368	$54.07		$10.81
29105	S		Apply long arm splint	0058	1.0368	$54.07		$10.81
29125	S		Apply forearm splint	0058	1.0368	$54.07		$10.81
29126	S		Apply forearm splint	0058	1.0368	$54.07		$10.81
29130	S		Application of finger splint	0058	1.0368	$54.07		$10.81
29131	S		Application of finger splint	0058	1.0368	$54.07		$10.81
29200	S		Strapping of chest	0058	1.0368	$54.07		$10.81
29220	S		Strapping of low back	0058	1.0368	$54.07		$10.81
29240	S		Strapping of shoulder	0058	1.0368	$54.07		$10.81
29260	S		Strapping of elbow or wrist	0058	1.0368	$54.07		$10.81
29280	S		Strapping of hand or finger	0058	1.0368	$54.07		$10.81
29305	S		Application of hip cast	0058	1.0368	$54.07		$10.81
29325	S		Application of hip casts	0058	1.0368	$54.07		$10.81
29345	S		Application of long leg cast	0058	1.0368	$54.07		$10.81
29355	S		Application of long leg cast	0058	1.0368	$54.07		$10.81
29358	S		Apply long leg cast brace	0058	1.0368	$54.07		$10.81
29365	S		Application of long leg cast	0058	1.0368	$54.07		$10.81
29405	S		Apply short leg cast	0058	1.0368	$54.07		$10.81
29425	S		Apply short leg cast	0058	1.0368	$54.07		$10.81
29435	S		Apply short leg cast	0058	1.0368	$54.07		$10.81
29440	S		Addition of walker to cast	0058	1.0368	$54.07		$10.81
29445	S		Apply rigid leg cast	0058	1.0368	$54.07		$10.81
29450	S		Application of leg cast	0058	1.0368	$54.07		$10.81
29505	S		Application, long leg splint	0058	1.0368	$54.07		$10.81
29515	S		Application lower leg splint	0058	1.0368	$54.07		$10.81
29520	S		Strapping of hip	0058	1.0368	$54.07		$10.81
29530	S		Strapping of knee	0058	1.0368	$54.07		$10.81
29540	S		Strapping of ankle	0058	1.0368	$54.07		$10.81
29550	S		Strapping of toes	0058	1.0368	$54.07		$10.81
29580	S		Application of paste boot	0058	1.0368	$54.07		$10.81
29590	S		Application of foot splint	0058	1.0368	$54.07		$10.81
29700	S		Removal/revision of cast	0058	1.0368	$54.07		$10.81
29705	S		Removal/revision of cast	0058	1.0368	$54.07		$10.81
29710	S		Removal/revision of cast	0058	1.0368	$54.07		$10.81
29715	S		Removal/revision of cast	0058	1.0368	$54.07		$10.81
29720	S		Repair of body cast	0058	1.0368	$54.07		$10.81
29730	S		Windowing of cast	0058	1.0368	$54.07		$10.81
29740	S		Wedging of cast	0058	1.0368	$54.07		$10.81
29750	S		Wedging of clubfoot cast	0058	1.0368	$54.07		$10.81
29799	S		Casting/strapping procedure	0058	1.0368	$54.07		$10.81
29800	T		Jaw arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29804	T		Jaw arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29805	T		Shoulder arthroscopy, dx	0041	26.1234	$1,362.36		$272.47
29806	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29807	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29819	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29820	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29821	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29822	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29823	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29824	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29825	T		Shoulder arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29826	T		Shoulder arthroscopy/surgery	0042	40.9680	$2,136.52	$804.74	$427.30
29827	T	NI	Arthroscop rotator cuff repr	0041	26.1234	$1,362.36		$272.47
29830	T		Elbow arthroscopy	0041	26.1234	$1,362.36		$272.47
29834	T		Elbow arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29835	T		Elbow arthroscopy/surgery	0042	40.9680	$2,136.52	$804.74	$427.30
29836	T		Elbow arthroscopy/surgery	0042	40.9680	$2,136.52	$804.74	$427.30
29837	T		Elbow arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29838	T		Elbow arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29840	T		Wrist arthroscopy	0041	26.1234	$1,362.36		$272.47
29843	T		Wrist arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29844	T		Wrist arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29845	T		Wrist arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29846	T		Wrist arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29847	T		Wrist arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29848	T		Wrist endoscopy/surgery	0041	26.1234	$1,362.36		$272.47
29850	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29851	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29855	T		Tibial arthroscopy/surgery	0042	40.9680	$2,136.52	$804.74	$427.30
29856	T		Tibial arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29860	T		Hip arthroscopy, dx	0041	26.1234	$1,362.36		$272.47
29861	T		Hip arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29862	T		Hip arthroscopy/surgery	0042	40.9680	$2,136.52	$804.74	$427.30
29863	T		Hip arthroscopy/surgery	0042	40.9680	$2,136.52	$804.74	$427.30
29870	T		Knee arthroscopy, dx	0041	26.1234	$1,362.36		$272.47
29871	T		Knee arthroscopy/drainage	0041	26.1234	$1,362.36		$272.47
29873	T	NI	Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29874	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29875	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29876	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29877	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29879	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29880	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29881	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29882	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29883	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29884	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29885	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29886	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29887	T		Knee arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29888	T		Knee arthroscopy/surgery	0042	40.9680	$2,136.52	$804.74	$427.30
29889	T		Knee arthroscopy/surgery	0042	40.9680	$2,136.52	$804.74	$427.30
29891	T		Ankle arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29892	T		Ankle arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29893	T		Scope, plantar fasciotomy	0055	17.6740	$921.72	$355.34	$184.34
29894	T		Ankle arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29895	T		Ankle arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29897	T		Ankle arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29898	T		Ankle arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29899	T	NI	Ankle arthroscopy/surgery	0041	26.1234	$1,362.36		$272.47
29900	T		Mcp joint arthroscopy, dx	0053	14.1760	$739.29	$253.49	$147.86
29901	T		Mcp joint arthroscopy, surg	0053	14.1760	$739.29	$253.49	$147.86
29902	T		Mcp joint arthroscopy, surg	0053	14.1760	$739.29	$253.49	$147.86
29999	T		Arthroscopy of joint	0041	26.1234	$1,362.36		$272.47
30000	T		Drainage of nose lesion	0251	1.9089	$99.55		$19.91
30020	T		Drainage of nose lesion	0251	1.9089	$99.55		$19.91
30100	T		Intranasal biopsy	0252	5.8041	$302.69	$113.41	$60.54
30110	T		Removal of nose polyp(s)	0253	14.4473	$753.44	$282.29	$150.69
30115	T		Removal of nose polyp(s)	0253	14.4473	$753.44	$282.29	$150.69
30117	T		Removal of intranasal lesion	0253	14.4473	$753.44	$282.29	$150.69
30118	T		Removal of intranasal lesion	0254	20.1158	$1,049.06	$321.35	$209.81
30120	T		Revision of nose	0253	14.4473	$753.44	$282.29	$150.69
30124	T		Removal of nose lesion	0252	5.8041	$302.69	$113.41	$60.54
30125	T		Removal of nose lesion	0256	34.0302	$1,774.71		$354.94
30130	T		Removal of turbinate bones	0253	14.4473	$753.44	$282.29	$150.69
30140	T		Removal of turbinate bones	0254	20.1158	$1,049.06	$321.35	$209.81

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
30150	T		Partial removal of nose	0256	34.0302	$1,774.71		$354.94
30160	T		Removal of nose	0256	34.0302	$1,774.71		$354.94
30200	T		Injection treatment of nose	0253	14.4473	$753.44	$282.29	$150.69
30210	T		Nasal sinus therapy	0252	5.8041	$302.69	$113.41	$60.54
30220	T		Insert nasal septal button	0252	5.8041	$302.69	$113.41	$60.54
30300	X		Remove nasal foreign body	0340	0.6492	$33.86		$6.77
30310	T		Remove nasal foreign body	0253	14.4473	$753.44	$282.29	$150.69
30320	T		Remove nasal foreign body	0253	14.4473	$753.44	$282.29	$150.69
30400	T		Reconstruction of nose	0256	34.0302	$1,774.71		$354.94
30410	T		Reconstruction of nose	0256	34.0302	$1,774.71		$354.94
30420	T		Reconstruction of nose	0256	34.0302	$1,774.71		$354.94
30430	T		Revision of nose	0254	20.1158	$1,049.06	$321.35	$209.81
30435	T		Revision of nose	0256	34.0302	$1,774.71		$354.94
30450	T		Revision of nose	0256	34.0302	$1,774.71		$354.94
30460	T		Revision of nose	0256	34.0302	$1,774.71		$354.94
30462	T		Revision of nose	0256	34.0302	$1,774.71		$354.94
30465	T		Repair nasal stenosis	0256	34.0302	$1,774.71		$354.94
30520	T		Repair of nasal septum	0254	20.1158	$1,049.06	$321.35	$209.81
30540	T		Repair nasal defect	0256	34.0302	$1,774.71		$354.94
30545	T		Repair nasal defect	0256	34.0302	$1,774.71		$354.94
30560	T		Release of nasal adhesions	0251	1.9089	$99.55		$19.91
30580	T		Repair upper jaw fistula	0256	34.0302	$1,774.71		$354.94
30600	T		Repair mouth/nose fistula	0256	34.0302	$1,774.71		$354.94
30620	T		Intranasal reconstruction	0256	34.0302	$1,774.71		$354.94
30630	T		Repair nasal septum defect	0254	20.1158	$1,049.06	$321.35	$209.81
30801	T		Cauterization, inner nose	0252	5.8041	$302.69	$113.41	$60.54
30802	T		Cauterization, inner nose	0253	14.4473	$753.44	$282.29	$150.69
30901	T		Control of nosebleed	0250	1.6376	$85.40	$29.89	$17.08
30903	T		Control of nosebleed	0250	1.6376	$85.40	$29.89	$17.08
30905	T		Control of nosebleed	0250	1.6376	$85.40	$29.89	$17.08
30906	T		Repeat control of nosebleed	0250	1.6376	$85.40	$29.89	$17.08
30915	T		Ligation, nasal sinus artery	0091	26.7048	$1,392.68	$348.23	$278.54
30920	T		Ligation, upper jaw artery	0092	23.7882	$1,240.58	$505.37	$248.12
30930	T		Therapy, fracture of nose	0253	14.4473	$753.44	$282.29	$150.69
30999	T		Nasal surgery procedure	0251	1.9089	$99.55		$19.91
31000	T		Irrigation, maxillary sinus	0251	1.9089	$99.55		$19.91
31002	T		Irrigation, sphenoid sinus	0252	5.8041	$302.69	$113.41	$60.54
31020	T		Exploration, maxillary sinus	0254	20.1158	$1,049.06	$321.35	$209.81
31030	T		Exploration, maxillary sinus	0256	34.0302	$1,774.71		$354.94
31032	T		Explore sinus, remove polyps	0256	34.0302	$1,774.71		$354.94
31040	T		Exploration behind upper jaw	0254	20.1158	$1,049.06	$321.35	$209.81
31050	T		Exploration, sphenoid sinus	0256	34.0302	$1,774.71		$354.94
31051	T		Sphenoid sinus surgery	0256	34.0302	$1,774.71		$354.94
31070	T		Exploration of frontal sinus	0254	20.1158	$1,049.06	$321.35	$209.81
31075	T		Exploration of frontal sinus	0256	34.0302	$1,774.71		$354.94
31080	T		Removal of frontal sinus	0256	34.0302	$1,774.71		$354.94
31081	T		Removal of frontal sinus	0256	34.0302	$1,774.71		$354.94
31084	T		Removal of frontal sinus	0256	34.0302	$1,774.71		$354.94
31085	T		Removal of frontal sinus	0256	34.0302	$1,774.71		$354.94
31086	T		Removal of frontal sinus	0256	34.0302	$1,774.71		$354.94
31087	T		Removal of frontal sinus	0256	34.0302	$1,774.71		$354.94
31090	T		Exploration of sinuses	0256	34.0302	$1,774.71		$354.94
31200	T		Removal of ethmoid sinus	0256	34.0302	$1,774.71		$354.94
31201	T		Removal of ethmoid sinus	0256	34.0302	$1,774.71		$354.94
31205	T		Removal of ethmoid sinus	0256	34.0302	$1,774.71		$354.94
31225	C		Removal of upper jaw					
31230	C		Removal of upper jaw					
31231	T		Nasal endoscopy, dx	0071	0.9205	$48.00	$12.89	$9.60
31233	T		Nasal/sinus endoscopy, dx	0073	3.1976	$166.76	$73.38	$33.35
31235	T		Nasal/sinus endoscopy, dx	0074	12.8582	$670.57	$295.70	$134.11
31237	T		Nasal/sinus endoscopy, surg	0075	19.6604	$1,025.31	$445.92	$205.06
31238	T		Nasal/sinus endoscopy, surg	0074	12.8582	$670.57	$295.70	$134.11
31239	T		Nasal/sinus endoscopy, surg	0075	19.6604	$1,025.31	$445.92	$205.06
31240	T		Nasal/sinus endoscopy, surg	0074	12.8582	$670.57	$295.70	$134.11
31254	T		Revision of ethmoid sinus	0075	19.6604	$1,025.31	$445.92	$205.06

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31255	T		Removal of ethmoid sinus	0075	19.6604	$1,025.31	$445.92	$205.06
31256	T		Exploration maxillary sinus	0075	19.6604	$1,025.31	$445.92	$205.06
31267	T		Endoscopy, maxillary sinus	0075	19.6604	$1,025.31	$445.92	$205.06
31276	T		Sinus endoscopy, surgical	0075	19.6604	$1,025.31	$445.92	$205.06
31287	T		Nasal/sinus endoscopy, surg	0075	19.6604	$1,025.31	$445.92	$205.06
31288	T		Nasal/sinus endoscopy, surg	0075	19.6604	$1,025.31	$445.92	$205.06
31290	C		Nasal/sinus endoscopy, surg					
31291	C		Nasal/sinus endoscopy, surg					
31292	C		Nasal/sinus endoscopy, surg					
31293	C		Nasal/sinus endoscopy, surg					
31294	C		Nasal/sinus endoscopy, surg					
31299	T		Sinus surgery procedure	0252	5.8041	$302.69	$113.41	$60.54
31300	T		Removal of larynx lesion	0256	34.0302	$1,774.71		$354.94
31320	T		Diagnostic incision, larynx	0256	34.0302	$1,774.71		$354.94
31360	C		Removal of larynx					
31365	C		Removal of larynx					
31367	C		Partial removal of larynx					
31368	C		Partial removal of larynx					
31370	C		Partial removal of larynx					
31375	C		Partial removal of larynx					
31380	C		Partial removal of larynx					
31382	C		Partial removal of larynx					
31390	C		Removal of larynx & pharynx					
31395	C		Reconstruct larynx & pharynx					
31400	T		Revision of larynx	0256	34.0302	$1,774.71		$354.94
31420	T		Removal of epiglottis	0256	34.0302	$1,774.71		$354.94
31500	S		Insert emergency airway	0094	3.8371	$200.11	$67.63	$40.02
31502	T		Change of windpipe airway	0121	2.0833	$108.65	$43.80	$21.73
31505	T		Diagnostic laryngoscopy	0072	1.1628	$60.64	$26.68	$12.13
31510	T		Laryngoscopy with biopsy	0074	12.8582	$670.57	$295.70	$134.11
31511	T		Remove foreign body, larynx	0072	1.1628	$60.64	$26.68	$12.13
31512	T		Removal of larynx lesion	0074	12.8582	$670.57	$295.70	$134.11
31513	T		Injection into vocal cord	0072	1.1628	$60.64	$26.68	$12.13
31515	T		Laryngoscopy for aspiration	0074	12.8582	$670.57	$295.70	$134.11
31520	T		Diagnostic laryngoscopy	0072	1.1628	$60.64	$26.68	$12.13
31525	T		Diagnostic laryngoscopy	0074	12.8582	$670.57	$295.70	$134.11
31526	T		Diagnostic laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31527	T		Laryngoscopy for treatment	0075	19.6604	$1,025.31	$445.92	$205.06
31528	T		Laryngoscopy and dilation	0074	12.8582	$670.57	$295.70	$134.11
31529	T		Laryngoscopy and dilation	0074	12.8582	$670.57	$295.70	$134.11
31530	T		Operative laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31531	T		Operative laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31535	T		Operative laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31536	T		Operative laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31540	T		Operative laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31541	T		Operative laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31560	T		Operative laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31561	T		Operative laryngoscopy	0075	19.6604	$1,025.31	$445.92	$205.06
31570	T		Laryngoscopy with injection	0074	12.8582	$670.57	$295.70	$134.11
31571	T		Laryngoscopy with injection	0075	19.6604	$1,025.31	$445.92	$205.06
31575	T		Diagnostic laryngoscopy	0071	0.9205	$48.00	$12.89	$9.60
31576	T		Laryngoscopy with biopsy	0075	19.6604	$1,025.31	$445.92	$205.06
31577	T		Remove foreign body, larynx	0073	3.1976	$166.76	$73.38	$33.35
31578	T		Removal of larynx lesion	0075	19.6604	$1,025.31	$445.92	$205.06
31579	T		Diagnostic laryngoscopy	0073	3.1976	$166.76	$73.38	$33.35
31580	T		Revision of larynx	0256	34.0302	$1,774.71		$354.94
31582	T		Revision of larynx	0256	34.0302	$1,774.71		$354.94
31584	C		Treat larynx fracture					
31585	T		Treat larynx fracture	0253	14.4473	$753.44	$282.29	$150.69
31586	T		Treat larynx fracture	0256	34.0302	$1,774.71		$354.94
31587	C		Revision of larynx					
31588	T		Revision of larynx	0256	34.0302	$1,774.71		$354.94
31590	T		Reinnervate larynx	0256	34.0302	$1,774.71		$354.94
31595	T		Larynx nerve surgery	0256	34.0302	$1,774.71		$354.94
31599	T		Larynx surgery procedure	0254	20.1158	$1,049.06	$321.35	$209.81

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31600	T		Incision of windpipe	0254	20.1158	$1,049.06	$321.35	$209.81
31601	T		Incision of windpipe	0254	20.1158	$1,049.06	$321.35	$209.81
31603	T		Incision of windpipe	0252	5.8041	$302.69	$113.41	$60.54
31605	T		Incision of windpipe	0253	14.4473	$753.44	$282.29	$150.69
31610	T		Incision of windpipe	0254	20.1158	$1,049.06	$321.35	$209.81
31611	T		Surgery/speech prosthesis	0254	20.1158	$1,049.06	$321.35	$209.81
31612	T		Puncture/clear windpipe	0254	20.1158	$1,049.06	$321.35	$209.81
31613	T		Repair windpipe opening	0254	20.1158	$1,049.06	$321.35	$209.81
31614	T		Repair windpipe opening	0256	34.0302	$1,774.71		$354.94
31615	T		Visualization of windpipe	0076	8.9533	$466.92	$189.82	$93.38
31622	T		Dx bronchoscope/wash	0076	8.9533	$466.92	$189.82	$93.38
31623	T		Dx bronchoscope/brush	0076	8.9533	$466.92	$189.82	$93.38
31624	T		Dx bronchoscope/lavage	0076	8.9533	$466.92	$189.82	$93.38
31625	T		Bronchoscopy w/biopsy(s)	0076	8.9533	$466.92	$189.82	$93.38
31628	T		Bronchoscopy/lung bx, each	0076	8.9533	$466.92	$189.82	$93.38
31629	T		Bronchoscopy/needle bx, each	0076	8.9533	$466.92	$189.82	$93.38
31630	T		Bronchoscopy dilate/fx repr	0076	8.9533	$466.92	$189.82	$93.38
31631	T		Bronchoscopy, dilate w/stent	0076	8.9533	$466.92	$189.82	$93.38
31635	T		Bronchoscopy w/fb removal	0076	8.9533	$466.92	$189.82	$93.38
31640	T		Bronchoscopy w/tumor excise	0076	8.9533	$466.92	$189.82	$93.38
31641	T		Bronchoscopy, treat blockage	0076	8.9533	$466.92	$189.82	$93.38
31643	T		Diag bronchoscope/catheter	0076	8.9533	$466.92	$189.82	$93.38
31645	T		Bronchoscopy, clear airways	0076	8.9533	$466.92	$189.82	$93.38
31646	T		Bronchoscopy, reclear airway	0076	8.9533	$466.92	$189.82	$93.38
31656	T		Bronchoscopy, inj for x-ray	0076	8.9533	$466.92	$189.82	$93.38
31700	T		Insertion of airway catheter	0072	1.1628	$60.64	$26.68	$12.13
31708	N		Instill airway contrast dye					
31710	N		Insertion of airway catheter					
31715	N		Injection for bronchus x-ray					
31717	T		Bronchial brush biopsy	0073	3.1976	$166.76	$73.38	$33.35
31720	T		Clearance of airways	0072	1.1628	$60.64	$26.68	$12.13
31725	C		Clearance of airways					
31730	T		Intro, windpipe wire/tube	0073	3.1976	$166.76	$73.38	$33.35
31750	T		Repair of windpipe	0256	34.0302	$1,774.71		$354.94
31755	T		Repair of windpipe	0256	34.0302	$1,774.71		$354.94
31760	C		Repair of windpipe					
31766	C		Reconstruction of windpipe					
31770	C		Repair/graft of bronchus					
31775	C		Reconstruct bronchus					
31780	C		Reconstruct windpipe					
31781	C		Reconstruct windpipe					
31785	T		Remove windpipe lesion	0254	20.1158	$1,049.06	$321.35	$209.81
31786	C		Remove windpipe lesion					
31800	C		Repair of windpipe injury					
31805	C		Repair of windpipe injury					
31820	T		Closure of windpipe lesion	0253	14.4473	$753.44	$282.29	$150.69
31825	T		Repair of windpipe defect	0254	20.1158	$1,049.06	$321.35	$209.81
31830	T		Revise windpipe scar	0254	20.1158	$1,049.06	$321.35	$209.81
31899	T		Airways surgical procedure	0076	8.9533	$466.92	$189.82	$93.38
32000	T		Drainage of chest	0070	3.3623	$175.35		$35.07
32002	T		Treatment of collapsed lung	0070	3.3623	$175.35		$35.07
32005	T		Treat lung lining chemically	0070	3.3623	$175.35		$35.07
32020	T		Insertion of chest tube	0070	3.3623	$175.35		$35.07
32035	C		Exploration of chest					
32036	C		Exploration of chest					
32095	C		Biopsy through chest wall					
32100	C		Exploration/biopsy of chest					
32110	C		Explore/repair chest					
32120	C		Re-exploration of chest					
32124	C		Explore chest free adhesions					
32140	C		Removal of lung lesion(s)					
32141	C		Remove/treat lung lesions					
32150	C		Removal of lung lesion(s)					
32151	C		Remove lung foreign body					
32160	C		Open chest heart massage					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
32200	C	.....	Drain, open, lung lesion	.....	.....	.....	.....	.....
32201	T	.....	Drain, percut, lung lesion	0070	3.3623	$175.35	.....	$35.07
32215	C	.....	Treat chest lining	.....	.....	.....	.....	.....
32220	C	.....	Release of lung	.....	.....	.....	.....	.....
32225	C	.....	Partial release of lung	.....	.....	.....	.....	.....
32310	C	.....	Removal of chest lining	.....	.....	.....	.....	.....
32320	C	.....	Free/remove chest lining	.....	.....	.....	.....	.....
32400	T	.....	Needle biopsy chest lining	0005	3.1201	$162.72	$71.59	$32.54
32402	C	.....	Open biopsy chest lining	.....	.....	.....	.....	.....
32405	T	.....	Biopsy, lung or mediastinum	0685	5.9882	$312.29	$137.40	$62.46
32420	T	.....	Puncture/clear lung	0070	3.3623	$175.35	.....	$35.07
32440	C	.....	Removal of lung	.....	.....	.....	.....	.....
32442	C	.....	Sleeve pneumonectomy	.....	.....	.....	.....	.....
32445	C	.....	Removal of lung	.....	.....	.....	.....	.....
32480	C	.....	Partial removal of lung	.....	.....	.....	.....	.....
32482	C	.....	Bilobectomy	.....	.....	.....	.....	.....
32484	C	.....	Segmentectomy	.....	.....	.....	.....	.....
32486	C	.....	Sleeve lobectomy	.....	.....	.....	.....	.....
32488	C	.....	Completion pneumonectomy	.....	.....	.....	.....	.....
32491	C	.....	Lung volume reduction	.....	.....	.....	.....	.....
32500	C	.....	Partial removal of lung	.....	.....	.....	.....	.....
32501	C	.....	Repair bronchus add-on	.....	.....	.....	.....	.....
32520	C	.....	Remove lung & revise chest	.....	.....	.....	.....	.....
32522	C	.....	Remove lung & revise chest	.....	.....	.....	.....	.....
32525	C	.....	Remove lung & revise chest	.....	.....	.....	.....	.....
32540	C	.....	Removal of lung lesion	.....	.....	.....	.....	.....
32601	T	.....	Thoracoscopy, diagnostic	0069	27.5575	$1,437.15	$591.64	$287.43
32602	T	.....	Thoracoscopy, diagnostic	0069	27.5575	$1,437.15	$591.64	$287.43
32603	T	.....	Thoracoscopy, diagnostic	0069	27.5575	$1,437.15	$591.64	$287.43
32604	T	.....	Thoracoscopy, diagnostic	0069	27.5575	$1,437.15	$591.64	$287.43
32605	T	.....	Thoracoscopy, diagnostic	0069	27.5575	$1,437.15	$591.64	$287.43
32606	T	.....	Thoracoscopy, diagnostic	0069	27.5575	$1,437.15	$591.64	$287.43
32650	C	.....	Thoracoscopy, surgical	.....	.....	.....	.....	.....
32651	C	.....	Thoracoscopy, surgical	.....	.....	.....	.....	.....
32652	C	.....	Thoracoscopy, surgical	.....	.....	.....	.....	.....
32653	C	.....	Thoracoscopy, surgical	.....	.....	.....	.....	.....
32654	C	.....	Thoracoscopy, surgical	.....	.....	.....	.....	.....
32655	C	.....	Thoracoscopy, surgical	.....	.....	.....	.....	.....
32656	C	.....	Thoracoscopy, surgical	.....	.....	.....	.....	.....
32657	C	.....	Thoracoscopy, surgical	.....	.....	.....	.....	.....
32658	C	.....	Thoracoscopy, surgical	.....	.....	.....	.....	.....
32659	C	.....	Thoracoscopy, surgical	.....	.....	.....	.....	.....
32660	C	.....	Thoracoscopy, surgical	.....	.....	.....	.....	.....
32661	C	.....	Thoracoscopy, surgical	.....	.....	.....	.....	.....
32662	C	.....	Thoracoscopy, surgical	.....	.....	.....	.....	.....
32663	C	.....	Thoracoscopy, surgical	.....	.....	.....	.....	.....
32664	C	.....	Thoracoscopy, surgical	.....	.....	.....	.....	.....
32665	C	.....	Thoracoscopy, surgical	.....	.....	.....	.....	.....
32800	C	.....	Repair lung hernia	.....	.....	.....	.....	.....
32810	C	.....	Close chest after drainage	.....	.....	.....	.....	.....
32815	C	.....	Close bronchial fistula	.....	.....	.....	.....	.....
32820	C	.....	Reconstruct injured chest	.....	.....	.....	.....	.....
32850	C	.....	Donor pneumonectomy	.....	.....	.....	.....	.....
32851	C	.....	Lung transplant, single	.....	.....	.....	.....	.....
32852	C	.....	Lung transplant with bypass	.....	.....	.....	.....	.....
32853	C	.....	Lung transplant, double	.....	.....	.....	.....	.....
32854	C	.....	Lung transplant with bypass	.....	.....	.....	.....	.....
32900	C	.....	Removal of rib(s)	.....	.....	.....	.....	.....
32905	C	.....	Revise & repair chest wall	.....	.....	.....	.....	.....
32906	C	.....	Revise & repair chest wall	.....	.....	.....	.....	.....
32940	C	.....	Revision of lung	.....	.....	.....	.....	.....
32960	T	.....	Therapeutic pneumothorax	0070	3.3623	$175.35	.....	$35.07
32997	C	.....	Total lung lavage	.....	.....	.....	.....	.....
32999	T	.....	Chest surgery procedure	0070	3.3623	$175.35	.....	$35.07
33010	T	.....	Drainage of heart sac	0070	3.3623	$175.35	.....	$35.07

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33011	T		Repeat drainage of heart sac	0070	3.3623	$175.35		$35.07
33015	C		Incision of heart sac					
33020	C		Incision of heart sac					
33025	C		Incision of heart sac					
33030	C		Partial removal of heart sac					
33031	C		Partial removal of heart sac					
33050	C		Removal of heart sac lesion					
33120	C		Removal of heart lesion					
33130	C		Removal of heart lesion					
33140	C		Heart revascularize (tmr)					
33141	C		Heart tmr w/other procedure					
33200	C		Insertion of heart pacemaker					
33201	C		Insertion of heart pacemaker					
33206	T		Insertion of heart pacemaker	0089	112.5555	$5,869.88	$1,722.59	$1,173.98
33207	T		Insertion of heart pacemaker	0089	112.5555	$5,869.88	$1,722.59	$1,173.98
33208	T		Insertion of heart pacemaker	0655	122.8654	$6,407.55		$1,281.51
33210	T		Insertion of heart electrode	0106	54.8243	$2,859.14		$571.83
33211	T		Insertion of heart electrode	0106	54.8243	$2,859.14		$571.83
33212	T		Insertion of pulse generator	0090	87.9631	$4,587.36	$1,651.45	$917.47
33213	T		Insertion of pulse generator	0654	91.8583	$4,790.50		$958.10
33214	T		Upgrade of pacemaker system	0655	122.8654	$6,407.55		$1,281.51
33215	T	NI	Reposition pacing-defib lead	0105	18.5945	$969.72	$370.40	$193.94
33216	T		Revise eltrd pacing-defib	0106	54.8243	$2,859.14		$571.83
33217	T		Insert lead pace-defib, dual	0106	54.8243	$2,859.14		$571.83
33218	T		Repair lead pace-defib, one	0106	54.8243	$2,859.14		$571.83
33220	T		Repair lead pace-defib, dual	0106	54.8243	$2,859.14		$571.83
33222	T		Revise pocket, pacemaker	0027	15.2225	$793.87	$329.72	$158.77
33223	T		Revise pocket, pacing-defib	0027	15.2225	$793.87	$329.72	$158.77
33224	T	NI	Insert pacing lead & connect	0976		$875.00		$175.00
33225	T	NI	L ventric pacing lead add-on	0977		$1,125.00		$225.00
33226	T	NI	Reposition l ventric lead	0105	18.5945	$969.72	$370.40	$193.94
33233	T		Removal of pacemaker system	0105	18.5945	$969.72	$370.40	$193.94
33234	T		Removal of pacemaker system	0105	18.5945	$969.72	$370.40	$193.94
33235	T		Removal pacemaker electrode	0105	18.5945	$969.72	$370.40	$193.94
33236	C		Remove electrode/thoracotomy					
33237	C		Remove electrode/thoracotomy					
33238	C		Remove electrode/thoracotomy					
33240	T		Insert pulse generator	0107	326.2231	$17,012.86	$3,699.14	$3,402.57
33241	T		Remove pulse generator	0105	18.5945	$969.72	$370.40	$193.94
33243	C		Remove eltrd/thoracotomy					
33244	T		Remove eltrd, transven	0105	18.5945	$969.72	$370.40	$193.94
33245	C		Insert epic eltrd pace-defib					
33246	C		Insert epic eltrd/generator					
33249	T		Eltrd/insert pace-defib	0108	443.5460	$23,131.37		$4,626.27
33250	C		Ablate heart dysrhythm focus					
33251	C		Ablate heart dysrhythm focus					
33253	C		Reconstruct atria					
33261	C		Ablate heart dysrhythm focus					
33282	S		Implant pat-active ht record	0680	56.1324	$2,927.36		$585.47
33284	T		Remove pat-active ht record	0109	7.4708	$389.61	$131.49	$77.92
33300	C		Repair of heart wound					
33305	C		Repair of heart wound					
33310	C		Exploratory heart surgery					
33315	C		Exploratory heart surgery					
33320	C		Repair major blood vessel(s)					
33321	C		Repair major vessel					
33322	C		Repair major blood vessel(s)					
33330	C		Insert major vessel graft					
33332	C		Insert major vessel graft					
33335	C		Insert major vessel graft					
33400	C		Repair of aortic valve					
33401	C		Valvuloplasty, open					
33403	C		Valvuloplasty, w/cp bypass					
33404	C		Prepare heart-aorta conduit					
33405	C		Replacement of aortic valve					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33406	C		Replacement of aortic valve					
33410	C		Replacement of aortic valve					
33411	C		Replacement of aortic valve					
33412	C		Replacement of aortic valve					
33413	C		Replacement of aortic valve					
33414	C		Repair of aortic valve					
33415	C		Revision, subvalvular tissue					
33416	C		Revise ventricle muscle					
33417	C		Repair of aortic valve					
33420	C		Revision of mitral valve					
33422	C		Revision of mitral valve					
33425	C		Repair of mitral valve					
33426	C		Repair of mitral valve					
33427	C		Repair of mitral valve					
33430	C		Replacement of mitral valve					
33460	C		Revision of tricuspid valve					
33463	C		Valvuloplasty, tricuspid					
33464	C		Valvuloplasty, tricuspid					
33465	C		Replace tricuspid valve					
33468	C		Revision of tricuspid valve					
33470	C		Revision of pulmonary valve					
33471	C		Valvotomy, pulmonary valve					
33472	C		Revision of pulmonary valve					
33474	C		Revision of pulmonary valve					
33475	C		Replacement, pulmonary valve					
33476	C		Revision of heart chamber					
33478	C		Revision of heart chamber					
33496	C		Repair, prosth valve clot					
33500	C		Repair heart vessel fistula					
33501	C		Repair heart vessel fistula					
33502	C		Coronary artery correction					
33503	C		Coronary artery graft					
33504	C		Coronary artery graft					
33505	C		Repair artery w/tunnel					
33506	C		Repair artery, translocation					
33508	N	NI	Endoscopic vein harvest					
33510	C		CABG, vein, single					
33511	C		CABG, vein, two					
33512	C		CABG, vein, three					
33513	C		CABG, vein, four					
33514	C		CABG, vein, five					
33516	C		Cabg, vein, six or more					
33517	C		CABG, artery-vein, single					
33518	C		CABG, artery-vein, two					
33519	C		CABG, artery-vein, three					
33521	C		CABG, artery-vein, four					
33522	C		CABG, artery-vein, five					
33523	C		Cabg, art-vein, six or more					
33530	C		Coronary artery, bypass/reop					
33533	C		CABG, arterial, single					
33534	C		CABG, arterial, two					
33535	C		CABG, arterial, three					
33536	C		Cabg, arterial, four or more					
33542	C		Removal of heart lesion					
33545	C		Repair of heart damage					
33572	C		Open coronary endarterectomy					
33600	C		Closure of valve					
33602	C		Closure of valve					
33606	C		Anastomosis/artery-aorta					
33608	C		Repair anomaly w/conduit					
33610	C		Repair by enlargement					
33611	C		Repair double ventricle					
33612	C		Repair double ventricle					
33615	C		Repair, modified fontan					
33617	C		Repair single ventricle					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33619	C		Repair single ventricle					
33641	C		Repair heart septum defect					
33645	C		Revision of heart veins					
33647	C		Repair heart septum defects					
33660	C		Repair of heart defects					
33665	C		Repair of heart defects					
33670	C		Repair of heart chambers					
33681	C		Repair heart septum defect					
33684	C		Repair heart septum defect					
33688	C		Repair heart septum defect					
33690	C		Reinforce pulmonary artery					
33692	C		Repair of heart defects					
33694	C		Repair of heart defects					
33697	C		Repair of heart defects					
33702	C		Repair of heart defects					
33710	C		Repair of heart defects					
33720	C		Repair of heart defect					
33722	C		Repair of heart defect					
33730	C		Repair heart-vein defect(s)					
33732	C		Repair heart-vein defect					
33735	C		Revision of heart chamber					
33736	C		Revision of heart chamber					
33737	C		Revision of heart chamber					
33750	C		Major vessel shunt					
33755	C		Major vessel shunt					
33762	C		Major vessel shunt					
33764	C		Major vessel shunt & graft					
33766	C		Major vessel shunt					
33767	C		Major vessel shunt					
33770	C		Repair great vessels defect					
33771	C		Repair great vessels defect					
33774	C		Repair great vessels defect					
33775	C		Repair great vessels defect					
33776	C		Repair great vessels defect					
33777	C		Repair great vessels defect					
33778	C		Repair great vessels defect					
33779	C		Repair great vessels defect					
33780	C		Repair great vessels defect					
33781	C		Repair great vessels defect					
33786	C		Repair arterial trunk					
33788	C		Revision of pulmonary artery					
33800	C		Aortic suspension					
33802	C		Repair vessel defect					
33803	C		Repair vessel defect					
33813	C		Repair septal defect					
33814	C		Repair septal defect					
33820	C		Revise major vessel					
33822	C		Revise major vessel					
33824	C		Revise major vessel					
33840	C		Remove aorta constriction					
33845	C		Remove aorta constriction					
33851	C		Remove aorta constriction					
33852	C		Repair septal defect					
33853	C		Repair septal defect					
33860	C		Ascending aortic graft					
33861	C		Ascending aortic graft					
33863	C		Ascending aortic graft					
33870	C		Transverse aortic arch graft					
33875	C		Thoracic aortic graft					
33877	C		Thoracoabdominal graft					
33910	C		Remove lung artery emboli					
33915	C		Remove lung artery emboli					
33916	C		Surgery of great vessel					
33917	C		Repair pulmonary artery					
33918	C		Repair pulmonary atresia					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33919	C		Repair pulmonary atresia					
33920	C		Repair pulmonary atresia					
33922	C		Transect pulmonary artery					
33924	C		Remove pulmonary shunt					
33930	C		Removal of donor heart/lung					
33935	C		Transplantation, heart/lung					
33940	C		Removal of donor heart					
33945	C		Transplantation of heart					
33960	C		External circulation assist					
33961	C		External circulation assist					
33967	C		Insert ia percut device					
33968	C		Remove aortic assist device					
33970	C		Aortic circulation assist					
33971	C		Aortic circulation assist					
33973	C		Insert balloon device					
33974	C		Remove intra-aortic balloon					
33975	C		Implant ventricular device					
33976	C		Implant ventricular device					
33977	C		Remove ventricular device					
33978	C		Remove ventricular device					
33979	C		Insert intracorporeal device					
33980	C		Remove intracorporeal device					
33999	T		Cardiac surgery procedure	0070	3.3623	$175.35		$35.07
34001	C		Removal of artery clot					
34051	C		Removal of artery clot					
34101	T		Removal of artery clot	0088	32.5768	$1,698.91	$655.22	$339.78
34111	T		Removal of arm artery clot	0088	32.5768	$1,698.91	$655.22	$339.78
34151	C		Removal of artery clot					
34201	T		Removal of artery clot	0088	32.5768	$1,698.91	$655.22	$339.78
34203	T		Removal of leg artery clot	0088	32.5768	$1,698.91	$655.22	$339.78
34401	C		Removal of vein clot					
34421	T		Removal of vein clot	0088	32.5768	$1,698.91	$655.22	$339.78
34451	C		Removal of vein clot					
34471	T		Removal of vein clot	0088	32.5768	$1,698.91	$655.22	$339.78
34490	T		Removal of vein clot	0088	32.5768	$1,698.91	$655.22	$339.78
34501	T		Repair valve, femoral vein	0088	32.5768	$1,698.91	$655.22	$339.78
34502	C		Reconstruct vena cava					
34510	T		Transposition of vein valve	0088	32.5768	$1,698.91	$655.22	$339.78
34520	T		Cross-over vein graft	0088	32.5768	$1,698.91	$655.22	$339.78
34530	T		Leg vein fusion	0088	32.5768	$1,698.91	$655.22	$339.78
34800	C		Endovasc abdo repair w/tube					
34802	C		Endovasc abdo repr w/device					
34804	C		Endovasc abdo repr w/device					
34808	C		Endovasc abdo occlud device					
34812	C		Xpose for endoprosth, aortic					
34813	C		Femoral endovas graft add-on					
34820	C		Xpose for endoprosth, iliac					
34825	C		Endovasc extend prosth, init					
34826	C		Endovasc exten prosth, addl					
34830	C		Open aortic tube prosth repr					
34831	C		Open aortoiliac prosth repr					
34832	C		Open aortofemor prosth repr					
34833	C	NI	Xpose for endoprosth, iliac					
34834	C	NI	Xpose, endoprosth, brachial					
34900	C	NI	Endovasc iliac repr w/graft					
35001	C		Repair defect of artery					
35002	C		Repair artery rupture, neck					
35005	C		Repair defect of artery					
35011	T		Repair defect of artery	0653	30.0284	$1,566.01		$313.20
35013	C		Repair artery rupture, arm					
35021	C		Repair defect of artery					
35022	C		Repair artery rupture, chest					
35045	C		Repair defect of arm artery					
35081	C		Repair defect of artery					
35082	C		Repair artery rupture, aorta					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35091	C	.....	Repair defect of artery	.....	.....	.....	.....	.....
35092	C	.....	Repair artery rupture, aorta	.....	.....	.....	.....	.....
35102	C	.....	Repair defect of artery	.....	.....	.....	.....	.....
35103	C	.....	Repair artery rupture, groin	.....	.....	.....	.....	.....
35111	C	.....	Repair defect of artery	.....	.....	.....	.....	.....
35112	C	.....	Repair artery rupture,spleen	.....	.....	.....	.....	.....
35121	C	.....	Repair defect of artery	.....	.....	.....	.....	.....
35122	C	.....	Repair artery rupture, belly	.....	.....	.....	.....	.....
35131	C	.....	Repair defect of artery	.....	.....	.....	.....	.....
35132	C	.....	Repair artery rupture, groin	.....	.....	.....	.....	.....
35141	C	.....	Repair defect of artery	.....	.....	.....	.....	.....
35142	C	.....	Repair artery rupture, thigh	.....	.....	.....	.....	.....
35151	C	.....	Repair defect of artery	.....	.....	.....	.....	.....
35152	C	.....	Repair artery rupture, knee	.....	.....	.....	.....	.....
35161	C	.....	Repair defect of artery	.....	.....	.....	.....	.....
35162	C	.....	Repair artery rupture	.....	.....	.....	.....	.....
35180	T	.....	Repair blood vessel lesion	0093	20.6294	$1,075.84	$277.34	$215.17
35182	C	.....	Repair blood vessel lesion	.....	.....	.....	.....	.....
35184	T	.....	Repair blood vessel lesion	0093	20.6294	$1,075.84	$277.34	$215.17
35188	T	.....	Repair blood vessel lesion	0088	32.5768	$1,698.91	$655.22	$339.78
35189	C	.....	Repair blood vessel lesion	.....	.....	.....	.....	.....
35190	T	.....	Repair blood vessel lesion	0093	20.6294	$1,075.84	$277.34	$215.17
35201	T	.....	Repair blood vessel lesion	0093	20.6294	$1,075.84	$277.34	$215.17
35206	T	.....	Repair blood vessel lesion	0093	20.6294	$1,075.84	$277.34	$215.17
35207	T	.....	Repair blood vessel lesion	0088	32.5768	$1,698.91	$655.22	$339.78
35211	C	.....	Repair blood vessel lesion	.....	.....	.....	.....	.....
35216	C	.....	Repair blood vessel lesion	.....	.....	.....	.....	.....
35221	C	.....	Repair blood vessel lesion	.....	.....	.....	.....	.....
35226	T	.....	Repair blood vessel lesion	0093	20.6294	$1,075.84	$277.34	$215.17
35231	T	.....	Repair blood vessel lesion	0093	20.6294	$1,075.84	$277.34	$215.17
35236	T	.....	Repair blood vessel lesion	0093	20.6294	$1,075.84	$277.34	$215.17
35241	C	.....	Repair blood vessel lesion	.....	.....	.....	.....	.....
35246	C	.....	Repair blood vessel lesion	.....	.....	.....	.....	.....
35251	C	.....	Repair blood vessel lesion	.....	.....	.....	.....	.....
35256	T	.....	Repair blood vessel lesion	0093	20.6294	$1,075.84	$277.34	$215.17
35261	T	.....	Repair blood vessel lesion	0653	30.0284	$1,566.01	.....	$313.20
35266	T	.....	Repair blood vessel lesion	0653	30.0284	$1,566.01	.....	$313.20
35271	C	.....	Repair blood vessel lesion	.....	.....	.....	.....	.....
35276	C	.....	Repair blood vessel lesion	.....	.....	.....	.....	.....
35281	C	.....	Repair blood vessel lesion	.....	.....	.....	.....	.....
35286	T	.....	Repair blood vessel lesion	0653	30.0284	$1,566.01	.....	$313.20
35301	C	.....	Rechanneling of artery	.....	.....	.....	.....	.....
35311	C	.....	Rechanneling of artery	.....	.....	.....	.....	.....
35321	T	.....	Rechanneling of artery	0093	20.6294	$1,075.84	$277.34	$215.17
35331	C	.....	Rechanneling of artery	.....	.....	.....	.....	.....
35341	C	.....	Rechanneling of artery	.....	.....	.....	.....	.....
35351	C	.....	Rechanneling of artery	.....	.....	.....	.....	.....
35355	C	.....	Rechanneling of artery	.....	.....	.....	.....	.....
35361	C	.....	Rechanneling of artery	.....	.....	.....	.....	.....
35363	C	.....	Rechanneling of artery	.....	.....	.....	.....	.....
35371	C	.....	Rechanneling of artery	.....	.....	.....	.....	.....
35372	C	.....	Rechanneling of artery	.....	.....	.....	.....	.....
35381	C	.....	Rechanneling of artery	.....	.....	.....	.....	.....
35390	C	.....	Reoperation, carotid add-on	.....	.....	.....	.....	.....
35400	C	.....	Angioscopy	.....	.....	.....	.....	.....
35450	C	.....	Repair arterial blockage	.....	.....	.....	.....	.....
35452	C	.....	Repair arterial blockage	.....	.....	.....	.....	.....
35454	C	.....	Repair arterial blockage	.....	.....	.....	.....	.....
35456	C	.....	Repair arterial blockage	.....	.....	.....	.....	.....
35458	T	.....	Repair arterial blockage	0081	43.5067	$2,268.92	.....	$453.78
35459	T	.....	Repair arterial blockage	0081	43.5067	$2,268.92	.....	$453.78
35460	T	.....	Repair venous blockage	0081	43.5067	$2,268.92	.....	$453.78
35470	T	.....	Repair arterial blockage	0081	43.5067	$2,268.92	.....	$453.78
35471	T	.....	Repair arterial blockage	0081	43.5067	$2,268.92	.....	$453.78
35472	T	.....	Repair arterial blockage	0081	43.5067	$2,268.92	.....	$453.78

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35473	T		Repair arterial blockage	0081	43.5067	$2,268.92		$453.78
35474	T		Repair arterial blockage	0081	43.5067	$2,268.92		$453.78
35475	T		Repair arterial blockage	0081	43.5067	$2,268.92		$453.78
35476	T		Repair venous blockage	0081	43.5067	$2,268.92		$453.78
35480	C		Atherectomy, open					
35481	C		Atherectomy, open					
35482	C		Atherectomy, open					
35483	C		Atherectomy, open					
35484	T		Atherectomy, open	0081	43.5067	$2,268.92		$453.78
35485	T		Atherectomy, open	0081	43.5067	$2,268.92		$453.78
35490	T		Atherectomy, percutaneous	0081	43.5067	$2,268.92		$453.78
35491	T		Atherectomy, percutaneous	0081	43.5067	$2,268.92		$453.78
35492	T		Atherectomy, percutaneous	0081	43.5067	$2,268.92		$453.78
35493	T		Atherectomy, percutaneous	0081	43.5067	$2,268.92		$453.78
35494	T		Atherectomy, percutaneous	0081	43.5067	$2,268.92		$453.78
35495	T		Atherectomy, percutaneous	0081	43.5067	$2,268.92		$453.78
35500	T		Harvest vein for bypass	0081	43.5067	$2,268.92		$453.78
35501	C		Artery bypass graft					
35506	C		Artery bypass graft					
35507	C		Artery bypass graft					
35508	C		Artery bypass graft					
35509	C		Artery bypass graft					
35511	C		Artery bypass graft					
35515	C		Artery bypass graft					
35516	C		Artery bypass graft					
35518	C		Artery bypass graft					
35521	C		Artery bypass graft					
35526	C		Artery bypass graft					
35531	C		Artery bypass graft					
35533	C		Artery bypass graft					
35536	C		Artery bypass graft					
35541	C		Artery bypass graft					
35546	C		Artery bypass graft					
35548	C		Artery bypass graft					
35549	C		Artery bypass graft					
35551	C		Artery bypass graft					
35556	C		Artery bypass graft					
35558	C		Artery bypass graft					
35560	C		Artery bypass graft					
35563	C		Artery bypass graft					
35565	C		Artery bypass graft					
35566	C		Artery bypass graft					
35571	C		Artery bypass graft					
35572	N	NI	Harvest femoropopliteal vein					
35582	C		Vein bypass graft					
35583	C		Vein bypass graft					
35585	C		Vein bypass graft					
35587	C		Vein bypass graft					
35600	C		Harvest artery for cabg					
35601	C		Artery bypass graft					
35606	C		Artery bypass graft					
35612	C		Artery bypass graft					
35616	C		Artery bypass graft					
35621	C		Artery bypass graft					
35623	C		Bypass graft, not vein					
35626	C		Artery bypass graft					
35631	C		Artery bypass graft					
35636	C		Artery bypass graft					
35641	C		Artery bypass graft					
35642	C		Artery bypass graft					
35645	C		Artery bypass graft					
35646	C		Artery bypass graft					
35647	C		Artery bypass graft					
35650	C		Artery bypass graft					
35651	C		Artery bypass graft					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35654	C		Artery bypass graft					
35656	C		Artery bypass graft					
35661	C		Artery bypass graft					
35663	C		Artery bypass graft					
35665	C		Artery bypass graft					
35666	C		Artery bypass graft					
35671	C		Artery bypass graft					
35681	C		Composite bypass graft					
35682	C		Composite bypass graft					
35683	C		Composite bypass graft					
35685	T		Bypass graft patency/patch	0093	20.6294	$1,075.84	$277.34	$215.17
35686	T		Bypass graft/av fist patency	0093	20.6294	$1,075.84	$277.34	$215.17
35691	C		Arterial transposition					
35693	C		Arterial transposition					
35694	C		Arterial transposition					
35695	C		Arterial transposition					
35700	C		Reoperation, bypass graft					
35701	C		Exploration, carotid artery					
35721	C		Exploration, femoral artery					
35741	C		Exploration popliteal artery					
35761	T		Exploration of artery/vein	0115	24.3211	$1,268.37	$459.35	$253.67
35800	C		Explore neck vessels					
35820	C		Explore chest vessels					
35840	C		Explore abdominal vessels					
35860	T		Explore limb vessels	0093	20.6294	$1,075.84	$277.34	$215.17
35870	C		Repair vessel graft defect					
35875	T		Removal of clot in graft	0088	32.5768	$1,698.91	$655.22	$339.78
35876	T		Removal of clot in graft	0088	32.5768	$1,698.91	$655.22	$339.78
35879	T		Revise graft w/vein	0088	32.5768	$1,698.91	$655.22	$339.78
35881	T		Revise graft w/vein	0088	32.5768	$1,698.91	$655.22	$339.78
35901	C		Excision, graft, neck					
35903	T		Excision, graft, extremity	0115	24.3211	$1,268.37	$459.35	$253.67
35905	C		Excision, graft, thorax					
35907	C		Excision, graft, abdomen					
36000	N		Place needle in vein					
36002	S		Pseudoaneurysm injection trt	0267	2.4418	$127.34	$65.52	$25.47
36005	N		Injection ext venography					
36010	N		Place catheter in vein					
36011	N		Place catheter in vein					
36012	N		Place catheter in vein					
36013	N		Place catheter in artery					
36014	N		Place catheter in artery					
36015	N		Place catheter in artery					
36100	N		Establish access to artery					
36120	N		Establish access to artery					
36140	N		Establish access to artery					
36145	N		Artery to vein shunt					
36160	N		Establish access to aorta					
36200	N		Place catheter in aorta					
36215	N		Place catheter in artery					
36216	N		Place catheter in artery					
36217	N		Place catheter in artery					
36218	N		Place catheter in artery					
36245	N		Place catheter in artery					
36246	N		Place catheter in artery					
36247	N		Place catheter in artery					
36248	N		Place catheter in artery					
36260	T		Insertion of infusion pump	0119	89.3100	$4,657.61		$931.52
36261	T		Revision of infusion pump	0124	50.0861	$2,612.04		$522.41
36262	T		Removal of infusion pump	0109	7.4708	$389.61	$131.49	$77.92
36299	N		Vessel injection procedure					
36400	N		Bl draw < 3 yrs fem/jugular					
36405	N		Bl draw < 3 yrs scalp vein					
36406	N		Bl draw < 3 yrs other vein					
36410	N		Non-routine bl draw > 3 yrs					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
36415	E		Drawing blood					
36416	E	NI	Capillary blood draw					
36420	T		Vein access cutdown < 1 yr	0035	0.2229	$11.62	$3.51	$2.32
36425	T		Vein access cutdown > 1 yr	0035	0.2229	$11.62	$3.51	$2.32
36430	S		Blood transfusion service	0110	4.0309	$210.22		$42.04
36440	S		Bl push transfuse, 2 yr or <	0110	4.0309	$210.22		$42.04
36450	S		Bl exchange/transfuse, nb	0110	4.0309	$210.22		$42.04
36455	S		Bl exchange/transfuse non-nb	0110	4.0309	$210.22		$42.04
36460	S		Transfusion service, fetal	0110	4.0309	$210.22		$42.04
36468	T		Injection(s), spider veins	0098	1.6666	$86.91	$20.88	$17.38
36469	T		Injection(s), spider veins	0098	1.6666	$86.91	$20.88	$17.38
36470	T		Injection therapy of vein	0098	1.6666	$86.91	$20.88	$17.38
36471	T		Injection therapy of veins	0098	1.6666	$86.91	$20.88	$17.38
36481	N		Insertion of catheter, vein					
36488	T		Insertion of catheter, vein	0032	11.4726	$598.31		$119.66
36489	T		Insertion of catheter, vein	0032	11.4726	$598.31		$119.66
36490	T		Insertion of catheter, vein	0032	11.4726	$598.31		$119.66
36491	T		Insertion of catheter, vein	0032	11.4726	$598.31		$119.66
36493	X		Repositioning of cvc	0187	3.9534	$206.17	$90.71	$41.23
36500	N		Insertion of catheter, vein					
36510	C		Insertion of catheter, vein					
36511	S	NI	Apheresis wbc	0111	14.9803	$781.24	$217.61	$156.25
36512	S	NI	Apheresis rbc	0111	14.9803	$781.24	$217.61	$156.25
36513	S	NI	Apheresis platelets	0111	14.9803	$781.24	$217.61	$156.25
36514	S	NI	Apheresis plasma	0111	14.9803	$781.24	$217.61	$156.25
36515	S	NI	Apheresis, adsorp/reinfuse	0112	36.4236	$1,899.53	$612.47	$379.91
36516	S	NI	Apheresis, selective	0112	36.4236	$1,899.53	$612.47	$379.91
36520	S	DG	Plasma and/or cell exchange	0111	14.9803	$781.24	$217.61	$156.25
36521	S	DG	Apheresis w/ adsorp/reinfuse	0112	36.4236	$1,899.53	$612.47	$379.91
36522	S		Photopheresis	0112	36.4236	$1,899.53	$612.47	$379.91
36530	T		Insertion of infusion pump	0119	89.3100	$4,657.61		$931.52
36531	T		Revision of infusion pump	0124	50.0861	$2,612.04		$522.41
36532	T		Removal of infusion pump	0109	7.4708	$389.61	$131.49	$77.92
36533	T		Insertion of access device	0115	24.3211	$1,268.37	$459.35	$253.67
36534	T		Revision of access device	0109	7.4708	$389.61	$131.49	$77.92
36535	T		Removal of access device	0109	7.4708	$389.61	$131.49	$77.92
36536	T	NI	Remove cva device obstruct	0973		$250.00		$50.00
36537	T	NI	Remove cva lumen obstruct	0973		$250.00		$50.00
36540	N		Collect blood venous device					
36550	T		Declot vascular device	0677	2.6453	$137.96		$27.59
36600	N		Withdrawal of arterial blood					
36620	N		Insertion catheter, artery					
36625	N		Insertion catheter, artery					
36640	T		Insertion catheter, artery	0032	11.4726	$598.31		$119.66
36660	C		Insertion catheter, artery					
36680	T		Insert needle, bone cavity	0120	2.1802	$113.70	$30.75	$22.74
36800	T		Insertion of cannula	0115	24.3211	$1,268.37	$459.35	$253.67
36810	T		Insertion of cannula	0115	24.3211	$1,268.37	$459.35	$253.67
36815	T		Insertion of cannula	0115	24.3211	$1,268.37	$459.35	$253.67
36819	T		Av fusion/uppr arm vein	0088	32.5768	$1,698.91	$655.22	$339.78
36820	T		Av fusion/forearm vein	0088	32.5768	$1,698.91	$655.22	$339.78
36821	T		Av fusion direct any site	0088	32.5768	$1,698.91	$655.22	$339.78
36822	C		Insertion of cannula(s)					
36823	C		Insertion of cannula(s)					
36825	T		Artery-vein autograft	0088	32.5768	$1,698.91	$655.22	$339.78
36830	T		Artery-vein graft	0088	32.5768	$1,698.91	$655.22	$339.78
36831	T		Open thrombect av fistula	0088	32.5768	$1,698.91	$655.22	$339.78
36832	T		Av fistula revision, open	0088	32.5768	$1,698.91	$655.22	$339.78
36833	T		Av fistula revision	0088	32.5768	$1,698.91	$655.22	$339.78
36834	T		Repair A-V aneurysm	0088	32.5768	$1,698.91	$655.22	$339.78
36835	T		Artery to vein shunt	0115	24.3211	$1,268.37	$459.35	$253.67
36860	T		External cannula declotting	0103	11.8408	$617.51	$223.63	$123.50
36861	T		Cannula declotting	0115	24.3211	$1,268.37	$459.35	$253.67
36870	T		Percut thrombect av fistula	0653	30.0284	$1,566.01		$313.20
37140	C		Revision of circulation					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
37145	C		Revision of circulation					
37160	C		Revision of circulation					
37180	C		Revision of circulation					
37181	C		Splice spleen/kidney veins					
37182	C	NI	Insert hepatic shunt (tips)					
37183	C	NI	Remove hepatic shunt (tips)					
37195	C		Thrombolytic therapy, stroke					
37200	T		Transcatheter biopsy	0685	5.9882	$312.29	$137.40	$62.46
37201	T		Transcatheter therapy infuse	0676	4.1278	$215.27	$58.21	$43.05
37202	T		Transcatheter therapy infuse	0677	2.6453	$137.96		$27.59
37203	T		Transcatheter retrieval	0103	11.8408	$617.51	$223.63	$123.50
37204	T		Transcatheter occlusion	0115	24.3211	$1,268.37	$459.35	$253.67
37205	T		Transcatheter stent	0229	57.4599	$2,996.59	$771.23	$599.32
37206	T		Transcatheter stent add-on	0229	57.4599	$2,996.59	$771.23	$599.32
37207	T		Transcatheter stent	0229	57.4599	$2,996.59	$771.23	$599.32
37208	T		Transcatheter stent add-on	0229	57.4599	$2,996.59	$771.23	$599.32
37209	T		Exchange arterial catheter	0103	11.8408	$617.51	$223.63	$123.50
37250	S		Iv us first vessel add-on	0670	30.2416	$1,577.13	$571.17	$315.43
37251	S		Iv us each add vessel add-on	0670	30.2416	$1,577.13	$571.17	$315.43
37500	T	NI	Endoscopy ligate perf veins	0092	23.7882	$1,240.58	$505.37	$248.12
37501	T	NI	Vascular endoscopy procedure	0092	23.7882	$1,240.58	$505.37	$248.12
37565	T		Ligation of neck vein	0093	20.6294	$1,075.84	$277.34	$215.17
37600	T		Ligation of neck artery	0093	20.6294	$1,075.84	$277.34	$215.17
37605	T		Ligation of neck artery	0091	26.7048	$1,392.68	$348.23	$278.54
37606	T		Ligation of neck artery	0091	26.7048	$1,392.68	$348.23	$278.54
37607	T		Ligation of a-v fistula	0092	23.7882	$1,240.58	$505.37	$248.12
37609	T		Temporal artery procedure	0021	13.9338	$726.66	$219.48	$145.33
37615	T		Ligation of neck artery	0091	26.7048	$1,392.68	$348.23	$278.54
37616	C		Ligation of chest artery					
37617	C		Ligation of abdomen artery					
37618	C		Ligation of extremity artery					
37620	T		Revision of major vein	0091	26.7048	$1,392.68	$348.23	$278.54
37650	T		Revision of major vein	0091	26.7048	$1,392.68	$348.23	$278.54
37660	C		Revision of major vein					
37700	T		Revise leg vein	0091	26.7048	$1,392.68	$348.23	$278.54
37720	T		Removal of leg vein	0092	23.7882	$1,240.58	$505.37	$248.12
37730	T		Removal of leg veins	0092	23.7882	$1,240.58	$505.37	$248.12
37735	T		Removal of leg veins/lesion	0092	23.7882	$1,240.58	$505.37	$248.12
37760	T		Revision of leg veins	0091	26.7048	$1,392.68	$348.23	$278.54
37780	T		Revision of leg vein	0091	26.7048	$1,392.68	$348.23	$278.54
37785	T		Revise secondary varicosity	0091	26.7048	$1,392.68	$348.23	$278.54
37788	C		Revascularization, penis					
37790	T		Penile venous occlusion	0181	29.2435	$1,525.08	$621.82	$305.02
37799	T		Vascular surgery procedure	0035	0.2229	$11.62	$3.51	$2.32
38100	C		Removal of spleen, total					
38101	C		Removal of spleen, partial					
38102	C		Removal of spleen, total					
38115	C		Repair of ruptured spleen					
38120	T		Laparoscopy, splenectomy	0131	40.2026	$2,096.61	$1,001.89	$419.32
38129	T		Laparoscope proc, spleen	0130	30.4644	$1,588.75	$659.53	$317.75
38200	N		Injection for spleen x-ray					
38204	E	NI	Bl donor search management					
38205	S	NI	Harvest allogenic stem cells	0111	14.9803	$781.24	$217.61	$156.25
38206	S	NI	Harvest auto stem cells	0111	14.9803	$781.24	$217.61	$156.25
38207	E	NI	Cryopreserve stem cells					
38208	E	NI	Thaw preserved stem cells					
38209	E	NI	Wash harvest stem cells					
38210	E	NI	T-cell depletion of harvest					
38211	E	NI	Tumor cell deplete of harvst					
38212	E	NI	Rbc depletion of harvest					
38213	E	NI	Platelet deplete of harvest					
38214	E	NI	Volume deplete of harvest					
38215	E	NI	Harvest stem cell concentrte					
38220	T		Bone marrow aspiration	0003	1.2306	$64.18		$12.84
38221	T		Bone marrow biopsy	0003	1.2306	$64.18		$12.84

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
38230	S		Bone marrow collection	0123	6.4049	$334.02		$66.80
38231	S	DG	Stem cell collection	0111	14.9803	$781.24	$217.61	$156.25
38240	S		Bone marrow/stem transplant	0123	6.4049	$334.02		$66.80
38241	S		Bone marrow/stem transplant	0123	6.4049	$334.02		$66.80
38242	S	NI	Lymphocyte infuse transplant	0111	14.9803	$781.24	$217.61	$156.25
38300	T		Drainage, lymph node lesion	0008	16.1430	$841.87		$168.37
38305	T		Drainage, lymph node lesion	0008	16.1430	$841.87		$168.37
38308	T		Incision of lymph channels	0113	18.7496	$977.81		$195.56
38380	C		Thoracic duct procedure					
38381	C		Thoracic duct procedure					
38382	C		Thoracic duct procedure					
38500	T		Biopsy/removal, lymph nodes	0113	18.7496	$977.81		$195.56
38505	T		Needle biopsy, lymph nodes	0005	3.1201	$162.72	$71.59	$32.54
38510	T		Biopsy/removal, lymph nodes	0113	18.7496	$977.81		$195.56
38520	T		Biopsy/removal, lymph nodes	0113	18.7496	$977.81		$195.56
38525	T		Biopsy/removal, lymph nodes	0113	18.7496	$977.81		$195.56
38530	T		Biopsy/removal, lymph nodes	0113	18.7496	$977.81		$195.56
38542	T		Explore deep node(s), neck	0114	36.1135	$1,883.36	$485.91	$376.67
38550	T		Removal, neck/armpit lesion	0113	18.7496	$977.81		$195.56
38555	T		Removal, neck/armpit lesion	0113	18.7496	$977.81		$195.56
38562	C		Removal, pelvic lymph nodes					
38564	C		Removal, abdomen lymph nodes					
38570	T		Laparoscopy, lymph node biop	0131	40.2026	$2,096.61	$1,001.89	$419.32
38571	T		Laparoscopy, lymphadenectomy	0132	56.9948	$2,972.34	$1,239.22	$594.47
38572	T		Laparoscopy, lymphadenectomy	0131	40.2026	$2,096.61	$1,001.89	$419.32
38589	T		Laparoscope proc, lymphatic	0130	30.4644	$1,588.75	$659.53	$317.75
38700	T		Removal of lymph nodes, neck	0113	18.7496	$977.81		$195.56
38720	T		Removal of lymph nodes, neck	0113	18.7496	$977.81		$195.56
38724	C		Removal of lymph nodes, neck					
38740	T		Remove armpit lymph nodes	0114	36.1135	$1,883.36	$485.91	$376.67
38745	T		Remove armpit lymph nodes	0114	36.1135	$1,883.36	$485.91	$376.67
38746	C		Remove thoracic lymph nodes					
38747	C		Remove abdominal lymph nodes					
38760	T		Remove groin lymph nodes	0113	18.7496	$977.81		$195.56
38765	C		Remove groin lymph nodes					
38770	C		Remove pelvis lymph nodes					
38780	C		Remove abdomen lymph nodes					
38790	N		Inject for lymphatic x-ray					
38792	N		Identify sentinel node					
38794	N		Access thoracic lymph duct					
38999	S		Blood/lymph system procedure	0110	4.0309	$210.22		$42.04
39000	C		Exploration of chest					
39010	C		Exploration of chest					
39200	C		Removal chest lesion					
39220	C		Removal chest lesion					
39400	T		Visualization of chest	0069	27.5575	$1,437.15	$591.64	$287.43
39499	C		Chest procedure					
39501	C		Repair diaphragm laceration					
39502	C		Repair paraesophageal hernia					
39503	C		Repair of diaphragm hernia					
39520	C		Repair of diaphragm hernia					
39530	C		Repair of diaphragm hernia					
39531	C		Repair of diaphragm hernia					
39540	C		Repair of diaphragm hernia					
39541	C		Repair of diaphragm hernia					
39545	C		Revision of diaphragm					
39560	C		Resect diaphragm, simple					
39561	C		Resect diaphragm, complex					
39599	C		Diaphragm surgery procedure					
40490	T		Biopsy of lip	0251	1.9089	$99.55		$19.91
40500	T		Partial excision of lip	0253	14.4473	$753.44	$282.29	$150.69
40510	T		Partial excision of lip	0254	20.1158	$1,049.06	$321.35	$209.81
40520	T		Partial excision of lip	0253	14.4473	$753.44	$282.29	$150.69
40525	T		Reconstruct lip with flap	0254	20.1158	$1,049.06	$321.35	$209.81
40527	T		Reconstruct lip with flap	0254	20.1158	$1,049.06	$321.35	$209.81

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
40530	T		Partial removal of lip	0254	20.1158	$1,049.06	$321.35	$209.81
40650	T		Repair lip	0252	5.8041	$302.69	$113.41	$60.54
40652	T		Repair lip	0252	5.8041	$302.69	$113.41	$60.54
40654	T		Repair lip	0252	5.8041	$302.69	$113.41	$60.54
40700	T		Repair cleft lip/nasal	0256	34.0302	$1,774.71		$354.94
40701	T		Repair cleft lip/nasal	0256	34.0302	$1,774.71		$354.94
40702	T		Repair cleft lip/nasal	0256	34.0302	$1,774.71		$354.94
40720	T		Repair cleft lip/nasal	0256	34.0302	$1,774.71		$354.94
40761	T		Repair cleft lip/nasal	0256	34.0302	$1,774.71		$354.94
40799	T		Lip surgery procedure	0253	14.4473	$753.44	$282.29	$150.69
40800	T		Drainage of mouth lesion	0251	1.9089	$99.55		$19.91
40801	T		Drainage of mouth lesion	0252	5.8041	$302.69	$113.41	$60.54
40804	X		Removal, foreign body, mouth	0340	0.6492	$33.86		$6.77
40805	T		Removal, foreign body, mouth	0252	5.8041	$302.69	$113.41	$60.54
40806	T		Incision of lip fold	0251	1.9089	$99.55		$19.91
40808	T		Biopsy of mouth lesion	0251	1.9089	$99.55		$19.91
40810	T		Excision of mouth lesion	0253	14.4473	$753.44	$282.29	$150.69
40812	T		Excise/repair mouth lesion	0253	14.4473	$753.44	$282.29	$150.69
40814	T		Excise/repair mouth lesion	0253	14.4473	$753.44	$282.29	$150.69
40816	T		Excision of mouth lesion	0254	20.1158	$1,049.06	$321.35	$209.81
40818	T		Excise oral mucosa for graft	0251	1.9089	$99.55		$19.91
40819	T		Excise lip or cheek fold	0252	5.8041	$302.69	$113.41	$60.54
40820	T		Treatment of mouth lesion	0253	14.4473	$753.44	$282.29	$150.69
40830	T		Repair mouth laceration	0251	1.9089	$99.55		$19.91
40831	T		Repair mouth laceration	0252	5.8041	$302.69	$113.41	$60.54
40840	T		Reconstruction of mouth	0254	20.1158	$1,049.06	$321.35	$209.81
40842	T		Reconstruction of mouth	0254	20.1158	$1,049.06	$321.35	$209.81
40843	T		Reconstruction of mouth	0254	20.1158	$1,049.06	$321.35	$209.81
40844	T		Reconstruction of mouth	0256	34.0302	$1,774.71		$354.94
40845	T		Reconstruction of mouth	0256	34.0302	$1,774.71		$354.94
40899	T		Mouth surgery procedure	0252	5.8041	$302.69	$113.41	$60.54
41000	T		Drainage of mouth lesion	0253	14.4473	$753.44	$282.29	$150.69
41005	T		Drainage of mouth lesion	0251	1.9089	$99.55		$19.91
41006	T		Drainage of mouth lesion	0254	20.1158	$1,049.06	$321.35	$209.81
41007	T		Drainage of mouth lesion	0253	14.4473	$753.44	$282.29	$150.69
41008	T		Drainage of mouth lesion	0253	14.4473	$753.44	$282.29	$150.69
41009	T		Drainage of mouth lesion	0251	1.9089	$99.55		$19.91
41010	T		Incision of tongue fold	0253	14.4473	$753.44	$282.29	$150.69
41015	T		Drainage of mouth lesion	0251	1.9089	$99.55		$19.91
41016	T		Drainage of mouth lesion	0252	5.8041	$302.69	$113.41	$60.54
41017	T		Drainage of mouth lesion	0252	5.8041	$302.69	$113.41	$60.54
41018	T		Drainage of mouth lesion	0252	5.8041	$302.69	$113.41	$60.54
41100	T		Biopsy of tongue	0252	5.8041	$302.69	$113.41	$60.54
41105	T		Biopsy of tongue	0253	14.4473	$753.44	$282.29	$150.69
41108	T		Biopsy of floor of mouth	0252	5.8041	$302.69	$113.41	$60.54
41110	T		Excision of tongue lesion	0253	14.4473	$753.44	$282.29	$150.69
41112	T		Excision of tongue lesion	0253	14.4473	$753.44	$282.29	$150.69
41113	T		Excision of tongue lesion	0253	14.4473	$753.44	$282.29	$150.69
41114	T		Excision of tongue lesion	0254	20.1158	$1,049.06	$321.35	$209.81
41115	T		Excision of tongue fold	0252	5.8041	$302.69	$113.41	$60.54
41116	T		Excision of mouth lesion	0253	14.4473	$753.44	$282.29	$150.69
41120	T		Partial removal of tongue	0254	20.1158	$1,049.06	$321.35	$209.81
41130	C		Partial removal of tongue					
41135	C		Tongue and neck surgery					
41140	C		Removal of tongue					
41145	C		Tongue removal, neck surgery					
41150	C		Tongue, mouth, jaw surgery					
41153	C		Tongue, mouth, neck surgery					
41155	C		Tongue, jaw, & neck surgery					
41250	T		Repair tongue laceration	0251	1.9089	$99.55		$19.91
41251	T		Repair tongue laceration	0252	5.8041	$302.69	$113.41	$60.54
41252	T		Repair tongue laceration	0252	5.8041	$302.69	$113.41	$60.54
41500	T		Fixation of tongue	0254	20.1158	$1,049.06	$321.35	$209.81
41510	T		Tongue to lip surgery	0253	14.4473	$753.44	$282.29	$150.69
41520	T		Reconstruction, tongue fold	0252	5.8041	$302.69	$113.41	$60.54

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
41599	T		Tongue and mouth surgery	0251	1.9089	$99.55		$19.91
41800	T		Drainage of gum lesion	0251	1.9089	$99.55		$19.91
41805	T		Removal foreign body, gum	0254	20.1158	$1,049.06	$321.35	$209.81
41806	T		Removal foreign body,jawbone	0253	14.4473	$753.44	$282.29	$150.69
41820	T		Excision, gum, each quadrant	0252	5.8041	$302.69	$113.41	$60.54
41821	T		Excision of gum flap	0252	5.8041	$302.69	$113.41	$60.54
41822	T		Excision of gum lesion	0253	14.4473	$753.44	$282.29	$150.69
41823	T		Excision of gum lesion	0254	20.1158	$1,049.06	$321.35	$209.81
41825	T		Excision of gum lesion	0253	14.4473	$753.44	$282.29	$150.69
41826	T		Excision of gum lesion	0253	14.4473	$753.44	$282.29	$150.69
41827	T		Excision of gum lesion	0254	20.1158	$1,049.06	$321.35	$209.81
41828	T		Excision of gum lesion	0253	14.4473	$753.44	$282.29	$150.69
41830	T		Removal of gum tissue	0253	14.4473	$753.44	$282.29	$150.69
41850	T		Treatment of gum lesion	0253	14.4473	$753.44	$282.29	$150.69
41870	T		Gum graft	0254	20.1158	$1,049.06	$321.35	$209.81
41872	T		Repair gum	0253	14.4473	$753.44	$282.29	$150.69
41874	T		Repair tooth socket	0254	20.1158	$1,049.06	$321.35	$209.81
41899	T		Dental surgery procedure	0253	14.4473	$753.44	$282.29	$150.69
42000	T		Drainage mouth roof lesion	0251	1.9089	$99.55		$19.91
42100	T		Biopsy roof of mouth	0252	5.8041	$302.69	$113.41	$60.54
42104	T		Excision lesion, mouth roof	0253	14.4473	$753.44	$282.29	$150.69
42106	T		Excision lesion, mouth roof	0253	14.4473	$753.44	$282.29	$150.69
42107	T		Excision lesion, mouth roof	0254	20.1158	$1,049.06	$321.35	$209.81
42120	T		Remove palate/lesion	0256	34.0302	$1,774.71		$354.94
42140	T		Excision of uvula	0252	5.8041	$302.69	$113.41	$60.54
42145	T		Repair palate, pharynx/uvula	0254	20.1158	$1,049.06	$321.35	$209.81
42160	T		Treatment mouth roof lesion	0253	14.4473	$753.44	$282.29	$150.69
42180	T		Repair palate	0251	1.9089	$99.55		$19.91
42182	T		Repair palate	0256	34.0302	$1,774.71		$354.94
42200	T		Reconstruct cleft palate	0256	34.0302	$1,774.71		$354.94
42205	T		Reconstruct cleft palate	0256	34.0302	$1,774.71		$354.94
42210	T		Reconstruct cleft palate	0256	34.0302	$1,774.71		$354.94
42215	T		Reconstruct cleft palate	0256	34.0302	$1,774.71		$354.94
42220	T		Reconstruct cleft palate	0256	34.0302	$1,774.71		$354.94
42225	T		Reconstruct cleft palate	0256	34.0302	$1,774.71		$354.94
42226	T		Lengthening of palate	0256	34.0302	$1,774.71		$354.94
42227	T		Lengthening of palate	0256	34.0302	$1,774.71		$354.94
42235	T		Repair palate	0253	14.4473	$753.44	$282.29	$150.69
42260	T		Repair nose to lip fistula	0254	20.1158	$1,049.06	$321.35	$209.81
42280	T		Preparation, palate mold	0251	1.9089	$99.55		$19.91
42281	T		Insertion, palate prosthesis	0253	14.4473	$753.44	$282.29	$150.69
42299	T		Palate/uvula surgery	0251	1.9089	$99.55		$19.91
42300	T		Drainage of salivary gland	0253	14.4473	$753.44	$282.29	$150.69
42305	T		Drainage of salivary gland	0253	14.4473	$753.44	$282.29	$150.69
42310	T		Drainage of salivary gland	0251	1.9089	$99.55		$19.91
42320	T		Drainage of salivary gland	0251	1.9089	$99.55		$19.91
42325	T		Create salivary cyst drain	0251	1.9089	$99.55		$19.91
42326	T		Create salivary cyst drain	0252	5.8041	$302.69	$113.41	$60.54
42330	T		Removal of salivary stone	0253	14.4473	$753.44	$282.29	$150.69
42335	T		Removal of salivary stone	0253	14.4473	$753.44	$282.29	$150.69
42340	T		Removal of salivary stone	0253	14.4473	$753.44	$282.29	$150.69
42400	T		Biopsy of salivary gland	0005	3.1201	$162.72	$71.59	$32.54
42405	T		Biopsy of salivary gland	0253	14.4473	$753.44	$282.29	$150.69
42408	T		Excision of salivary cyst	0253	14.4473	$753.44	$282.29	$150.69
42409	T		Drainage of salivary cyst	0253	14.4473	$753.44	$282.29	$150.69
42410	T		Excise parotid gland/lesion	0256	34.0302	$1,774.71		$354.94
42415	T		Excise parotid gland/lesion	0256	34.0302	$1,774.71		$354.94
42420	T		Excise parotid gland/lesion	0256	34.0302	$1,774.71		$354.94
42425	T		Excise parotid gland/lesion	0256	34.0302	$1,774.71		$354.94
42426	C		Excise parotid gland/lesion					
42440	T		Excise submaxillary gland	0256	34.0302	$1,774.71		$354.94
42450	T		Excise sublingual gland	0254	20.1158	$1,049.06	$321.35	$209.81
42500	T		Repair salivary duct	0254	20.1158	$1,049.06	$321.35	$209.81
42505	T		Repair salivary duct	0256	34.0302	$1,774.71		$354.94
42507	T		Parotid duct diversion	0256	34.0302	$1,774.71		$354.94

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42508	T		Parotid duct diversion	0256	34.0302	$1,774.71		$354.94
42509	T		Parotid duct diversion	0256	34.0302	$1,774.71		$354.94
42510	T		Parotid duct diversion	0256	34.0302	$1,774.71		$354.94
42550	N		Injection for salivary x-ray					
42600	T		Closure of salivary fistula	0253	14.4473	$753.44	$282.29	$150.69
42650	T		Dilation of salivary duct	0252	5.8041	$302.69	$113.41	$60.54
42660	T		Dilation of salivary duct	0252	5.8041	$302.69	$113.41	$60.54
42665	T		Ligation of salivary duct	0254	20.1158	$1,049.06	$321.35	$209.81
42699	T		Salivary surgery procedure	0253	14.4473	$753.44	$282.29	$150.69
42700	T		Drainage of tonsil abscess	0251	1.9089	$99.55		$19.91
42720	T		Drainage of throat abscess	0253	14.4473	$753.44	$282.29	$150.69
42725	T		Drainage of throat abscess	0256	34.0302	$1,774.71		$354.94
42800	T		Biopsy of throat	0252	5.8041	$302.69	$113.41	$60.54
42802	T		Biopsy of throat	0253	14.4473	$753.44	$282.29	$150.69
42804	T		Biopsy of upper nose/throat	0253	14.4473	$753.44	$282.29	$150.69
42806	T		Biopsy of upper nose/throat	0254	20.1158	$1,049.06	$321.35	$209.81
42808	T		Excise pharynx lesion	0253	14.4473	$753.44	$282.29	$150.69
42809	X		Remove pharynx foreign body	0340	0.6492	$33.86		$6.77
42810	T		Excision of neck cyst	0254	20.1158	$1,049.06	$321.35	$209.81
42815	T		Excision of neck cyst	0256	34.0302	$1,774.71		$354.94
42820	T		Remove tonsils and adenoids	0258	19.8736	$1,036.43	$437.25	$207.29
42821	T		Remove tonsils and adenoids	0258	19.8736	$1,036.43	$437.25	$207.29
42825	T		Removal of tonsils	0258	19.8736	$1,036.43	$437.25	$207.29
42826	T		Removal of tonsils	0258	19.8736	$1,036.43	$437.25	$207.29
42830	T		Removal of adenoids	0258	19.8736	$1,036.43	$437.25	$207.29
42831	T		Removal of adenoids	0258	19.8736	$1,036.43	$437.25	$207.29
42835	T		Removal of adenoids	0258	19.8736	$1,036.43	$437.25	$207.29
42836	T		Removal of adenoids	0258	19.8736	$1,036.43	$437.25	$207.29
42842	T		Extensive surgery of throat	0254	20.1158	$1,049.06	$321.35	$209.81
42844	T		Extensive surgery of throat	0256	34.0302	$1,774.71		$354.94
42845	C		Extensive surgery of throat					
42860	T		Excision of tonsil tags	0258	19.8736	$1,036.43	$437.25	$207.29
42870	T		Excision of lingual tonsil	0258	19.8736	$1,036.43	$437.25	$207.29
42890	T		Partial removal of pharynx	0256	34.0302	$1,774.71		$354.94
42892	T		Revision of pharyngeal walls	0256	34.0302	$1,774.71		$354.94
42894	C		Revision of pharyngeal walls					
42900	T		Repair throat wound	0252	5.8041	$302.69	$113.41	$60.54
42950	T		Reconstruction of throat	0254	20.1158	$1,049.06	$321.35	$209.81
42953	C		Repair throat, esophagus					
42955	T		Surgical opening of throat	0254	20.1158	$1,049.06	$321.35	$209.81
42960	T		Control throat bleeding	0250	1.6376	$85.40	$29.89	$17.08
42961	C		Control throat bleeding					
42962	T		Control throat bleeding	0256	34.0302	$1,774.71		$354.94
42970	T		Control nose/throat bleeding	0250	1.6376	$85.40	$29.89	$17.08
42971	C		Control nose/throat bleeding					
42972	T		Control nose/throat bleeding	0253	14.4473	$753.44	$282.29	$150.69
42999	T		Throat surgery procedure	0252	5.8041	$302.69	$113.41	$60.54
43020	T		Incision of esophagus	0252	5.8041	$302.69	$113.41	$60.54
43030	T		Throat muscle surgery	0253	14.4473	$753.44	$282.29	$150.69
43045	C		Incision of esophagus					
43100	C		Excision of esophagus lesion					
43101	C		Excision of esophagus lesion					
43107	C		Removal of esophagus					
43108	C		Removal of esophagus					
43112	C		Removal of esophagus					
43113	C		Removal of esophagus					
43116	C		Partial removal of esophagus					
43117	C		Partial removal of esophagus					
43118	C		Partial removal of esophagus					
43121	C		Partial removal of esophagus					
43122	C		Partial removal of esophagus					
43123	C		Partial removal of esophagus					
43124	C		Removal of esophagus					
43130	T		Removal of esophagus pouch	0254	20.1158	$1,049.06	$321.35	$209.81
43135	C		Removal of esophagus pouch					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43200	T		Esophagus endoscopy	0141	7.4126	$386.57	$143.38	$77.31
43201	T	NI	Esoph scope w/submucous inj	0141	7.4126	$386.57	$143.38	$77.31
43202	T		Esophagus endoscopy, biopsy	0141	7.4126	$386.57	$143.38	$77.31
43204	T		Esoph scope w/sclerosis inj	0141	7.4126	$386.57	$143.38	$77.31
43205	T		Esophagus endoscopy/ligation	0141	7.4126	$386.57	$143.38	$77.31
43215	T		Esophagus endoscopy	0141	7.4126	$386.57	$143.38	$77.31
43216	T		Esophagus endoscopy/lesion	0141	7.4126	$386.57	$143.38	$77.31
43217	T		Esophagus endoscopy	0141	7.4126	$386.57	$143.38	$77.31
43219	T		Esophagus endoscopy	0141	7.4126	$386.57	$143.38	$77.31
43220	T		Esoph endoscopy, dilation	0141	7.4126	$386.57	$143.38	$77.31
43226	T		Esoph endoscopy, dilation	0141	7.4126	$386.57	$143.38	$77.31
43227	T		Esoph endoscopy, repair	0141	7.4126	$386.57	$143.38	$77.31
43228	T		Esoph endoscopy, ablation	0141	7.4126	$386.57	$143.38	$77.31
43231	T		Esoph endoscopy w/us exam	0141	7.4126	$386.57	$143.38	$77.31
43232	T		Esoph endoscopy w/us fn bx	0141	7.4126	$386.57	$143.38	$77.31
43234	T		Upper GI endoscopy, exam	0141	7.4126	$386.57	$143.38	$77.31
43235	T		Uppr gi endoscopy, diagnosis	0141	7.4126	$386.57	$143.38	$77.31
43236	T	NI	Uppr gi scope w/submuc inj	0141	7.4126	$386.57	$143.38	$77.31
43239	T		Upper GI endoscopy, biopsy	0141	7.4126	$386.57	$143.38	$77.31
43240	T		Esoph endoscope w/drain cyst	0141	7.4126	$386.57	$143.38	$77.31
43241	T		Upper GI endoscopy with tube	0141	7.4126	$386.57	$143.38	$77.31
43242	T		Uppr gi endoscopy w/us fn bx	0141	7.4126	$386.57	$143.38	$77.31
43243	T		Upper gi endoscopy & inject	0141	7.4126	$386.57	$143.38	$77.31
43244	T		Upper GI endoscopy/ligation	0141	7.4126	$386.57	$143.38	$77.31
43245	T		Uppr gi scope dilate strictr	0141	7.4126	$386.57	$143.38	$77.31
43246	T		Place gastrostomy tube	0141	7.4126	$386.57	$143.38	$77.31
43247	T		Operative upper GI endoscopy	0141	7.4126	$386.57	$143.38	$77.31
43248	T		Uppr gi endoscopy/guide wire	0141	7.4126	$386.57	$143.38	$77.31
43249	T		Esoph endoscopy, dilation	0141	7.4126	$386.57	$143.38	$77.31
43250	T		Upper GI endoscopy/tumor	0141	7.4126	$386.57	$143.38	$77.31
43251	T		Operative upper GI endoscopy	0141	7.4126	$386.57	$143.38	$77.31
43255	T		Operative upper GI endoscopy	0141	7.4126	$386.57	$143.38	$77.31
43256	T		Uppr gi endoscopy w stent	0141	7.4126	$386.57	$143.38	$77.31
43258	T		Operative upper GI endoscopy	0141	7.4126	$386.57	$143.38	$77.31
43259	T		Endoscopic ultrasound exam	0141	7.4126	$386.57	$143.38	$77.31
43260	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43261	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43262	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43263	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43264	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43265	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43267	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43268	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43269	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43271	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43272	T		Endo cholangiopancreatograph	0151	17.5093	$913.13	$245.46	$182.63
43280	T		Laparoscopy, fundoplasty	0132	56.9948	$2,972.34	$1,239.22	$594.47
43289	T		Laparoscope proc, esoph	0130	30.4644	$1,588.75	$659.53	$317.75
43300	C		Repair of esophagus					
43305	C		Repair esophagus and fistula					
43310	C		Repair of esophagus					
43312	C		Repair esophagus and fistula					
43313	C		Esophagoplasty congenital					
43314	C		Tracheo-esophagoplasty cong					
43320	C		Fuse esophagus & stomach					
43324	C		Revise esophagus & stomach					
43325	C		Revise esophagus & stomach					
43326	C		Revise esophagus & stomach					
43330	C		Repair of esophagus					
43331	C		Repair of esophagus					
43340	C		Fuse esophagus & intestine					
43341	C		Fuse esophagus & intestine					
43350	C		Surgical opening, esophagus					
43351	C		Surgical opening, esophagus					
43352	C		Surgical opening, esophagus					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43360	C	.....	Gastrointestinal repair	.....	.....	.....	.....	.....
43361	C	.....	Gastrointestinal repair	.....	.....	.....	.....	.....
43400	C	.....	Ligate esophagus veins	.....	.....	.....	.....	.....
43401	C	.....	Esophagus surgery for veins	.....	.....	.....	.....	.....
43405	C	.....	Ligate/staple esophagus	.....	.....	.....	.....	.....
43410	C	.....	Repair esophagus wound	.....	.....	.....	.....	.....
43415	C	.....	Repair esophagus wound	.....	.....	.....	.....	.....
43420	C	.....	Repair esophagus opening	.....	.....	.....	.....	.....
43425	C	.....	Repair esophagus opening	.....	.....	.....	.....	.....
43450	T	.....	Dilate esophagus	0140	6.0948	$317.85	$107.24	$63.57
43453	T	.....	Dilate esophagus	0140	6.0948	$317.85	$107.24	$63.57
43456	T	.....	Dilate esophagus	0140	6.0948	$317.85	$107.24	$63.57
43458	T	.....	Dilate esophagus	0140	6.0948	$317.85	$107.24	$63.57
43460	C	.....	Pressure treatment esophagus	.....	.....	.....	.....	.....
43496	C	.....	Free jejunum flap, microvasc	.....	.....	.....	.....	.....
43499	T	.....	Esophagus surgery procedure	0141	7.4126	$386.57	$143.38	$77.31
43500	C	.....	Surgical opening of stomach	.....	.....	.....	.....	.....
43501	C	.....	Surgical repair of stomach	.....	.....	.....	.....	.....
43502	C	.....	Surgical repair of stomach	.....	.....	.....	.....	.....
43510	C	.....	Surgical opening of stomach	.....	.....	.....	.....	.....
43520	C	.....	Incision of pyloric muscle	.....	.....	.....	.....	.....
43600	T	.....	Biopsy of stomach	0141	7.4126	$386.57	$143.38	$77.31
43605	C	.....	Biopsy of stomach	.....	.....	.....	.....	.....
43610	C	.....	Excision of stomach lesion	.....	.....	.....	.....	.....
43611	C	.....	Excision of stomach lesion	.....	.....	.....	.....	.....
43620	C	.....	Removal of stomach	.....	.....	.....	.....	.....
43621	C	.....	Removal of stomach	.....	.....	.....	.....	.....
43622	C	.....	Removal of stomach	.....	.....	.....	.....	.....
43631	C	.....	Removal of stomach, partial	.....	.....	.....	.....	.....
43632	C	.....	Removal of stomach, partial	.....	.....	.....	.....	.....
43633	C	.....	Removal of stomach, partial	.....	.....	.....	.....	.....
43634	C	.....	Removal of stomach, partial	.....	.....	.....	.....	.....
43635	C	.....	Removal of stomach, partial	.....	.....	.....	.....	.....
43638	C	.....	Removal of stomach, partial	.....	.....	.....	.....	.....
43639	C	.....	Removal of stomach, partial	.....	.....	.....	.....	.....
43640	C	.....	Vagotomy & pylorus repair	.....	.....	.....	.....	.....
43641	C	.....	Vagotomy & pylorus repair	.....	.....	.....	.....	.....
43651	T	.....	Laparoscopy, vagus nerve	0132	56.9948	$2,972.34	$1,239.22	$594.47
43652	T	.....	Laparoscopy, vagus nerve	0132	56.9948	$2,972.34	$1,239.22	$594.47
43653	T	.....	Laparoscopy, gastrostomy	0131	40.2026	$2,096.61	$1,001.89	$419.32
43659	T	.....	Laparoscope proc, stom	0130	30.4644	$1,588.75	$659.53	$317.75
43750	T	.....	Place gastrostomy tube	0141	7.4126	$386.57	$143.38	$77.31
43752	E	.....	Nasal/orogastric w/stent	.....	.....	.....	.....	.....
43760	T	.....	Change gastrostomy tube	0121	2.0833	$108.65	$43.80	$21.73
43761	T	.....	Reposition gastrostomy tube	0121	2.0833	$108.65	$43.80	$21.73
43800	C	.....	Reconstruction of pylorus	.....	.....	.....	.....	.....
43810	C	.....	Fusion of stomach and bowel	.....	.....	.....	.....	.....
43820	C	.....	Fusion of stomach and bowel	.....	.....	.....	.....	.....
43825	C	.....	Fusion of stomach and bowel	.....	.....	.....	.....	.....
43830	T	.....	Place gastrostomy tube	0141	7.4126	$386.57	$143.38	$77.31
43831	T	.....	Place gastrostomy tube	0141	7.4126	$386.57	$143.38	$77.31
43832	C	.....	Place gastrostomy tube	.....	.....	.....	.....	.....
43840	C	.....	Repair of stomach lesion	.....	.....	.....	.....	.....
43842	C	.....	Gastroplasty for obesity	.....	.....	.....	.....	.....
43843	C	.....	Gastroplasty for obesity	.....	.....	.....	.....	.....
43846	C	.....	Gastric bypass for obesity	.....	.....	.....	.....	.....
43847	C	.....	Gastric bypass for obesity	.....	.....	.....	.....	.....
43848	C	.....	Revision gastroplasty	.....	.....	.....	.....	.....
43850	C	.....	Revise stomach-bowel fusion	.....	.....	.....	.....	.....
43855	C	.....	Revise stomach-bowel fusion	.....	.....	.....	.....	.....
43860	C	.....	Revise stomach-bowel fusion	.....	.....	.....	.....	.....
43865	C	.....	Revise stomach-bowel fusion	.....	.....	.....	.....	.....
43870	T	.....	Repair stomach opening	0141	7.4126	$386.57	$143.38	$77.31
43880	C	.....	Repair stomach-bowel fistula	.....	.....	.....	.....	.....
43999	T	.....	Stomach surgery procedure	0141	7.4126	$386.57	$143.38	$77.31

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
44005	C		Freeing of bowel adhesion					
44010	C		Incision of small bowel					
44015	C		Insert needle cath bowel					
44020	C		Explore small intestine					
44021	C		Decompress small bowel					
44025	C		Incision of large bowel					
44050	C		Reduce bowel obstruction					
44055	C		Correct malrotation of bowel					
44100	T		Biopsy of bowel	0141	7.4126	$386.57	$143.38	$77.31
44110	C		Excise intestine lesion(s)					
44111	C		Excision of bowel lesion(s)					
44120	C		Removal of small intestine					
44121	C		Removal of small intestine					
44125	C		Removal of small intestine					
44126	C		Enterectomy w/o taper, cong					
44127	C		Enterectomy w/taper, cong					
44128	C		Enterectomy cong, add-on					
44130	C		Bowel to bowel fusion					
44132	C		Enterectomy, cadaver donor					
44133	C		Enterectomy, live donor					
44135	C		Intestine transplnt, cadaver					
44136	C		Intestine transplant, live					
44139	C		Mobilization of colon					
44140	C		Partial removal of colon					
44141	C		Partial removal of colon					
44143	C		Partial removal of colon					
44144	C		Partial removal of colon					
44145	C		Partial removal of colon					
44146	C		Partial removal of colon					
44147	C		Partial removal of colon					
44150	C		Removal of colon					
44151	C		Removal of colon/ileostomy					
44152	C		Removal of colon/ileostomy					
44153	C		Removal of colon/ileostomy					
44155	C		Removal of colon/ileostomy					
44156	C		Removal of colon/ileostomy					
44160	C		Removal of colon					
44200	T		Laparoscopy, enterolysis	0131	40.2026	$2,096.61	$1,001.89	$419.32
44201	T		Laparoscopy, jejunostomy	0131	40.2026	$2,096.61	$1,001.89	$419.32
44202	C		Lap resect s/intestine singl					
44203	C		Lap resect s/intestine, addl					
44204	C		Laparo partial colectomy					
44205	C		Lap colectomy part w/ileum					
44206	T	NI	Lap part colectomy w/stoma	0132	56.9948	$2,972.34	$1,239.22	$594.47
44207	T	NI	L colectomy/coloproctostomy	0132	56.9948	$2,972.34	$1,239.22	$594.47
44208	T	NI	L colectomy/coloproctostomy	0132	56.9948	$2,972.34	$1,239.22	$594.47
44209	T	DG	Laparoscope proc, intestine	0130	30.4644	$1,588.75	$659.53	$317.75
44210	C	NI	Laparo total proctocolectomy					
44211	C	NI	Laparo total proctocolectomy					
44212	C	NI	Laparo total proctocolectomy					
44238	T	NI	Laparoscope proc, intestine	0130	30.4644	$1,588.75	$659.53	$317.75
44239	T	NI	Laparoscope proc, rectum	0130	30.4644	$1,588.75	$659.53	$317.75
44300	C		Open bowel to skin					
44310	C		Ileostomy/jejunostomy					
44312	T		Revision of ileostomy	0027	15.2225	$793.87	$329.72	$158.77
44314	C		Revision of ileostomy					
44316	C		Devise bowel pouch					
44320	C		Colostomy					
44322	C		Colostomy with biopsies					
44340	T		Revision of colostomy	0027	15.2225	$793.87	$329.72	$158.77
44345	C		Revision of colostomy					
44346	C		Revision of colostomy					
44360	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44361	T		Small bowel endoscopy/biopsy	0142	8.1393	$424.47	$152.78	$84.89
44363	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
44364	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44365	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44366	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44369	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44370	T		Small bowel endoscopy/stent	0142	8.1393	$424.47	$152.78	$84.89
44372	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44373	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44376	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44377	T		Small bowel endoscopy/biopsy	0142	8.1393	$424.47	$152.78	$84.89
44378	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44379	T		S bowel endoscope w/stent	0142	8.1393	$424.47	$152.78	$84.89
44380	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44382	T		Small bowel endoscopy	0142	8.1393	$424.47	$152.78	$84.89
44383	T		Ileoscopy w/stent	0142	8.1393	$424.47	$152.78	$84.89
44385	T		Endoscopy of bowel pouch	0143	7.9165	$412.85	$186.06	$82.57
44386	T		Endoscopy, bowel pouch/biop	0143	7.9165	$412.85	$186.06	$82.57
44388	T		Colon endoscopy	0143	7.9165	$412.85	$186.06	$82.57
44389	T		Colonoscopy with biopsy	0143	7.9165	$412.85	$186.06	$82.57
44390	T		Colonoscopy for foreign body	0143	7.9165	$412.85	$186.06	$82.57
44391	T		Colonoscopy for bleeding	0143	7.9165	$412.85	$186.06	$82.57
44392	T		Colonoscopy & polypectomy	0143	7.9165	$412.85	$186.06	$82.57
44393	T		Colonoscopy, lesion removal	0143	7.9165	$412.85	$186.06	$82.57
44394	T		Colonoscopy w/snare	0143	7.9165	$412.85	$186.06	$82.57
44397	T		Colonoscopy w/stent	0143	7.9165	$412.85	$186.06	$82.57
44500	T		Intro, gastrointestinal tube	0121	2.0833	$108.65	$43.80	$21.73
44602	C		Suture, small intestine					
44603	C		Suture, small intestine					
44604	C		Suture, large intestine					
44605	C		Repair of bowel lesion					
44615	C		Intestinal stricturoplasty					
44620	C		Repair bowel opening					
44625	C		Repair bowel opening					
44626	C		Repair bowel opening					
44640	C		Repair bowel-skin fistula					
44650	C		Repair bowel fistula					
44660	C		Repair bowel-bladder fistula					
44661	C		Repair bowel-bladder fistula					
44680	C		Surgical revision, intestine					
44700	C		Suspend bowel w/prosthesis					
44701	N	NI	Intraop colon lavage add-on					
44799	T		Intestine surgery procedure	0142	8.1393	$424.47	$152.78	$84.89
44800	C		Excision of bowel pouch					
44820	C		Excision of mesentery lesion					
44850	C		Repair of mesentery					
44899	C		Bowel surgery procedure					
44900	C		Drain app abscess, open					
44901	C		Drain app abscess, percut					
44950	C		Appendectomy					
44955	C		Appendectomy add-on					
44960	C		Appendectomy					
44970	T		Laparoscopy, appendectomy	0130	30.4644	$1,588.75	$659.53	$317.75
44979	T		Laparoscope proc, app	0130	30.4644	$1,588.75	$659.53	$317.75
45000	T		Drainage of pelvic abscess	0149	16.3756	$854.00	$293.06	$170.80
45005	T		Drainage of rectal abscess	0148	3.4205	$178.38	$63.38	$35.68
45020	T		Drainage of rectal abscess	0149	16.3756	$854.00	$293.06	$170.80
45100	T		Biopsy of rectum	0149	16.3756	$854.00	$293.06	$170.80
45108	T		Removal of anorectal lesion	0150	21.2398	$1,107.68	$437.12	$221.54
45110	C		Removal of rectum					
45111	C		Partial removal of rectum					
45112	C		Removal of rectum					
45113	C		Partial proctectomy					
45114	C		Partial removal of rectum					
45116	C		Partial removal of rectum					
45119	C		Remove rectum w/reservoir					
45120	C		Removal of rectum					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
45121	C	.....	Removal of rectum and colon	.....	.....	.....	.....	.....
45123	C	.....	Partial proctectomy	.....	.....	.....	.....	.....
45126	C	.....	Pelvic exenteration	.....	.....	.....	.....	.....
45130	C	.....	Excision of rectal prolapse	.....	.....	.....	.....	.....
45135	C	.....	Excision of rectal prolapse	.....	.....	.....	.....	.....
45136	C	.....	Excise ileoanal reservior	.....	.....	.....	.....	.....
45150	T	.....	Excision of rectal stricture	0150	21.2398	$1,107.68	$437.12	$221.54
45160	T	.....	Excision of rectal lesion	0150	21.2398	$1,107.68	$437.12	$221.54
45170	T	.....	Excision of rectal lesion	0150	21.2398	$1,107.68	$437.12	$221.54
45190	T	.....	Destruction, rectal tumor	0150	21.2398	$1,107.68	$437.12	$221.54
45300	T	.....	Proctosigmoidoscopy dx	0146	3.4302	$178.89	$64.40	$35.78
45303	T	.....	Proctosigmoidoscopy dilate	0146	3.4302	$178.89	$64.40	$35.78
45305	T	.....	Proctosigmoidoscopy w/bx	0146	3.4302	$178.89	$64.40	$35.78
45307	T	.....	Proctosigmoidoscopy fb	0146	3.4302	$178.89	$64.40	$35.78
45308	T	.....	Proctosigmoidoscopy removal	0147	7.0153	$365.85	$79.46	$73.17
45309	T	.....	Proctosigmoidoscopy removal	0147	7.0153	$365.85	$79.46	$73.17
45315	T	.....	Proctosigmoidoscopy removal	0147	7.0153	$365.85	$79.46	$73.17
45317	T	.....	Proctosigmoidoscopy bleed	0146	3.4302	$178.89	$64.40	$35.78
45320	T	.....	Proctosigmoidoscopy ablate	0147	7.0153	$365.85	$79.46	$73.17
45321	T	.....	Proctosigmoidoscopy volvul	0147	7.0153	$365.85	$79.46	$73.17
45327	T	.....	Proctosigmoidoscopy w/stent	0147	7.0153	$365.85	$79.46	$73.17
45330	T	.....	Diagnostic sigmoidoscopy	0146	3.4302	$178.89	$64.40	$35.78
45331	T	.....	Sigmoidoscopy and biopsy	0146	3.4302	$178.89	$64.40	$35.78
45332	T	.....	Sigmoidoscopy w/fb removal	0146	3.4302	$178.89	$64.40	$35.78
45333	T	.....	Sigmoidoscopy & polypectomy	0147	7.0153	$365.85	$79.46	$73.17
45334	T	.....	Sigmoidoscopy for bleeding	0147	7.0153	$365.85	$79.46	$73.17
45335	T	NI	Sigmoidoscope w/submuc inj	0147	7.0153	$365.85	$79.46	$73.17
45337	T	.....	Sigmoidoscopy & decompress	0147	7.0153	$365.85	$79.46	$73.17
45338	T	.....	Sigmoidoscpy w/tumr remove	0147	7.0153	$365.85	$79.46	$73.17
45339	T	.....	Sigmoidoscopy w/ablate tumr	0147	7.0153	$365.85	$79.46	$73.17
45340	T	NI	Sig w/balloon dilation	0147	7.0153	$365.85	$79.46	$73.17
45341	T	.....	Sigmoidoscopy w/ultrasound	0147	7.0153	$365.85	$79.46	$73.17
45342	T	.....	Sigmoidoscopy w/us guide bx	0147	7.0153	$365.85	$79.46	$73.17
45345	T	.....	Sigmoidoscopy w/stent	0147	7.0153	$365.85	$79.46	$73.17
45355	T	.....	Surgical colonoscopy	0143	7.9165	$412.85	$186.06	$82.57
45378	T	.....	Diagnostic colonoscopy	0143	7.9165	$412.85	$186.06	$82.57
45379	T	.....	Colonoscopy w/fb removal	0143	7.9165	$412.85	$186.06	$82.57
45380	T	.....	Colonoscopy and biopsy	0143	7.9165	$412.85	$186.06	$82.57
45381	T	NI	Colonoscope, submucous inj	0143	7.9165	$412.85	$186.06	$82.57
45382	T	.....	Colonoscopy/control bleeding	0143	7.9165	$412.85	$186.06	$82.57
45383	T	.....	Lesion removal colonoscopy	0143	7.9165	$412.85	$186.06	$82.57
45384	T	.....	Lesion remove colonoscopy	0143	7.9165	$412.85	$186.06	$82.57
45385	T	.....	Lesion removal colonoscopy	0143	7.9165	$412.85	$186.06	$82.57
45386	T	NI	Colonoscope dilate stricture	0143	7.9165	$412.85	$186.06	$82.57
45387	T	.....	Colonoscopy w/stent	0143	7.9165	$412.85	$186.06	$82.57
45500	T	.....	Repair of rectum	0150	21.2398	$1,107.68	$437.12	$221.54
45505	T	.....	Repair of rectum	0150	21.2398	$1,107.68	$437.12	$221.54
45520	T	.....	Treatment of rectal prolapse	0098	1.6666	$86.91	$20.88	$17.38
45540	C	.....	Correct rectal prolapse	.....	.....	.....	.....	.....
45541	C	.....	Correct rectal prolapse	.....	.....	.....	.....	.....
45550	C	.....	Repair rectum/remove sigmoid	.....	.....	.....	.....	.....
45560	T	.....	Repair of rectocele	0150	21.2398	$1,107.68	$437.12	$221.54
45562	C	.....	Exploration/repair of rectum	.....	.....	.....	.....	.....
45563	C	.....	Exploration/repair of rectum	.....	.....	.....	.....	.....
45800	C	.....	Repair rect/bladder fistula	.....	.....	.....	.....	.....
45805	C	.....	Repair fistula w/colostomy	.....	.....	.....	.....	.....
45820	C	.....	Repair rectourethral fistula	.....	.....	.....	.....	.....
45825	C	.....	Repair fistula w/colostomy	.....	.....	.....	.....	.....
45900	T	.....	Reduction of rectal prolapse	0148	3.4205	$178.38	$63.38	$35.68
45905	T	.....	Dilation of anal sphincter	0149	16.3756	$854.00	$293.06	$170.80
45910	T	.....	Dilation of rectal narrowing	0149	16.3756	$854.00	$293.06	$170.80
45915	T	.....	Remove rectal obstruction	0148	3.4205	$178.38	$63.38	$35.68
45999	T	.....	Rectum surgery procedure	0148	3.4205	$178.38	$63.38	$35.68
46020	T	.....	Placement of seton	0148	3.4205	$178.38	$63.38	$35.68
46030	T	.....	Removal of rectal marker	0148	3.4205	$178.38	$63.38	$35.68

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
46040	T		Incision of rectal abscess	0155	10.1936	$531.61	$188.89	$106.32
46045	T		Incision of rectal abscess	0150	21.2398	$1,107.68	$437.12	$221.54
46050	T		Incision of anal abscess	0148	3.4205	$178.38	$63.38	$35.68
46060	T		Incision of rectal abscess	0150	21.2398	$1,107.68	$437.12	$221.54
46070	T		Incision of anal septum	0155	10.1936	$531.61	$188.89	$106.32
46080	T		Incision of anal sphincter	0149	16.3756	$854.00	$293.06	$170.80
46083	T		Incise external hemorrhoid	0148	3.4205	$178.38	$63.38	$35.68
46200	T		Removal of anal fissure	0150	21.2398	$1,107.68	$437.12	$221.54
46210	T		Removal of anal crypt	0149	16.3756	$854.00	$293.06	$170.80
46211	T		Removal of anal crypts	0150	21.2398	$1,107.68	$437.12	$221.54
46220	T		Removal of anal tag	0149	16.3756	$854.00	$293.06	$170.80
46221	T		Ligation of hemorrhoid(s)	0148	3.4205	$178.38	$63.38	$35.68
46230	T		Removal of anal tags	0149	16.3756	$854.00	$293.06	$170.80
46250	T		Hemorrhoidectomy	0150	21.2398	$1,107.68	$437.12	$221.54
46255	T		Hemorrhoidectomy	0150	21.2398	$1,107.68	$437.12	$221.54
46257	T		Remove hemorrhoids & fissure	0150	21.2398	$1,107.68	$437.12	$221.54
46258	T		Remove hemorrhoids & fistula	0150	21.2398	$1,107.68	$437.12	$221.54
46260	T		Hemorrhoidectomy	0150	21.2398	$1,107.68	$437.12	$221.54
46261	T		Remove hemorrhoids & fissure	0150	21.2398	$1,107.68	$437.12	$221.54
46262	T		Remove hemorrhoids & fistula	0150	21.2398	$1,107.68	$437.12	$221.54
46270	T		Removal of anal fistula	0150	21.2398	$1,107.68	$437.12	$221.54
46275	T		Removal of anal fistula	0150	21.2398	$1,107.68	$437.12	$221.54
46280	T		Removal of anal fistula	0150	21.2398	$1,107.68	$437.12	$221.54
46285	T		Removal of anal fistula	0150	21.2398	$1,107.68	$437.12	$221.54
46288	T		Repair anal fistula	0150	21.2398	$1,107.68	$437.12	$221.54
46320	T		Removal of hemorrhoid clot	0148	3.4205	$178.38	$63.38	$35.68
46500	T		Injection into hemorrhoid(s)	0155	10.1936	$531.61	$188.89	$106.32
46600	X		Diagnostic anoscopy	0340	0.6492	$33.86		$6.77
46604	T		Anoscopy and dilation	0147	7.0153	$365.85	$79.46	$73.17
46606	T		Anoscopy and biopsy	0147	7.0153	$365.85	$79.46	$73.17
46608	T		Anoscopy, remove for body	0147	7.0153	$365.85	$79.46	$73.17
46610	T		Anoscopy, remove lesion	0147	7.0153	$365.85	$79.46	$73.17
46611	T		Anoscopy	0147	7.0153	$365.85	$79.46	$73.17
46612	T		Anoscopy, remove lesions	0147	7.0153	$365.85	$79.46	$73.17
46614	T		Anoscopy, control bleeding	0147	7.0153	$365.85	$79.46	$73.17
46615	T		Anoscopy	0147	7.0153	$365.85	$79.46	$73.17
46700	T		Repair of anal stricture	0150	21.2398	$1,107.68	$437.12	$221.54
46705	C		Repair of anal stricture					
46706	T	NI	Repr of anal fistula w/glue	0148	3.4205	$178.38	$63.38	$35.68
46715	C		Repair of anovaginal fistula					
46716	C		Repair of anovaginal fistula					
46730	C		Construction of absent anus					
46735	C		Construction of absent anus					
46740	C		Construction of absent anus					
46742	C		Repair of imperforated anus					
46744	C		Repair of cloacal anomaly					
46746	C		Repair of cloacal anomaly					
46748	C		Repair of cloacal anomaly					
46750	T		Repair of anal sphincter	0150	21.2398	$1,107.68	$437.12	$221.54
46751	C		Repair of anal sphincter					
46753	T		Reconstruction of anus	0150	21.2398	$1,107.68	$437.12	$221.54
46754	T		Removal of suture from anus	0149	16.3756	$854.00	$293.06	$170.80
46760	T		Repair of anal sphincter	0150	21.2398	$1,107.68	$437.12	$221.54
46761	T		Repair of anal sphincter	0150	21.2398	$1,107.68	$437.12	$221.54
46762	T		Implant artificial sphincter	0150	21.2398	$1,107.68	$437.12	$221.54
46900	T		Destruction, anal lesion(s)	0016	2.6162	$136.44	$57.31	$27.29
46910	T		Destruction, anal lesion(s)	0017	15.8233	$825.20	$227.84	$165.04
46916	T		Cryosurgery, anal lesion(s)	0013	1.0756	$56.09	$14.20	$11.22
46917	T		Laser surgery, anal lesions	0695	18.6817	$974.27	$266.59	$194.85
46922	T		Excision of anal lesion(s)	0695	18.6817	$974.27	$266.59	$194.85
46924	T		Destruction, anal lesion(s)	0695	18.6817	$974.27	$266.59	$194.85
46934	T		Destruction of hemorrhoids	0155	10.1936	$531.61	$188.89	$106.32
46935	T		Destruction of hemorrhoids	0155	10.1936	$531.61	$188.89	$106.32
46936	T		Destruction of hemorrhoids	0149	16.3756	$854.00	$293.06	$170.80
46937	T		Cryotherapy of rectal lesion	0149	16.3756	$854.00	$293.06	$170.80

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
46938	T		Cryotherapy of rectal lesion	0150	21.2398	$1,107.68	$437.12	$221.54
46940	T		Treatment of anal fissure	0149	16.3756	$854.00	$293.06	$170.80
46942	T		Treatment of anal fissure	0148	3.4205	$178.38	$63.38	$35.68
46945	T		Ligation of hemorrhoids	0155	10.1936	$531.61	$188.89	$106.32
46946	T		Ligation of hemorrhoids	0155	10.1936	$531.61	$188.89	$106.32
46999	T		Anus surgery procedure	0148	3.4205	$178.38	$63.38	$35.68
47000	T		Needle biopsy of liver	0685	5.9882	$312.29	$137.40	$62.46
47001	N		Needle biopsy, liver add-on					
47010	C		Open drainage, liver lesion					
47011	T		Percut drain, liver lesion	0005	3.1201	$162.72	$71.59	$32.54
47015	C		Inject/aspirate liver cyst					
47100	C		Wedge biopsy of liver					
47120	C		Partial removal of liver					
47122	C		Extensive removal of liver					
47125	C		Partial removal of liver					
47130	C		Partial removal of liver					
47133	C		Removal of donor liver					
47134	C		Partial removal, donor liver					
47135	C		Transplantation of liver					
47136	C		Transplantation of liver					
47300	C		Surgery for liver lesion					
47350	C		Repair liver wound					
47360	C		Repair liver wound					
47361	C		Repair liver wound					
47362	C		Repair liver wound					
47370	T		Laparo ablate liver tumor rf	0130	30.4644	$1,588.75	$659.53	$317.75
47371	T		Laparo ablate liver cryosurg	0130	30.4644	$1,588.75	$659.53	$317.75
47379	T		Laparoscope procedure, liver	0130	30.4644	$1,588.75	$659.53	$317.75
47380	C		Open ablate liver tumor rf					
47381	C		Open ablate liver tumor cryo					
47382	T		Percut ablate liver rf	0980		$1,875.00		$375.00
47399	T		Liver surgery procedure	0005	3.1201	$162.72	$71.59	$32.54
47400	C		Incision of liver duct					
47420	C		Incision of bile duct					
47425	C		Incision of bile duct					
47460	C		Incise bile duct sphincter					
47480	C		Incision of gallbladder					
47490	T		Incision of gallbladder	0152	10.0288	$523.01	$131.28	$104.60
47500	N		Injection for liver x-rays					
47505	N		Injection for liver x-rays					
47510	T		Insert catheter, bile duct	0152	10.0288	$523.01	$131.28	$104.60
47511	T		Insert bile duct drain	0152	10.0288	$523.01	$131.28	$104.60
47525	T		Change bile duct catheter	0122	10.7459	$560.41	$114.93	$112.08
47530	T		Revise/reinsert bile tube	0121	2.0833	$108.65	$43.80	$21.73
47550	C		Bile duct endoscopy add-on					
47552	T		Biliary endoscopy thru skin	0152	10.0288	$523.01	$131.28	$104.60
47553	T		Biliary endoscopy thru skin	0152	10.0288	$523.01	$131.28	$104.60
47554	T		Biliary endoscopy thru skin	0152	10.0288	$523.01	$131.28	$104.60
47555	T		Biliary endoscopy thru skin	0152	10.0288	$523.01	$131.28	$104.60
47556	T		Biliary endoscopy thru skin	0152	10.0288	$523.01	$131.28	$104.60
47560	T		Laparoscopy w/cholangio	0130	30.4644	$1,588.75	$659.53	$317.75
47561	T		Laparo w/cholangio/biopsy	0130	30.4644	$1,588.75	$659.53	$317.75
47562	T		Laparoscopic cholecystectomy	0131	40.2026	$2,096.61	$1,001.89	$419.32
47563	T		Laparo cholecystectomy/graph	0131	40.2026	$2,096.61	$1,001.89	$419.32
47564	T		Laparo cholecystectomy/explr	0131	40.2026	$2,096.61	$1,001.89	$419.32
47570	C		Laparo cholecystoenterostomy					
47579	T		Laparoscope proc, biliary	0130	30.4644	$1,588.75	$659.53	$317.75
47600	C		Removal of gallbladder					
47605	C		Removal of gallbladder					
47610	C		Removal of gallbladder					
47612	C		Removal of gallbladder					
47620	C		Removal of gallbladder					
47630	T		Remove bile duct stone	0152	10.0288	$523.01	$131.28	$104.60
47700	C		Exploration of bile ducts					
47701	C		Bile duct revision					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
47711	C	.....	Excision of bile duct tumor	.....	.....	.....	.....	.....
47712	C	.....	Excision of bile duct tumor	.....	.....	.....	.....	.....
47715	C	.....	Excision of bile duct cyst	.....	.....	.....	.....	.....
47716	C	.....	Fusion of bile duct cyst	.....	.....	.....	.....	.....
47720	C	.....	Fuse gallbladder & bowel	.....	.....	.....	.....	.....
47721	C	.....	Fuse upper gi structures	.....	.....	.....	.....	.....
47740	C	.....	Fuse gallbladder & bowel	.....	.....	.....	.....	.....
47741	C	.....	Fuse gallbladder & bowel	.....	.....	.....	.....	.....
47760	C	.....	Fuse bile ducts and bowel	.....	.....	.....	.....	.....
47765	C	.....	Fuse liver ducts & bowel	.....	.....	.....	.....	.....
47780	C	.....	Fuse bile ducts and bowel	.....	.....	.....	.....	.....
47785	C	.....	Fuse bile ducts and bowel	.....	.....	.....	.....	.....
47800	C	.....	Reconstruction of bile ducts	.....	.....	.....	.....	.....
47801	C	.....	Placement, bile duct support	.....	.....	.....	.....	.....
47802	C	.....	Fuse liver duct & intestine	.....	.....	.....	.....	.....
47900	C	.....	Suture bile duct injury	.....	.....	.....	.....	.....
47999	T	.....	Bile tract surgery procedure	0152	10.0288	$523.01	$131.28	$104.60
48000	C	.....	Drainage of abdomen	.....	.....	.....	.....	.....
48001	C	.....	Placement of drain, pancreas	.....	.....	.....	.....	.....
48005	C	.....	Resect/debride pancreas	.....	.....	.....	.....	.....
48020	C	.....	Removal of pancreatic stone	.....	.....	.....	.....	.....
48100	C	.....	Biopsy of pancreas, open	.....	.....	.....	.....	.....
48102	T	.....	Needle biopsy, pancreas	0685	5.9882	$312.29	$137.40	$62.46
48120	C	.....	Removal of pancreas lesion	.....	.....	.....	.....	.....
48140	C	.....	Partial removal of pancreas	.....	.....	.....	.....	.....
48145	C	.....	Partial removal of pancreas	.....	.....	.....	.....	.....
48146	C	.....	Pancreatectomy	.....	.....	.....	.....	.....
48148	C	.....	Removal of pancreatic duct	.....	.....	.....	.....	.....
48150	C	.....	Partial removal of pancreas	.....	.....	.....	.....	.....
48152	C	.....	Pancreatectomy	.....	.....	.....	.....	.....
48153	C	.....	Pancreatectomy	.....	.....	.....	.....	.....
48154	C	.....	Pancreatectomy	.....	.....	.....	.....	.....
48155	C	.....	Removal of pancreas	.....	.....	.....	.....	.....
48160	E	.....	Pancreas removal/transplant	.....	.....	.....	.....	.....
48180	C	.....	Fuse pancreas and bowel	.....	.....	.....	.....	.....
48400	C	.....	Injection, intraop add-on	.....	.....	.....	.....	.....
48500	C	.....	Surgery of pancreatic cyst	.....	.....	.....	.....	.....
48510	C	.....	Drain pancreatic pseudocyst	.....	.....	.....	.....	.....
48511	T	.....	Drain pancreatic pseudocyst	0005	3.1201	$162.72	$71.59	$32.54
48520	C	.....	Fuse pancreas cyst and bowel	.....	.....	.....	.....	.....
48540	C	.....	Fuse pancreas cyst and bowel	.....	.....	.....	.....	.....
48545	C	.....	Pancreatorrhaphy	.....	.....	.....	.....	.....
48547	C	.....	Duodenal exclusion	.....	.....	.....	.....	.....
48550	E	.....	Donor pancreatectomy	.....	.....	.....	.....	.....
48554	E	.....	Transpl allograft pancreas	.....	.....	.....	.....	.....
48556	C	.....	Removal, allograft pancreas	.....	.....	.....	.....	.....
48999	T	.....	Pancreas surgery procedure	0005	3.1201	$162.72	$71.59	$32.54
49000	C	.....	Exploration of abdomen	.....	.....	.....	.....	.....
49002	C	.....	Reopening of abdomen	.....	.....	.....	.....	.....
49010	C	.....	Exploration behind abdomen	.....	.....	.....	.....	.....
49020	C	.....	Drain abdominal abscess	.....	.....	.....	.....	.....
49021	C	.....	Drain abdominal abscess	.....	.....	.....	.....	.....
49040	C	.....	Drain, open, abdom abscess	.....	.....	.....	.....	.....
49041	C	.....	Drain, percut, abdom abscess	.....	.....	.....	.....	.....
49060	C	.....	Drain, open, retrop abscess	.....	.....	.....	.....	.....
49061	C	.....	Drain, percut, retroper absc	.....	.....	.....	.....	.....
49062	C	.....	Drain to peritoneal cavity	.....	.....	.....	.....	.....
49080	T	.....	Puncture, peritoneal cavity	0070	3.3623	$175.35	.....	$35.07
49081	T	.....	Removal of abdominal fluid	0070	3.3623	$175.35	.....	$35.07
49085	T	.....	Remove abdomen foreign body	0153	19.5441	$1,019.24	$410.87	$203.85
49180	T	.....	Biopsy, abdominal mass	0685	5.9882	$312.29	$137.40	$62.46
49200	T	.....	Removal of abdominal lesion	0130	30.4644	$1,588.75	$659.53	$317.75
49201	C	.....	Remove abdom lesion, complex	.....	.....	.....	.....	.....
49215	C	.....	Excise sacral spine tumor	.....	.....	.....	.....	.....
49220	C	.....	Multiple surgery, abdomen	.....	.....	.....	.....	.....

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
49250	T		Excision of umbilicus	0153	19.5441	$1,019.24	$410.87	$203.85
49255	C		Removal of omentum					
49320	T		Diag laparo separate proc	0130	30.4644	$1,588.75	$659.53	$317.75
49321	T		Laparoscopy, biopsy	0130	30.4644	$1,588.75	$659.53	$317.75
49322	T		Laparoscopy, aspiration	0130	30.4644	$1,588.75	$659.53	$317.75
49323	T		Laparo drain lymphocele	0130	30.4644	$1,588.75	$659.53	$317.75
49329	T		Laparo proc, abdm/per/oment	0130	30.4644	$1,588.75	$659.53	$317.75
49400	N		Air injection into abdomen					
49419	T	NI	Insrt abdom cath for chemotx	0119	89.3100	$4,657.61		$931.52
49420	T		Insert abdom drain, temp	0652	28.1292	$1,466.97		$293.39
49421	T		Insert abdom drain, perm	0652	28.1292	$1,466.97		$293.39
49422	T		Remove perm cannula/catheter	0105	18.5945	$969.72	$370.40	$193.94
49423	T		Exchange drainage catheter	0152	10.0288	$523.01	$131.28	$104.60
49424	N		Assess cyst, contrast inject					
49425	C		Insert abdomen-venous drain					
49426	T		Revise abdomen-venous shunt	0153	19.5441	$1,019.24	$410.87	$203.85
49427	N		Injection, abdominal shunt					
49428	C		Ligation of shunt					
49429	T		Removal of shunt	0105	18.5945	$969.72	$370.40	$193.94
49491	T		Rpr hern preemie reduc	0154	25.7262	$1,341.65	$464.85	$268.33
49492	T		Rpr ing hern premie, blocked	0154	25.7262	$1,341.65	$464.85	$268.33
49495	T		Rpr ing hernia baby, reduc	0154	25.7262	$1,341.65	$464.85	$268.33
49496	T		Rpr ing hernia baby, blocked	0154	25.7262	$1,341.65	$464.85	$268.33
49500	T		Rpr ing hernia, init, reduce	0154	25.7262	$1,341.65	$464.85	$268.33
49501	T		Rpr ing hernia, init blocked	0154	25.7262	$1,341.65	$464.85	$268.33
49505	T		Prp i/hern init reduc>5 yr	0154	25.7262	$1,341.65	$464.85	$268.33
49507	T		Prp i/hern init block>5 yr	0154	25.7262	$1,341.65	$464.85	$268.33
49520	T		Rerepair ing hernia, reduce	0154	25.7262	$1,341.65	$464.85	$268.33
49521	T		Rerepair ing hernia, blocked	0154	25.7262	$1,341.65	$464.85	$268.33
49525	T		Repair ing hernia, sliding	0154	25.7262	$1,341.65	$464.85	$268.33
49540	T		Repair lumbar hernia	0154	25.7262	$1,341.65	$464.85	$268.33
49550	T		Rpr rem hernia, init, reduce	0154	25.7262	$1,341.65	$464.85	$268.33
49553	T		Rpr fem hernia, init blocked	0154	25.7262	$1,341.65	$464.85	$268.33
49555	T		Rerepair fem hernia, reduce	0154	25.7262	$1,341.65	$464.85	$268.33
49557	T		Rerepair fem hernia, blocked	0154	25.7262	$1,341.65	$464.85	$268.33
49560	T		Rpr ventral hern init, reduc	0154	25.7262	$1,341.65	$464.85	$268.33
49561	T		Rpr ventral hern init, block	0154	25.7262	$1,341.65	$464.85	$268.33
49565	T		Rerepair ventrl hern, reduce	0154	25.7262	$1,341.65	$464.85	$268.33
49566	T		Rerepair ventrl hern, block	0154	25.7262	$1,341.65	$464.85	$268.33
49568	T		Hernia repair w/mesh	0154	25.7262	$1,341.65	$464.85	$268.33
49570	T		Rpr epigastric hern, reduce	0154	25.7262	$1,341.65	$464.85	$268.33
49572	T		Rpr epigastric hern, blocked	0154	25.7262	$1,341.65	$464.85	$268.33
49580	T		Rpr umbil hern, reduc < 5 yr	0154	25.7262	$1,341.65	$464.85	$268.33
49582	T		Rpr umbil hern, block < 5 yr	0154	25.7262	$1,341.65	$464.85	$268.33
49585	T		Rpr umbil hern, reduc > 5 yr	0154	25.7262	$1,341.65	$464.85	$268.33
49587	T		Rpr umbil hern, block > 5 yr	0154	25.7262	$1,341.65	$464.85	$268.33
49590	T		Repair spigilian hernia	0154	25.7262	$1,341.65	$464.85	$268.33
49600	T		Repair umbilical lesion	0154	25.7262	$1,341.65	$464.85	$268.33
49605	C		Repair umbilical lesion					
49606	C		Repair umbilical lesion					
49610	C		Repair umbilical lesion					
49611	C		Repair umbilical lesion					
49650	T		Laparo hernia repair initial	0131	40.2026	$2,096.61	$1,001.89	$419.32
49651	T		Laparo hernia repair recur	0131	40.2026	$2,096.61	$1,001.89	$419.32
49659	T		Laparo proc, hernia repair	0131	40.2026	$2,096.61	$1,001.89	$419.32
49900	C		Repair of abdominal wall					
49904	C	NI	Omental flap, extra-abdom					
49905	C		Omental flap					
49906	C		Free omental flap, microvasc					
49999	T		Abdomen surgery procedure	0153	19.5441	$1,019.24	$410.87	$203.85
50010	C		Exploration of kidney					
50020	C		Renal abscess, open drain					
50021	T		Renal abscess, percut drain	0005	3.1201	$162.72	$71.59	$32.54
50040	C		Drainage of kidney					
50045	C		Exploration of kidney					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
50060	C		Removal of kidney stone					
50065	C		Incision of kidney					
50070	C		Incision of kidney					
50075	C		Removal of kidney stone					
50080	T		Removal of kidney stone	0163	28.3714	$1,479.60		$295.92
50081	T		Removal of kidney stone	0163	28.3714	$1,479.60		$295.92
50100	C		Revise kidney blood vessels					
50120	C		Exploration of kidney					
50125	C		Explore and drain kidney					
50130	C		Removal of kidney stone					
50135	C		Exploration of kidney					
50200	T		Biopsy of kidney	0685	5.9882	$312.29	$137.40	$62.46
50205	C		Biopsy of kidney					
50220	C		Remove kidney, open					
50225	C		Removal kidney open, complex					
50230	C		Removal kidney open, radical					
50234	C		Removal of kidney & ureter					
50236	C		Removal of kidney & ureter					
50240	C		Partial removal of kidney					
50280	C		Removal of kidney lesion					
50290	C		Removal of kidney lesion					
50300	C		Removal of donor kidney					
50320	C		Removal of donor kidney					
50340	C		Removal of kidney					
50360	C		Transplantation of kidney					
50365	C		Transplantation of kidney					
50370	C		Remove transplanted kidney					
50380	C		Reimplantation of kidney					
50390	T		Drainage of kidney lesion	0685	5.9882	$312.29	$137.40	$62.46
50392	T		Insert kidney drain	0161	15.7070	$819.14	$249.36	$163.83
50393	T		Insert ureteral tube	0161	15.7070	$819.14	$249.36	$163.83
50394	N		Injection for kidney x-ray					
50395	T		Create passage to kidney	0161	15.7070	$819.14	$249.36	$163.83
50396	T		Measure kidney pressure	0164	1.1240	$58.62	$17.59	$11.72
50398	T		Change kidney tube	0122	10.7459	$560.41	$114.93	$112.08
50400	C		Revision of kidney/ureter					
50405	C		Revision of kidney/ureter					
50500	C		Repair of kidney wound					
50520	C		Close kidney-skin fistula					
50525	C		Repair renal-abdomen fistula					
50526	C		Repair renal-abdomen fistula					
50540	C		Revision of horseshoe kidney					
50541	T		Laparo ablate renal cyst	0130	30.4644	$1,588.75	$659.53	$317.75
50542	T	NI	Laparo ablate renal mass	0131	40.2026	$2,096.61	$1,001.89	$419.32
50543	T	NI	Laparo partial nephrectomy	0131	40.2026	$2,096.61	$1,001.89	$419.32
50544	T		Laparoscopy, pyeloplasty	0130	30.4644	$1,588.75	$659.53	$317.75
50545	C		Laparo radical nephrectomy					
50546	C		Laparoscopic nephrectomy					
50547	C		Laparo removal donor kidney					
50548	C		Laparo remove k/ureter					
50549	T		Laparoscope proc, renal	0130	30.4644	$1,588.75	$659.53	$317.75
50551	T		Kidney endoscopy	0160	6.3080	$328.97	$105.06	$65.79
50553	T		Kidney endoscopy	0161	15.7070	$819.14	$249.36	$163.83
50555	T		Kidney endoscopy & biopsy	0160	6.3080	$328.97	$105.06	$65.79
50557	T		Kidney endoscopy & treatment	0162	20.5906	$1,073.82		$214.76
50559	T		Renal endoscopy/radiotracer	0160	6.3080	$328.97	$105.06	$65.79
50561	T		Kidney endoscopy & treatment	0161	15.7070	$819.14	$249.36	$163.83
50562	T	NI	Renal scope w/tumor resect	0160	6.3080	$328.97	$105.06	$65.79
50570	C		Kidney endoscopy					
50572	C		Kidney endoscopy					
50574	C		Kidney endoscopy & biopsy					
50575	C		Kidney endoscopy					
50576	C		Kidney endoscopy & treatment					
50578	C		Renal endoscopy/radiotracer					
50580	C		Kidney endoscopy & treatment					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
50590	T		Fragmenting of kidney stone	0169	44.0978	$2,299.74	$1,115.69	$459.95
50600	C		Exploration of ureter					
50605	C		Insert ureteral support					
50610	C		Removal of ureter stone					
50620	C		Removal of ureter stone					
50630	C		Removal of ureter stone					
50650	C		Removal of ureter					
50660	C		Removal of ureter					
50684	N		Injection for ureter x-ray					
50686	T		Measure ureter pressure	0164	1.1240	$58.62	$17.59	$11.72
50688	T		Change of ureter tube	0121	2.0833	$108.65	$43.80	$21.73
50690	N		Injection for ureter x-ray					
50700	C		Revision of ureter					
50715	C		Release of ureter					
50722	C		Release of ureter					
50725	C		Release/revise ureter					
50727	C		Revise ureter					
50728	C		Revise ureter					
50740	C		Fusion of ureter & kidney					
50750	C		Fusion of ureter & kidney					
50760	C		Fusion of ureters					
50770	C		Splicing of ureters					
50780	C		Reimplant ureter in bladder					
50782	C		Reimplant ureter in bladder					
50783	C		Reimplant ureter in bladder					
50785	C		Reimplant ureter in bladder					
50800	C		Implant ureter in bowel					
50810	C		Fusion of ureter & bowel					
50815	C		Urine shunt to intestine					
50820	C		Construct bowel bladder					
50825	C		Construct bowel bladder					
50830	C		Revise urine flow					
50840	C		Replace ureter by bowel					
50845	C		Appendico-vesicostomy					
50860	C		Transplant ureter to skin					
50900	C		Repair of ureter					
50920	C		Closure ureter/skin fistula					
50930	C		Closure ureter/bowel fistula					
50940	C		Release of ureter					
50945	T		Laparoscopy ureterolithotomy	0131	40.2026	$2,096.61	$1,001.89	$419.32
50947	T		Laparo new ureter/bladder	0131	40.2026	$2,096.61	$1,001.89	$419.32
50948	T		Laparo new ureter/bladder	0131	40.2026	$2,096.61	$1,001.89	$419.32
50949	T		Laparoscope proc, ureter	0130	30.4644	$1,588.75	$659.53	$317.75
50951	T		Endoscopy of ureter	0160	6.3080	$328.97	$105.06	$65.79
50953	T		Endoscopy of ureter	0160	6.3080	$328.97	$105.06	$65.79
50955	T		Ureter endoscopy & biopsy	0161	15.7070	$819.14	$249.36	$163.83
50957	T		Ureter endoscopy & treatment	0161	15.7070	$819.14	$249.36	$163.83
50959	T		Ureter endoscopy & tracer	0161	15.7070	$819.14	$249.36	$163.83
50961	T		Ureter endoscopy & treatment	0161	15.7070	$819.14	$249.36	$163.83
50970	T		Ureter endoscopy	0160	6.3080	$328.97	$105.06	$65.79
50972	T		Ureter endoscopy & catheter	0160	6.3080	$328.97	$105.06	$65.79
50974	T		Ureter endoscopy & biopsy	0161	15.7070	$819.14	$249.36	$163.83
50976	T		Ureter endoscopy & treatment	0161	15.7070	$819.14	$249.36	$163.83
50978	T		Ureter endoscopy & tracer	0161	15.7070	$819.14	$249.36	$163.83
50980	T		Ureter endoscopy & treatment	0161	15.7070	$819.14	$249.36	$163.83
51000	T		Drainage of bladder	0165	12.2672	$639.75		$127.95
51005	T		Drainage of bladder	0164	1.1240	$58.62	$17.59	$11.72
51010	T		Drainage of bladder	0165	12.2672	$639.75		$127.95
51020	T		Incise & treat bladder	0162	20.5906	$1,073.82		$214.76
51030	T		Incise & treat bladder	0162	20.5906	$1,073.82		$214.76
51040	T		Incise & drain bladder	0162	20.5906	$1,073.82		$214.76
51045	T		Incise bladder/drain ureter	0160	6.3080	$328.97	$105.06	$65.79
51050	T		Removal of bladder stone	0162	20.5906	$1,073.82		$214.76
51060	C		Removal of ureter stone					
51065	T		Remove ureter calculus	0162	20.5906	$1,073.82		$214.76

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
51080	T		Drainage of bladder abscess	0007	10.0191	$522.51	$108.89	$104.50
51500	T		Removal of bladder cyst	0154	25.7262	$1,341.65	$464.85	$268.33
51520	T		Removal of bladder lesion	0162	20.5906	$1,073.82		$214.76
51525	C		Removal of bladder lesion					
51530	C		Removal of bladder lesion					
51535	C		Repair of ureter lesion					
51550	C		Partial removal of bladder					
51555	C		Partial removal of bladder					
51565	C		Revise bladder & ureter(s)					
51570	C		Removal of bladder					
51575	C		Removal of bladder & nodes					
51580	C		Remove bladder/revise tract					
51585	C		Removal of bladder & nodes					
51590	C		Remove bladder/revise tract					
51595	C		Remove bladder/revise tract					
51596	C		Remove bladder/create pouch					
51597	C		Removal of pelvic structures					
51600	N		Injection for bladder x-ray					
51605	N		Preparation for bladder xray					
51610	N		Injection for bladder x-ray					
51700	T		Irrigation of bladder	0164	1.1240	$58.62	$17.59	$11.72
51701	N	NI	Insert bladder catheter					
51702	N	NI	Insert temp bladder cath					
51703	N	NI	Insert bladder cath, complex					
51705	T		Change of bladder tube	0121	2.0833	$108.65	$43.80	$21.73
51710	T		Change of bladder tube	0121	2.0833	$108.65	$43.80	$21.73
51715	T		Endoscopic injection/implant	0167	28.3230	$1,477.07	$555.84	$295.41
51720	T		Treatment of bladder lesion	0156	2.9747	$155.13	$46.55	$31.03
51725	T		Simple cystometrogram	0156	2.9747	$155.13	$46.55	$31.03
51726	T		Complex cystometrogram	0156	2.9747	$155.13	$46.55	$31.03
51736	T		Urine flow measurement	0164	1.1240	$58.62	$17.59	$11.72
51741	T		Electro-uroflowmetry, first	0164	1.1240	$58.62	$17.59	$11.72
51772	T		Urethra pressure profile	0164	1.1240	$58.62	$17.59	$11.72
51784	T		Anal/urinary muscle study	0164	1.1240	$58.62	$17.59	$11.72
51785	T		Anal/urinary muscle study	0164	1.1240	$58.62	$17.59	$11.72
51792	T		Urinary reflex study	0164	1.1240	$58.62	$17.59	$11.72
51795	T		Urine voiding pressure study	0164	1.1240	$58.62	$17.59	$11.72
51797	T		Intraabdominal pressure test	0164	1.1240	$58.62	$17.59	$11.72
51798	X	NI	Us urine capacity measure	0340	0.6492	$33.86		$6.77
51800	C		Revision of bladder/urethra					
51820	C		Revision of urinary tract					
51840	C		Attach bladder/urethra					
51841	C		Attach bladder/urethra					
51845	C		Repair bladder neck					
51860	C		Repair of bladder wound					
51865	C		Repair of bladder wound					
51880	T		Repair of bladder opening	0162	20.5906	$1,073.82		$214.76
51900	C		Repair bladder/vagina lesion					
51920	C		Close bladder-uterus fistula					
51925	C		Hysterectomy/bladder repair					
51940	C		Correction of bladder defect					
51960	C		Revision of bladder & bowel					
51980	C		Construct bladder opening					
51990	T		Laparo urethral suspension	0131	40.2026	$2,096.61	$1,001.89	$419.32
51992	T		Laparo sling operation	0132	56.9948	$2,972.34	$1,239.22	$594.47
52000	T		Cystoscopy	0160	6.3080	$328.97	$105.06	$65.79
52001	T		Cystoscopy, removal of clots	0160	6.3080	$328.97	$105.06	$65.79
52005	T		Cystoscopy & ureter catheter	0161	15.7070	$819.14	$249.36	$163.83
52007	T		Cystoscopy and biopsy	0161	15.7070	$819.14	$249.36	$163.83
52010	T		Cystoscopy & duct catheter	0160	6.3080	$328.97	$105.06	$65.79
52204	T		Cystoscopy	0161	15.7070	$819.14	$249.36	$163.83
52214	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76
52224	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76
52234	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76
52235	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
52240	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76
52250	T		Cystoscopy and radiotracer	0162	20.5906	$1,073.82		$214.76
52260	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52265	T		Cystoscopy and treatment	0160	6.3080	$328.97	$105.06	$65.79
52270	T		Cystoscopy & revise urethra	0161	15.7070	$819.14	$249.36	$163.83
52275	T		Cystoscopy & revise urethra	0161	15.7070	$819.14	$249.36	$163.83
52276	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52277	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76
52281	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52282	T		Cystoscopy, implant stent	0163	28.3714	$1,479.60		$295.92
52283	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52285	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52290	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52300	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52301	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52305	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52310	T		Cystoscopy and treatment	0160	6.3080	$328.97	$105.06	$65.79
52315	T		Cystoscopy and treatment	0161	15.7070	$819.14	$249.36	$163.83
52317	T		Remove bladder stone	0162	20.5906	$1,073.82		$214.76
52318	T		Remove bladder stone	0162	20.5906	$1,073.82		$214.76
52320	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76
52325	T		Cystoscopy, stone removal	0162	20.5906	$1,073.82		$214.76
52327	T		Cystoscopy, inject material	0162	20.5906	$1,073.82		$214.76
52330	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76
52332	T		Cystoscopy and treatment	0162	20.5906	$1,073.82		$214.76
52334	T		Create passage to kidney	0162	20.5906	$1,073.82		$214.76
52341	T		Cysto w/ureter stricture tx	0162	20.5906	$1,073.82		$214.76
52342	T		Cysto w/up stricture tx	0162	20.5906	$1,073.82		$214.76
52343	T		Cysto w/renal stricture tx	0162	20.5906	$1,073.82		$214.76
52344	T		Cysto/uretero, stone remove	0162	20.5906	$1,073.82		$214.76
52345	T		Cysto/uretero w/up stricture	0162	20.5906	$1,073.82		$214.76
52346	T		Cystouretero w/renal strict	0162	20.5906	$1,073.82		$214.76
52347	T		Cystoscopy, resect ducts	0160	6.3080	$328.97	$105.06	$65.79
52351	T		Cystouretero & or pyeloscope	0160	6.3080	$328.97	$105.06	$65.79
52352	T		Cystouretero w/stone remove	0162	20.5906	$1,073.82		$214.76
52353	T		Cystouretero w/lithotripsy	0163	28.3714	$1,479.60		$295.92
52354	T		Cystouretero w/biopsy	0162	20.5906	$1,073.82		$214.76
52355	T		Cystouretero w/excise tumor	0162	20.5906	$1,073.82		$214.76
52400	T		Cystouretero w/congen repr	0162	20.5906	$1,073.82		$214.76
52450	T		Incision of prostate	0162	20.5906	$1,073.82		$214.76
52500	T		Revision of bladder neck	0162	20.5906	$1,073.82		$214.76
52510	T		Dilation prostatic urethra	0161	15.7070	$819.14	$249.36	$163.83
52601	T		Prostatectomy (TURP)	0163	28.3714	$1,479.60		$295.92
52606	T		Control postop bleeding	0162	20.5906	$1,073.82		$214.76
52612	T		Prostatectomy, first stage	0163	28.3714	$1,479.60		$295.92
52614	T		Prostatectomy, second stage	0163	28.3714	$1,479.60		$295.92
52620	T		Remove residual prostate	0163	28.3714	$1,479.60		$295.92
52630	T		Remove prostate regrowth	0163	28.3714	$1,479.60		$295.92
52640	T		Relieve bladder contracture	0162	20.5906	$1,073.82		$214.76
52647	T		Laser surgery of prostate	0163	28.3714	$1,479.60		$295.92
52648	T		Laser surgery of prostate	0163	28.3714	$1,479.60		$295.92
52700	T		Drainage of prostate abscess	0162	20.5906	$1,073.82		$214.76
53000	T		Incision of urethra	0166	15.4163	$803.98	$218.73	$160.80
53010	T		Incision of urethra	0166	15.4163	$803.98	$218.73	$160.80
53020	T		Incision of urethra	0166	15.4163	$803.98	$218.73	$160.80
53025	T		Incision of urethra	0166	15.4163	$803.98	$218.73	$160.80
53040	T		Drainage of urethra abscess	0166	15.4163	$803.98	$218.73	$160.80
53060	T		Drainage of urethra abscess	0166	15.4163	$803.98	$218.73	$160.80
53080	T		Drainage of urinary leakage	0166	15.4163	$803.98	$218.73	$160.80
53085	C		Drainage of urinary leakage					
53200	T		Biopsy of urethra	0166	15.4163	$803.98	$218.73	$160.80
53210	T		Removal of urethra	0168	24.4665	$1,275.95	$405.60	$255.19
53215	T		Removal of urethra	0168	24.4665	$1,275.95	$405.60	$255.19
53220	T		Treatment of urethra lesion	0168	24.4665	$1,275.95	$405.60	$255.19
53230	T		Removal of urethra lesion	0168	24.4665	$1,275.95	$405.60	$255.19

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
53235	T		Removal of urethra lesion	0168	24.4665	$1,275.95	$405.60	$255.19
53240	T		Surgery for urethra pouch	0168	24.4665	$1,275.95	$405.60	$255.19
53250	T		Removal of urethra gland	0166	15.4163	$803.98	$218.73	$160.80
53260	T		Treatment of urethra lesion	0166	15.4163	$803.98	$218.73	$160.80
53265	T		Treatment of urethra lesion	0166	15.4163	$803.98	$218.73	$160.80
53270	T		Removal of urethra gland	0167	28.3230	$1,477.07	$555.84	$295.41
53275	T		Repair of urethra defect	0166	15.4163	$803.98	$218.73	$160.80
53400	T		Revise urethra, stage 1	0168	24.4665	$1,275.95	$405.60	$255.19
53405	T		Revise urethra, stage 2	0168	24.4665	$1,275.95	$405.60	$255.19
53410	T		Reconstruction of urethra	0168	24.4665	$1,275.95	$405.60	$255.19
53415	C		Reconstruction of urethra					
53420	T		Reconstruct urethra, stage 1	0168	24.4665	$1,275.95	$405.60	$255.19
53425	T		Reconstruct urethra, stage 2	0168	24.4665	$1,275.95	$405.60	$255.19
53430	T		Reconstruction of urethra	0168	24.4665	$1,275.95	$405.60	$255.19
53431	T		Reconstruct urethra/bladder	0168	24.4665	$1,275.95	$405.60	$255.19
53440	T		Correct bladder function	0179	104.3581	$5,442.38	$2,340.22	$1,088.48
53442	T		Remove perineal prosthesis	0166	15.4163	$803.98	$218.73	$160.80
53444	T		Insert tandem cuff	0179	104.3581	$5,442.38	$2,340.22	$1,088.48
53445	T		Insert uro/ves nck sphincter	0179	104.3581	$5,442.38	$2,340.22	$1,088.48
53446	T		Remove uro sphincter	0168	24.4665	$1,275.95	$405.60	$255.19
53447	T		Remove/replace ur sphincter	0179	104.3581	$5,442.38	$2,340.22	$1,088.48
53448	C		Remov/replc ur sphinctr comp					
53449	T		Repair uro sphincter	0168	24.4665	$1,275.95	$405.60	$255.19
53450	T		Revision of urethra	0168	24.4665	$1,275.95	$405.60	$255.19
53460	T		Revision of urethra	0168	24.4665	$1,275.95	$405.60	$255.19
53502	T		Repair of urethra injury	0166	15.4163	$803.98	$218.73	$160.80
53505	T		Repair of urethra injury	0167	28.3230	$1,477.07	$555.84	$295.41
53510	T		Repair of urethra injury	0166	15.4163	$803.98	$218.73	$160.80
53515	T		Repair of urethra injury	0168	24.4665	$1,275.95	$405.60	$255.19
53520	T		Repair of urethra defect	0168	24.4665	$1,275.95	$405.60	$255.19
53600	T		Dilate urethra stricture	0156	2.9747	$155.13	$46.55	$31.03
53601	T		Dilate urethra stricture	0164	1.1240	$58.62	$17.59	$11.72
53605	T		Dilate urethra stricture	0161	15.7070	$819.14	$249.36	$163.83
53620	T		Dilate urethra stricture	0165	12.2672	$639.75		$127.95
53621	T		Dilate urethra stricture	0164	1.1240	$58.62	$17.59	$11.72
53660	T		Dilation of urethra	0164	1.1240	$58.62	$17.59	$11.72
53661	T		Dilation of urethra	0164	1.1240	$58.62	$17.59	$11.72
53665	T		Dilation of urethra	0166	15.4163	$803.98	$218.73	$160.80
53670	N	DG	Insert urinary catheter					
53675	T	DG	Insert urinary catheter	0164	1.1240	$58.62	$17.59	$11.72
53850	T		Prostatic microwave thermotx	0675	48.5648	$2,532.70		$506.54
53852	T		Prostatic rf thermotx	0675	48.5648	$2,532.70		$506.54
53853	T		Prostatic water thermother	0977		$1,125.00		$225.00
53899	T		Urology surgery procedure	0164	1.1240	$58.62	$17.59	$11.72
54000	T		Slitting of prepuce	0166	15.4163	$803.98	$218.73	$160.80
54001	T		Slitting of prepuce	0166	15.4163	$803.98	$218.73	$160.80
54015	T		Drain penis lesion	0007	10.0191	$522.51	$108.89	$104.50
54050	T		Destruction, penis lesion(s)	0013	1.0756	$56.09	$14.20	$11.22
54055	T		Destruction, penis lesion(s)	0017	15.8233	$825.20	$227.84	$165.04
54056	T		Cryosurgery, penis lesion(s)	0012	0.7849	$40.93	$11.18	$8.19
54057	T		Laser surg, penis lesion(s)	0017	15.8233	$825.20	$227.84	$165.04
54060	T		Excision of penis lesion(s)	0017	15.8233	$825.20	$227.84	$165.04
54065	T		Destruction, penis lesion(s)	0695	18.6817	$974.27	$266.59	$194.85
54100	T		Biopsy of penis	0021	13.9338	$726.66	$219.48	$145.33
54105	T		Biopsy of penis	0022	17.3930	$907.06	$354.45	$181.41
54110	T		Treatment of penis lesion	0181	29.2435	$1,525.08	$621.82	$305.02
54111	T		Treat penis lesion, graft	0181	29.2435	$1,525.08	$621.82	$305.02
54112	T		Treat penis lesion, graft	0181	29.2435	$1,525.08	$621.82	$305.02
54115	T		Treatment of penis lesion	0008	16.1430	$841.87		$168.37
54120	T		Partial removal of penis	0181	29.2435	$1,525.08	$621.82	$305.02
54125	C		Removal of penis					
54130	C		Remove penis & nodes					
54135	C		Remove penis & nodes					
54150	T		Circumcision	0180	18.1004	$943.95	$304.87	$188.79
54152	T		Circumcision	0180	18.1004	$943.95	$304.87	$188.79

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54160	T		Circumcision	0180	18.1004	$943.95	$304.87	$188.79
54161	T		Circumcision	0180	18.1004	$943.95	$304.87	$188.79
54162	T		Lysis penil circumic lesion	0180	18.1004	$943.95	$304.87	$188.79
54163	T		Repair of circumcision	0180	18.1004	$943.95	$304.87	$188.79
54164	T		Frenulotomy of penis	0180	18.1004	$943.95	$304.87	$188.79
54200	T		Treatment of penis lesion	0156	2.9747	$155.13	$46.55	$31.03
54205	T		Treatment of penis lesion	0181	29.2435	$1,525.08	$621.82	$305.02
54220	T		Treatment of penis lesion	0156	2.9747	$155.13	$46.55	$31.03
54230	N		Prepare penis study					
54231	T		Dynamic cavernosometry	0165	12.2672	$639.75		$127.95
54235	T		Penile injection	0164	1.1240	$58.62	$17.59	$11.72
54240	T		Penis study	0164	1.1240	$58.62	$17.59	$11.72
54250	T		Penis study	0165	12.2672	$639.75		$127.95
54300	T		Revision of penis	0181	29.2435	$1,525.08	$621.82	$305.02
54304	T		Revision of penis	0181	29.2435	$1,525.08	$621.82	$305.02
54308	T		Reconstruction of urethra	0181	29.2435	$1,525.08	$621.82	$305.02
54312	T		Reconstruction of urethra	0181	29.2435	$1,525.08	$621.82	$305.02
54316	T		Reconstruction of urethra	0181	29.2435	$1,525.08	$621.82	$305.02
54318	T		Reconstruction of urethra	0181	29.2435	$1,525.08	$621.82	$305.02
54322	T		Reconstruction of urethra	0181	29.2435	$1,525.08	$621.82	$305.02
54324	T		Reconstruction of urethra	0181	29.2435	$1,525.08	$621.82	$305.02
54326	T		Reconstruction of urethra	0181	29.2435	$1,525.08	$621.82	$305.02
54328	T		Revise penis/urethra	0181	29.2435	$1,525.08	$621.82	$305.02
54332	C		Revise penis/urethra					
54336	C		Revise penis/urethra					
54340	T		Secondary urethral surgery	0181	29.2435	$1,525.08	$621.82	$305.02
54344	T		Secondary urethral surgery	0181	29.2435	$1,525.08	$621.82	$305.02
54348	T		Secondary urethral surgery	0181	29.2435	$1,525.08	$621.82	$305.02
54352	T		Reconstruct urethra/penis	0181	29.2435	$1,525.08	$621.82	$305.02
54360	T		Penis plastic surgery	0181	29.2435	$1,525.08	$621.82	$305.02
54380	T		Repair penis	0181	29.2435	$1,525.08	$621.82	$305.02
54385	T		Repair penis	0181	29.2435	$1,525.08	$621.82	$305.02
54390	C		Repair penis and bladder					
54400	T		Insert semi-rigid prosthesis	0182	95.4145	$4,975.96		$995.19
54401	T		Insert self-contd prosthesis	0182	95.4145	$4,975.96		$995.19
54405	T		Insert multi-comp penis pros	0182	95.4145	$4,975.96		$995.19
54406	T		Remove muti-comp penis pros	0181	29.2435	$1,525.08	$621.82	$305.02
54408	T		Repair multi-comp penis pros	0181	29.2435	$1,525.08	$621.82	$305.02
54410	T		Remove/replace penis prosth	0182	95.4145	$4,975.96		$995.19
54411	C		Remov/replc penis pros, comp					
54415	T		Remove self-contd penis pros	0181	29.2435	$1,525.08	$621.82	$305.02
54416	T		Remv/repl penis contain pros	0182	95.4145	$4,975.96		$995.19
54417	C		Remv/replc penis pros, compl					
54420	T		Revision of penis	0181	29.2435	$1,525.08	$621.82	$305.02
54430	C		Revision of penis					
54435	T		Revision of penis	0181	29.2435	$1,525.08	$621.82	$305.02
54440	T		Repair of penis	0181	29.2435	$1,525.08	$621.82	$305.02
54450	T		Preputial stretching	0156	2.9747	$155.13	$46.55	$31.03
54500	T		Biopsy of testis	0005	3.1201	$162.72	$71.59	$32.54
54505	T		Biopsy of testis	0183	21.2592	$1,108.69		$221.74
54512	T		Excise lesion testis	0183	21.2592	$1,108.69		$221.74
54520	T		Removal of testis	0183	21.2592	$1,108.69		$221.74
54522	T		Orchiectomy, partial	0183	21.2592	$1,108.69		$221.74
54530	T		Removal of testis	0154	25.7262	$1,341.65	$464.85	$268.33
54535	C		Extensive testis surgery					
54550	T		Exploration for testis	0154	25.7262	$1,341.65	$464.85	$268.33
54560	C		Exploration for testis					
54600	T		Reduce testis torsion	0183	21.2592	$1,108.69		$221.74
54620	T		Suspension of testis	0183	21.2592	$1,108.69		$221.74
54640	T		Suspension of testis	0154	25.7262	$1,341.65	$464.85	$268.33
54650	C		Orchiopexy (Fowler-Stephens)					
54660	T		Revision of testis	0183	21.2592	$1,108.69		$221.74
54670	T		Repair testis injury	0183	21.2592	$1,108.69		$221.74
54680	T		Relocation of testis(es)	0183	21.2592	$1,108.69		$221.74
54690	T		Laparoscopy, orchiectomy	0131	40.2026	$2,096.61	$1,001.89	$419.32

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54692	T		Laparoscopy, orchiopexy	0132	56.9948	$2,972.34	$1,239.22	$594.47
54699	T		Laparoscope proc, testis	0130	30.4644	$1,588.75	$659.53	$317.75
54700	T		Drainage of scrotum	0183	21.2592	$1,108.69		$221.74
54800	T		Biopsy of epididymis	0004	1.7441	$90.96	$23.47	$18.19
54820	T		Exploration of epididymis	0183	21.2592	$1,108.69		$221.74
54830	T		Remove epididymis lesion	0183	21.2592	$1,108.69		$221.74
54840	T		Remove epididymis lesion	0183	21.2592	$1,108.69		$221.74
54860	T		Removal of epididymis	0183	21.2592	$1,108.69		$221.74
54861	T		Removal of epididymis	0183	21.2592	$1,108.69		$221.74
54900	T		Fusion of spermatic ducts	0183	21.2592	$1,108.69		$221.74
54901	T		Fusion of spermatic ducts	0183	21.2592	$1,108.69		$221.74
55000	T		Drainage of hydrocele	0004	1.7441	$90.96	$23.47	$18.19
55040	T		Removal of hydrocele	0154	25.7262	$1,341.65	$464.85	$268.33
55041	T		Removal of hydroceles	0154	25.7262	$1,341.65	$464.85	$268.33
55060	T		Repair of hydrocele	0183	21.2592	$1,108.69		$221.74
55100	T		Drainage of scrotum abscess	0007	10.0191	$522.51	$108.89	$104.50
55110	T		Explore scrotum	0183	21.2592	$1,108.69		$221.74
55120	T		Removal of scrotum lesion	0183	21.2592	$1,108.69		$221.74
55150	T		Removal of scrotum	0183	21.2592	$1,108.69		$221.74
55175	T		Revision of scrotum	0183	21.2592	$1,108.69		$221.74
55180	T		Revision of scrotum	0183	21.2592	$1,108.69		$221.74
55200	T		Incision of sperm duct	0183	21.2592	$1,108.69		$221.74
55250	T		Removal of sperm duct(s)	0183	21.2592	$1,108.69		$221.74
55300	N		Prepare, sperm duct x-ray					
55400	T		Repair of sperm duct	0183	21.2592	$1,108.69		$221.74
55450	T		Ligation of sperm duct	0183	21.2592	$1,108.69		$221.74
55500	T		Removal of hydrocele	0183	21.2592	$1,108.69		$221.74
55520	T		Removal of sperm cord lesion	0183	21.2592	$1,108.69		$221.74
55530	T		Revise spermatic cord veins	0183	21.2592	$1,108.69		$221.74
55535	T		Revise spermatic cord veins	0154	25.7262	$1,341.65	$464.85	$268.33
55540	T		Revise hernia & sperm veins	0154	25.7262	$1,341.65	$464.85	$268.33
55550	T		Laparo ligate spermatic vein	0131	40.2026	$2,096.61	$1,001.89	$419.32
55559	T		Laparo proc, spermatic cord	0130	30.4644	$1,588.75	$659.53	$317.75
55600	C		Incise sperm duct pouch					
55605	C		Incise sperm duct pouch					
55650	C		Remove sperm duct pouch					
55680	T		Remove sperm pouch lesion	0183	21.2592	$1,108.69		$221.74
55700	T		Biopsy of prostate	0184	3.6918	$192.53	$96.27	$38.51
55705	T		Biopsy of prostate	0184	3.6918	$192.53	$96.27	$38.51
55720	T		Drainage of prostate abscess	0162	20.5906	$1,073.82		$214.76
55725	T		Drainage of prostate abscess	0162	20.5906	$1,073.82		$214.76
55801	C		Removal of prostate					
55810	C		Extensive prostate surgery					
55812	C		Extensive prostate surgery					
55815	C		Extensive prostate surgery					
55821	C		Removal of prostate					
55831	C		Removal of prostate					
55840	C		Extensive prostate surgery					
55842	C		Extensive prostate surgery					
55845	C		Extensive prostate surgery					
55859	T		Percut/needle insert, pros	0163	28.3714	$1,479.60		$295.92
55860	T		Surgical exposure, prostate	0165	12.2672	$639.75		$127.95
55862	C		Extensive prostate surgery					
55865	C		Extensive prostate surgery					
55866	C	NI	Laparo radical prostatectomy					
55870	T		Vag hyst w/enterocele repair	0197	1.5697	$81.86	$33.06	$16.37
55873	T		Cryoablate prostate	0674	62.9152	$3,281.09		$656.22
55899	T		Genital surgery procedure	0164	1.1240	$58.62	$17.59	$11.72
55970	E		Sex transformation, M to F					
55980	E		Sex transformation, F to M					
56405	T		I & D of vulva/perineum	0192	2.7228	$142.00	$39.11	$28.40
56420	T		Drainage of gland abscess	0192	2.7228	$142.00	$39.11	$28.40
56440	T		Surgery for vulva lesion	0194	18.0228	$939.91	$397.84	$187.98
56441	T		Lysis of labial lesion(s)	0193	14.4764	$754.96	$171.13	$150.99
56501	T		Destroy, vulva lesions, sim	0017	15.8233	$825.20	$227.84	$165.04

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
56515	T		Destroy vulva lesion/s compl	0695	18.6817	$974.27	$266.59	$194.85
56605	T		Biopsy of vulva/perineum	0019	3.7693	$196.57	$71.87	$39.31
56606	T		Biopsy of vulva/perineum	0019	3.7693	$196.57	$71.87	$39.31
56620	T		Partial removal of vulva	0195	23.7301	$1,237.55	$483.80	$247.51
56625	T		Complete removal of vulva	0195	23.7301	$1,237.55	$483.80	$247.51
56630	C		Extensive vulva surgery					
56631	C		Extensive vulva surgery					
56632	C		Extensive vulva surgery					
56633	C		Extensive vulva surgery					
56634	C		Extensive vulva surgery					
56637	C		Extensive vulva surgery					
56640	C		Extensive vulva surgery					
56700	T		Partial removal of hymen	0194	18.0228	$939.91	$397.84	$187.98
56720	T		Incision of hymen	0193	14.4764	$754.96	$171.13	$150.99
56740	T		Remove vagina gland lesion	0194	18.0228	$939.91	$397.84	$187.98
56800	T		Repair of vagina	0194	18.0228	$939.91	$397.84	$187.98
56805	T		Repair clitoris	0194	18.0228	$939.91	$397.84	$187.98
56810	T		Repair of perineum	0194	18.0228	$939.91	$397.84	$187.98
56820	T	NI	Exam of vulva w/scope	0188	1.0465	$54.58	$11.95	$10.92
56821	T	NI	Exam/biopsy of vulva w/scope	0189	1.5310	$79.84	$18.60	$15.97
57000	T		Exploration of vagina	0194	18.0228	$939.91	$397.84	$187.98
57010	T		Drainage of pelvic abscess	0194	18.0228	$939.91	$397.84	$187.98
57020	T		Drainage of pelvic fluid	0192	2.7228	$142.00	$39.11	$28.40
57022	T		I & d vaginal hematoma, pp	0007	10.0191	$522.51	$108.89	$104.50
57023	T		I & d vag hematoma, non-ob	0007	10.0191	$522.51	$108.89	$104.50
57061	T		Destroy vag lesions, simple	0194	18.0228	$939.91	$397.84	$187.98
57065	T		Destroy vag lesions, complex	0194	18.0228	$939.91	$397.84	$187.98
57100	T		Biopsy of vagina	0192	2.7228	$142.00	$39.11	$28.40
57105	T		Biopsy of vagina	0194	18.0228	$939.91	$397.84	$187.98
57106	T		Remove vagina wall, partial	0194	18.0228	$939.91	$397.84	$187.98
57107	T		Remove vagina tissue, part	0195	23.7301	$1,237.55	$483.80	$247.51
57109	T		Vaginectomy partial w/nodes	0202	45.5610	$2,376.05	$1,164.26	$475.21
57110	C		Remove vagina wall, complete					
57111	C		Remove vagina tissue, compl					
57112	C		Vaginectomy w/nodes, compl					
57120	T		Closure of vagina	0194	18.0228	$939.91	$397.84	$187.98
57130	T		Remove vagina lesion	0194	18.0228	$939.91	$397.84	$187.98
57135	T		Remove vagina lesion	0194	18.0228	$939.91	$397.84	$187.98
57150	T		Treat vagina infection	0191	0.2035	$10.61	$3.08	$2.12
57155	T		Insert uteri tandems/ovoids	0192	2.7228	$142.00	$39.11	$28.40
57160	T		Insert pessary/other device	0188	1.0465	$54.58	$11.95	$10.92
57170	T		Fitting of diaphragm/cap	0191	0.2035	$10.61	$3.08	$2.12
57180	T		Treat vaginal bleeding	0192	2.7228	$142.00	$39.11	$28.40
57200	T		Repair of vagina	0194	18.0228	$939.91	$397.84	$187.98
57210	T		Repair vagina/perineum	0194	18.0228	$939.91	$397.84	$187.98
57220	T		Revision of urethra	0195	23.7301	$1,237.55	$483.80	$247.51
57230	T		Repair of urethral lesion	0194	18.0228	$939.91	$397.84	$187.98
57240	T		Repair bladder & vagina	0195	23.7301	$1,237.55	$483.80	$247.51
57250	T		Repair rectum & vagina	0195	23.7301	$1,237.55	$483.80	$247.51
57260	T		Repair of vagina	0195	23.7301	$1,237.55	$483.80	$247.51
57265	T		Extensive repair of vagina	0195	23.7301	$1,237.55	$483.80	$247.51
57268	T		Repair of bowel bulge	0195	23.7301	$1,237.55	$483.80	$247.51
57270	C		Repair of bowel pouch					
57280	C		Suspension of vagina					
57282	C		Repair of vaginal prolapse					
57284	T		Repair paravaginal defect	0195	23.7301	$1,237.55	$483.80	$247.51
57287	T		Revise/remove sling repair	0202	45.5610	$2,376.05	$1,164.26	$475.21
57288	T		Repair bladder defect	0202	45.5610	$2,376.05	$1,164.26	$475.21
57289	T		Repair bladder & vagina	0195	23.7301	$1,237.55	$483.80	$247.51
57291	T		Construction of vagina	0195	23.7301	$1,237.55	$483.80	$247.51
57292	C		Construct vagina with graft					
57300	T		Repair rectum-vagina fistula	0195	23.7301	$1,237.55	$483.80	$247.51
57305	C		Repair rectum-vagina fistula					
57307	C		Fistula repair & colostomy					
57308	C		Fistula repair, transperine					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
57310	T		Repair urethrovaginal lesion	0195	23.7301	$1,237.55	$483.80	$247.51
57311	C		Repair urethrovaginal lesion					
57320	T		Repair bladder-vagina lesion	0195	23.7301	$1,237.55	$483.80	$247.51
57330	T		Repair bladder-vagina lesion	0195	23.7301	$1,237.55	$483.80	$247.51
57335	C		Repair vagina					
57400	T		Dilation of vagina	0194	18.0228	$939.91	$397.84	$187.98
57410	T		Pelvic examination	0194	18.0228	$939.91	$397.84	$187.98
57415	T		Remove vaginal foreign body	0194	18.0228	$939.91	$397.84	$187.98
57420	T	NI	Exam of vagina w/scope	0192	2.7228	$142.00	$39.11	$28.40
57421	T	NI	Exam/biopsy of vag w/scope	0192	2.7228	$142.00	$39.11	$28.40
57452	T		Examination of vagina	0189	1.5310	$79.84	$18.60	$15.97
57454	T		Vagina examination & biopsy	0192	2.7228	$142.00	$39.11	$28.40
57455	T	NI	Biopsy of cervix w/scope	0192	2.7228	$142.00	$39.11	$28.40
57456	T	NI	Endocerv curettage w/scope	0192	2.7228	$142.00	$39.11	$28.40
57460	T		Cervix excision	0193	14.4764	$754.96	$171.13	$150.99
57461	T	NI	Conz of cervix w/scope, leep	0194	18.0228	$939.91	$397.84	$187.98
57500	T		Biopsy of cervix	0192	2.7228	$142.00	$39.11	$28.40
57505	T		Endocervical curettage	0192	2.7228	$142.00	$39.11	$28.40
57510	T		Cauterization of cervix	0193	14.4764	$754.96	$171.13	$150.99
57511	T		Cryocautery of cervix	0189	1.5310	$79.84	$18.60	$15.97
57513	T		Laser surgery of cervix	0193	14.4764	$754.96	$171.13	$150.99
57520	T		Conization of cervix	0194	18.0228	$939.91	$397.84	$187.98
57522	T		Conization of cervix	0195	23.7301	$1,237.55	$483.80	$247.51
57530	T		Removal of cervix	0195	23.7301	$1,237.55	$483.80	$247.51
57531	C		Removal of cervix, radical					
57540	C		Removal of residual cervix					
57545	C		Remove cervix/repair pelvis					
57550	T		Removal of residual cervix	0195	23.7301	$1,237.55	$483.80	$247.51
57555	T		Remove cervix/repair vagina	0195	23.7301	$1,237.55	$483.80	$247.51
57556	T		Remove cervix, repair bowel	0195	23.7301	$1,237.55	$483.80	$247.51
57700	T		Revision of cervix	0194	18.0228	$939.91	$397.84	$187.98
57720	T		Revision of cervix	0194	18.0228	$939.91	$397.84	$187.98
57800	T		Dilation of cervical canal	0193	14.4764	$754.96	$171.13	$150.99
57820	T		D & c of residual cervix	0196	15.5035	$808.52	$338.23	$161.70
58100	T		Biopsy of uterus lining	0188	1.0465	$54.58	$11.95	$10.92
58120	T		Dilation and curettage	0196	15.5035	$808.52	$338.23	$161.70
58140	C		Removal of uterus lesion					
58145	T		Myomectomy vag method	0195	23.7301	$1,237.55	$483.80	$247.51
58146	C	NI	Myomectomy abdom complex					
58150	C		Total hysterectomy					
58152	C		Total hysterectomy					
58180	C		Partial hysterectomy					
58200	C		Extensive hysterectomy					
58210	C		Extensive hysterectomy					
58240	C		Removal of pelvis contents					
58260	C		Vaginal hysterectomy					
58262	C		Vag hyst including t/o					
58263	C		Vag hyst w/t/o & vag repair					
58267	C		Vag hyst w/urinary repair					
58270	C		Vag hyst w/enterocele repair					
58275	C		Hysterectomy/revise vagina					
58280	C		Hysterectomy/revise vagina					
58285	C		Extensive hysterectomy					
58290	C	NI	Vag hyst complex					
58291	C	NI	Vag hyst incl t/o, complex					
58292	C	NI	Vag hyst t/o & repair, compl					
58293	C	NI	Vag hyst w/uro repair, compl					
58294	C	NI	Vag hyst w/enterocele, compl					
58300	E		Insert intrauterine device					
58301	T		Remove intrauterine device	0189	1.5310	$79.84	$18.60	$15.97
58321	T		Artificial insemination	0197	1.5697	$81.86	$33.06	$16.37
58322	T		Artificial insemination	0197	1.5697	$81.86	$33.06	$16.37
58323	T		Sperm washing	0197	1.5697	$81.86	$33.06	$16.37
58340	N		Catheter for hysterography					
58345	T		Reopen fallopian tube	0194	18.0228	$939.91	$397.84	$187.98

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
58346	T		Insert heyman uteri capsule	0192	2.7228	$142.00	$39.11	$28.40
58350	T		Reopen fallopian tube	0194	18.0228	$939.91	$397.84	$187.98
58353	T		Endometr ablate, thermal	0193	14.4764	$754.96	$171.13	$150.99
58400	C		Suspension of uterus					
58410	C		Suspension of uterus					
58520	C		Repair of ruptured uterus					
58540	C		Revision of uterus					
58545	T	NI	Laparoscopic myomectomy	0130	30.4644	$1,588.75	$659.53	$317.75
58546	T	NI	Laparo-myomectomy, complex	0131	40.2026	$2,096.61	$1,001.89	$419.32
58550	T		Laparo-asst vag hysterectomy	0132	56.9948	$2,972.34	$1,239.22	$594.47
58551	T	DG	Laparoscopy, remove myoma	0131	40.2026	$2,096.61	$1,001.89	$419.32
58552	T	NI	Laparo-vag hyst incl t/o	0131	40.2026	$2,096.61	$1,001.89	$419.32
58553	T	NI	Laparo-vag hyst, complex	0131	40.2026	$2,096.61	$1,001.89	$419.32
58554	T	NI	Laparo-vag hyst w/t/o, compl	0131	40.2026	$2,096.61	$1,001.89	$419.32
58555	T		Hysteroscopy, dx, sep proc	0194	18.0228	$939.91	$397.84	$187.98
58558	T		Hysteroscopy, biopsy	0190	19.0596	$993.98	$424.28	$198.80
58559	T		Hysteroscopy, lysis	0190	19.0596	$993.98	$424.28	$198.80
58560	T		Hysteroscopy, resect septum	0190	19.0596	$993.98	$424.28	$198.80
58561	T		Hysteroscopy, remove myoma	0190	19.0596	$993.98	$424.28	$198.80
58562	T		Hysteroscopy, remove fb	0190	19.0596	$993.98	$424.28	$198.80
58563	T		Hysteroscopy, ablation	0190	19.0596	$993.98	$424.28	$198.80
58578	T		Laparo proc, uterus	0190	19.0596	$993.98	$424.28	$198.80
58579	T		Hysteroscope procedure	0190	19.0596	$993.98	$424.28	$198.80
58600	T		Division of fallopian tube	0194	18.0228	$939.91	$397.84	$187.98
58605	C		Division of fallopian tube					
58611	C		Ligate oviduct(s) add-on					
58615	T		Occlude fallopian tube(s)	0194	18.0228	$939.91	$397.84	$187.98
58660	T		Laparoscopy, lysis	0131	40.2026	$2,096.61	$1,001.89	$419.32
58661	T		Laparoscopy, remove adnexa	0131	40.2026	$2,096.61	$1,001.89	$419.32
58662	T		Laparoscopy, excise lesions	0131	40.2026	$2,096.61	$1,001.89	$419.32
58670	T		Laparoscopy, tubal cautery	0131	40.2026	$2,096.61	$1,001.89	$419.32
58671	T		Laparoscopy, tubal block	0131	40.2026	$2,096.61	$1,001.89	$419.32
58672	T		Laparoscopy, fimbrioplasty	0131	40.2026	$2,096.61	$1,001.89	$419.32
58673	T		Laparoscopy, salpingostomy	0131	40.2026	$2,096.61	$1,001.89	$419.32
58679	T		Laparo proc, oviduct-ovary	0130	30.4644	$1,588.75	$659.53	$317.75
58700	C		Removal of fallopian tube					
58720	C		Removal of ovary/tube(s)					
58740	C		Revise fallopian tube(s)					
58750	C		Repair oviduct					
58752	C		Revise ovarian tube(s)					
58760	C		Remove tubal obstruction					
58770	C		Create new tubal opening					
58800	T		Drainage of ovarian cyst(s)	0195	23.7301	$1,237.55	$483.80	$247.51
58805	C		Drainage of ovarian cyst(s)					
58820	T		Drain ovary abscess, open	0195	23.7301	$1,237.55	$483.80	$247.51
58822	C		Drain ovary abscess, percut					
58823	T		Drain pelvic abscess, percut	0193	14.4764	$754.96	$171.13	$150.99
58825	C		Transposition, ovary(s)					
58900	T		Biopsy of ovary(s)	0195	23.7301	$1,237.55	$483.80	$247.51
58920	T		Partial removal of ovary(s)	0202	45.5610	$2,376.05	$1,164.26	$475.21
58925	T		Removal of ovarian cyst(s)	0202	45.5610	$2,376.05	$1,164.26	$475.21
58940	C		Removal of ovary(s)					
58943	C		Removal of ovary(s)					
58950	C		Resect ovarian malignancy					
58951	C		Resect ovarian malignancy					
58952	C		Resect ovarian malignancy					
58953	C		Tah, rad dissect for debulk					
58954	C		Tah rad debulk/lymph remove					
58960	C		Exploration of abdomen					
58970	T		Retrieval of oocyte	0194	18.0228	$939.91	$397.84	$187.98
58974	T		Transfer of embryo	0197	1.5697	$81.86	$33.06	$16.37
58976	T		Transfer of embryo	0197	1.5697	$81.86	$33.06	$16.37
58999	T		Genital surgery procedure	0191	0.2035	$10.61	$3.08	$2.12
59000	T		Amniocentesis, diagnostic	0198	1.2597	$65.69	$32.19	$13.14
59001	T		Amniocentesis, therapeutic	0198	1.2597	$65.69	$32.19	$13.14

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
59012	T		Fetal cord puncture,prenatal	0198	1.2597	$65.69	$32.19	$13.14
59015	T		Chorion biopsy	0198	1.2597	$65.69	$32.19	$13.14
59020	T		Fetal contract stress test	0198	1.2597	$65.69	$32.19	$13.14
59025	T		Fetal non-stress test	0198	1.2597	$65.69	$32.19	$13.14
59030	T		Fetal scalp blood sample	0198	1.2597	$65.69	$32.19	$13.14
59050	E		Fetal monitor w/report					
59051	E		Fetal monitor/interpret only					
59100	C		Remove uterus lesion					
59120	C		Treat ectopic pregnancy					
59121	C		Treat ectopic pregnancy					
59130	C		Treat ectopic pregnancy					
59135	C		Treat ectopic pregnancy					
59136	C		Treat ectopic pregnancy					
59140	C		Treat ectopic pregnancy					
59150	T		Treat ectopic pregnancy	0131	40.2026	$2,096.61	$1,001.89	$419.32
59151	T		Treat ectopic pregnancy	0131	40.2026	$2,096.61	$1,001.89	$419.32
59160	T		D & c after delivery	0196	15.5035	$808.52	$338.23	$161.70
59200	T		Insert cervical dilator	0189	1.5310	$79.84	$18.60	$15.97
59300	T		Episiotomy or vaginal repair	0193	14.4764	$754.96	$171.13	$150.99
59320	T		Revision of cervix	0194	18.0228	$939.91	$397.84	$187.98
59325	C		Revision of cervix					
59350	C		Repair of uterus					
59400	E		Obstetrical care					
59409	T		Obstetrical care	0199	3.9146	$204.15	$57.16	$40.83
59410	E		Obstetrical care					
59412	T		Antepartum manipulation	0199	3.9146	$204.15	$57.16	$40.83
59414	T		Deliver placenta	0199	3.9146	$204.15	$57.16	$40.83
59425	E		Antepartum care only					
59426	E		Antepartum care only					
59430	E		Care after delivery					
59510	E		Cesarean delivery					
59514	C		Cesarean delivery only					
59515	E		Cesarean delivery					
59525	C		Remove uterus after cesarean					
59610	E		Vbac delivery					
59612	T		Vbac delivery only	0199	3.9146	$204.15	$57.16	$40.83
59614	E		Vbac care after delivery					
59618	E		Attempted vbac delivery					
59620	C		Attempted vbac delivery only					
59622	E		Attempted vbac after care					
59812	T		Treatment of miscarriage	0201	15.3097	$798.42	$329.65	$159.68
59820	T		Care of miscarriage	0201	15.3097	$798.42	$329.65	$159.68
59821	T		Treatment of miscarriage	0201	15.3097	$798.42	$329.65	$159.68
59830	C		Treat uterus infection					
59840	T		Abortion	0200	15.1838	$791.85	$307.83	$158.37
59841	T		Abortion	0200	15.1838	$791.85	$307.83	$158.37
59850	C		Abortion					
59851	C		Abortion					
59852	C		Abortion					
59855	C		Abortion					
59856	C		Abortion					
59857	C		Abortion					
59866	T		Abortion (mpr)	0198	1.2597	$65.69	$32.19	$13.14
59870	T		Evacuate mole of uterus	0201	15.3097	$798.42	$329.65	$159.68
59871	T		Remove cerclage suture	0194	18.0228	$939.91	$397.84	$187.98
59898	T		Laparo proc, ob care/deliver	0130	30.4644	$1,588.75	$659.53	$317.75
59899	T		Maternity care procedure	0198	1.2597	$65.69	$32.19	$13.14
60000	T		Drain thyroid/tongue cyst	0252	5.8041	$302.69	$113.41	$60.54
60001	T		Aspirate/inject thyriod cyst	0004	1.7441	$90.96	$23.47	$18.19
60100	T		Biopsy of thyroid	0004	1.7441	$90.96	$23.47	$18.19
60200	T		Remove thyroid lesion	0114	36.1135	$1,883.36	$485.91	$376.67
60210	T		Partial thyroid excision	0114	36.1135	$1,883.36	$485.91	$376.67
60212	T		Partial thyroid excision	0114	36.1135	$1,883.36	$485.91	$376.67
60220	T		Partial removal of thyroid	0114	36.1135	$1,883.36	$485.91	$376.67
60225	T		Partial removal of thyroid	0114	36.1135	$1,883.36	$485.91	$376.67

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
60240	T		Removal of thyroid	0114	36.1135	$1,883.36	$485.91	$376.67
60252	T		Removal of thyroid	0256	34.0302	$1,774.71		$354.94
60254	C		Extensive thyroid surgery					
60260	T		Repeat thyroid surgery	0256	34.0302	$1,774.71		$354.94
60270	C		Removal of thyroid					
60271	C		Removal of thyroid					
60280	T		Remove thyroid duct lesion	0114	36.1135	$1,883.36	$485.91	$376.67
60281	T		Remove thyroid duct lesion	0114	36.1135	$1,883.36	$485.91	$376.67
60500	T		Explore parathyroid glands	0256	34.0302	$1,774.71		$354.94
60502	C		Re-explore parathyroids					
60505	C		Explore parathyroid glands					
60512	T		Autotransplant parathyroid	0022	17.3930	$907.06	$354.45	$181.41
60520	C		Removal of thymus gland					
60521	C		Removal of thymus gland					
60522	C		Removal of thymus gland					
60540	C		Explore adrenal gland					
60545	C		Explore adrenal gland					
60600	C		Remove carotid body lesion					
60605	C		Remove carotid body lesion					
60650	C		Laparoscopy adrenalectomy					
60659	T		Laparo proc, endocrine	0130	30.4644	$1,588.75	$659.53	$317.75
60699	T		Endocrine surgery procedure	0114	36.1135	$1,883.36	$485.91	$376.67
61000	T		Remove cranial cavity fluid	0212	3.3139	$172.82	$79.53	$34.56
61001	T		Remove cranial cavity fluid	0212	3.3139	$172.82	$79.53	$34.56
61020	T		Remove brain cavity fluid	0212	3.3139	$172.82	$79.53	$34.56
61026	T		Injection into brain canal	0212	3.3139	$172.82	$79.53	$34.56
61050	T		Remove brain canal fluid	0212	3.3139	$172.82	$79.53	$34.56
61055	T		Injection into brain canal	0212	3.3139	$172.82	$79.53	$34.56
61070	T		Brain canal shunt procedure	0212	3.3139	$172.82	$79.53	$34.56
61105	C		Twist drill hole					
61107	C		Drill skull for implantation					
61108	C		Drill skull for drainage					
61120	C		Burr hole for puncture					
61140	C		Pierce skull for biopsy					
61150	C		Pierce skull for drainage					
61151	C		Pierce skull for drainage					
61154	C		Pierce skull & remove clot					
61156	C		Pierce skull for drainage					
61210	C		Pierce skull, implant device					
61215	T		Insert brain-fluid device	0224	34.0302	$1,774.71	$453.41	$354.94
61250	C		Pierce skull & explore					
61253	C		Pierce skull & explore					
61304	C		Open skull for exploration					
61305	C		Open skull for exploration					
61312	C		Open skull for drainage					
61313	C		Open skull for drainage					
61314	C		Open skull for drainage					
61315	C		Open skull for drainage					
61316	N	NI	Implt cran bone flap to abdo					
61320	C		Open skull for drainage					
61321	C		Open skull for drainage					
61322	C	NI	Decompressive craniotomy					
61323	C	NI	Decompressive lobectomy					
61330	T		Decompress eye socket	0256	34.0302	$1,774.71		$354.94
61332	C		Explore/biopsy eye socket					
61333	C		Explore orbit/remove lesion					
61334	C		Explore orbit/remove object					
61340	C		Relieve cranial pressure					
61343	C		Incise skull (press relief)					
61345	C		Relieve cranial pressure					
61440	C		Incise skull for surgery					
61450	C		Incise skull for surgery					
61458	C		Incise skull for brain wound					
61460	C		Incise skull for surgery					
61470	C		Incise skull for surgery					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
61480	C		Incise skull for surgery					
61490	C		Incise skull for surgery					
61500	C		Removal of skull lesion					
61501	C		Remove infected skull bone					
61510	C		Removal of brain lesion					
61512	C		Remove brain lining lesion					
61514	C		Removal of brain abscess					
61516	C		Removal of brain lesion					
61517	N	NI	Implt brain chemotx add-on					
61518	C		Removal of brain lesion					
61519	C		Remove brain lining lesion					
61520	C		Removal of brain lesion					
61521	C		Removal of brain lesion					
61522	C		Removal of brain abscess					
61524	C		Removal of brain lesion					
61526	C		Removal of brain lesion					
61530	C		Removal of brain lesion					
61531	C		Implant brain electrodes					
61533	C		Implant brain electrodes					
61534	C		Removal of brain lesion					
61535	C		Remove brain electrodes					
61536	C		Removal of brain lesion					
61538	C		Removal of brain tissue					
61539	C		Removal of brain tissue					
61541	C		Incision of brain tissue					
61542	C		Removal of brain tissue					
61543	C		Removal of brain tissue					
61544	C		Remove & treat brain lesion					
61545	C		Excision of brain tumor					
61546	C		Removal of pituitary gland					
61548	C		Removal of pituitary gland					
61550	C		Release of skull seams					
61552	C		Release of skull seams					
61556	C		Incise skull/sutures					
61557	C		Incise skull/sutures					
61558	C		Excision of skull/sutures					
61559	C		Excision of skull/sutures					
61563	C		Excision of skull tumor					
61564	C		Excision of skull tumor					
61570	C		Remove foreign body, brain					
61571	C		Incise skull for brain wound					
61575	C		Skull base/brainstem surgery					
61576	C		Skull base/brainstem surgery					
61580	C		Craniofacial approach, skull					
61581	C		Craniofacial approach, skull					
61582	C		Craniofacial approach, skull					
61583	C		Craniofacial approach, skull					
61584	C		Orbitocranial approach/skull					
61585	C		Orbitocranial approach/skull					
61586	C		Resect nasopharynx, skull					
61590	C		Infratemporal approach/skull					
61591	C		Infratemporal approach/skull					
61592	C		Orbitocranial approach/skull					
61595	C		Transtemporal approach/skull					
61596	C		Transcochlear approach/skull					
61597	C		Transcondylar approach/skull					
61598	C		Transpetrosal approach/skull					
61600	C		Resect/excise cranial lesion					
61601	C		Resect/excise cranial lesion					
61605	C		Resect/excise cranial lesion					
61606	C		Resect/excise cranial lesion					
61607	C		Resect/excise cranial lesion					
61608	C		Resect/excise cranial lesion					
61609	C		Transect artery, sinus					
61610	C		Transect artery, sinus					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
61611	C		Transect artery, sinus					
61612	C		Transect artery, sinus					
61613	C		Remove aneurysm, sinus					
61615	C		Resect/excise lesion, skull					
61616	C		Resect/excise lesion, skull					
61618	C		Repair dura					
61619	C		Repair dura					
61623	T	NI	Endovasc tempory vessel occl	0979		$1,625.00		$325.00
61624	C		Occlusion/embolization cath					
61626	T		Transcath occlusion, non-cns	0081	43.5067	$2,268.92		$453.78
61680	C		Intracranial vessel surgery					
61682	C		Intracranial vessel surgery					
61684	C		Intracranial vessel surgery					
61686	C		Intracranial vessel surgery					
61690	C		Intracranial vessel surgery					
61692	C		Intracranial vessel surgery					
61697	C		Brain aneurysm repr, complx					
61698	C		Brain aneurysm repr, complx					
61700	C		Brain aneurysm repr, simple					
61702	C		Inner skull vessel surgery					
61703	C		Clamp neck artery					
61705	C		Revise circulation to head					
61708	C		Revise circulation to head					
61710	C		Revise circulation to head					
61711	C		Fusion of skull arteries					
61720	C		Incise skull/brain surgery					
61735	C		Incise skull/brain surgery					
61750	C		Incise skull/brain biopsy					
61751	C		Brain biopsy w/ ct/mr guide					
61760	C		Implant brain electrodes					
61770	C		Incise skull for treatment					
61790	T		Treat trigeminal nerve	0220	15.8136	$824.70		$164.94
61791	T		Treat trigeminal tract	0204	2.0251	$105.61	$40.13	$21.12
61793	E		Focus radiation beam					
61795	S		Brain surgery using computer	0302	9.2343	$481.58	$182.43	$96.32
61850	C		Implant neuroelectrodes					
61860	C		Implant neuroelectrodes					
61862	C		Implant neurostimul, subcort					
61870	C		Implant neuroelectrodes					
61875	C		Implant neuroelectrodes					
61880	T		Revise/remove neuroelectrode	0687	25.8424	$1,347.71	$619.95	$269.54
61885	T		Implant neurostim one array	0222	227.7370	$11,876.71		$2,375.34
61886	T		Implant neurostim arrays	0222	227.7370	$11,876.71		$2,375.34
61888	T		Revise/remove neuroreceiver	0688	74.5719	$3,889.00	$1,905.61	$777.80
62000	C		Treat skull fracture					
62005	C		Treat skull fracture					
62010	C		Treatment of head injury					
62100	C		Repair brain fluid leakage					
62115	C		Reduction of skull defect					
62116	C		Reduction of skull defect					
62117	C		Reduction of skull defect					
62120	C		Repair skull cavity lesion					
62121	C		Incise skull repair					
62140	C		Repair of skull defect					
62141	C		Repair of skull defect					
62142	C		Remove skull plate/flap					
62143	C		Replace skull plate/flap					
62145	C		Repair of skull & brain					
62146	C		Repair of skull with graft					
62147	C		Repair of skull with graft					
62148	N	NI	Retr bone flap to fix skull					
62160	N	NI	Neuroendoscopy add-on					
62161	C	NI	Dissect brain w/scope					
62162	C	NI	Remove colloid cyst w/scope					
62163	C	NI	Neuroendoscopy w/fb removal					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
62164	C	NI	Remove brain tumor w/scope					
62165	C	NI	Remove pituit tumor w/scope					
62180	C		Establish brain cavity shunt					
62190	C		Establish brain cavity shunt					
62192	C		Establish brain cavity shunt					
62194	T		Replace/irrigate catheter	0121	2.0833	$108.65	$43.80	$21.73
62200	C		Establish brain cavity shunt					
62201	C		Establish brain cavity shunt					
62220	C		Establish brain cavity shunt					
62223	C		Establish brain cavity shunt					
62225	T		Replace/irrigate catheter	0121	2.0833	$108.65	$43.80	$21.73
62230	T		Replace/revise brain shunt	0224	34.0302	$1,774.71	$453.41	$354.94
62252	S		Csf shunt reprogram	0691	2.9166	$152.10	$83.65	$30.42
62256	C		Remove brain cavity shunt					
62258	C		Replace brain cavity shunt					
62263	T		Lysis epidural adhesions	0203	11.7924	$614.99	$276.76	$123.00
62264	T	NI	Epidural lysis on single day	0203	11.7924	$614.99	$276.76	$123.00
62268	T		Drain spinal cord cyst	0212	3.3139	$172.82	$79.53	$34.56
62269	T		Needle biopsy, spinal cord	0005	3.1201	$162.72	$71.59	$32.54
62270	T		Spinal fluid tap, diagnostic	0206	4.7867	$249.63	$75.55	$49.93
62272	T		Drain cerebro spinal fluid	0206	4.7867	$249.63	$75.55	$49.93
62273	T		Treat epidural spine lesion	0206	4.7867	$249.63	$75.55	$49.93
62280	T		Treat spinal cord lesion	0207	5.7654	$300.67	$123.69	$60.13
62281	T		Treat spinal cord lesion	0207	5.7654	$300.67	$123.69	$60.13
62282	T		Treat spinal canal lesion	0207	5.7654	$300.67	$123.69	$60.13
62284	N		Injection for myelogram					
62287	T		Percutaneous diskectomy	0220	15.8136	$824.70		$164.94
62290	N		Inject for spine disk x-ray					
62291	N		Inject for spine disk x-ray					
62292	T		Injection into disk lesion	0212	3.3139	$172.82	$79.53	$34.56
62294	T		Injection into spinal artery	0212	3.3139	$172.82	$79.53	$34.56
62310	T		Inject spine c/t	0206	4.7867	$249.63	$75.55	$49.93
62311	T		Inject spine l/s (cd)	0206	4.7867	$249.63	$75.55	$49.93
62318	T		Inject spine w/cath, c/t	0206	4.7867	$249.63	$75.55	$49.93
62319	T		Inject spine w/cath l/s (cd)	0206	4.7867	$249.63	$75.55	$49.93
62350	T		Implant spinal canal cath	0223	41.0262	$2,139.56		$427.91
62351	T		Implant spinal canal cath	0208	38.4487	$2,005.14		$401.03
62355	T		Remove spinal canal catheter	0203	11.7924	$614.99	$276.76	$123.00
62360	T		Insert spine infusion device	0226	144.3474	$7,527.86		$1,505.57
62361	T		Implant spine infusion pump	0227	144.5122	$7,536.46		$1,507.29
62362	T		Implant spine infusion pump	0227	144.5122	$7,536.46		$1,507.29
62365	T		Remove spine infusion device	0203	11.7924	$614.99	$276.76	$123.00
62367	S		Analyze spine infusion pump	0691	2.9166	$152.10	$83.65	$30.42
62368	S		Analyze spine infusion pump	0691	2.9166	$152.10	$83.65	$30.42
63001	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63003	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63005	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63011	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63012	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63015	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63016	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63017	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63020	T		Neck spine disk surgery	0208	38.4487	$2,005.14		$401.03
63030	T		Low back disk surgery	0208	38.4487	$2,005.14		$401.03
63035	T		Spinal disk surgery add-on	0208	38.4487	$2,005.14		$401.03
63040	T		Laminotomy, single cervical	0208	38.4487	$2,005.14		$401.03
63042	T		Laminotomy, single lumbar	0208	38.4487	$2,005.14		$401.03
63043	C		Laminotomy, addl cervical					
63044	C		Laminotomy, addl lumbar					
63045	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63046	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63047	T		Removal of spinal lamina	0208	38.4487	$2,005.14		$401.03
63048	T		Remove spinal lamina add-on	0208	38.4487	$2,005.14		$401.03
63055	T		Decompress spinal cord	0208	38.4487	$2,005.14		$401.03
63056	T		Decompress spinal cord	0208	38.4487	$2,005.14		$401.03

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
63057	T		Decompress spine cord add-on	0208	38.4487	$2,005.14		$401.03
63064	T		Decompress spinal cord	0208	38.4487	$2,005.14		$401.03
63066	T		Decompress spine cord add-on	0208	38.4487	$2,005.14		$401.03
63075	C		Neck spine disk surgery					
63076	C		Neck spine disk surgery					
63077	C		Spine disk surgery, thorax					
63078	C		Spine disk surgery, thorax					
63081	C		Removal of vertebral body					
63082	C		Remove vertebral body add-on					
63085	C		Removal of vertebral body					
63086	C		Remove vertebral body add-on					
63087	C		Removal of vertebral body					
63088	C		Remove vertebral body add-on					
63090	C		Removal of vertebral body					
63091	C		Remove vertebral body add-on					
63170	C		Incise spinal cord tract(s)					
63172	C		Drainage of spinal cyst					
63173	C		Drainage of spinal cyst					
63180	C		Revise spinal cord ligaments					
63182	C		Revise spinal cord ligaments					
63185	C		Incise spinal column/nerves					
63190	C		Incise spinal column/nerves					
63191	C		Incise spinal column/nerves					
63194	C		Incise spinal column & cord					
63195	C		Incise spinal column & cord					
63196	C		Incise spinal column & cord					
63197	C		Incise spinal column & cord					
63198	C		Incise spinal column & cord					
63199	C		Incise spinal column & cord					
63200	C		Release of spinal cord					
63250	C		Revise spinal cord vessels					
63251	C		Revise spinal cord vessels					
63252	C		Revise spinal cord vessels					
63265	C		Excise intraspinal lesion					
63266	C		Excise intraspinal lesion					
63267	C		Excise intraspinal lesion					
63268	C		Excise intraspinal lesion					
63270	C		Excise intraspinal lesion					
63271	C		Excise intraspinal lesion					
63272	C		Excise intraspinal lesion					
63273	C		Excise intraspinal lesion					
63275	C		Biopsy/excise spinal tumor					
63276	C		Biopsy/excise spinal tumor					
63277	C		Biopsy/excise spinal tumor					
63278	C		Biopsy/excise spinal tumor					
63280	C		Biopsy/excise spinal tumor					
63281	C		Biopsy/excise spinal tumor					
63282	C		Biopsy/excise spinal tumor					
63283	C		Biopsy/excise spinal tumor					
63285	C		Biopsy/excise spinal tumor					
63286	C		Biopsy/excise spinal tumor					
63287	C		Biopsy/excise spinal tumor					
63290	C		Biopsy/excise spinal tumor					
63300	C		Removal of vertebral body					
63301	C		Removal of vertebral body					
63302	C		Removal of vertebral body					
63303	C		Removal of vertebral body					
63304	C		Removal of vertebral body					
63305	C		Removal of vertebral body					
63306	C		Removal of vertebral body					
63307	C		Removal of vertebral body					
63308	C		Remove vertebral body add-on					
63600	T		Remove spinal cord lesion	0220	15.8136	$824.70		$164.94
63610	T		Stimulation of spinal cord	0220	15.8136	$824.70		$164.94
63615	T		Remove lesion of spinal cord	0220	15.8136	$824.70		$164.94

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
63650	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
63655	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
63660	T		Revise/remove neuroelectrode	0687	25.8424	$1,347.71	$619.95	$269.54
63685	T		Implant neuroreceiver	0222	227.7370	$11,876.71		$2,375.34
63688	T		Revise/remove neuroreceiver	0688	74.5719	$3,889.00	$1,905.61	$777.80
63700	C		Repair of spinal herniation					
63702	C		Repair of spinal herniation					
63704	C		Repair of spinal herniation					
63706	C		Repair of spinal herniation					
63707	C		Repair spinal fluid leakage					
63709	C		Repair spinal fluid leakage					
63710	C		Graft repair of spine defect					
63740	C		Install spinal shunt					
63741	T		Install spinal shunt	0228	59.6207	$3,109.28	$696.46	$621.86
63744	T		Revision of spinal shunt	0228	59.6207	$3,109.28	$696.46	$621.86
63746	T		Removal of spinal shunt	0109	7.4708	$389.61	$131.49	$77.92
64400	T		N block inj, trigeminal	0204	2.0251	$105.61	$40.13	$21.12
64402	T		N block inj, facial	0204	2.0251	$105.61	$40.13	$21.12
64405	T		N block inj, occipital	0204	2.0251	$105.61	$40.13	$21.12
64408	T		N block inj, vagus	0204	2.0251	$105.61	$40.13	$21.12
64410	T		N block inj, phrenic	0204	2.0251	$105.61	$40.13	$21.12
64412	T		N block inj, spinal accessor	0204	2.0251	$105.61	$40.13	$21.12
64413	T		N block inj, cervical plexus	0204	2.0251	$105.61	$40.13	$21.12
64415	T		Injection for nerve block	0204	2.0251	$105.61	$40.13	$21.12
64416	T	NI	N block cont infuse, b plex	0204	2.0251	$105.61	$40.13	$21.12
64417	T		N block inj, axillary	0204	2.0251	$105.61	$40.13	$21.12
64418	T		N block inj, suprascapular	0204	2.0251	$105.61	$40.13	$21.12
64420	T		N block inj, intercost, sng	0207	5.7654	$300.67	$123.69	$60.13
64421	T		N block inj, intercost, mlt	0207	5.7654	$300.67	$123.69	$60.13
64425	T		N block inj ilio-ing/hypogi	0204	2.0251	$105.61	$40.13	$21.12
64430	T		N block inj, pudendal	0204	2.0251	$105.61	$40.13	$21.12
64435	T		N block inj, paracervical	0204	2.0251	$105.61	$40.13	$21.12
64445	T		Injection for nerve block	0204	2.0251	$105.61	$40.13	$21.12
64446	T	NI	N blk inj, sciatic, cont inf	0204	2.0251	$105.61	$40.13	$21.12
64447	T	NI	N block inj fem, single	0204	2.0251	$105.61	$40.13	$21.12
64448	T	NI	N block inj fem, cont inf	0204	2.0251	$105.61	$40.13	$21.12
64450	T		N block, other peripheral	0204	2.0251	$105.61	$40.13	$21.12
64470	T		Inj paravertebral c/t	0207	5.7654	$300.67	$123.69	$60.13
64472	T		Inj paravertebral c/t add-on	0207	5.7654	$300.67	$123.69	$60.13
64475	T		Inj paravertebral l/s	0207	5.7654	$300.67	$123.69	$60.13
64476	T		Inj paravertebral l/s add-on	0207	5.7654	$300.67	$123.69	$60.13
64479	T		Inj foramen epidural c/t	0207	5.7654	$300.67	$123.69	$60.13
64480	T		Inj foramen epidural add-on	0207	5.7654	$300.67	$123.69	$60.13
64483	T		Inj foramen epidural l/s	0207	5.7654	$300.67	$123.69	$60.13
64484	T		Inj foramen epidural add-on	0207	5.7654	$300.67	$123.69	$60.13
64505	T		N block, spenopalatine gangl	0204	2.0251	$105.61	$40.13	$21.12
64508	T		N block, carotid sinus s/p	0204	2.0251	$105.61	$40.13	$21.12
64510	T		N block, stellate ganglion	0207	5.7654	$300.67	$123.69	$60.13
64520	T		N block, lumbar/thoracic	0207	5.7654	$300.67	$123.69	$60.13
64530	T		N block inj, celiac pelus	0207	5.7654	$300.67	$123.69	$60.13
64550	A		Apply neurostimulator					
64553	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64555	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64560	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64561	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64565	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64573	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64575	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64577	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64580	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64581	S		Implant neuroelectrodes	0225	139.3379	$7,266.61		$1,453.32
64585	T		Revise/remove neuroelectrode	0687	25.8424	$1,347.71	$619.95	$269.54
64590	T		Implant neuroreceiver	0222	227.7370	$11,876.71		$2,375.34
64595	T		Revise/remove neuroreceiver	0688	74.5719	$3,889.00	$1,905.61	$777.80
64600	T		Injection treatment of nerve	0203	11.7924	$614.99	$276.76	$123.00

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64605	T		Injection treatment of nerve	0203	11.7924	$614.99	$276.76	$123.00
64610	T		Injection treatment of nerve	0203	11.7924	$614.99	$276.76	$123.00
64612	T		Destroy nerve, face muscle	0204	2.0251	$105.61	$40.13	$21.12
64613	T		Destroy nerve, spine muscle	0204	2.0251	$105.61	$40.13	$21.12
64614	T		Destroy nerve, extrem musc	0204	2.0251	$105.61	$40.13	$21.12
64620	T		Injection treatment of nerve	0203	11.7924	$614.99	$276.76	$123.00
64622	T		Destr paravertebrl nerve l/s	0203	11.7924	$614.99	$276.76	$123.00
64623	T		Destr paravertebral n add-on	0203	11.7924	$614.99	$276.76	$123.00
64626	T		Destr paravertebrl nerve c/t	0203	11.7924	$614.99	$276.76	$123.00
64627	T		Destr paravertebral n add-on	0203	11.7924	$614.99	$276.76	$123.00
64630	T		Injection treatment of nerve	0207	5.7654	$300.67	$123.69	$60.13
64640	T		Injection treatment of nerve	0207	5.7654	$300.67	$123.69	$60.13
64680	T		Injection treatment of nerve	0203	11.7924	$614.99	$276.76	$123.00
64702	T		Revise finger/toe nerve	0220	15.8136	$824.70		$164.94
64704	T		Revise hand/foot nerve	0220	15.8136	$824.70		$164.94
64708	T		Revise arm/leg nerve	0220	15.8136	$824.70		$164.94
64712	T		Revision of sciatic nerve	0220	15.8136	$824.70		$164.94
64713	T		Revision of arm nerve(s)	0220	15.8136	$824.70		$164.94
64714	T		Revise low back nerve(s)	0220	15.8136	$824.70		$164.94
64716	T		Revision of cranial nerve	0220	15.8136	$824.70		$164.94
64718	T		Revise ulnar nerve at elbow	0220	15.8136	$824.70		$164.94
64719	T		Revise ulnar nerve at wrist	0220	15.8136	$824.70		$164.94
64721	T		Carpal tunnel surgery	0220	15.8136	$824.70		$164.94
64722	T		Relieve pressure on nerve(s)	0220	15.8136	$824.70		$164.94
64726	T		Release foot/toe nerve	0220	15.8136	$824.70		$164.94
64727	T		Internal nerve revision	0220	15.8136	$824.70		$164.94
64732	T		Incision of brow nerve	0220	15.8136	$824.70		$164.94
64734	T		Incision of cheek nerve	0220	15.8136	$824.70		$164.94
64736	T		Incision of chin nerve	0220	15.8136	$824.70		$164.94
64738	T		Incision of jaw nerve	0220	15.8136	$824.70		$164.94
64740	T		Incision of tongue nerve	0220	15.8136	$824.70		$164.94
64742	T		Incision of facial nerve	0220	15.8136	$824.70		$164.94
64744	T		Incise nerve, back of head	0220	15.8136	$824.70		$164.94
64746	T		Incise diaphragm nerve	0220	15.8136	$824.70		$164.94
64752	C		Incision of vagus nerve					
64755	C		Incision of stomach nerves					
64760	C		Incision of vagus nerve					
64761	T		Incision of pelvis nerve	0220	15.8136	$824.70		$164.94
64763	C		Incise hip/thigh nerve					
64766	C		Incise hip/thigh nerve					
64771	T		Sever cranial nerve	0220	15.8136	$824.70		$164.94
64772	T		Incision of spinal nerve	0220	15.8136	$824.70		$164.94
64774	T		Remove skin nerve lesion	0220	15.8136	$824.70		$164.94
64776	T		Remove digit nerve lesion	0220	15.8136	$824.70		$164.94
64778	T		Digit nerve surgery add-on	0220	15.8136	$824.70		$164.94
64782	T		Remove limb nerve lesion	0220	15.8136	$824.70		$164.94
64783	T		Limb nerve surgery add-on	0220	15.8136	$824.70		$164.94
64784	T		Remove nerve lesion	0220	15.8136	$824.70		$164.94
64786	T		Remove sciatic nerve lesion	0221	21.5208	$1,122.33	$463.62	$224.47
64787	T		Implant nerve end	0220	15.8136	$824.70		$164.94
64788	T		Remove skin nerve lesion	0220	15.8136	$824.70		$164.94
64790	T		Removal of nerve lesion	0220	15.8136	$824.70		$164.94
64792	T		Removal of nerve lesion	0221	21.5208	$1,122.33	$463.62	$224.47
64795	T		Biopsy of nerve	0220	15.8136	$824.70		$164.94
64802	T		Remove sympathetic nerves	0220	15.8136	$824.70		$164.94
64804	C		Remove sympathetic nerves					
64809	C		Remove sympathetic nerves					
64818	C		Remove sympathetic nerves					
64820	T		Remove sympathetic nerves	0220	15.8136	$824.70		$164.94
64821	T		Remove sympathestic nerves	0054	22.7223	$1,184.99		$237.00
64822	T		Remove sympathetic nerves	0054	22.7223	$1,184.99		$237.00
64823	T		Remove sympathetic nerves	0054	22.7223	$1,184.99		$237.00
64831	T		Repair of digit nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64832	T		Repair nerve add-on	0221	21.5208	$1,122.33	$463.62	$224.47
64834	T		Repair of hand or foot nerve	0221	21.5208	$1,122.33	$463.62	$224.47

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64835	T		Repair of hand or foot nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64836	T		Repair of hand or foot nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64837	T		Repair nerve add-on	0221	21.5208	$1,122.33	$463.62	$224.47
64840	T		Repair of leg nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64856	T		Repair/transpose nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64857	T		Repair arm/leg nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64858	T		Repair sciatic nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64859	T		Nerve surgery	0221	21.5208	$1,122.33	$463.62	$224.47
64861	T		Repair of arm nerves	0221	21.5208	$1,122.33	$463.62	$224.47
64862	T		Repair of low back nerves	0221	21.5208	$1,122.33	$463.62	$224.47
64864	T		Repair of facial nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64865	T		Repair of facial nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64866	C		Fusion of facial/other nerve					
64868	C		Fusion of facial/other nerve					
64870	T		Fusion of facial/other nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64872	T		Subsequent repair of nerve	0221	21.5208	$1,122.33	$463.62	$224.47
64874	T		Repair & revise nerve add-on	0221	21.5208	$1,122.33	$463.62	$224.47
64876	T		Repair nerve/shorten bone	0221	21.5208	$1,122.33	$463.62	$224.47
64885	T		Nerve graft, head or neck	0221	21.5208	$1,122.33	$463.62	$224.47
64886	T		Nerve graft, head or neck	0221	21.5208	$1,122.33	$463.62	$224.47
64890	T		Nerve graft, hand or foot	0221	21.5208	$1,122.33	$463.62	$224.47
64891	T		Nerve graft, hand or foot	0221	21.5208	$1,122.33	$463.62	$224.47
64892	T		Nerve graft, arm or leg	0221	21.5208	$1,122.33	$463.62	$224.47
64893	T		Nerve graft, arm or leg	0221	21.5208	$1,122.33	$463.62	$224.47
64895	T		Nerve graft, hand or foot	0221	21.5208	$1,122.33	$463.62	$224.47
64896	T		Nerve graft, hand or foot	0221	21.5208	$1,122.33	$463.62	$224.47
64897	T		Nerve graft, arm or leg	0221	21.5208	$1,122.33	$463.62	$224.47
64898	T		Nerve graft, arm or leg	0221	21.5208	$1,122.33	$463.62	$224.47
64901	T		Nerve graft add-on	0221	21.5208	$1,122.33	$463.62	$224.47
64902	T		Nerve graft add-on	0221	21.5208	$1,122.33	$463.62	$224.47
64905	T		Nerve pedicle transfer	0221	21.5208	$1,122.33	$463.62	$224.47
64907	T		Nerve pedicle transfer	0221	21.5208	$1,122.33	$463.62	$224.47
64999	T		Nervous system surgery	0204	2.0251	$105.61	$40.13	$21.12
65091	T		Revise eye	0242	28.0517	$1,462.92	$597.36	$292.58
65093	T		Revise eye with implant	0241	20.6294	$1,075.84	$384.47	$215.17
65101	T		Removal of eye	0242	28.0517	$1,462.92	$597.36	$292.58
65103	T		Remove eye/insert implant	0242	28.0517	$1,462.92	$597.36	$292.58
65105	T		Remove eye/attach implant	0242	28.0517	$1,462.92	$597.36	$292.58
65110	T		Removal of eye	0242	28.0517	$1,462.92	$597.36	$292.58
65112	T		Remove eye/revise socket	0242	28.0517	$1,462.92	$597.36	$292.58
65114	T		Remove eye/revise socket	0242	28.0517	$1,462.92	$597.36	$292.58
65125	T		Revise ocular implant	0240	16.3078	$850.47	$315.31	$170.09
65130	T		Insert ocular implant	0241	20.6294	$1,075.84	$384.47	$215.17
65135	T		Insert ocular implant	0241	20.6294	$1,075.84	$384.47	$215.17
65140	T		Attach ocular implant	0242	28.0517	$1,462.92	$597.36	$292.58
65150	T		Revise ocular implant	0241	20.6294	$1,075.84	$384.47	$215.17
65155	T		Reinsert ocular implant	0242	28.0517	$1,462.92	$597.36	$292.58
65175	T		Removal of ocular implant	0240	16.3078	$850.47	$315.31	$170.09
65205	S		Remove foreign body from eye	0698	0.9205	$48.00	$18.72	$9.60
65210	S		Remove foreign body from eye	0231	2.1705	$113.19	$50.94	$22.64
65220	S		Remove foreign body from eye	0231	2.1705	$113.19	$50.94	$22.64
65222	S		Remove foreign body from eye	0231	2.1705	$113.19	$50.94	$22.64
65235	T		Remove foreign body from eye	0233	13.4202	$699.88	$266.33	$139.98
65260	T		Remove foreign body from eye	0236	19.4278	$1,013.18		$202.64
65265	T		Remove foreign body from eye	0236	19.4278	$1,013.18		$202.64
65270	T		Repair of eye wound	0240	16.3078	$850.47	$315.31	$170.09
65272	T		Repair of eye wound	0233	13.4202	$699.88	$266.33	$139.98
65273	C		Repair of eye wound					
65275	T		Repair of eye wound	0233	13.4202	$699.88	$266.33	$139.98
65280	T		Repair of eye wound	0234	20.4259	$1,065.23	$511.31	$213.05
65285	T		Repair of eye wound	0234	20.4259	$1,065.23	$511.31	$213.05
65286	T		Repair of eye wound	0233	13.4202	$699.88	$266.33	$139.98
65290	T		Repair of eye socket wound	0243	19.9705	$1,041.48	$431.39	$208.30
65400	T		Removal of eye lesion	0233	13.4202	$699.88	$266.33	$139.98
65410	T		Biopsy of cornea	0233	13.4202	$699.88	$266.33	$139.98

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
65420	T		Removal of eye lesion	0233	13.4202	$699.88	$266.33	$139.98
65426	T		Removal of eye lesion	0234	20.4259	$1,065.23	$511.31	$213.05
65430	S		Corneal smear	0230	0.7364	$38.40	$14.97	$7.68
65435	T		Curette/treat cornea	0239	6.8119	$355.25	$115.94	$71.05
65436	T		Curette/treat cornea	0233	13.4202	$699.88	$266.33	$139.98
65450	S		Treatment of corneal lesion	0231	2.1705	$113.19	$50.94	$22.64
65600	T		Revision of cornea	0240	16.3078	$850.47	$315.31	$170.09
65710	T		Corneal transplant	0244	35.6290	$1,858.09	$803.26	$371.62
65730	T		Corneal transplant	0244	35.6290	$1,858.09	$803.26	$371.62
65750	T		Corneal transplant	0244	35.6290	$1,858.09	$803.26	$371.62
65755	T		Corneal transplant	0244	35.6290	$1,858.09	$803.26	$371.62
65760	E		Revision of cornea					
65765	E		Revision of cornea					
65767	E		Corneal tissue transplant					
65770	T		Revise cornea with implant	0244	35.6290	$1,858.09	$803.26	$371.62
65771	E		Radial keratotomy					
65772	T		Correction of astigmatism	0233	13.4202	$699.88	$266.33	$139.98
65775	T		Correction of astigmatism	0233	13.4202	$699.88	$266.33	$139.98
65800	T		Drainage of eye	0233	13.4202	$699.88	$266.33	$139.98
65805	T		Drainage of eye	0233	13.4202	$699.88	$266.33	$139.98
65810	T		Drainage of eye	0234	20.4259	$1,065.23	$511.31	$213.05
65815	T		Drainage of eye	0234	20.4259	$1,065.23	$511.31	$213.05
65820	T		Relieve inner eye pressure	0232	4.4960	$234.47	$103.17	$46.89
65850	T		Incision of eye	0234	20.4259	$1,065.23	$511.31	$213.05
65855	T		Laser surgery of eye	0247	4.7092	$245.59	$104.31	$49.12
65860	T		Incise inner eye adhesions	0247	4.7092	$245.59	$104.31	$49.12
65865	T		Incise inner eye adhesions	0233	13.4202	$699.88	$266.33	$139.98
65870	T		Incise inner eye adhesions	0234	20.4259	$1,065.23	$511.31	$213.05
65875	T		Incise inner eye adhesions	0234	20.4259	$1,065.23	$511.31	$213.05
65880	T		Incise inner eye adhesions	0233	13.4202	$699.88	$266.33	$139.98
65900	T		Remove eye lesion	0233	13.4202	$699.88	$266.33	$139.98
65920	T		Remove implant of eye	0233	13.4202	$699.88	$266.33	$139.98
65930	T		Remove blood clot from eye	0234	20.4259	$1,065.23	$511.31	$213.05
66020	T		Injection treatment of eye	0233	13.4202	$699.88	$266.33	$139.98
66030	T		Injection treatment of eye	0233	13.4202	$699.88	$266.33	$139.98
66130	T		Remove eye lesion	0234	20.4259	$1,065.23	$511.31	$213.05
66150	T		Glaucoma surgery	0233	13.4202	$699.88	$266.33	$139.98
66155	T		Glaucoma surgery	0234	20.4259	$1,065.23	$511.31	$213.05
66160	T		Glaucoma surgery	0234	20.4259	$1,065.23	$511.31	$213.05
66165	T		Glaucoma surgery	0234	20.4259	$1,065.23	$511.31	$213.05
66170	T		Glaucoma surgery	0234	20.4259	$1,065.23	$511.31	$213.05
66172	T		Incision of eye	0673	25.9490	$1,353.27	$649.56	$270.65
66180	T		Implant eye shunt	0673	25.9490	$1,353.27	$649.56	$270.65
66185	T		Revise eye shunt	0673	25.9490	$1,353.27	$649.56	$270.65
66220	T		Repair eye lesion	0236	19.4278	$1,013.18		$202.64
66225	T		Repair/graft eye lesion	0673	25.9490	$1,353.27	$649.56	$270.65
66250	T		Follow-up surgery of eye	0233	13.4202	$699.88	$266.33	$139.98
66500	T		Incision of iris	0232	4.4960	$234.47	$103.17	$46.89
66505	T		Incision of iris	0232	4.4960	$234.47	$103.17	$46.89
66600	T		Remove iris and lesion	0233	13.4202	$699.88	$266.33	$139.98
66605	T		Removal of iris	0234	20.4259	$1,065.23	$511.31	$213.05
66625	T		Removal of iris	0233	13.4202	$699.88	$266.33	$139.98
66630	T		Removal of iris	0233	13.4202	$699.88	$266.33	$139.98
66635	T		Removal of iris	0234	20.4259	$1,065.23	$511.31	$213.05
66680	T		Repair iris & ciliary body	0234	20.4259	$1,065.23	$511.31	$213.05
66682	T		Repair iris & ciliary body	0234	20.4259	$1,065.23	$511.31	$213.05
66700	T		Destruction, ciliary body	0233	13.4202	$699.88	$266.33	$139.98
66710	T		Destruction, ciliary body	0233	13.4202	$699.88	$266.33	$139.98
66720	T		Destruction, ciliary body	0233	13.4202	$699.88	$266.33	$139.98
66740	T		Destruction, ciliary body	0233	13.4202	$699.88	$266.33	$139.98
66761	T		Revision of iris	0247	4.7092	$245.59	$104.31	$49.12
66762	T		Revision of iris	0247	4.7092	$245.59	$104.31	$49.12
66770	T		Removal of inner eye lesion	0247	4.7092	$245.59	$104.31	$49.12
66820	T		Incision, secondary cataract	0232	4.4960	$234.47	$103.17	$46.89
66821	T		After cataract laser surgery	0247	4.7092	$245.59	$104.31	$49.12

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
66825	T		Reposition intraocular lens	0234	20.4259	$1,065.23	$511.31	$213.05
66830	T		Removal of lens lesion	0232	4.4960	$234.47	$103.17	$46.89
66840	T		Removal of lens material	0245	14.5442	$758.49	$251.21	$151.70
66850	T		Removal of lens material	0249	26.7242	$1,393.69	$524.67	$278.74
66852	T		Removal of lens material	0249	26.7242	$1,393.69	$524.67	$278.74
66920	T		Extraction of lens	0249	26.7242	$1,393.69	$524.67	$278.74
66930	T		Extraction of lens	0249	26.7242	$1,393.69	$524.67	$278.74
66940	T		Extraction of lens	0245	14.5442	$758.49	$251.21	$151.70
66982	T		Cataract surgery, complex	0246	22.2379	$1,159.73	$495.96	$231.95
66983	T		Cataract surg w/iol, 1 stage	0246	22.2379	$1,159.73	$495.96	$231.95
66984	T		Cataract surg w/iol, 1 stage	0246	22.2379	$1,159.73	$495.96	$231.95
66985	T		Insert lens prosthesis	0246	22.2379	$1,159.73	$495.96	$231.95
66986	T		Exchange lens prosthesis	0246	22.2379	$1,159.73	$495.96	$231.95
66990	N	NI	Ophthalmic endoscope add-on					
66999	T		Eye surgery procedure	0232	4.4960	$234.47	$103.17	$46.89
67005	T		Partial removal of eye fluid	0237	33.2647	$1,734.79	$818.54	$346.96
67010	T		Partial removal of eye fluid	0237	33.2647	$1,734.79	$818.54	$346.96
67015	T		Release of eye fluid	0237	33.2647	$1,734.79	$818.54	$346.96
67025	T		Replace eye fluid	0236	19.4278	$1,013.18		$202.64
67027	T		Implant eye drug system	0237	33.2647	$1,734.79	$818.54	$346.96
67028	T		Injection eye drug	0235	5.0871	$265.30	$73.44	$53.06
67030	T		Incise inner eye strands	0236	19.4278	$1,013.18		$202.64
67031	T		Laser surgery, eye strands	0247	4.7092	$245.59	$104.31	$49.12
67036	T		Removal of inner eye fluid	0237	33.2647	$1,734.79	$818.54	$346.96
67038	T		Strip retinal membrane	0237	33.2647	$1,734.79	$818.54	$346.96
67039	T		Laser treatment of retina	0237	33.2647	$1,734.79	$818.54	$346.96
67040	T		Laser treatment of retina	0672	37.9061	$1,976.84	$988.43	$395.37
67101	T		Repair detached retina	0235	5.0871	$265.30	$73.44	$53.06
67105	T		Repair detached retina	0248	4.2925	$223.86	$95.08	$44.77
67107	T		Repair detached retina	0672	37.9061	$1,976.84	$988.43	$395.37
67108	T		Repair detached retina	0672	37.9061	$1,976.84	$988.43	$395.37
67110	T		Repair detached retina	0235	5.0871	$265.30	$73.44	$53.06
67112	T		Rerepair detached retina	0672	37.9061	$1,976.84	$988.43	$395.37
67115	T		Release encircling material	0236	19.4278	$1,013.18		$202.64
67120	T		Remove eye implant material	0236	19.4278	$1,013.18		$202.64
67121	T		Remove eye implant material	0237	33.2647	$1,734.79	$818.54	$346.96
67141	T		Treatment of retina	0235	5.0871	$265.30	$73.44	$53.06
67145	T		Treatment of retina	0248	4.2925	$223.86	$95.08	$44.77
67208	T		Treatment of retinal lesion	0235	5.0871	$265.30	$73.44	$53.06
67210	T		Treatment of retinal lesion	0248	4.2925	$223.86	$95.08	$44.77
67218	T		Treatment of retinal lesion	0236	19.4278	$1,013.18		$202.64
67220	T		Treatment of choroid lesion	0235	5.0871	$265.30	$73.44	$53.06
67221	T		Ocular photodynamic ther	0235	5.0871	$265.30	$73.44	$53.06
67225	T		Eye photodynamic ther add-on	0235	5.0871	$265.30	$73.44	$53.06
67227	T		Treatment of retinal lesion	0235	5.0871	$265.30	$73.44	$53.06
67228	T		Treatment of retinal lesion	0248	4.2925	$223.86	$95.08	$44.77
67250	T		Reinforce eye wall	0240	16.3078	$850.47	$315.31	$170.09
67255	T		Reinforce/graft eye wall	0237	33.2647	$1,734.79	$818.54	$346.96
67299	T		Eye surgery procedure	0235	5.0871	$265.30	$73.44	$53.06
67311	T		Revise eye muscle	0243	19.9705	$1,041.48	$431.39	$208.30
67312	T		Revise two eye muscles	0243	19.9705	$1,041.48	$431.39	$208.30
67314	T		Revise eye muscle	0243	19.9705	$1,041.48	$431.39	$208.30
67316	T		Revise two eye muscles	0243	19.9705	$1,041.48	$431.39	$208.30
67318	T		Revise eye muscle(s)	0243	19.9705	$1,041.48	$431.39	$208.30
67320	T		Revise eye muscle(s) add-on	0243	19.9705	$1,041.48	$431.39	$208.30
67331	T		Eye surgery follow-up add-on	0243	19.9705	$1,041.48	$431.39	$208.30
67332	T		Rerevise eye muscles add-on	0243	19.9705	$1,041.48	$431.39	$208.30
67334	T		Revise eye muscle w/suture	0243	19.9705	$1,041.48	$431.39	$208.30
67335	T		Eye suture during surgery	0243	19.9705	$1,041.48	$431.39	$208.30
67340	T		Revise eye muscle add-on	0243	19.9705	$1,041.48	$431.39	$208.30
67343	T		Release eye tissue	0243	19.9705	$1,041.48	$431.39	$208.30
67345	T		Destroy nerve of eye muscle	0238	2.9747	$155.13	$58.96	$31.03
67350	T		Biopsy eye muscle	0699	3.7596	$196.07	$88.23	$39.21
67399	T		Eye muscle surgery procedure	0243	19.9705	$1,041.48	$431.39	$208.30
67400	T		Explore/biopsy eye socket	0241	20.6294	$1,075.84	$384.47	$215.17

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67405	T		Explore/drain eye socket	0241	20.6294	$1,075.84	$384.47	$215.17
67412	T		Explore/treat eye socket	0241	20.6294	$1,075.84	$384.47	$215.17
67413	T		Explore/treat eye socket	0241	20.6294	$1,075.84	$384.47	$215.17
67414	T		Explr/decompress eye socket	0242	28.0517	$1,462.92	$597.36	$292.58
67415	T		Aspiration, orbital contents	0239	6.8119	$355.25	$115.94	$71.05
67420	T		Explore/treat eye socket	0242	28.0517	$1,462.92	$597.36	$292.58
67430	T		Explore/treat eye socket	0242	28.0517	$1,462.92	$597.36	$292.58
67440	T		Explore/drain eye socket	0242	28.0517	$1,462.92	$597.36	$292.58
67445	T		Explr/decompress eye socket	0242	28.0517	$1,462.92	$597.36	$292.58
67450	T		Explore/biopsy eye socket	0242	28.0517	$1,462.92	$597.36	$292.58
67500	S		Inject/treat eye socket	0231	2.1705	$113.19	$50.94	$22.64
67505	T		Inject/treat eye socket	0238	2.9747	$155.13	$58.96	$31.03
67515	T		Inject/treat eye socket	0239	6.8119	$355.25	$115.94	$71.05
67550	T		Insert eye socket implant	0242	28.0517	$1,462.92	$597.36	$292.58
67560	T		Revise eye socket implant	0241	20.6294	$1,075.84	$384.47	$215.17
67570	T		Decompress optic nerve	0242	28.0517	$1,462.92	$597.36	$292.58
67599	T		Orbit surgery procedure	0239	6.8119	$355.25	$115.94	$71.05
67700	T		Drainage of eyelid abscess	0238	2.9747	$155.13	$58.96	$31.03
67710	T		Incision of eyelid	0239	6.8119	$355.25	$115.94	$71.05
67715	T		Incision of eyelid fold	0240	16.3078	$850.47	$315.31	$170.09
67800	T		Remove eyelid lesion	0238	2.9747	$155.13	$58.96	$31.03
67801	T		Remove eyelid lesions	0239	6.8119	$355.25	$115.94	$71.05
67805	T		Remove eyelid lesions	0238	2.9747	$155.13	$58.96	$31.03
67808	T		Remove eyelid lesion(s)	0240	16.3078	$850.47	$315.31	$170.09
67810	T		Biopsy of eyelid	0238	2.9747	$155.13	$58.96	$31.03
67820	S		Revise eyelashes	0230	0.7364	$38.40	$14.97	$7.68
67825	T		Revise eyelashes	0238	2.9747	$155.13	$58.96	$31.03
67830	T		Revise eyelashes	0239	6.8119	$355.25	$115.94	$71.05
67835	T		Revise eyelashes	0240	16.3078	$850.47	$315.31	$170.09
67840	T		Remove eyelid lesion	0239	6.8119	$355.25	$115.94	$71.05
67850	T		Treat eyelid lesion	0239	6.8119	$355.25	$115.94	$71.05
67875	T		Closure of eyelid by suture	0239	6.8119	$355.25	$115.94	$71.05
67880	T		Revision of eyelid	0233	13.4202	$699.88	$266.33	$139.98
67882	T		Revision of eyelid	0240	16.3078	$850.47	$315.31	$170.09
67900	T		Repair brow defect	0240	16.3078	$850.47	$315.31	$170.09
67901	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67902	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67903	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67904	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67906	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67908	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67909	T		Revise eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67911	T		Revise eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67914	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67915	T		Repair eyelid defect	0239	6.8119	$355.25	$115.94	$71.05
67916	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67917	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67921	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67922	T		Repair eyelid defect	0239	6.8119	$355.25	$115.94	$71.05
67923	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67924	T		Repair eyelid defect	0240	16.3078	$850.47	$315.31	$170.09
67930	T		Repair eyelid wound	0240	16.3078	$850.47	$315.31	$170.09
67935	T		Repair eyelid wound	0240	16.3078	$850.47	$315.31	$170.09
67938	S		Remove eyelid foreign body	0698	0.9205	$48.00	$18.72	$9.60
67950	T		Revision of eyelid	0240	16.3078	$850.47	$315.31	$170.09
67961	T		Revision of eyelid	0240	16.3078	$850.47	$315.31	$170.09
67966	T		Revision of eyelid	0240	16.3078	$850.47	$315.31	$170.09
67971	T		Reconstruction of eyelid	0241	20.6294	$1,075.84	$384.47	$215.17
67973	T		Reconstruction of eyelid	0241	20.6294	$1,075.84	$384.47	$215.17
67974	T		Reconstruction of eyelid	0241	20.6294	$1,075.84	$384.47	$215.17
67975	T		Reconstruction of eyelid	0240	16.3078	$850.47	$315.31	$170.09
67999	T		Revision of eyelid	0240	16.3078	$850.47	$315.31	$170.09
68020	T		Incise/drain eyelid lining	0240	16.3078	$850.47	$315.31	$170.09
68040	S		Treatment of eyelid lesions	0698	0.9205	$48.00	$18.72	$9.60
68100	T		Biopsy of eyelid lining	0232	4.4960	$234.47	$103.17	$46.89

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
68110	T		Remove eyelid lining lesion	0699	3.7596	$196.07	$88.23	$39.21
68115	T		Remove eyelid lining lesion	0239	6.8119	$355.25	$115.94	$71.05
68130	T		Remove eyelid lining lesion	0233	13.4202	$699.88	$266.33	$139.98
68135	T		Remove eyelid lining lesion	0239	6.8119	$355.25	$115.94	$71.05
68200	S		Treat eyelid by injection	0698	0.9205	$48.00	$18.72	$9.60
68320	T		Revise/graft eyelid lining	0240	16.3078	$850.47	$315.31	$170.09
68325	T		Revise/graft eyelid lining	0242	28.0517	$1,462.92	$597.36	$292.58
68326	T		Revise/graft eyelid lining	0241	20.6294	$1,075.84	$384.47	$215.17
68328	T		Revise/graft eyelid lining	0241	20.6294	$1,075.84	$384.47	$215.17
68330	T		Revise eyelid lining	0233	13.4202	$699.88	$266.33	$139.98
68335	T		Revise/graft eyelid lining	0241	20.6294	$1,075.84	$384.47	$215.17
68340	T		Separate eyelid adhesions	0240	16.3078	$850.47	$315.31	$170.09
68360	T		Revise eyelid lining	0234	20.4259	$1,065.23	$511.31	$213.05
68362	T		Revise eyelid lining	0234	20.4259	$1,065.23	$511.31	$213.05
68399	T		Eyelid lining surgery	0239	6.8119	$355.25	$115.94	$71.05
68400	T		Incise/drain tear gland	0238	2.9747	$155.13	$58.96	$31.03
68420	T		Incise/drain tear sac	0240	16.3078	$850.47	$315.31	$170.09
68440	T		Incise tear duct opening	0238	2.9747	$155.13	$58.96	$31.03
68500	T		Removal of tear gland	0241	20.6294	$1,075.84	$384.47	$215.17
68505	T		Partial removal, tear gland	0241	20.6294	$1,075.84	$384.47	$215.17
68510	T		Biopsy of tear gland	0240	16.3078	$850.47	$315.31	$170.09
68520	T		Removal of tear sac	0241	20.6294	$1,075.84	$384.47	$215.17
68525	T		Biopsy of tear sac	0240	16.3078	$850.47	$315.31	$170.09
68530	T		Clearance of tear duct	0240	16.3078	$850.47	$315.31	$170.09
68540	T		Remove tear gland lesion	0241	20.6294	$1,075.84	$384.47	$215.17
68550	T		Remove tear gland lesion	0242	28.0517	$1,462.92	$597.36	$292.58
68700	T		Repair tear ducts	0241	20.6294	$1,075.84	$384.47	$215.17
68705	T		Revise tear duct opening	0238	2.9747	$155.13	$58.96	$31.03
68720	T		Create tear sac drain	0242	28.0517	$1,462.92	$597.36	$292.58
68745	T		Create tear duct drain	0241	20.6294	$1,075.84	$384.47	$215.17
68750	T		Create tear duct drain	0242	28.0517	$1,462.92	$597.36	$292.58
68760	S		Close tear duct opening	0698	0.9205	$48.00	$18.72	$9.60
68761	S		Close tear duct opening	0231	2.1705	$113.19	$50.94	$22.64
68770	T		Close tear system fistula	0240	16.3078	$850.47	$315.31	$170.09
68801	S		Dilate tear duct opening	0231	2.1705	$113.19	$50.94	$22.64
68810	T		Probe nasolacrimal duct	0699	3.7596	$196.07	$88.23	$39.21
68811	T		Probe nasolacrimal duct	0240	16.3078	$850.47	$315.31	$170.09
68815	T		Probe nasolacrimal duct	0240	16.3078	$850.47	$315.31	$170.09
68840	T		Explore/irrigate tear ducts	0699	3.7596	$196.07	$88.23	$39.21
68850	N		Injection for tear sac x-ray					
68899	T		Tear duct system surgery	0699	3.7596	$196.07	$88.23	$39.21
69000	T		Drain external ear lesion	0006	1.7926	$93.49	$24.12	$18.70
69005	T		Drain external ear lesion	0007	10.0191	$522.51	$108.89	$104.50
69020	T		Drain outer ear canal lesion	0006	1.7926	$93.49	$24.12	$18.70
69090	E		Pierce earlobes					
69100	T		Biopsy of external ear	0019	3.7693	$196.57	$71.87	$39.31
69105	T		Biopsy of external ear canal	0253	14.4473	$753.44	$282.29	$150.69
69110	T		Remove external ear, partial	0021	13.9338	$726.66	$219.48	$145.33
69120	T		Removal of external ear	0254	20.1158	$1,049.06	$321.35	$209.81
69140	T		Remove ear canal lesion(s)	0254	20.1158	$1,049.06	$321.35	$209.81
69145	T		Remove ear canal lesion(s)	0021	13.9338	$726.66	$219.48	$145.33
69150	T		Extensive ear canal surgery	0252	5.8041	$302.69	$113.41	$60.54
69155	C		Extensive ear/neck surgery					
69200	X		Clear outer ear canal	0340	0.6492	$33.86		$6.77
69205	T		Clear outer ear canal	0022	17.3930	$907.06	$354.45	$181.41
69210	X		Remove impacted ear wax	0340	0.6492	$33.86		$6.77
69220	T		Clean out mastoid cavity	0012	0.7849	$40.93	$11.18	$8.19
69222	T		Clean out mastoid cavity	0253	14.4473	$753.44	$282.29	$150.69
69300	T		Revise external ear	0254	20.1158	$1,049.06	$321.35	$209.81
69310	T		Rebuild outer ear canal	0256	34.0302	$1,774.71		$354.94
69320	T		Rebuild outer ear canal	0256	34.0302	$1,774.71		$354.94
69399	T		Outer ear surgery procedure	0251	1.9089	$99.55		$19.91
69400	T		Inflate middle ear canal	0251	1.9089	$99.55		$19.91
69401	T		Inflate middle ear canal	0251	1.9089	$99.55		$19.91
69405	T		Catheterize middle ear canal	0252	5.8041	$302.69	$113.41	$60.54

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69410	T		Inset middle ear (baffle)	0252	5.8041	$302.69	$113.41	$60.54
69420	T		Incision of eardrum	0251	1.9089	$99.55		$19.91
69421	T		Incision of eardrum	0253	14.4473	$753.44	$282.29	$150.69
69424	T		Remove ventilating tube	0252	5.8041	$302.69	$113.41	$60.54
69433	T		Create eardrum opening	0252	5.8041	$302.69	$113.41	$60.54
69436	T		Create eardrum opening	0253	14.4473	$753.44	$282.29	$150.69
69440	T		Exploration of middle ear	0254	20.1158	$1,049.06	$321.35	$209.81
69450	T		Eardrum revision	0256	34.0302	$1,774.71		$354.94
69501	T		Mastoidectomy	0256	34.0302	$1,774.71		$354.94
69502	T		Mastoidectomy	0254	20.1158	$1,049.06	$321.35	$209.81
69505	T		Remove mastoid structures	0256	34.0302	$1,774.71		$354.94
69511	T		Extensive mastoid surgery	0256	34.0302	$1,774.71		$354.94
69530	T		Extensive mastoid surgery	0256	34.0302	$1,774.71		$354.94
69535	C		Remove part of temporal bone					
69540	T		Remove ear lesion	0253	14.4473	$753.44	$282.29	$150.69
69550	T		Remove ear lesion	0256	34.0302	$1,774.71		$354.94
69552	T		Remove ear lesion	0256	34.0302	$1,774.71		$354.94
69554	C		Remove ear lesion					
69601	T		Mastoid surgery revision	0256	34.0302	$1,774.71		$354.94
69602	T		Mastoid surgery revision	0256	34.0302	$1,774.71		$354.94
69603	T		Mastoid surgery revision	0256	34.0302	$1,774.71		$354.94
69604	T		Mastoid surgery revision	0256	34.0302	$1,774.71		$354.94
69605	T		Mastoid surgery revision	0256	34.0302	$1,774.71		$354.94
69610	T		Repair of eardrum	0254	20.1158	$1,049.06	$321.35	$209.81
69620	T		Repair of eardrum	0254	20.1158	$1,049.06	$321.35	$209.81
69631	T		Repair eardrum structures	0256	34.0302	$1,774.71		$354.94
69632	T		Rebuild eardrum structures	0256	34.0302	$1,774.71		$354.94
69633	T		Rebuild eardrum structures	0256	34.0302	$1,774.71		$354.94
69635	T		Repair eardrum structures	0256	34.0302	$1,774.71		$354.94
69636	T		Rebuild eardrum structures	0256	34.0302	$1,774.71		$354.94
69637	T		Rebuild eardrum structures	0256	34.0302	$1,774.71		$354.94
69641	T		Revise middle ear & mastoid	0256	34.0302	$1,774.71		$354.94
69642	T		Revise middle ear & mastoid	0256	34.0302	$1,774.71		$354.94
69643	T		Revise middle ear & mastoid	0256	34.0302	$1,774.71		$354.94
69644	T		Revise middle ear & mastoid	0256	34.0302	$1,774.71		$354.94
69645	T		Revise middle ear & mastoid	0256	34.0302	$1,774.71		$354.94
69646	T		Revise middle ear & mastoid	0256	34.0302	$1,774.71		$354.94
69650	T		Release middle ear bone	0254	20.1158	$1,049.06	$321.35	$209.81
69660	T		Revise middle ear bone	0256	34.0302	$1,774.71		$354.94
69661	T		Revise middle ear bone	0256	34.0302	$1,774.71		$354.94
69662	T		Revise middle ear bone	0256	34.0302	$1,774.71		$354.94
69666	T		Repair middle ear structures	0256	34.0302	$1,774.71		$354.94
69667	T		Repair middle ear structures	0256	34.0302	$1,774.71		$354.94
69670	T		Remove mastoid air cells	0256	34.0302	$1,774.71		$354.94
69676	T		Remove middle ear nerve	0256	34.0302	$1,774.71		$354.94
69700	T		Close mastoid fistula	0256	34.0302	$1,774.71		$354.94
69710	E		Implant/replace hearing aid					
69711	T		Remove/repair hearing aid	0256	34.0302	$1,774.71		$354.94
69714	T		Implant temple bone w/stimul	0256	34.0302	$1,774.71		$354.94
69715	T		Temple bne implnt w/stimulat	0256	34.0302	$1,774.71		$354.94
69717	T		Temple bone implant revision	0256	34.0302	$1,774.71		$354.94
69718	T		Revise temple bone implant	0256	34.0302	$1,774.71		$354.94
69720	T		Release facial nerve	0256	34.0302	$1,774.71		$354.94
69725	T		Release facial nerve	0256	34.0302	$1,774.71		$354.94
69740	T		Repair facial nerve	0256	34.0302	$1,774.71		$354.94
69745	T		Repair facial nerve	0256	34.0302	$1,774.71		$354.94
69799	T		Middle ear surgery procedure	0253	14.4473	$753.44	$282.29	$150.69
69801	T		Incise inner ear	0256	34.0302	$1,774.71		$354.94
69802	T		Incise inner ear	0256	34.0302	$1,774.71		$354.94
69805	T		Explore inner ear	0256	34.0302	$1,774.71		$354.94
69806	T		Explore inner ear	0256	34.0302	$1,774.71		$354.94
69820	T		Establish inner ear window	0256	34.0302	$1,774.71		$354.94
69840	T		Revise inner ear window	0256	34.0302	$1,774.71		$354.94
69905	T		Remove inner ear	0256	34.0302	$1,774.71		$354.94
69910	T		Remove inner ear & mastoid	0256	34.0302	$1,774.71		$354.94

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69915	T		Incise inner ear nerve	0256	34.0302	$1,774.71		$354.94
69930	T		Implant cochlear device	0259	367.6466	$19,173.14	$9,394.83	$3,834.63
69949	T		Inner ear surgery procedure	0253	14.4473	$753.44	$282.29	$150.69
69950	C		Incise inner ear nerve					
69955	T		Release facial nerve	0256	34.0302	$1,774.71		$354.94
69960	T		Release inner ear canal	0256	34.0302	$1,774.71		$354.94
69970	C		Remove inner ear lesion					
69979	T		Temporal bone surgery	0251	1.9089	$99.55		$19.91
69990	N		Microsurgery add-on					
70010	S		Contrast x-ray of brain	0274	3.8759	$202.13	$96.54	$40.43
70015	S		Contrast x-ray of brain	0274	3.8759	$202.13	$96.54	$40.43
70030	X		X-ray eye for foreign body	0260	0.7655	$39.92	$21.95	$7.98
70100	X		X-ray exam of jaw	0260	0.7655	$39.92	$21.95	$7.98
70110	X		X-ray exam of jaw	0260	0.7655	$39.92	$21.95	$7.98
70120	X		X-ray exam of mastoids	0260	0.7655	$39.92	$21.95	$7.98
70130	X		X-ray exam of mastoids	0260	0.7655	$39.92	$21.95	$7.98
70134	X		X-ray exam of middle ear	0261	1.2887	$67.21		$13.44
70140	X		X-ray exam of facial bones	0260	0.7655	$39.92	$21.95	$7.98
70150	X		X-ray exam of facial bones	0260	0.7655	$39.92	$21.95	$7.98
70160	X		X-ray exam of nasal bones	0260	0.7655	$39.92	$21.95	$7.98
70170	X		X-ray exam of tear duct	0263	1.8992	$99.05	$43.58	$19.81
70190	X		X-ray exam of eye sockets	0260	0.7655	$39.92	$21.95	$7.98
70200	X		X-ray exam of eye sockets	0260	0.7655	$39.92	$21.95	$7.98
70210	X		X-ray exam of sinuses	0260	0.7655	$39.92	$21.95	$7.98
70220	X		X-ray exam of sinuses	0260	0.7655	$39.92	$21.95	$7.98
70240	X		X-ray exam, pituitary saddle	0260	0.7655	$39.92	$21.95	$7.98
70250	X		X-ray exam of skull	0260	0.7655	$39.92	$21.95	$7.98
70260	X		X-ray exam of skull	0261	1.2887	$67.21		$13.44
70300	X		X-ray exam of teeth	0262	0.5717	$29.81	$9.82	$5.96
70310	X		X-ray exam of teeth	0262	0.5717	$29.81	$9.82	$5.96
70320	X		Full mouth x-ray of teeth	0262	0.5717	$29.81	$9.82	$5.96
70328	X		X-ray exam of jaw joint	0260	0.7655	$39.92	$21.95	$7.98
70330	X		X-ray exam of jaw joints	0260	0.7655	$39.92	$21.95	$7.98
70332	S		X-ray exam of jaw joint	0275	2.9747	$155.13	$69.09	$31.03
70336	S		Magnetic image, jaw joint	0335	6.2983	$328.46	$151.46	$65.69
70350	X		X-ray head for orthodontia	0260	0.7655	$39.92	$21.95	$7.98
70355	X		Panoramic x-ray of jaws	0260	0.7655	$39.92	$21.95	$7.98
70360	X		X-ray exam of neck	0260	0.7655	$39.92	$21.95	$7.98
70370	X		Throat x-ray & fluoroscopy	0272	1.3372	$69.74	$38.36	$13.95
70371	X		Speech evaluation, complex	0272	1.3372	$69.74	$38.36	$13.95
70373	X		Contrast x-ray of larynx	0263	1.8992	$99.05	$43.58	$19.81
70380	X		X-ray exam of salivary gland	0260	0.7655	$39.92	$21.95	$7.98
70390	X		X-ray exam of salivary duct	0264	2.8197	$147.05	$79.41	$29.41
70450	S		Ct head/brain w/o dye	0332	3.4398	$179.39	$91.27	$35.88
70460	S		Ct head/brain w/dye	0283	4.5057	$234.98	$126.27	$47.00
70470	S		Ct head/brain w/o&w dye	0333	5.3681	$279.95	$146.98	$55.99
70480	S		Ct orbit/ear/fossa w/o dye	0332	3.4398	$179.39	$91.27	$35.88
70481	S		Ct orbit/ear/fossa w/dye	0283	4.5057	$234.98	$126.27	$47.00
70482	S		Ct orbit/ear/fossa w/o&w dye	0333	5.3681	$279.95	$146.98	$55.99
70486	S		Ct maxillofacial w/o dye	0332	3.4398	$179.39	$91.27	$35.88
70487	S		Ct maxillofacial w/dye	0283	4.5057	$234.98	$126.27	$47.00
70488	S		Ct maxillofacial w/o&w dye	0333	5.3681	$279.95	$146.98	$55.99
70490	S		Ct soft tissue neck w/o dye	0332	3.4398	$179.39	$91.27	$35.88
70491	S		Ct soft tissue neck w/dye	0283	4.5057	$234.98	$126.27	$47.00
70492	S		Ct sft tsue nck w/o & w/dye	0333	5.3681	$279.95	$146.98	$55.99
70496	S		Ct angiography, head	0662	5.4553	$284.50	$156.47	$56.90
70498	S		Ct angiography, neck	0662	5.4553	$284.50	$156.47	$56.90
70540	S		Mri orbit/face/neck w/o dye	0336	6.5987	$344.13	$176.94	$68.83
70542	S		Mri orbit/face/neck w/dye	0284	7.2382	$377.48	$201.02	$75.50
70543	S		Mri orbt/fac/nck w/o&w dye	0337	9.2440	$482.08	$240.77	$96.42
70544	S		Mr angiography head w/o dye	0336	6.5987	$344.13	$176.94	$68.83
70545	S		Mr angiography head w/dye	0284	7.2382	$377.48	$201.02	$75.50
70546	S		Mr angiograph head w/o&w dye	0337	9.2440	$482.08	$240.77	$96.42
70547	S		Mr angiography neck w/o dye	0336	6.5987	$344.13	$176.94	$68.83
70548	S		Mr angiography neck w/dye	0284	7.2382	$377.48	$201.02	$75.50

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
70549	S		Mr angiograph neck w/o&w dye	0337	9.2440	$482.08	$240.77	$96.42
70551	S		Mri brain w/o dye	0336	6.5987	$344.13	$176.94	$68.83
70552	S		Mri brain w/dye	0284	7.2382	$377.48	$201.02	$75.50
70553	S		Mri brain w/o&w dye	0337	9.2440	$482.08	$240.77	$96.42
71010	X		Chest x-ray	0260	0.7655	$39.92	$21.95	$7.98
71015	X		Chest x-ray	0260	0.7655	$39.92	$21.95	$7.98
71020	X		Chest x-ray	0260	0.7655	$39.92	$21.95	$7.98
71021	X		Chest x-ray	0260	0.7655	$39.92	$21.95	$7.98
71022	X		Chest x-ray	0260	0.7655	$39.92	$21.95	$7.98
71023	X		Chest x-ray and fluoroscopy	0272	1.3372	$69.74	$38.36	$13.95
71030	X		Chest x-ray	0260	0.7655	$39.92	$21.95	$7.98
71034	X		Chest x-ray and fluoroscopy	0272	1.3372	$69.74	$38.36	$13.95
71035	X		Chest x-ray	0260	0.7655	$39.92	$21.95	$7.98
71040	X		Contrast x-ray of bronchi	0263	1.8992	$99.05	$43.58	$19.81
71060	X		Contrast x-ray of bronchi	0264	2.8197	$147.05	$79.41	$29.41
71090	X		X-ray & pacemaker insertion	0272	1.3372	$69.74	$38.36	$13.95
71100	X		X-ray exam of ribs	0260	0.7655	$39.92	$21.95	$7.98
71101	X		X-ray exam of ribs/chest	0260	0.7655	$39.92	$21.95	$7.98
71110	X		X-ray exam of ribs	0260	0.7655	$39.92	$21.95	$7.98
71111	X		X-ray exam of ribs/ chest	0261	1.2887	$67.21		$13.44
71120	X		X-ray exam of breastbone	0260	0.7655	$39.92	$21.95	$7.98
71130	X		X-ray exam of breastbone	0260	0.7655	$39.92	$21.95	$7.98
71250	S		Ct thorax w/o dye	0332	3.4398	$179.39	$91.27	$35.88
71260	S		Ct thorax w/dye	0283	4.5057	$234.98	$126.27	$47.00
71270	S		Ct thorax w/o&w dye	0333	5.3681	$279.95	$146.98	$55.99
71275	S		Ct angiography, chest	0662	5.4553	$284.50	$156.47	$56.90
71550	S		Mri chest w/o dye	0336	6.5987	$344.13	$176.94	$68.83
71551	S		Mri chest w/dye	0284	7.2382	$377.48	$201.02	$75.50
71552	S		Mri chest w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
71555	E		Mri angio chest w or w/o dye					
72010	X		X-ray exam of spine	0261	1.2887	$67.21		$13.44
72020	X		X-ray exam of spine	0260	0.7655	$39.92	$21.95	$7.98
72040	X		X-ray exam of neck spine	0260	0.7655	$39.92	$21.95	$7.98
72050	X		X-ray exam of neck spine	0261	1.2887	$67.21		$13.44
72052	X		X-ray exam of neck spine	0261	1.2887	$67.21		$13.44
72069	X		X-ray exam of trunk spine	0260	0.7655	$39.92	$21.95	$7.98
72070	X		X-ray exam of thoracic spine	0260	0.7655	$39.92	$21.95	$7.98
72072	X		X-ray exam of thoracic spine	0260	0.7655	$39.92	$21.95	$7.98
72074	X		X-ray exam of thoracic spine	0260	0.7655	$39.92	$21.95	$7.98
72080	X		X-ray exam of trunk spine	0260	0.7655	$39.92	$21.95	$7.98
72090	X		X-ray exam of trunk spine	0261	1.2887	$67.21		$13.44
72100	X		X-ray exam of lower spine	0260	0.7655	$39.92	$21.95	$7.98
72110	X		X-ray exam of lower spine	0261	1.2887	$67.21		$13.44
72114	X		X-ray exam of lower spine	0261	1.2887	$67.21		$13.44
72120	X		X-ray exam of lower spine	0260	0.7655	$39.92	$21.95	$7.98
72125	S		Ct neck spine w/o dye	0332	3.4398	$179.39	$91.27	$35.88
72126	S		Ct neck spine w/dye	0283	4.5057	$234.98	$126.27	$47.00
72127	S		Ct neck spine w/o&w/dye	0333	5.3681	$279.95	$146.98	$55.99
72128	S		Ct chest spine w/o dye	0332	3.4398	$179.39	$91.27	$35.88
72129	S		Ct chest spine w/dye	0283	4.5057	$234.98	$126.27	$47.00
72130	S		Ct chest spine w/o&w/dye	0333	5.3681	$279.95	$146.98	$55.99
72131	S		Ct lumbar spine w/o dye	0332	3.4398	$179.39	$91.27	$35.88
72132	S		Ct lumbar spine w/dye	0283	4.5057	$234.98	$126.27	$47.00
72133	S		Ct lumbar spine w/o&w/dye	0333	5.3681	$279.95	$146.98	$55.99
72141	S		Mri neck spine w/o dye	0336	6.5987	$344.13	$176.94	$68.83
72142	S		Mri neck spine w/dye	0284	7.2382	$377.48	$201.02	$75.50
72146	S		Mri chest spine w/o dye	0336	6.5987	$344.13	$176.94	$68.83
72147	S		Mri chest spine w/dye	0284	7.2382	$377.48	$201.02	$75.50
72148	S		Mri lumbar spine w/o dye	0336	6.5987	$344.13	$176.94	$68.83
72149	S		Mri lumbar spine w/dye	0284	7.2382	$377.48	$201.02	$75.50
72156	S		Mri neck spine w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
72157	S		Mri chest spine w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
72158	S		Mri lumbar spine w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
72159	E		Mr angio spine w/o&w/dye					
72170	X		X-ray exam of pelvis	0260	0.7655	$39.92	$21.95	$7.98

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
72190	X		X-ray exam of pelvis	0260	0.7655	$39.92	$21.95	$7.98
72191	S		Ct angiograph pelv w/o&w/dye	0662	5.4553	$284.50	$156.47	$56.90
72192	S		Ct pelvis w/o dye	0332	3.4398	$179.39	$91.27	$35.88
72193	S		Ct pelvis w/dye	0283	4.5057	$234.98	$126.27	$47.00
72194	S		Ct pelvis w/o&w/dye	0333	5.3681	$279.95	$146.98	$55.99
72195	S		Mri pelvis w/o dye	0336	6.5987	$344.13	$176.94	$68.83
72196	S		Mri pelvis w/dye	0284	7.2382	$377.48	$201.02	$75.50
72197	S		Mri pelvis w/o & w/dye	0337	9.2440	$482.08	$240.77	$96.42
72198	E		Mr angio pelvis w/o&w/dye					
72200	X		X-ray exam sacroiliac joints	0260	0.7655	$39.92	$21.95	$7.98
72202	X		X-ray exam sacroiliac joints	0260	0.7655	$39.92	$21.95	$7.98
72220	X		X-ray exam of tailbone	0260	0.7655	$39.92	$21.95	$7.98
72240	S		Contrast x-ray of neck spine	0274	3.8759	$202.13	$96.54	$40.43
72255	S		Contrast x-ray, thorax spine	0274	3.8759	$202.13	$96.54	$40.43
72265	S		Contrast x-ray, lower spine	0274	3.8759	$202.13	$96.54	$40.43
72270	S		Contrast x-ray of spine	0274	3.8759	$202.13	$96.54	$40.43
72275	S		Epidurography	0274	3.8759	$202.13	$96.54	$40.43
72285	S		X-ray c/t spine disk	0274	3.8759	$202.13	$96.54	$40.43
72295	S		X-ray of lower spine disk	0274	3.8759	$202.13	$96.54	$40.43
73000	X		X-ray exam of collar bone	0260	0.7655	$39.92	$21.95	$7.98
73010	X		X-ray exam of shoulder blade	0260	0.7655	$39.92	$21.95	$7.98
73020	X		X-ray exam of shoulder	0260	0.7655	$39.92	$21.95	$7.98
73030	X		X-ray exam of shoulder	0260	0.7655	$39.92	$21.95	$7.98
73040	S		Contrast x-ray of shoulder	0275	2.9747	$155.13	$69.09	$31.03
73050	X		X-ray exam of shoulders	0260	0.7655	$39.92	$21.95	$7.98
73060	X		X-ray exam of humerus	0260	0.7655	$39.92	$21.95	$7.98
73070	X		X-ray exam of elbow	0260	0.7655	$39.92	$21.95	$7.98
73080	X		X-ray exam of elbow	0260	0.7655	$39.92	$21.95	$7.98
73085	S		Contrast x-ray of elbow	0275	2.9747	$155.13	$69.09	$31.03
73090	X		X-ray exam of forearm	0260	0.7655	$39.92	$21.95	$7.98
73092	X		X-ray exam of arm, infant	0260	0.7655	$39.92	$21.95	$7.98
73100	X		X-ray exam of wrist	0260	0.7655	$39.92	$21.95	$7.98
73110	X		X-ray exam of wrist	0260	0.7655	$39.92	$21.95	$7.98
73115	S		Contrast x-ray of wrist	0275	2.9747	$155.13	$69.09	$31.03
73120	X		X-ray exam of hand	0260	0.7655	$39.92	$21.95	$7.98
73130	X		X-ray exam of hand	0260	0.7655	$39.92	$21.95	$7.98
73140	X		X-ray exam of finger(s)	0260	0.7655	$39.92	$21.95	$7.98
73200	S		Ct upper extremity w/o dye	0332	3.4398	$179.39	$91.27	$35.88
73201	S		Ct upper extremity w/dye	0283	4.5057	$234.98	$126.27	$47.00
73202	S		Ct uppr extremity w/o&w/dye	0333	5.3681	$279.95	$146.98	$55.99
73206	S		Ct angio upr extrm w/o&w/dye	0662	5.4553	$284.50	$156.47	$56.90
73218	S		Mri upper extremity w/o dye	0336	6.5987	$344.13	$176.94	$68.83
73219	S		Mri upper extremity w/dye	0284	7.2382	$377.48	$201.02	$75.50
73220	S		Mri uppr extremity w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
73221	S		Mri joint upr extrem w/o dye	0336	6.5987	$344.13	$176.94	$68.83
73222	S		Mri joint upr extrem w/dye	0284	7.2382	$377.48	$201.02	$75.50
73223	S		Mri joint upr extr w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
73225	E		Mr angio upr extr w/o&w/dye					
73500	X		X-ray exam of hip	0260	0.7655	$39.92	$21.95	$7.98
73510	X		X-ray exam of hip	0260	0.7655	$39.92	$21.95	$7.98
73520	X		X-ray exam of hips	0260	0.7655	$39.92	$21.95	$7.98
73525	S		Contrast x-ray of hip	0275	2.9747	$155.13	$69.09	$31.03
73530	X		X-ray exam of hip	0261	1.2887	$67.21		$13.44
73540	X		X-ray exam of pelvis & hips	0260	0.7655	$39.92	$21.95	$7.98
73542	S		X-ray exam, sacroiliac joint	0275	2.9747	$155.13	$69.09	$31.03
73550	X		X-ray exam of thigh	0260	0.7655	$39.92	$21.95	$7.98
73560	X		X-ray exam of knee, 1 or 2	0260	0.7655	$39.92	$21.95	$7.98
73562	X		X-ray exam of knee, 3	0260	0.7655	$39.92	$21.95	$7.98
73564	X		X-ray exam, knee, 4 or more	0260	0.7655	$39.92	$21.95	$7.98
73565	X		X-ray exam of knees	0260	0.7655	$39.92	$21.95	$7.98
73580	S		Contrast x-ray of knee joint	0275	2.9747	$155.13	$69.09	$31.03
73590	X		X-ray exam of lower leg	0260	0.7655	$39.92	$21.95	$7.98
73592	X		X-ray exam of leg, infant	0260	0.7655	$39.92	$21.95	$7.98
73600	X		X-ray exam of ankle	0260	0.7655	$39.92	$21.95	$7.98
73610	X		X-ray exam of ankle	0260	0.7655	$39.92	$21.95	$7.98

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
73615	S		Contrast x-ray of ankle	0275	2.9747	$155.13	$69.09	$31.03
73620	X		X-ray exam of foot	0260	0.7655	$39.92	$21.95	$7.98
73630	X		X-ray exam of foot	0260	0.7655	$39.92	$21.95	$7.98
73650	X		X-ray exam of heel	0260	0.7655	$39.92	$21.95	$7.98
73660	X		X-ray exam of toe(s)	0260	0.7655	$39.92	$21.95	$7.98
73700	S		Ct lower extremity w/o dye	0332	3.4398	$179.39	$91.27	$35.88
73701	S		Ct lower extremity w/dye	0283	4.5057	$234.98	$126.27	$47.00
73702	S		Ct lwr extremity w/o&w/dye	0333	5.3681	$279.95	$146.98	$55.99
73706	S		Ct angio lwr extr w/o&w/dye	0662	5.4553	$284.50	$156.47	$56.90
73718	S		Mri lower extremity w/o dye	0336	6.5987	$344.13	$176.94	$68.83
73719	S		Mri lower extremity w/dye	0284	7.2382	$377.48	$201.02	$75.50
73720	S		Mri lwr extremity w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
73721	S		Mri jnt of lwr extre w/o dye	0336	6.5987	$344.13	$176.94	$68.83
73722	S		Mri joint of lwr extr w/dye	0284	7.2382	$377.48	$201.02	$75.50
73723	S		Mri joint lwr extr w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
73725	E		Mr ang lwr ext w or w/o dye					
74000	X		X-ray exam of abdomen	0260	0.7655	$39.92	$21.95	$7.98
74010	X		X-ray exam of abdomen	0260	0.7655	$39.92	$21.95	$7.98
74020	X		X-ray exam of abdomen	0260	0.7655	$39.92	$21.95	$7.98
74022	X		X-ray exam series, abdomen	0261	1.2887	$67.21		$13.44
74150	S		Ct abdomen w/o dye	0332	3.4398	$179.39	$91.27	$35.88
74160	S		Ct abdomen w/dye	0283	4.5057	$234.98	$126.27	$47.00
74170	S		Ct abdomen w/o&w/dye	0333	5.3681	$279.95	$146.98	$55.99
74175	S		Ct angio abdom w/o&w/dye	0662	5.4553	$284.50	$156.47	$56.90
74181	S		Mri abdomen w/o dye	0336	6.5987	$344.13	$176.94	$68.83
74182	S		Mri abdomen w/dye	0284	7.2382	$377.48	$201.02	$75.50
74183	S		Mri abdomen w/o&w/dye	0337	9.2440	$482.08	$240.77	$96.42
74185	E		Mri angio, abdom w or w/o dy					
74190	X		X-ray exam of peritoneum	0263	1.8992	$99.05	$43.58	$19.81
74210	S		Contrst x-ray exam of throat	0276	1.5891	$82.87	$41.72	$16.57
74220	S		Contrast x-ray, esophagus	0276	1.5891	$82.87	$41.72	$16.57
74230	S		Cine/vid x-ray, throat/esoph	0276	1.5891	$82.87	$41.72	$16.57
74235	S		Remove esophagus obstruction	0296	2.4127	$125.82	$69.20	$25.16
74240	S		X-ray exam, upper gi tract	0276	1.5891	$82.87	$41.72	$16.57
74241	S		X-ray exam, upper gi tract	0276	1.5891	$82.87	$41.72	$16.57
74245	S		X-ray exam, upper gi tract	0277	2.3546	$122.79	$60.47	$24.56
74246	S		Contrst x-ray uppr gi tract	0276	1.5891	$82.87	$41.72	$16.57
74247	S		Contrst x-ray uppr gi tract	0276	1.5891	$82.87	$41.72	$16.57
74249	S		Contrst x-ray uppr gi tract	0277	2.3546	$122.79	$60.47	$24.56
74250	S		X-ray exam of small bowel	0276	1.5891	$82.87	$41.72	$16.57
74251	S		X-ray exam of small bowel	0277	2.3546	$122.79	$60.47	$24.56
74260	S		X-ray exam of small bowel	0277	2.3546	$122.79	$60.47	$24.56
74270	S		Contrast x-ray exam of colon	0276	1.5891	$82.87	$41.72	$16.57
74280	S		Contrast x-ray exam of colon	0277	2.3546	$122.79	$60.47	$24.56
74283	S		Contrast x-ray exam of colon	0276	1.5891	$82.87	$41.72	$16.57
74290	S		Contrast x-ray, gallbladder	0276	1.5891	$82.87	$41.72	$16.57
74291	S		Contrast x-rays, gallbladder	0276	1.5891	$82.87	$41.72	$16.57
74300	X		X-ray bile ducts/pancreas	0263	1.8992	$99.05	$43.58	$19.81
74301	X		X-rays at surgery add-on	0263	1.8992	$99.05	$43.58	$19.81
74305	X		X-ray bile ducts/pancreas	0263	1.8992	$99.05	$43.58	$19.81
74320	X		Contrast x-ray of bile ducts	0264	2.8197	$147.05	$79.41	$29.41
74327	S		X-ray bile stone removal	0296	2.4127	$125.82	$69.20	$25.16
74328	N		X-ray bile duct endoscopy					
74329	N		X-ray for pancreas endoscopy					
74330	N		X-ray bile/panc endoscopy					
74340	X		X-ray guide for GI tube	0272	1.3372	$69.74	$38.36	$13.95
74350	X		X-ray guide, stomach tube	0263	1.8992	$99.05	$43.58	$19.81
74355	X		X-ray guide, intestinal tube	0263	1.8992	$99.05	$43.58	$19.81
74360	S		X-ray guide, GI dilation	0296	2.4127	$125.82	$69.20	$25.16
74363	S		X-ray, bile duct dilation	0297	7.6839	$400.72	$172.51	$80.14
74400	S		Contrst x-ray, urinary tract	0278	2.5290	$131.89	$66.07	$26.38
74410	S		Contrst x-ray, urinary tract	0278	2.5290	$131.89	$66.07	$26.38
74415	S		Contrst x-ray, urinary tract	0278	2.5290	$131.89	$66.07	$26.38
74420	S		Contrst x-ray, urinary tract	0278	2.5290	$131.89	$66.07	$26.38
74425	S		Contrst x-ray, urinary tract	0278	2.5290	$131.89	$66.07	$26.38

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
74430	S		Contrast x-ray, bladder	0278	2.5290	$131.89	$66.07	$26.38
74440	S		X-ray, male genital tract	0278	2.5290	$131.89	$66.07	$26.38
74445	S		X-ray exam of penis	0278	2.5290	$131.89	$66.07	$26.38
74450	S		X-ray, urethra/bladder	0278	2.5290	$131.89	$66.07	$26.38
74455	S		X-ray, urethra/bladder	0278	2.5290	$131.89	$66.07	$26.38
74470	X		X-ray exam of kidney lesion	0264	2.8197	$147.05	$79.41	$29.41
74475	S		X-ray control, cath insert	0297	7.6839	$400.72	$172.51	$80.14
74480	S		X-ray control, cath insert	0296	2.4127	$125.82	$69.20	$25.16
74485	S		X-ray guide, GU dilation	0296	2.4127	$125.82	$69.20	$25.16
74710	X		X-ray measurement of pelvis	0260	0.7655	$39.92	$21.95	$7.98
74740	X		X-ray, female genital tract	0264	2.8197	$147.05	$79.41	$29.41
74742	X		X-ray, fallopian tube	0263	1.8992	$99.05	$43.58	$19.81
74775	S		X-ray exam of perineum	0278	2.5290	$131.89	$66.07	$26.38
75552	S		Heart mri for morph w/o dye	0336	6.5987	$344.13	$176.94	$68.83
75553	S		Heart mri for morph w/dye	0284	7.2382	$377.48	$201.02	$75.50
75554	S		Cardiac MRI/function	0335	6.2983	$328.46	$151.46	$65.69
75555	S		Cardiac MRI/limited study	0335	6.2983	$328.46	$151.46	$65.69
75556	E		Cardiac MRI/flow mapping					
75600	S		Contrast x-ray exam of aorta	0280	15.2128	$793.36	$353.85	$158.67
75605	S		Contrast x-ray exam of aorta	0280	15.2128	$793.36	$353.85	$158.67
75625	S		Contrast x-ray exam of aorta	0280	15.2128	$793.36	$353.85	$158.67
75630	S		X-ray aorta, leg arteries	0280	15.2128	$793.36	$353.85	$158.67
75635	S		Ct angio abdominal arteries	0662	5.4553	$284.50	$156.47	$56.90
75650	S		Artery x-rays, head & neck	0280	15.2128	$793.36	$353.85	$158.67
75658	S		Artery x-rays, arm	0280	15.2128	$793.36	$353.85	$158.67
75660	S		Artery x-rays, head & neck	0279	8.6432	$450.75	$174.57	$90.15
75662	S		Artery x-rays, head & neck	0279	8.6432	$450.75	$174.57	$90.15
75665	S		Artery x-rays, head & neck	0280	15.2128	$793.36	$353.85	$158.67
75671	S		Artery x-rays, head & neck	0280	15.2128	$793.36	$353.85	$158.67
75676	S		Artery x-rays, neck	0280	15.2128	$793.36	$353.85	$158.67
75680	S		Artery x-rays, neck	0280	15.2128	$793.36	$353.85	$158.67
75685	S		Artery x-rays, spine	0279	8.6432	$450.75	$174.57	$90.15
75705	S		Artery x-rays, spine	0279	8.6432	$450.75	$174.57	$90.15
75710	S		Artery x-rays, arm/leg	0280	15.2128	$793.36	$353.85	$158.67
75716	S		Artery x-rays, arms/legs	0280	15.2128	$793.36	$353.85	$158.67
75722	S		Artery x-rays, kidney	0280	15.2128	$793.36	$353.85	$158.67
75724	S		Artery x-rays, kidneys	0280	15.2128	$793.36	$353.85	$158.67
75726	S		Artery x-rays, abdomen	0280	15.2128	$793.36	$353.85	$158.67
75731	S		Artery x-rays, adrenal gland	0280	15.2128	$793.36	$353.85	$158.67
75733	S		Artery x-rays, adrenals	0280	15.2128	$793.36	$353.85	$158.67
75736	S		Artery x-rays, pelvis	0280	15.2128	$793.36	$353.85	$158.67
75741	S		Artery x-rays, lung	0279	8.6432	$450.75	$174.57	$90.15
75743	S		Artery x-rays, lungs	0280	15.2128	$793.36	$353.85	$158.67
75746	S		Artery x-rays, lung	0279	8.6432	$450.75	$174.57	$90.15
75756	S		Artery x-rays, chest	0279	8.6432	$450.75	$174.57	$90.15
75774	S		Artery x-ray, each vessel	0668	10.3292	$538.68	$237.76	$107.74
75790	S		Visualize A-V shunt	0281	5.2227	$272.37	$115.16	$54.47
75801	X		Lymph vessel x-ray, arm/leg	0264	2.8197	$147.05	$79.41	$29.41
75803	X		Lymph vessel x-ray,arms/legs	0264	2.8197	$147.05	$79.41	$29.41
75805	X		Lymph vessel x-ray, trunk	0264	2.8197	$147.05	$79.41	$29.41
75807	X		Lymph vessel x-ray, trunk	0264	2.8197	$147.05	$79.41	$29.41
75809	X		Nonvascular shunt, x-ray	0263	1.8992	$99.05	$43.58	$19.81
75810	S		Vein x-ray, spleen/liver	0279	8.6432	$450.75	$174.57	$90.15
75820	S		Vein x-ray, arm/leg	0281	5.2227	$272.37	$115.16	$54.47
75822	S		Vein x-ray, arms/legs	0281	5.2227	$272.37	$115.16	$54.47
75825	S		Vein x-ray, trunk	0279	8.6432	$450.75	$174.57	$90.15
75827	S		Vein x-ray, chest	0279	8.6432	$450.75	$174.57	$90.15
75831	S		Vein x-ray, kidney	0287	6.9863	$364.34	$114.51	$72.87
75833	S		Vein x-ray, kidneys	0279	8.6432	$450.75	$174.57	$90.15
75840	S		Vein x-ray, adrenal gland	0287	6.9863	$364.34	$114.51	$72.87
75842	S		Vein x-ray, adrenal glands	0287	6.9863	$364.34	$114.51	$72.87
75860	S		Vein x-ray, neck	0287	6.9863	$364.34	$114.51	$72.87
75870	S		Vein x-ray, skull	0287	6.9863	$364.34	$114.51	$72.87
75872	S		Vein x-ray, skull	0287	6.9863	$364.34	$114.51	$72.87
75880	S		Vein x-ray, eye socket	0287	6.9863	$364.34	$114.51	$72.87

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
75885	S		Vein x-ray, liver	0279	8.6432	$450.75	$174.57	$90.15
75887	S		Vein x-ray, liver	0280	15.2128	$793.36	$353.85	$158.67
75889	S		Vein x-ray, liver	0279	8.6432	$450.75	$174.57	$90.15
75891	S		Vein x-ray, liver	0279	8.6432	$450.75	$174.57	$90.15
75893	N		Venous sampling by catheter					
75894	S		X-rays, transcath therapy	0297	7.6839	$400.72	$172.51	$80.14
75896	S		X-rays, transcath therapy	0297	7.6839	$400.72	$172.51	$80.14
75898	X		Follow-up angiography	0264	2.8197	$147.05	$79.41	$29.41
75900	C		Arterial catheter exchange					
75901	X	NI	Remove cva device obstruct	0264	2.8197	$147.05	$79.41	$29.41
75902	X	NI	Remove cva lumen obstruct	0263	1.8992	$99.05	$43.58	$19.81
75940	X		X-ray placement, vein filter	0187	3.9534	$206.17	$90.71	$41.23
75945	S		Intravascular us	0267	2.4418	$127.34	$65.52	$25.47
75946	S		Intravascular us add-on	0267	2.4418	$127.34	$65.52	$25.47
75952	C		Endovasc repair abdom aorta					
75953	C		Abdom aneurysm endovas rpr					
75954	C	NI	Iliac aneurysm endovas rpr					
75960	S		Transcatheter intro, stent	0280	15.2128	$793.36	$353.85	$158.67
75961	S		Retrieval, broken catheter	0280	15.2128	$793.36	$353.85	$158.67
75962	S		Repair arterial blockage	0280	15.2128	$793.36	$353.85	$158.67
75964	S		Repair artery blockage, each	0280	15.2128	$793.36	$353.85	$158.67
75966	S		Repair arterial blockage	0280	15.2128	$793.36	$353.85	$158.67
75968	S		Repair artery blockage, each	0280	15.2128	$793.36	$353.85	$158.67
75970	S		Vascular biopsy	0280	15.2128	$793.36	$353.85	$158.67
75978	S		Repair venous blockage	0668	10.3292	$538.68	$237.76	$107.74
75980	S		Contrast xray exam bile duct	0296	2.4127	$125.82	$69.20	$25.16
75982	S		Contrast xray exam bile duct	0297	7.6839	$400.72	$172.51	$80.14
75984	X		Xray control catheter change	0264	2.8197	$147.05	$79.41	$29.41
75989	N		Abscess drainage under x-ray					
75992	S		Atherectomy, x-ray exam	0280	15.2128	$793.36	$353.85	$158.67
75993	S		Atherectomy, x-ray exam	0280	15.2128	$793.36	$353.85	$158.67
75994	S		Atherectomy, x-ray exam	0280	15.2128	$793.36	$353.85	$158.67
75995	S		Atherectomy, x-ray exam	0280	15.2128	$793.36	$353.85	$158.67
75996	S		Atherectomy, x-ray exam	0280	15.2128	$793.36	$353.85	$158.67
76000	X		Fluoroscope examination	0272	1.3372	$69.74	$38.36	$13.95
76001	N		Fluoroscope exam, extensive					
76003	N		Needle localization by x-ray					
76005	N		Fluoroguide for spine inject					
76006	X		X-ray stress view	0260	0.7655	$39.92	$21.95	$7.98
76010	X		X-ray, nose to rectum	0260	0.7655	$39.92	$21.95	$7.98
76012	S		Percut vertebroplasty fluor	0274	3.8759	$202.13	$96.54	$40.43
76013	S		Percut vertebroplasty, ct	0274	3.8759	$202.13	$96.54	$40.43
76020	X		X-rays for bone age	0260	0.7655	$39.92	$21.95	$7.98
76040	X		X-rays, bone evaluation	0260	0.7655	$39.92	$21.95	$7.98
76061	X		X-rays, bone survey	0261	1.2887	$67.21		$13.44
76062	X		X-rays, bone survey	0261	1.2887	$67.21		$13.44
76065	X		X-rays, bone evaluation	0261	1.2887	$67.21		$13.44
76066	X		Joint survey, single view	0260	0.7655	$39.92	$21.95	$7.98
76070	E		CT scan, bone density study					
76071	S	NI	Ct bone density, peripheral	0282	1.6763	$87.42	$44.51	$17.48
76075	S		Dexa, axial skeleton study	0288	1.2984	$67.71		$13.54
76076	S		Dexa, peripheral study	0665	0.8236	$42.95		$8.59
76078	X		Radiographic absorptiometry	0261	1.2887	$67.21		$13.44
76080	X		X-ray exam of fistula	0263	1.8992	$99.05	$43.58	$19.81
76085	A		Computer mammogram add-on					
76086	X		X-ray of mammary duct	0263	1.8992	$99.05	$43.58	$19.81
76088	X		X-ray of mammary ducts	0263	1.8992	$99.05	$43.58	$19.81
76090	S		Mammogram, one breast	0271	0.6492	$33.86	$16.80	$6.77
76091	S		Mammogram, both breasts	0271	0.6492	$33.86	$16.80	$6.77
76092	A		Mammogram, screening					
76093	E		Magnetic image, breast					
76094	E		Magnetic image, both breasts					
76095	X		Stereotactic breast biopsy	0187	3.9534	$206.17	$90.71	$41.23
76096	X		X-ray of needle wire, breast	0289	1.8992	$99.05	$44.80	$19.81
76098	X		X-ray exam, breast specimen	0260	0.7655	$39.92	$21.95	$7.98

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76100	X		X-ray exam of body section	0261	1.2887	$67.21		$13.44
76101	X		Complex body section x-ray	0264	2.8197	$147.05	$79.41	$29.41
76102	X		Complex body section x-rays	0264	2.8197	$147.05	$79.41	$29.41
76120	X		Cine/video x-rays	0260	0.7655	$39.92	$21.95	$7.98
76125	X		Cine/video x-rays add-on	0260	0.7655	$39.92	$21.95	$7.98
76140	E		X-ray consultation					
76150	X		X-ray exam, dry process	0260	0.7655	$39.92	$21.95	$7.98
76350	N		Special x-ray contrast study					
76355	S		CAT scan for localization	0283	4.5057	$234.98	$126.27	$47.00
76360	S		CAT scan for needle biopsy	0283	4.5057	$234.98	$126.27	$47.00
76362	N		Cat scan for tissue ablation					
76370	S		CAT scan for therapy guide	0282	1.6763	$87.42	$44.51	$17.48
76375	S		3d/holograph reconstr add-on	0282	1.6763	$87.42	$44.51	$17.48
76380	S		CAT scan follow-up study	0282	1.6763	$87.42	$44.51	$17.48
76390	E		Mr spectroscopy					
76393	N		Mr guidance for needle place					
76394	N		Mri for tissue ablation					
76400	S		Magnetic image, bone marrow	0335	6.2983	$328.46	$151.46	$65.69
76490	N		Us for tissue ablation					
76496	X	NI	Fluoroscopic procedure	0272	1.3372	$69.74	$38.36	$13.95
76497	S	NI	Ct procedure	0282	1.6763	$87.42	$44.51	$17.48
76498	S	NI	Mri procedure	0335	6.2983	$328.46	$151.46	$65.69
76499	X		Radiographic procedure	0260	0.7655	$39.92	$21.95	$7.98
76506	S		Echo exam of head	0266	1.5988	$83.38	$45.86	$16.68
76511	S		Echo exam of eye	0266	1.5988	$83.38	$45.86	$16.68
76512	S		Echo exam of eye	0266	1.5988	$83.38	$45.86	$16.68
76513	S		Echo exam of eye, water bath	0265	0.9787	$51.04	$28.07	$10.21
76516	S		Echo exam of eye	0266	1.5988	$83.38	$45.86	$16.68
76519	S		Echo exam of eye	0266	1.5988	$83.38	$45.86	$16.68
76529	S		Echo exam of eye	0265	0.9787	$51.04	$28.07	$10.21
76536	S		Us exam of head and neck	0266	1.5988	$83.38	$45.86	$16.68
76604	S		Us exam, chest, b-scan	0266	1.5988	$83.38	$45.86	$16.68
76645	S		Us exam, breast(s)	0265	0.9787	$51.04	$28.07	$10.21
76700	S		Us exam, abdom, complete	0266	1.5988	$83.38	$45.86	$16.68
76705	S		Echo exam of abdomen	0266	1.5988	$83.38	$45.86	$16.68
76770	S		Us exam abdo back wall, comp	0266	1.5988	$83.38	$45.86	$16.68
76775	S		Us eam abdo back wall, lim	0266	1.5988	$83.38	$45.86	$16.68
76778	S		Us exam kidney transplant	0266	1.5988	$83.38	$45.86	$16.68
76800	S		Us exam, spinal canal	0266	1.5988	$83.38	$45.86	$16.68
76801	S	NI	Ob us < 14 wks, single fetus	0265	0.9787	$51.04	$28.07	$10.21
76802	S	NI	Ob us < 14 wks, addl fetus	0265	0.9787	$51.04	$28.07	$10.21
76805	S		Us exam, pg uterus, compl	0266	1.5988	$83.38	$45.86	$16.68
76810	S		Us exam, pg uterus, mult	0265	0.9787	$51.04	$28.07	$10.21
76811	S	NI	Ob us, detailed, sngl fetus	0267	2.4418	$127.34	$65.52	$25.47
76812	S	NI	Ob us, detailed, addl fetus	0266	1.5988	$83.38	$45.86	$16.68
76815	S		Us exam, pg uterus limit	0265	0.9787	$51.04	$28.07	$10.21
76816	S		Us exam pg uterus repeat	0265	0.9787	$51.04	$28.07	$10.21
76817	S	NI	Transvaginal us, obstetric	0265	0.9787	$51.04	$28.07	$10.21
76818	S		Fetal biophys profile w/nst	0266	1.5988	$83.38	$45.86	$16.68
76819	S		Fetal biophys profil w/o nst	0266	1.5988	$83.38	$45.86	$16.68
76825	S		Echo exam of fetal heart	0671	2.3643	$123.30	$64.12	$24.66
76826	S		Echo exam of fetal heart	0697	1.5697	$81.86	$42.57	$16.37
76827	S		Echo exam of fetal heart	0671	2.3643	$123.30	$64.12	$24.66
76828	S		Echo exam of fetal heart	0697	1.5697	$81.86	$42.57	$16.37
76830	S		Transvaginal us, non-ob	0266	1.5988	$83.38	$45.86	$16.68
76831	S		Echo exam, uterus	0266	1.5988	$83.38	$45.86	$16.68
76856	S		Us exam, pelvic, complete	0266	1.5988	$83.38	$45.86	$16.68
76857	S		Us exam, pelvic, limited	0265	0.9787	$51.04	$28.07	$10.21
76870	S		Us exam, scrotum	0266	1.5988	$83.38	$45.86	$16.68
76872	S		Echo exam, transrectal	0266	1.5988	$83.38	$45.86	$16.68
76873	S		Echograp trans r, pros study	0266	1.5988	$83.38	$45.86	$16.68
76880	S		Us exam, extremity	0266	1.5988	$83.38	$45.86	$16.68
76885	S		Us exam infant hips, dynamic	0266	1.5988	$83.38	$45.86	$16.68
76886	S		Us exam infant hips, static	0266	1.5988	$83.38	$45.86	$16.68
76930	S		Echo guide, cardiocentesis	0268	1.3856	$72.26		$14.45

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76932	S		Echo guide for heart biopsy	0268	1.3856	$72.26		$14.45
76936	S		Echo guide for artery repair	0268	1.3856	$72.26		$14.45
76941	S		Echo guide for transfusion	0268	1.3856	$72.26		$14.45
76942	S		Echo guide for biopsy	0268	1.3856	$72.26		$14.45
76945	S		Echo guide, villus sampling	0268	1.3856	$72.26		$14.45
76946	S		Echo guide for amniocentesis	0268	1.3856	$72.26		$14.45
76948	S		Echo guide, ova aspiration	0268	1.3856	$72.26		$14.45
76950	S		Echo guidance radiotherapy	0268	1.3856	$72.26		$14.45
76965	S		Echo guidance radiotherapy	0268	1.3856	$72.26		$14.45
76970	S		Ultrasound exam follow-up	0265	0.9787	$51.04	$28.07	$10.21
76975	S		GI endoscopic ultrasound	0266	1.5988	$83.38	$45.86	$16.68
76977	S		Us bone density measure	0265	0.9787	$51.04	$28.07	$10.21
76986	S		Ultrasound guide intraoper	0266	1.5988	$83.38	$45.86	$16.68
76999	S		Echo examination procedure	0265	0.9787	$51.04	$28.07	$10.21
77261	E		Radiation therapy planning					
77262	E		Radiation therapy planning					
77263	E		Radiation therapy planning					
77280	X		Set radiation therapy field	0304	1.6182	$84.39	$41.52	$16.88
77285	X		Set radiation therapy field	0305	3.6530	$190.51	$91.38	$38.10
77290	X		Set radiation therapy field	0305	3.6530	$190.51	$91.38	$38.10
77295	X		Set radiation therapy field	0310	13.6625	$712.51	$325.27	$142.50
77299	E		Radiation therapy planning					
77300	X		Radiation therapy dose plan	0304	1.6182	$84.39	$41.52	$16.88
77301	S		Radiotherapy dose plan, imrt	0712		$875.00		$175.00
77305	X		Teletx isodose plan simple	0304	1.6182	$84.39	$41.52	$16.88
77310	X		Teletx isodose plan intermed	0304	1.6182	$84.39	$41.52	$16.88
77315	X		Teletx isodose plan complex	0305	3.6530	$190.51	$91.38	$38.10
77321	X		Special teletx port plan	0305	3.6530	$190.51	$91.38	$38.10
77326	X		Radiation therapy dose plan	0305	3.6530	$190.51	$91.38	$38.10
77327	X		Brachytx isodose calc interm	0305	3.6530	$190.51	$91.38	$38.10
77328	X		Brachytx isodose plan compl	0305	3.6530	$190.51	$91.38	$38.10
77331	X		Special radiation dosimetry	0304	1.6182	$84.39	$41.52	$16.88
77332	X		Radiation treatment aid(s)	0303	2.8391	$148.06	$66.95	$29.61
77333	X		Radiation treatment aid(s)	0303	2.8391	$148.06	$66.95	$29.61
77334	X		Radiation treatment aid(s)	0303	2.8391	$148.06	$66.95	$29.61
77336	X		Radiation physics consult	0304	1.6182	$84.39	$41.52	$16.88
77370	X		Radiation physics consult	0305	3.6530	$190.51	$91.38	$38.10
77399	X		External radiation dosimetry	0304	1.6182	$84.39	$41.52	$16.88
77401	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77402	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77403	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77404	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77406	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77407	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77408	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77409	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77411	S		Radiation treatment delivery	0300	1.5794	$82.37		$16.47
77412	S		Radiation treatment delivery	0301	3.1588	$164.73		$32.95
77413	S		Radiation treatment delivery	0301	3.1588	$164.73		$32.95
77414	S		Radiation treatment delivery	0301	3.1588	$164.73		$32.95
77416	S		Radiation treatment delivery	0301	3.1588	$164.73		$32.95
77417	X		Radiology port film(s)	0260	0.7655	$39.92	$21.95	$7.98
77418	S		Radiation tx delivery, imrt	0710		$400.00		$80.00
77427	E		Radiation tx management, x5					
77431	E		Radiation therapy management					
77432	E		Stereotactic radiation trmt					
77470	S		Special radiation treatment	0299	5.9785	$311.78		$62.36
77499	E		Radiation therapy management					
77520	S		Proton trmt, simple w/o comp	0664	10.0482	$524.02		$104.80
77522	S		Proton trmt, simple w/comp	0664	10.0482	$524.02		$104.80
77523	S		Proton trmt, intermediate	0650	12.0152	$626.60		$125.32
77525	S		Proton treatment, complex	0650	12.0152	$626.60		$125.32
77600	S		Hyperthermia treatment	0314	4.1763	$217.80	$101.77	$43.56
77605	S		Hyperthermia treatment	0314	4.1763	$217.80	$101.77	$43.56
77610	S		Hyperthermia treatment	0314	4.1763	$217.80	$101.77	$43.56

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
77615	S		Hyperthermia treatment	0314	4.1763	$217.80	$101.77	$43.56
77620	S		Hyperthermia treatment	0314	4.1763	$217.80	$101.77	$43.56
77750	S		Infuse radioactive materials	0300	1.5794	$82.37		$16.47
77761	S		Apply intrcav radiat simple	0312	52.8864	$2,758.08		$551.62
77762	S		Apply intrcav radiat interm	0312	52.8864	$2,758.08		$551.62
77763	S		Apply intrcav radiat compl	0312	52.8864	$2,758.08		$551.62
77776	S		Apply interstit radiat simpl	0312	52.8864	$2,758.08		$551.62
77777	S		Apply interstit radiat inter	0312	52.8864	$2,758.08		$551.62
77778	S		Apply interstit radiat compl	0651	54.7177	$2,853.58		$570.72
77781	S		High intensity brachytherapy	0313	21.0363	$1,097.06		$219.41
77782	S		High intensity brachytherapy	0313	21.0363	$1,097.06		$219.41
77783	S		High intensity brachytherapy	0313	21.0363	$1,097.06		$219.41
77784	S		High intensity brachytherapy	0313	21.0363	$1,097.06		$219.41
77789	S		Apply surface radiation	0300	1.5794	$82.37		$16.47
77790	N		Radiation handling					
77799	S		Radium/radioisotope therapy	0313	21.0363	$1,097.06		$219.41
78000	S		Thyroid, single uptake	0290	2.0251	$105.61	$53.17	$21.12
78001	S		Thyroid, multiple uptakes	0290	2.0251	$105.61	$53.17	$21.12
78003	S		Thyroid suppress/stimul	0290	2.0251	$105.61	$53.17	$21.12
78006	S		Thyroid imaging with uptake	0291	3.9825	$207.69	$104.55	$41.54
78007	S		Thyroid image, mult uptakes	0292	4.2925	$223.86	$112.69	$44.77
78010	S		Thyroid imaging	0291	3.9825	$207.69	$104.55	$41.54
78011	S		Thyroid imaging with flow	0292	4.2925	$223.86	$112.69	$44.77
78015	S		Thyroid met imaging	0291	3.9825	$207.69	$104.55	$41.54
78016	S		Thyroid met imaging/studies	0292	4.2925	$223.86	$112.69	$44.77
78018	S		Thyroid met imaging, body	0292	4.2925	$223.86	$112.69	$44.77
78020	S		Thyroid met uptake	0666	2.9650	$154.63	$85.05	$30.93
78070	S		Parathyroid nuclear imaging	0292	4.2925	$223.86	$112.69	$44.77
78075	S		Adrenal nuclear imaging	0292	4.2925	$223.86	$112.69	$44.77
78099	S		Endocrine nuclear procedure	0291	3.9825	$207.69	$104.55	$41.54
78102	S		Bone marrow imaging, ltd	0291	3.9825	$207.69	$104.55	$41.54
78103	S		Bone marrow imaging, mult	0291	3.9825	$207.69	$104.55	$41.54
78104	S		Bone marrow imaging, body	0291	3.9825	$207.69	$104.55	$41.54
78110	S		Plasma volume, single	0290	2.0251	$105.61	$53.17	$21.12
78111	S		Plasma volume, multiple	0290	2.0251	$105.61	$53.17	$21.12
78120	S		Red cell mass, single	0290	2.0251	$105.61	$53.17	$21.12
78121	S		Red cell mass, multiple	0290	2.0251	$105.61	$53.17	$21.12
78122	S		Blood volume	0290	2.0251	$105.61	$53.17	$21.12
78130	S		Red cell survival study	0290	2.0251	$105.61	$53.17	$21.12
78135	S		Red cell survival kinetics	0290	2.0251	$105.61	$53.17	$21.12
78140	S		Red cell sequestration	0290	2.0251	$105.61	$53.17	$21.12
78160	S		Plasma iron turnover	0290	2.0251	$105.61	$53.17	$21.12
78162	S		Radioiron absorption exam	0290	2.0251	$105.61	$53.17	$21.12
78170	S		Red cell iron utilization	0290	2.0251	$105.61	$53.17	$21.12
78172	S		Total body iron estimation	0290	2.0251	$105.61	$53.17	$21.12
78185	S		Spleen imaging	0291	3.9825	$207.69	$104.55	$41.54
78190	S		Platelet survival, kinetics	0290	2.0251	$105.61	$53.17	$21.12
78191	S		Platelet survival	0292	4.2925	$223.86	$112.69	$44.77
78195	S		Lymph system imaging	0292	4.2925	$223.86	$112.69	$44.77
78199	S		Blood/lymph nuclear exam	0291	3.9825	$207.69	$104.55	$41.54
78201	S		Liver imaging	0291	3.9825	$207.69	$104.55	$41.54
78202	S		Liver imaging with flow	0291	3.9825	$207.69	$104.55	$41.54
78205	S		Liver imaging (3D)	0291	3.9825	$207.69	$104.55	$41.54
78206	S		Liver image (3d) with flow	0292	4.2925	$223.86	$112.69	$44.77
78215	S		Liver and spleen imaging	0291	3.9825	$207.69	$104.55	$41.54
78216	S		Liver & spleen image/flow	0291	3.9825	$207.69	$104.55	$41.54
78220	S		Liver function study	0291	3.9825	$207.69	$104.55	$41.54
78223	S		Hepatobiliary imaging	0292	4.2925	$223.86	$112.69	$44.77
78230	S		Salivary gland imaging	0292	4.2925	$223.86	$112.69	$44.77
78231	S		Serial salivary imaging	0292	4.2925	$223.86	$112.69	$44.77
78232	S		Salivary gland function exam	0292	4.2925	$223.86	$112.69	$44.77
78258	S		Esophageal motility study	0291	3.9825	$207.69	$104.55	$41.54
78261	S		Gastric mucosa imaging	0291	3.9825	$207.69	$104.55	$41.54
78262	S		Gastroesophageal reflux exam	0292	4.2925	$223.86	$112.69	$44.77
78264	S		Gastric emptying study	0292	4.2925	$223.86	$112.69	$44.77

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78267	A	.....	Breath tst attain/anal c-14	.....	.....	.....	.....	.....
78268	A	.....	Breath test analysis, c-14	.....	.....	.....	.....	.....
78270	S	.....	Vit B-12 absorption exam	0290	2.0251	$105.61	$53.17	$21.12
78271	S	.....	Vit b-12 absrp exam, int fac	0290	2.0251	$105.61	$53.17	$21.12
78272	S	.....	Vit B-12 absorp, combined	0290	2.0251	$105.61	$53.17	$21.12
78278	S	.....	Acute GI blood loss imaging	0292	4.2925	$223.86	$112.69	$44.77
78282	S	.....	GI protein loss exam	0290	2.0251	$105.61	$53.17	$21.12
78290	S	.....	Meckel's divert exam	0292	4.2925	$223.86	$112.69	$44.77
78291	S	.....	Leveen/shunt patency exam	0292	4.2925	$223.86	$112.69	$44.77
78299	S	.....	GI nuclear procedure	0291	3.9825	$207.69	$104.55	$41.54
78300	S	.....	Bone imaging, limited area	0291	3.9825	$207.69	$104.55	$41.54
78305	S	.....	Bone imaging, multiple areas	0291	3.9825	$207.69	$104.55	$41.54
78306	S	.....	Bone imaging, whole body	0291	3.9825	$207.69	$104.55	$41.54
78315	S	.....	Bone imaging, 3 phase	0292	4.2925	$223.86	$112.69	$44.77
78320	S	.....	Bone imaging (3D)	0291	3.9825	$207.69	$104.55	$41.54
78350	X	.....	Bone mineral, single photon	0261	1.2887	$67.21	.....	$13.44
78351	E	.....	Bone mineral, dual photon	.....	.....	.....	.....	.....
78399	S	.....	Musculoskeletal nuclear exam	0291	3.9825	$207.69	$104.55	$41.54
78414	S	.....	Non-imaging heart function	0290	2.0251	$105.61	$53.17	$21.12
78428	S	.....	Cardiac shunt imaging	0291	3.9825	$207.69	$104.55	$41.54
78445	S	.....	Vascular flow imaging	0291	3.9825	$207.69	$104.55	$41.54
78455	S	.....	Venous thrombosis study	0290	2.0251	$105.61	$53.17	$21.12
78456	S	.....	Acute venous thrombus image	0292	4.2925	$223.86	$112.69	$44.77
78457	S	.....	Venous thrombosis imaging	0291	3.9825	$207.69	$104.55	$41.54
78458	S	.....	Ven thrombosis images, bilat	0292	4.2925	$223.86	$112.69	$44.77
78459	E	.....	Heart muscle imaging (PET)	.....	.....	.....	.....	.....
78460	S	.....	Heart muscle blood, single	0286	6.5309	$340.59	$187.32	$68.12
78461	S	.....	Heart muscle blood, multiple	0286	6.5309	$340.59	$187.32	$68.12
78464	S	.....	Heart image (3d), single	0286	6.5309	$340.59	$187.32	$68.12
78465	S	.....	Heart image (3d), multiple	0286	6.5309	$340.59	$187.32	$68.12
78466	S	.....	Heart infarct image	0291	3.9825	$207.69	$104.55	$41.54
78468	S	.....	Heart infarct image (ef)	0291	3.9825	$207.69	$104.55	$41.54
78469	S	.....	Heart infarct image (3D)	0291	3.9825	$207.69	$104.55	$41.54
78472	S	.....	Gated heart, planar, single	0286	6.5309	$340.59	$187.32	$68.12
78473	S	.....	Gated heart, multiple	0286	6.5309	$340.59	$187.32	$68.12
78478	S	.....	Heart wall motion add-on	0666	2.9650	$154.63	$85.05	$30.93
78480	S	.....	Heart function add-on	0666	2.9650	$154.63	$85.05	$30.93
78481	S	.....	Heart first pass, single	0286	6.5309	$340.59	$187.32	$68.12
78483	S	.....	Heart first pass, multiple	0286	6.5309	$340.59	$187.32	$68.12
78491	E	.....	Heart image (pet), single	.....	.....	.....	.....	.....
78492	E	.....	Heart image (pet), multiple	.....	.....	.....	.....	.....
78494	S	.....	Heart image, spect	0286	6.5309	$340.59	$187.32	$68.12
78496	S	.....	Heart first pass add-on	0666	2.9650	$154.63	$85.05	$30.93
78499	S	.....	Cardiovascular nuclear exam	0291	3.9825	$207.69	$104.55	$41.54
78580	S	.....	Lung perfusion imaging	0291	3.9825	$207.69	$104.55	$41.54
78584	S	.....	Lung V/Q image single breath	0292	4.2925	$223.86	$112.69	$44.77
78585	S	.....	Lung V/Q imaging	0292	4.2925	$223.86	$112.69	$44.77
78586	S	.....	Aerosol lung image, single	0291	3.9825	$207.69	$104.55	$41.54
78587	S	.....	Aerosol lung image, multiple	0291	3.9825	$207.69	$104.55	$41.54
78588	S	.....	Perfusion lung image	0292	4.2925	$223.86	$112.69	$44.77
78591	S	.....	Vent image, 1 breath, 1 proj	0291	3.9825	$207.69	$104.55	$41.54
78593	S	.....	Vent image, 1 proj, gas	0291	3.9825	$207.69	$104.55	$41.54
78594	S	.....	Vent image, mult proj, gas	0291	3.9825	$207.69	$104.55	$41.54
78596	S	.....	Lung differential function	0292	4.2925	$223.86	$112.69	$44.77
78599	S	.....	Respiratory nuclear exam	0291	3.9825	$207.69	$104.55	$41.54
78600	S	.....	Brain imaging, ltd static	0291	3.9825	$207.69	$104.55	$41.54
78601	S	.....	Brain imaging, ltd w/ flow	0291	3.9825	$207.69	$104.55	$41.54
78605	S	.....	Brain imaging, complete	0291	3.9825	$207.69	$104.55	$41.54
78606	S	.....	Brain imaging, compl w/flow	0291	3.9825	$207.69	$104.55	$41.54
78607	S	.....	Brain imaging (3D)	0291	3.9825	$207.69	$104.55	$41.54
78608	E	.....	Brain imaging (PET)	.....	.....	.....	.....	.....
78609	E	.....	Brain imaging (PET)	.....	.....	.....	.....	.....
78610	S	.....	Brain flow imaging only	0291	3.9825	$207.69	$104.55	$41.54
78615	S	.....	Cerebral vascular flow image	0291	3.9825	$207.69	$104.55	$41.54
78630	S	.....	Cerebrospinal fluid scan	0292	4.2925	$223.86	$112.69	$44.77

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78635	S		CSF ventriculography	0292	4.2925	$223.86	$112.69	$44.77
78645	S		CSF shunt evaluation	0292	4.2925	$223.86	$112.69	$44.77
78647	S		Cerebrospinal fluid scan	0292	4.2925	$223.86	$112.69	$44.77
78650	S		CSF leakage imaging	0292	4.2925	$223.86	$112.69	$44.77
78660	S		Nuclear exam of tear flow	0291	3.9825	$207.69	$104.55	$41.54
78699	S		Nervous system nuclear exam	0291	3.9825	$207.69	$104.55	$41.54
78700	S		Kidney imaging, static	0291	3.9825	$207.69	$104.55	$41.54
78701	S		Kidney imaging with flow	0291	3.9825	$207.69	$104.55	$41.54
78704	S		Imaging renogram	0291	3.9825	$207.69	$104.55	$41.54
78707	S		Kidney flow/function image	0291	3.9825	$207.69	$104.55	$41.54
78708	S		Kidney flow/function image	0292	4.2925	$223.86	$112.69	$44.77
78709	S		Kidney flow/function image	0292	4.2925	$223.86	$112.69	$44.77
78710	S		Kidney imaging (3D)	0291	3.9825	$207.69	$104.55	$41.54
78715	S		Renal vascular flow exam	0291	3.9825	$207.69	$104.55	$41.54
78725	S		Kidney function study	0290	2.0251	$105.61	$53.17	$21.12
78730	S		Urinary bladder retention	0291	3.9825	$207.69	$104.55	$41.54
78740	S		Ureteral reflux study	0292	4.2925	$223.86	$112.69	$44.77
78760	S		Testicular imaging	0291	3.9825	$207.69	$104.55	$41.54
78761	S		Testicular imaging/flow	0291	3.9825	$207.69	$104.55	$41.54
78799	S		Genitourinary nuclear exam	0291	3.9825	$207.69	$104.55	$41.54
78800	S		Tumor imaging, limited area	0292	4.2925	$223.86	$112.69	$44.77
78801	S		Tumor imaging, mult areas	0292	4.2925	$223.86	$112.69	$44.77
78802	S		Tumor imaging, whole body	0292	4.2925	$223.86	$112.69	$44.77
78803	S		Tumor imaging (3D)	0292	4.2925	$223.86	$112.69	$44.77
78805	S		Abscess imaging, ltd area	0292	4.2925	$223.86	$112.69	$44.77
78806	S		Abscess imaging, whole body	0292	4.2925	$223.86	$112.69	$44.77
78807	S		Nuclear localization/abscess	0292	4.2925	$223.86	$112.69	$44.77
78810	E		Tumor imaging (PET)					
78890	N		Nuclear medicine data proc					
78891	N		Nuclear med data proc					
78990	N		Provide diag radionuclide(s)					
78999	S		Nuclear diagnostic exam	0291	3.9825	$207.69	$104.55	$41.54
79000	S		Init hyperthyroid therapy	0294	4.0794	$212.74	$117.01	$42.55
79001	S		Repeat hyperthyroid therapy	0294	4.0794	$212.74	$117.01	$42.55
79020	S		Thyroid ablation	0294	4.0794	$212.74	$117.01	$42.55
79030	S		Thyroid ablation, carcinoma	0294	4.0794	$212.74	$117.01	$42.55
79035	S		Thyroid metastatic therapy	0294	4.0794	$212.74	$117.01	$42.55
79100	S		Hematopoetic nuclear therapy	0294	4.0794	$212.74	$117.01	$42.55
79200	S		Intracavitary nuclear trmt	0294	4.0794	$212.74	$117.01	$42.55
79300	S		Interstitial nuclear therapy	0294	4.0794	$212.74	$117.01	$42.55
79400	S		Nonhemato nuclear therapy	0294	4.0794	$212.74	$117.01	$42.55
79420	S		Intravascular nuclear ther	0294	4.0794	$212.74	$117.01	$42.55
79440	S		Nuclear joint therapy	0294	4.0794	$212.74	$117.01	$42.55
79900	N		Provide ther radiopharm(s)					
79999	S		Nuclear medicine therapy	0294	4.0794	$212.74	$117.01	$42.55
80048	A		Basic metabolic panel					
80050	A		General health panel					
80051	A		Electrolyte panel					
80053	A		Comprehen metabolic panel					
80055	A		Obstetric panel					
80061	A		Lipid panel					
80069	A		Renal function panel					
80074	A		Acute hepatitis panel					
80076	A		Hepatic function panel					
80090	A	DG	Torch antibody panel					
80100	A		Drug screen, qualitate/multi					
80101	A		Drug screen, single					
80102	A		Drug confirmation					
80103	N		Drug analysis, tissue prep					
80150	A		Assay of amikacin					
80152	A		Assay of amitriptyline					
80154	A		Assay of benzodiazepines					
80156	A		Assay, carbamazepine, total					
80157	A		Assay, carbamazepine, free					
80158	A		Assay of cyclosporine					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
80160	A		Assay of desipramine					
80162	A		Assay of digoxin					
80164	A		Assay, dipropylacetic acid					
80166	A		Assay of doxepin					
80168	A		Assay of ethosuximide					
80170	A		Assay of gentamicin					
80172	A		Assay of gold					
80173	A		Assay of haloperidol					
80174	A		Assay of imipramine					
80176	A		Assay of lidocaine					
80178	A		Assay of lithium					
80182	A		Assay of nortriptyline					
80184	A		Assay of phenobarbital					
80185	A		Assay of phenytoin, total					
80186	A		Assay of phenytoin, free					
80188	A		Assay of primidone					
80190	A		Assay of procainamide					
80192	A		Assay of procainamide					
80194	A		Assay of quinidine					
80196	A		Assay of salicylate					
80197	A		Assay of tacrolimus					
80198	A		Assay of theophylline					
80200	A		Assay of tobramycin					
80201	A		Assay of topiramate					
80202	A		Assay of vancomycin					
80299	A		Quantitative assay, drug					
80400	A		Acth stimulation panel					
80402	A		Acth stimulation panel					
80406	A		Acth stimulation panel					
80408	A		Aldosterone suppression eval					
80410	A		Calcitonin stimul panel					
80412	A		CRH stimulation panel					
80414	A		Testosterone response					
80415	A		Estradiol response panel					
80416	A		Renin stimulation panel					
80417	A		Renin stimulation panel					
80418	A		Pituitary evaluation panel					
80420	A		Dexamethasone panel					
80422	A		Glucagon tolerance panel					
80424	A		Glucagon tolerance panel					
80426	A		Gonadotropin hormone panel					
80428	A		Growth hormone panel					
80430	A		Growth hormone panel					
80432	A		Insulin suppression panel					
80434	A		Insulin tolerance panel					
80435	A		Insulin tolerance panel					
80436	A		Metyrapone panel					
80438	A		TRH stimulation panel					
80439	A		TRH stimulation panel					
80440	A		TRH stimulation panel					
80500	X		Lab pathology consultation	0343	0.4457	$23.24	$12.55	$4.65
80502	X		Lab pathology consultation	0342	0.2132	$11.12	$5.88	$2.22
81000	A		Urinalysis, nonauto w/scope					
81001	A		Urinalysis, auto w/scope					
81002	A		Urinalysis nonauto w/o scope					
81003	A		Urinalysis, auto, w/o scope					
81005	A		Urinalysis					
81007	A		Urine screen for bacteria					
81015	A		Microscopic exam of urine					
81020	A		Urinalysis, glass test					
81025	A		Urine pregnancy test					
81050	A		Urinalysis, volume measure					
81099	A		Urinalysis test procedure					
82000	A		Assay of blood acetaldehyde					
82003	A		Assay of acetaminophen					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
82009	A		Test for acetone/ketones					
82010	A		Acetone assay					
82013	A		Acetylcholinesterase assay					
82016	A		Acylcarnitines, qual					
82017	A		Acylcarnitines, quant					
82024	A		Assay of acth					
82030	A		Assay of adp & amp					
82040	A		Assay of serum albumin					
82042	A		Assay of urine albumin					
82043	A		Microalbumin, quantitative					
82044	A		Microalbumin, semiquant					
82055	A		Assay of ethanol					
82075	A		Assay of breath ethanol					
82085	A		Assay of aldolase					
82088	A		Assay of aldosterone					
82101	A		Assay of urine alkaloids					
82103	A		Alpha-1-antitrypsin, total					
82104	A		Alpha-1-antitrypsin, pheno					
82105	A		Alpha-fetoprotein, serum					
82106	A		Alpha-fetoprotein, amniotic					
82108	A		Assay of aluminum					
82120	A		Amines, vaginal fluid qual					
82127	A		Amino acid, single qual					
82128	A		Amino acids, mult qual					
82131	A		Amino acids, single quant					
82135	A		Assay, aminolevulinic acid					
82136	A		Amino acids, quant, 2-5					
82139	A		Amino acids, quan, 6 or more					
82140	A		Assay of ammonia					
82143	A		Amniotic fluid scan					
82145	A		Assay of amphetamines					
82150	A		Assay of amylase					
82154	A		Androstanediol glucuronide					
82157	A		Assay of androstenedione					
82160	A		Assay of androsterone					
82163	A		Assay of angiotensin II					
82164	A		Angiotensin I enzyme test					
82172	A		Assay of apolipoprotein					
82175	A		Assay of arsenic					
82180	A		Assay of ascorbic acid					
82190	A		Atomic absorption					
82205	A		Assay of barbiturates					
82232	A		Assay of beta-2 protein					
82239	A		Bile acids, total					
82240	A		Bile acids, cholylglycine					
82247	A		Bilirubin, total					
82248	A		Bilirubin, direct					
82252	A		Fecal bilirubin test					
82261	A		Assay of biotinidase					
82270	A		Test for blood, feces					
82273	A		Test for blood, other source					
82274	A		Assay test for blood, fecal					
82286	A		Assay of bradykinin					
82300	A		Assay of cadmium					
82306	A		Assay of vitamin D					
82307	A		Assay of vitamin D					
82308	A		Assay of calcitonin					
82310	A		Assay of calcium					
82330	A		Assay of calcium					
82331	A		Calcium infusion test					
82340	A		Assay of calcium in urine					
82355	A		Calculus analysis, qual					
82360	A		Calculus assay, quant					
82365	A		Calculus spectroscopy					
82370	A		X-ray assay, calculus					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
82373	A		Assay, c-d transfer measure					
82374	A		Assay, blood carbon dioxide					
82375	A		Assay, blood carbon monoxide					
82376	A		Test for carbon monoxide					
82378	A		Carcinoembryonic antigen					
82379	A		Assay of carnitine					
82380	A		Assay of carotene					
82382	A		Assay, urine catecholamines					
82383	A		Assay, blood catecholamines					
82384	A		Assay, three catecholamines					
82387	A		Assay of cathepsin-d					
82390	A		Assay of ceruloplasmin					
82397	A		Chemiluminescent assay					
82415	A		Assay of chloramphenicol					
82435	A		Assay of blood chloride					
82436	A		Assay of urine chloride					
82438	A		Assay, other fluid chlorides					
82441	A		Test for chlorohydrocarbons					
82465	A		Assay, bld/serum cholesterol					
82480	A		Assay, serum cholinesterase					
82482	A		Assay, rbc cholinesterase					
82485	A		Assay, chondroitin sulfate					
82486	A		Gas/liquid chromatography					
82487	A		Paper chromatography					
82488	A		Paper chromatography					
82489	A		Thin layer chromatography					
82491	A		Chromotography, quant, sing					
82492	A		Chromotography, quant, mult					
82495	A		Assay of chromium					
82507	A		Assay of citrate					
82520	A		Assay of cocaine					
82523	A		Collagen crosslinks					
82525	A		Assay of copper					
82528	A		Assay of corticosterone					
82530	A		Cortisol, free					
82533	A		Total cortisol					
82540	A		Assay of creatine					
82541	A		Column chromotography, qual					
82542	A		Column chromotography, quant					
82543	A		Column chromotograph/isotope					
82544	A		Column chromotograph/isotope					
82550	A		Assay of ck (cpk)					
82552	A		Assay of cpk in blood					
82553	A		Creatine, MB fraction					
82554	A		Creatine, isoforms					
82565	A		Assay of creatinine					
82570	A		Assay of urine creatinine					
82575	A		Creatinine clearance test					
82585	A		Assay of cryofibrinogen					
82595	A		Assay of cryoglobulin					
82600	A		Assay of cyanide					
82607	A		Vitamin B-12					
82608	A		B-12 binding capacity					
82615	A		Test for urine cystines					
82626	A		Dehydroepiandrosterone					
82627	A		Dehydroepiandrosterone					
82633	A		Desoxycorticosterone					
82634	A		Deoxycortisol					
82638	A		Assay of dibucaine number					
82646	A		Assay of dihydrocodeinone					
82649	A		Assay of dihydromorphinone					
82651	A		Assay of dihydrotestosterone					
82652	A		Assay of dihydroxyvitamin d					
82654	A		Assay of dimethadione					
82657	A		Enzyme cell activity					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
82658	A		Enzyme cell activity, ra					
82664	A		Electrophoretic test					
82666	A		Assay of epiandrosterone					
82668	A		Assay of erythropoietin					
82670	A		Assay of estradiol					
82671	A		Assay of estrogens					
82672	A		Assay of estrogen					
82677	A		Assay of estriol					
82679	A		Assay of estrone					
82690	A		Assay of ethchlorvynol					
82693	A		Assay of ethylene glycol					
82696	A		Assay of etiocholanolone					
82705	A		Fats/lipids, feces, qual					
82710	A		Fats/lipids, feces, quant					
82715	A		Assay of fecal fat					
82725	A		Assay of blood fatty acids					
82726	A		Long chain fatty acids					
82728	A		Assay of ferritin					
82731	A		Assay of fetal fibronectin					
82735	A		Assay of fluoride					
82742	A		Assay of flurazepam					
82746	A		Blood folic acid serum					
82747	A		Assay of folic acid, rbc					
82757	A		Assay of semen fructose					
82759	A		Assay of rbc galactokinase					
82760	A		Assay of galactose					
82775	A		Assay galactose transferase					
82776	A		Galactose transferase test					
82784	A		Assay of gammaglobulin igm					
82785	A		Assay of gammaglobulin ige					
82787	A		Igg 1, 2, 3 or 4, each					
82800	A		Blood pH					
82803	A		Blood gases: pH, pO2 & pCO2					
82805	A		Blood gases W/02 saturation					
82810	A		Blood gases, O2 sat only					
82820	A		Hemoglobin-oxygen affinity					
82926	A		Assay of gastric acid					
82928	A		Assay of gastric acid					
82938	A		Gastrin test					
82941	A		Assay of gastrin					
82943	A		Assay of glucagon					
82945	A		Glucose other fluid					
82946	A		Glucagon tolerance test					
82947	A		Assay, glucose, blood quant					
82948	A		Reagent strip/blood glucose					
82950	A		Glucose test					
82951	A		Glucose tolerance test (GTT)					
82952	A		GTT-added samples					
82953	A		Glucose-tolbutamide test					
82955	A		Assay of g6pd enzyme					
82960	A		Test for G6PD enzyme					
82962	A		Glucose blood test					
82963	A		Assay of glucosidase					
82965	A		Assay of gdh enzyme					
82975	A		Assay of glutamine					
82977	A		Assay of GGT					
82978	A		Assay of glutathione					
82979	A		Assay, rbc glutathione					
82980	A		Assay of glutethimide					
82985	A		Glycated protein					
83001	A		Gonadotropin (FSH)					
83002	A		Gonadotropin (LH)					
83003	A		Assay, growth hormone (hgh)					
83008	A		Assay of guanosine					
83010	A		Assay of haptoglobin, quant					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
83012	A		Assay of haptoglobins					
83013	A		H pylori analysis					
83014	A		H pylori drug admin/collect					
83015	A		Heavy metal screen					
83018	A		Quantitative screen, metals					
83020	A		Hemoglobin electrophoresis					
83021	A		Hemoglobin chromotography					
83026	A		Hemoglobin, copper sulfate					
83030	A		Fetal hemoglobin, chemical					
83033	A		Fetal hemoglobin assay, qual					
83036	A		Glycated hemoglobin test					
83045	A		Blood methemoglobin test					
83050	A		Blood methemoglobin assay					
83051	A		Assay of plasma hemoglobin					
83055	A		Blood sulfhemoglobin test					
83060	A		Blood sulfhemoglobin assay					
83065	A		Assay of hemoglobin heat					
83068	A		Hemoglobin stability screen					
83069	A		Assay of urine hemoglobin					
83070	A		Assay of hemosiderin, qual					
83071	A		Assay of hemosiderin, quant					
83080	A		Assay of b hexosaminidase					
83088	A		Assay of histamine					
83090	A		Assay of homocystine					
83150	A		Assay of for hva					
83491	A		Assay of corticosteroids					
83497	A		Assay of 5-hiaa					
83498	A		Assay of progesterone					
83499	A		Assay of progesterone					
83500	A		Assay, free hydroxyproline					
83505	A		Assay, total hydroxyproline					
83516	A		Immunoassay, nonantibody					
83518	A		Immunoassay, dipstick					
83519	A		Immunoassay, nonantibody					
83520	A		Immunoassay, RIA					
83525	A		Assay of insulin					
83527	A		Assay of insulin					
83528	A		Assay of intrinsic factor					
83540	A		Assay of iron					
83550	A		Iron binding test					
83570	A		Assay of idh enzyme					
83582	A		Assay of ketogenic steroids					
83586	A		Assay 17- ketosteroids					
83593	A		Fractionation, ketosteroids					
83605	A		Assay of lactic acid					
83615	A		Lactate (LD) (LDH) enzyme					
83625	A		Assay of ldh enzymes					
83632	A		Placental lactogen					
83633	A		Test urine for lactose					
83634	A		Assay of urine for lactose					
83655	A		Assay of lead					
83661	A		L/s ratio, fetal lung					
83662	A		Foam stability, fetal lung					
83663	A		Fluoro polarize, fetal lung					
83664	A		Lamellar bdy, fetal lung					
83670	A		Assay of lap enzyme					
83690	A		Assay of lipase					
83715	A		Assay of blood lipoproteins					
83716	A		Assay of blood lipoproteins					
83718	A		Assay of lipoprotein					
83719	A		Assay of blood lipoprotein					
83721	A		Assay of blood lipoprotein					
83727	A		Assay of lrh hormone					
83735	A		Assay of magnesium					
83775	A		Assay of md enzyme					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
83785	A		Assay of manganese					
83788	A		Mass spectrometry qual					
83789	A		Mass spectrometry quant					
83805	A		Assay of meprobamate					
83825	A		Assay of mercury					
83835	A		Assay of metanephrines					
83840	A		Assay of methadone					
83857	A		Assay of methemalbumin					
83858	A		Assay of methsuximide					
83864	A		Mucopolysaccharides					
83866	A		Mucopolysaccharides screen					
83872	A		Assay synovial fluid mucin					
83873	A		Assay of csf protein					
83874	A		Assay of myoglobin					
83880	A	NI	Natriuretic peptide					
83883	A		Assay, nephelometry not spec					
83885	A		Assay of nickel					
83887	A		Assay of nicotine					
83890	A		Molecule isolate					
83891	A		Molecule isolate nucleic					
83892	A		Molecular diagnostics					
83893	A		Molecule dot/slot/blot					
83894	A		Molecule gel electrophor					
83896	A		Molecular diagnostics					
83897	A		Molecule nucleic transfer					
83898	A		Molecule nucleic ampli					
83901	A		Molecule nucleic ampli					
83902	A		Molecular diagnostics					
83903	A		Molecule mutation scan					
83904	A		Molecule mutation identify					
83905	A		Molecule mutation identify					
83906	A		Molecule mutation identify					
83912	A		Genetic examination					
83915	A		Assay of nucleotidase					
83916	A		Oligoclonal bands					
83918	A		Organic acids, total, quant					
83919	A		Organic acids, qual, each					
83921	A		Organic acid, single, quant					
83925	A		Assay of opiates					
83930	A		Assay of blood osmolality					
83935	A		Assay of urine osmolality					
83937	A		Assay of osteocalcin					
83945	A		Assay of oxalate					
83950	A		Oncoprotein, her-2/neu					
83970	A		Assay of parathormone					
83986	A		Assay of body fluid acidity					
83992	A		Assay for phencyclidine					
84022	A		Assay of phenothiazine					
84030	A		Assay of blood pku					
84035	A		Assay of phenylketones					
84060	A		Assay acid phosphatase					
84061	A		Phosphatase, forensic exam					
84066	A		Assay prostate phosphatase					
84075	A		Assay alkaline phosphatase					
84078	A		Assay alkaline phosphatase					
84080	A		Assay alkaline phosphatases					
84081	A		Amniotic fluid enzyme test					
84085	A		Assay of rbc pg6d enzyme					
84087	A		Assay phosphohexose enzymes					
84100	A		Assay of phosphorus					
84105	A		Assay of urine phosphorus					
84106	A		Test for porphobilinogen					
84110	A		Assay of porphobilinogen					
84119	A		Test urine for porphyrins					
84120	A		Assay of urine porphyrins					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
84126	A		Assay of feces porphyrins					
84127	A		Assay of feces porphyrins					
84132	A		Assay of serum potassium					
84133	A		Assay of urine potassium					
84134	A		Assay of prealbumin					
84135	A		Assay of pregnanediol					
84138	A		Assay of pregnanetriol					
84140	A		Assay of pregnenolone					
84143	A		Assay of 17-hydroxypregneno					
84144	A		Assay of progesterone					
84146	A		Assay of prolactin					
84150	A		Assay of prostaglandin					
84152	A		Assay of psa, complexed					
84153	A		Assay of psa, total					
84154	A		Assay of psa, free					
84155	A		Assay of protein					
84160	A		Assay of serum protein					
84165	A		Assay of serum proteins					
84181	A		Western blot test					
84182	A		Protein, western blot test					
84202	A		Assay RBC protoporphyrin					
84203	A		Test RBC protoporphyrin					
84206	A		Assay of proinsulin					
84207	A		Assay of vitamin b-6					
84210	A		Assay of pyruvate					
84220	A		Assay of pyruvate kinase					
84228	A		Assay of quinine					
84233	A		Assay of estrogen					
84234	A		Assay of progesterone					
84235	A		Assay of endocrine hormone					
84238	A		Assay, nonendocrine receptor					
84244	A		Assay of renin					
84252	A		Assay of vitamin b-2					
84255	A		Assay of selenium					
84260	A		Assay of serotonin					
84270	A		Assay of sex hormone globul					
84275	A		Assay of sialic acid					
84285	A		Assay of silica					
84295	A		Assay of serum sodium					
84300	A		Assay of urine sodium					
84302	A	NI	Assay of sweat sodium					
84305	A		Assay of somatomedin					
84307	A		Assay of somatostatin					
84311	A		Spectrophotometry					
84315	A		Body fluid specific gravity					
84375	A		Chromatogram assay, sugars					
84376	A		Sugars, single, qual					
84377	A		Sugars, multiple, qual					
84378	A		Sugars single quant					
84379	A		Sugars multiple quant					
84392	A		Assay of urine sulfate					
84402	A		Assay of testosterone					
84403	A		Assay of total testosterone					
84425	A		Assay of vitamin b-1					
84430	A		Assay of thiocyanate					
84432	A		Assay of thyroglobulin					
84436	A		Assay of total thyroxine					
84437	A		Assay of neonatal thyroxine					
84439	A		Assay of free thyroxine					
84442	A		Assay of thyroid activity					
84443	A		Assay thyroid stim hormone					
84445	A		Assay of tsi					
84446	A		Assay of vitamin e					
84449	A		Assay of transcortin					
84450	A		Transferase (AST) (SGOT)					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
84460	A		Alanine amino (ALT) (SGPT)					
84466	A		Assay of transferrin					
84478	A		Assay of triglycerides					
84479	A		Assay of thyroid (t3 or t4)					
84480	A		Assay, triiodothyronine (t3)					
84481	A		Free assay (FT-3)					
84482	A		T3 reverse					
84484	A		Assay of troponin, quant					
84485	A		Assay duodenal fluid trypsin					
84488	A		Test feces for trypsin					
84490	A		Assay of feces for trypsin					
84510	A		Assay of tyrosine					
84512	A		Assay of troponin, qual					
84520	A		Assay of urea nitrogen					
84525	A		Urea nitrogen semi-quant					
84540	A		Assay of urine/urea-n					
84545	A		Urea-N clearance test					
84550	A		Assay of blood/uric acid					
84560	A		Assay of urine/uric acid					
84577	A		Assay of feces/urobilinogen					
84578	A		Test urine urobilinogen					
84580	A		Assay of urine urobilinogen					
84583	A		Assay of urine urobilinogen					
84585	A		Assay of urine vma					
84586	A		Assay of vip					
84588	A		Assay of vasopressin					
84590	A		Assay of vitamin a					
84591	A		Assay of nos vitamin					
84597	A		Assay of vitamin k					
84600	A		Assay of volatiles					
84620	A		Xylose tolerance test					
84630	A		Assay of zinc					
84681	A		Assay of c-peptide					
84702	A		Chorionic gonadotropin test					
84703	A		Chorionic gonadotropin assay					
84830	A		Ovulation tests					
84999	A		Clinical chemistry test					
85002	A		Bleeding time test					
85004	A	NI	Automated diff wbc count					
85007	A		Differential WBC count					
85008	A		Nondifferential WBC count					
85009	A		Differential WBC count					
85013	A		Spun microhematocrit					
85014	A		Hematocrit					
85018	A		Hemoglobin					
85021	A	DG	Automated hemogram					
85022	A	DG	Automated hemogram					
85023	A	DG	Automated hemogram					
85024	A	DG	Automated hemogram					
85025	A		Automated hemogram					
85027	A		Automated hemogram					
85031	A	DG	Manual hemogram, cbc					
85032	A	NI	Manual cell count, each					
85041	A		Red blood cell (RBC) count					
85044	A		Reticulocyte count					
85045	A		Reticulocyte count					
85046	A		Reticyte/hgb concentrate					
85048	A		White blood cell (WBC) count					
85049	A	NI	Automated platelet count					
85060	X		Blood smear interpretation	0342	0.2132	$11.12	$5.88	$2.22
85097	X		Bone marrow interpretation	0343	0.4457	$23.24	$12.55	$4.65
85130	A		Chromogenic substrate assay					
85170	A		Blood clot retraction					
85175	A		Blood clot lysis time					
85210	A		Blood clot factor II test					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
85220	A		Blood clot factor V test					
85230	A		Blood clot factor VII test					
85240	A		Blood clot factor VIII test					
85244	A		Blood clot factor VIII test					
85245	A		Blood clot factor VIII test					
85246	A		Blood clot factor VIII test					
85247	A		Blood clot factor VIII test					
85250	A		Blood clot factor IX test					
85260	A		Blood clot factor X test					
85270	A		Blood clot factor XI test					
85280	A		Blood clot factor XII test					
85290	A		Blood clot factor XIII test					
85291	A		Blood clot factor XIII test					
85292	A		Blood clot factor assay					
85293	A		Blood clot factor assay					
85300	A		Antithrombin III test					
85301	A		Antithrombin III test					
85302	A		Blood clot inhibitor antigen					
85303	A		Blood clot inhibitor test					
85305	A		Blood clot inhibitor assay					
85306	A		Blood clot inhibitor test					
85307	A		Assay activated protein c					
85335	A		Factor inhibitor test					
85337	A		Thrombomodulin					
85345	A		Coagulation time					
85347	A		Coagulation time					
85348	A		Coagulation time					
85360	A		Euglobulin lysis					
85362	A		Fibrin degradation products					
85366	A		Fibrinogen test					
85370	A		Fibrinogen test					
85378	A		Fibrin degradation					
85379	A		Fibrin degradation, quant					
85380	A	NI	Fibrin degradation, vte					
85384	A		Fibrinogen					
85385	A		Fibrinogen					
85390	A		Fibrinolysins screen					
85400	A		Fibrinolytic plasmin					
85410	A		Fibrinolytic antiplasmin					
85415	A		Fibrinolytic plasminogen					
85420	A		Fibrinolytic plasminogen					
85421	A		Fibrinolytic plasminogen					
85441	A		Heinz bodies, direct					
85445	A		Heinz bodies, induced					
85460	A		Hemoglobin, fetal					
85461	A		Hemoglobin, fetal					
85475	A		Hemolysin					
85520	A		Heparin assay					
85525	A		Heparin neutralization					
85530	A		Heparin-protamine tolerance					
85536	A		Iron stain peripheral blood					
85540	A		Wbc alkaline phosphatase					
85547	A		RBC mechanical fragility					
85549	A		Muramidase					
85555	A		RBC osmotic fragility					
85557	A		RBC osmotic fragility					
85576	A		Blood platelet aggregation					
85585	A	DG	Blood platelet estimation					
85590	A	DG	Platelet count, manual					
85595	A	DG	Platelet count, automated					
85597	A		Platelet neutralization					
85610	A		Prothrombin time					
85611	A		Prothrombin test					
85612	A		Viper venom prothrombin time					
85613	A		Russell viper venom, diluted					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
85635	A		Reptilase test					
85651	A		Rbc sed rate, nonautomated					
85652	A		Rbc sed rate, automated					
85660	A		RBC sickle cell test					
85670	A		Thrombin time, plasma					
85675	A		Thrombin time, titer					
85705	A		Thromboplastin inhibition					
85730	A		Thromboplastin time, partial					
85732	A		Thromboplastin time, partial					
85810	A		Blood viscosity examination					
85999	A		Hematology procedure					
86000	A		Agglutinins, febrile					
86001	A		Allergen specific igg					
86003	A		Allergen specific IgE					
86005	A		Allergen specific IgE					
86021	A		WBC antibody identification					
86022	A		Platelet antibodies					
86023	A		Immunoglobulin assay					
86038	A		Antinuclear antibodies					
86039	A		Antinuclear antibodies (ANA)					
86060	A		Antistreptolysin o, titer					
86063	A		Antistreptolysin o, screen					
86077	X		Physician blood bank service	0343	0.4457	$23.24	$12.55	$4.65
86078	X		Physician blood bank service	0344	0.6201	$32.34	$17.46	$6.47
86079	X		Physician blood bank service	0344	0.6201	$32.34	$17.46	$6.47
86140	A		C-reactive protein					
86141	A		C-reactive protein, hs					
86146	A		Glycoprotein antibody					
86147	A		Cardiolipin antibody					
86148	A		Phospholipid antibody					
86155	A		Chemotaxis assay					
86156	A		Cold agglutinin, screen					
86157	A		Cold agglutinin, titer					
86160	A		Complement, antigen					
86161	A		Complement/function activity					
86162	A		Complement, total (CH50)					
86171	A		Complement fixation, each					
86185	A		Counterimmunoelectrophoresis					
86215	A		Deoxyribonuclease, antibody					
86225	A		DNA antibody					
86226	A		DNA antibody, single strand					
86235	A		Nuclear antigen antibody					
86243	A		Fc receptor					
86255	A		Fluorescent antibody, screen					
86256	A		Fluorescent antibody, titer					
86277	A		Growth hormone antibody					
86280	A		Hemagglutination inhibition					
86294	A		Immunoassay, tumor qual					
86300	A		Immunoassay, tumor ca 15-3					
86301	A		Immunoassay, tumor ca 19-9					
86304	A		Immunoassay, tumor, ca 125					
86308	A		Heterophile antibodies					
86309	A		Heterophile antibodies					
86310	A		Heterophile antibodies					
86316	A		Immunoassay, tumor other					
86317	A		Immunoassay,infectious agent					
86318	A		Immunoassay,infectious agent					
86320	A		Serum immunoelectrophoresis					
86325	A		Other immunoelectrophoresis					
86327	A		Immunoelectrophoresis assay					
86329	A		Immunodiffusion					
86331	A		Immunodiffusion ouchterlony					
86332	A		Immune complex assay					
86334	A		Immunofixation procedure					
86336	A		Inhibin A					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86337	A		Insulin antibodies					
86340	A		Intrinsic factor antibody					
86341	A		Islet cell antibody					
86343	A		Leukocyte histamine release					
86344	A		Leukocyte phagocytosis					
86353	A		Lymphocyte transformation					
86359	A		T cells, total count					
86360	A		T cell, absolute count/ratio					
86361	A		T cell, absolute count					
86376	A		Microsomal antibody					
86378	A		Migration inhibitory factor					
86382	A		Neutralization test, viral					
86384	A		Nitroblue tetrazolium dye					
86403	A		Particle agglutination test					
86406	A		Particle agglutination test					
86430	A		Rheumatoid factor test					
86431	A		Rheumatoid factor, quant					
86485	X		Skin test, candida	0341	0.1453	$7.58	$3.08	$1.52
86490	X		Coccidioidomycosis skin test	0341	0.1453	$7.58	$3.08	$1.52
86510	X		Histoplasmosis skin test	0341	0.1453	$7.58	$3.08	$1.52
86580	X		TB intradermal test	0341	0.1453	$7.58	$3.08	$1.52
86585	X		TB tine test	0341	0.1453	$7.58	$3.08	$1.52
86586	X		Skin test, unlisted	0341	0.1453	$7.58	$3.08	$1.52
86590	A		Streptokinase, antibody					
86592	A		Blood serology, qualitative					
86593	A		Blood serology, quantitative					
86602	A		Antinomyces antibody					
86603	A		Adenovirus antibody					
86606	A		Aspergillus antibody					
86609	A		Bacterium antibody					
86611	A		Bartonella antibody					
86612	A		Blastomyces antibody					
86615	A		Bordetella antibody					
86617	A		Lyme disease antibody					
86618	A		Lyme disease antibody					
86619	A		Borrelia antibody					
86622	A		Brucella antibody					
86625	A		Campylobacter antibody					
86628	A		Candida antibody					
86631	A		Chlamydia antibody					
86632	A		Chlamydia igm antibody					
86635	A		Coccidioides antibody					
86638	A		Q fever antibody					
86641	A		Cryptococcus antibody					
86644	A		CMV antibody					
86645	A		CMV antibody, IgM					
86648	A		Diphtheria antibody					
86651	A		Encephalitis antibody					
86652	A		Encephalitis antibody					
86653	A		Encephalitis antibody					
86654	A		Encephalitis antibody					
86658	A		Enterovirus antibody					
86663	A		Epstein-barr antibody					
86664	A		Epstein-barr antibody					
86665	A		Epstein-barr antibody					
86666	A		Ehrlichia antibody					
86668	A		Francisella tularensis					
86671	A		Fungus antibody					
86674	A		Giardia lamblia antibody					
86677	A		Helicobacter pylori					
86682	A		Helminth antibody					
86684	A		Hemophilus influenza					
86687	A		Htlv-i antibody					
86688	A		Htlv-ii antibody					
86689	A		HTLV/HIV confirmatory test					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86692	A		Hepatitis, delta agent					
86694	A		Herpes simplex test					
86695	A		Herpes simplex test					
86696	A		Herpes simplex type 2					
86698	A		Histoplasma					
86701	A		HIV-1					
86702	A		HIV-2					
86703	A		HIV-1/HIV-2, single assay					
86704	A		Hep b core antibody, total					
86705	A		Hep b core antibody, igm					
86706	A		Hep b surface antibody					
86707	A		Hep be antibody					
86708	A		Hep a antibody, total					
86709	A		Hep a antibody, igm					
86710	A		Influenza virus antibody					
86713	A		Legionella antibody					
86717	A		Leishmania antibody					
86720	A		Leptospira antibody					
86723	A		Listeria monocytogenes ab					
86727	A		Lymph choriomeningitis ab					
86729	A		Lympho venereum antibody					
86732	A		Mucormycosis antibody					
86735	A		Mumps antibody					
86738	A		Mycoplasma antibody					
86741	A		Neisseria meningitidis					
86744	A		Nocardia antibody					
86747	A		Parvovirus antibody					
86750	A		Malaria antibody					
86753	A		Protozoa antibody nos					
86756	A		Respiratory virus antibody					
86757	A		Rickettsia antibody					
86759	A		Rotavirus antibody					
86762	A		Rubella antibody					
86765	A		Rubeola antibody					
86768	A		Salmonella antibody					
86771	A		Shigella antibody					
86774	A		Tetanus antibody					
86777	A		Toxoplasma antibody					
86778	A		Toxoplasma antibody, igm					
86781	A		Treponema pallidum, confirm					
86784	A		Trichinella antibody					
86787	A		Varicella-zoster antibody					
86790	A		Virus antibody nos					
86793	A		Yersinia antibody					
86800	A		Thyroglobulin antibody					
86803	A		Hepatitis c ab test					
86804	A		Hep c ab test, confirm					
86805	A		Lymphocytotoxicity assay					
86806	A		Lymphocytotoxicity assay					
86807	A		Cytotoxic antibody screening					
86808	A		Cytotoxic antibody screening					
86812	A		HLA typing, A, B, or C					
86813	A		HLA typing, A, B, or C					
86816	A		HLA typing, DR/DQ					
86817	A		HLA typing, DR/DQ					
86821	A		Lymphocyte culture, mixed					
86822	A		Lymphocyte culture, primed					
86849	A		Immunology procedure					
86850	X		RBC antibody screen	0345	0.1938	$10.11	$3.10	$2.02
86860	X		RBC antibody elution	0346	0.5136	$26.78	$6.75	$5.36
86870	X		RBC antibody identification	0346	0.5136	$26.78	$6.75	$5.36
86880	X		Coombs test, direct	0341	0.1453	$7.58	$3.08	$1.52
86885	X		Coombs test, indirect, qual	0341	0.1453	$7.58	$3.08	$1.52
86886	X		Coombs test, indirect, titer	0341	0.1453	$7.58	$3.08	$1.52
86890	X		Autologous blood process	0347	1.1240	$58.62	$14.76	$11.72

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86891	X		Autologous blood, op salvage	0345	0.1938	$10.11	$3.10	$2.02
86900	X		Blood typing, ABO	0341	0.1453	$7.58	$3.08	$1.52
86901	X		Blood typing, Rh (D)	0345	0.1938	$10.11	$3.10	$2.02
86903	X		Blood typing, antigen screen	0345	0.1938	$10.11	$3.10	$2.02
86904	X		Blood typing, patient serum	0345	0.1938	$10.11	$3.10	$2.02
86905	X		Blood typing, RBC antigens	0345	0.1938	$10.11	$3.10	$2.02
86906	X		Blood typing, Rh phenotype	0345	0.1938	$10.11	$3.10	$2.02
86910	E		Blood typing, paternity test					
86911	E		Blood typing, antigen system					
86915	S	DG	Bone marrow/stem cell prep	0110	4.0309	$210.22		$42.04
86920	X		Compatibility test	0346	0.5136	$26.78	$6.75	$5.36
86921	X		Compatibility test	0345	0.1938	$10.11	$3.10	$2.02
86922	X		Compatibility test	0346	0.5136	$26.78	$6.75	$5.36
86927	X		Plasma, fresh frozen	0346	0.5136	$26.78	$6.75	$5.36
86930	X		Frozen blood prep	0347	1.1240	$58.62	$14.76	$11.72
86931	X		Frozen blood thaw	0347	1.1240	$58.62	$14.76	$11.72
86932	X		Frozen blood freeze/thaw	0347	1.1240	$58.62	$14.76	$11.72
86940	A		Hemolysins/agglutinins, auto					
86941	A		Hemolysins/agglutinins					
86945	X		Blood product/irradiation	0346	0.5136	$26.78	$6.75	$5.36
86950	X		Leukacyte transfusion	0347	1.1240	$58.62	$14.76	$11.72
86965	X		Pooling blood platelets	0346	0.5136	$26.78	$6.75	$5.36
86970	X		RBC pretreatment	0345	0.1938	$10.11	$3.10	$2.02
86971	X		RBC pretreatment	0345	0.1938	$10.11	$3.10	$2.02
86972	X		RBC pretreatment	0345	0.1938	$10.11	$3.10	$2.02
86975	X		RBC pretreatment, serum	0345	0.1938	$10.11	$3.10	$2.02
86976	X		RBC pretreatment, serum	0345	0.1938	$10.11	$3.10	$2.02
86977	X		RBC pretreatment, serum	0345	0.1938	$10.11	$3.10	$2.02
86978	X		RBC pretreatment, serum	0345	0.1938	$10.11	$3.10	$2.02
86985	X		Split blood or products	0347	1.1240	$58.62	$14.76	$11.72
86999	X		Transfusion procedure	0345	0.1938	$10.11	$3.10	$2.02
87001	A		Small animal inoculation					
87003	A		Small animal inoculation					
87015	A		Specimen concentration					
87040	A		Blood culture for bacteria					
87045	A		Feces culture, bacteria					
87046	A		Stool cultr, bacteria, each					
87070	A		Culture, bacteria, other					
87071	A		Culture bacteri aerobic othr					
87073	A		Culture bacteria anaerobic					
87075	A		Culture bacteria anaerobic					
87076	A		Culture anaerobe ident, each					
87077	A		Culture aerobic identify					
87081	A		Culture screen only					
87084	A		Culture of specimen by kit					
87086	A		Urine culture/colony count					
87088	A		Urine bacteria culture					
87101	A		Skin fungi culture					
87102	A		Fungus isolation culture					
87103	A		Blood fungus culture					
87106	A		Fungi identification, yeast					
87107	A		Fungi identification, mold					
87109	A		Mycoplasma					
87110	A		Chlamydia culture					
87116	A		Mycobacteria culture					
87118	A		Mycobacteric identification					
87140	A		Culture type immunofluoresc					
87143	A		Culture typing, glc/hplc					
87147	A		Culture type, immunologic					
87149	A		Culture type, nucleic acid					
87152	A		Culture type pulse field gel					
87158	A		Culture typing, added method					
87164	A		Dark field examination					
87166	A		Dark field examination					
87168	A		Macroscopic exam arthropod					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87169	A		Macroscopic exam parasite					
87172	A		Pinworm exam					
87176	A		Tissue homogenization, cultr					
87177	A		Ova and parasites smears					
87181	A		Microbe susceptible, diffuse					
87184	A		Microbe susceptible, disk					
87185	A		Microbe susceptible, enzyme					
87186	A		Microbe susceptible, mic					
87187	A		Microbe susceptible, mlc					
87188	A		Microbe suscept, macrobroth					
87190	A		Microbe suscept, mycobacteri					
87197	A		Bactericidal level, serum					
87198	A	DG	Cytomegalovirus antibody dfa					
87199	A	DG	Enterovirus antibody, dfa					
87205	A		Smear, gram stain					
87206	A		Smear, fluorescent/acid stai					
87207	A		Smear, special stain					
87210	A		Smear, wet mount, saline/ink					
87220	A		Tissue exam for fungi					
87230	A		Assay, toxin or antitoxin					
87250	A		Virus inoculate, eggs/animal					
87252	A		Virus inoculation, tissue					
87253	A		Virus inoculate tissue, addl					
87254	A		Virus inoculation, shell via					
87255	A	NI	Genet virus isolate, hsv					
87260	A		Adenovirus ag, if					
87265	A		Pertussis ag, if					
87267	A	NI	Enterovirus antibody, dfa					
87270	A		Chlamydia trachomatis ag, if					
87271	A	NI	Cryptosporidum/gardia ag, if					
87272	A		Cryptosporidum/gardia ag, if					
87273	A		Herpes simplex 2, ag, if					
87274	A		Herpes simplex 1, ag, if					
87275	A		Influenza b, ag, if					
87276	A		Influenza a, ag, if					
87277	A		Legionella micdadei, ag, if					
87278	A		Legion pneumophilia ag, if					
87279	A		Parainfluenza, ag, if					
87280	A		Respiratory syncytial ag, if					
87281	A		Pneumocystis carinii, ag, if					
87283	A		Rubeola, ag, if					
87285	A		Treponema pallidum, ag, if					
87290	A		Varicella zoster, ag, if					
87299	A		Antibody detection, nos, if					
87300	A		Ag detection, polyval, if					
87301	A		Adenovirus ag, eia					
87320	A		Chylmd trach ag, eia					
87324	A		Clostridium ag, eia					
87327	A		Cryptococcus neoform ag, eia					
87328	A		Cryptospor ag, eia					
87332	A		Cytomegalovirus ag, eia					
87335	A		E coli 0157 ag, eia					
87336	A		Entamoeb hist dispr, ag, eia					
87337	A		Entamoeb hist group, ag, eia					
87338	A		Hpylori, stool, eia					
87339	A		H pylori ag, eia					
87340	A		Hepatitis b surface ag, eia					
87341	A		Hepatitis b surface, ag, eia					
87350	A		Hepatitis be ag, eia					
87380	A		Hepatitis delta ag, eia					
87385	A		Histoplasma capsul ag, eia					
87390	A		Hiv-1 ag, eia					
87391	A		Hiv-2 ag, eia					
87400	A		Influenza a/b, ag, eia					
87420	A		Resp syncytial ag, eia					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87425	A		Rotavirus ag, eia					
87427	A		Shiga-like toxin ag, eia					
87430	A		Strep a ag, eia					
87449	A		Ag detect nos, eia, mult					
87450	A		Ag detect nos, eia, single					
87451	A		Ag detect polyval, eia, mult					
87470	A		Bartonella, dna, dir probe					
87471	A		Bartonella, dna, amp probe					
87472	A		Bartonella, dna, quant					
87475	A		Lyme dis, dna, dir probe					
87476	A		Lyme dis, dna, amp probe					
87477	A		Lyme dis, dna, quant					
87480	A		Candida, dna, dir probe					
87481	A		Candida, dna, amp probe					
87482	A		Candida, dna, quant					
87485	A		Chylmd pneum, dna, dir probe					
87486	A		Chylmd pneum, dna, amp probe					
87487	A		Chylmd pneum, dna, quant					
87490	A		Chylmd trach, dna, dir probe					
87491	A		Chylmd trach, dna, amp probe					
87492	A		Chylmd trach, dna, quant					
87495	A		Cytomeg, dna, dir probe					
87496	A		Cytomeg, dna, amp probe					
87497	A		Cytomeg, dna, quant					
87510	A		Gardner vag, dna, dir probe					
87511	A		Gardner vag, dna, amp probe					
87512	A		Gardner vag, dna, quant					
87515	A		Hepatitis b, dna, dir probe					
87516	A		Hepatitis b, dna, amp probe					
87517	A		Hepatitis b, dna, quant					
87520	A		Hepatitis c, rna, dir probe					
87521	A		Hepatitis c, rna, amp probe					
87522	A		Hepatitis c, rna, quant					
87525	A		Hepatitis g, dna, dir probe					
87526	A		Hepatitis g, dna, amp probe					
87527	A		Hepatitis g, dna, quant					
87528	A		Hsv, dna, dir probe					
87529	A		Hsv, dna, amp probe					
87530	A		Hsv, dna, quant					
87531	A		Hhv-6, dna, dir probe					
87532	A		Hhv-6, dna, amp probe					
87533	A		Hhv-6, dna, quant					
87534	A		Hiv-1, dna, dir probe					
87535	A		Hiv-1, dna, amp probe					
87536	A		Hiv-1, dna, quant					
87537	A		Hiv-2, dna, dir probe					
87538	A		Hiv-2, dna, amp probe					
87539	A		Hiv-2, dna, quant					
87540	A		Legion pneumo, dna, dir prob					
87541	A		Legion pneumo, dna, amp prob					
87542	A		Legion pneumo, dna, quant					
87550	A		Mycobacteria, dna, dir probe					
87551	A		Mycobacteria, dna, amp probe					
87552	A		Mycobacteria, dna, quant					
87555	A		M.tuberculo, dna, dir probe					
87556	A		M.tuberculo, dna, amp probe					
87557	A		M.tuberculo, dna, quant					
87560	A		M.avium-intra, dna, dir prob					
87561	A		M.avium-intra, dna, amp prob					
87562	A		M.avium-intra, dna, quant					
87580	A		M.pneumon, dna, dir probe					
87581	A		M.pneumon, dna, amp probe					
87582	A		M.pneumon, dna, quant					
87590	A		N.gonorrhoeae, dna, dir prob					
87591	A		N.gonorrhoeae, dna, amp prob					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87592	A		N.gonorrhoeae, dna, quant					
87620	A		Hpv, dna, dir probe					
87621	A		Hpv, dna, amp probe					
87622	A		Hpv, dna, quant					
87650	A		Strep a, dna, dir probe					
87651	A		Strep a, dna, amp probe					
87652	A		Strep a, dna, quant					
87797	A		Detect agent nos, dna, dir					
87798	A		Detect agent nos, dna, amp					
87799	A		Detect agent nos, dna, quant					
87800	A		Detect agnt mult, dna, direc					
87801	A		Detect agnt mult, dna, ampli					
87802	A		Strep b assay w/optic					
87803	A		Clostridium toxin a w/optic					
87804	A		Influenza assay w/optic					
87810	A		Chylmd trach assay w/optic					
87850	A		N. gonorrhoeae assay w/optic					
87880	A		Strep a assay w/optic					
87899	A		Agent nos assay w/optic					
87901	A		Genotype, dna, hiv reverse t					
87902	A		Genotype, dna, hepatitis C					
87903	A		Phenotype, dna hiv w/culture					
87904	A		Phenotype, dna hiv w/clt add					
87999	A		Microbiology procedure					
88000	E		Autopsy (necropsy), gross					
88005	E		Autopsy (necropsy), gross					
88007	E		Autopsy (necropsy), gross					
88012	E		Autopsy (necropsy), gross					
88014	E		Autopsy (necropsy), gross					
88016	E		Autopsy (necropsy), gross					
88020	E		Autopsy (necropsy), complete					
88025	E		Autopsy (necropsy), complete					
88027	E		Autopsy (necropsy), complete					
88028	E		Autopsy (necropsy), complete					
88029	E		Autopsy (necropsy), complete					
88036	E		Limited autopsy					
88037	E		Limited autopsy					
88040	E		Forensic autopsy (necropsy)					
88045	E		Coroner's autopsy (necropsy)					
88099	E		Necropsy (autopsy) procedure					
88104	X		Cytopathology, fluids	0343	0.4457	$23.24	$12.55	$4.65
88106	X		Cytopathology, fluids	0343	0.4457	$23.24	$12.55	$4.65
88107	X		Cytopathology, fluids	0343	0.4457	$23.24	$12.55	$4.65
88108	X		Cytopath, concentrate tech	0343	0.4457	$23.24	$12.55	$4.65
88125	X		Forensic cytopathology	0342	0.2132	$11.12	$5.88	$2.22
88130	A		Sex chromatin identification					
88140	A		Sex chromatin identification					
88141	N		Cytopath, c/v, interpret					
88142	A		Cytopath, c/v, thin layer					
88143	A		Cytopath c/v thin layer redo					
88144	A	DG	Cytopath, c/v, thin lyr redo					
88145	A	DG	Cytopath, c/v, thin lyr sel					
88147	A		Cytopath, c/v, automated					
88148	A		Cytopath, c/v, auto rescreen					
88150	A		Cytopath, c/v, manual					
88152	A		Cytopath, c/v, auto redo					
88153	A		Cytopath, c/v, redo					
88154	A		Cytopath, c/v, select					
88155	A		Cytopath, c/v, index add-on					
88160	X		Cytopath smear, other source	0342	0.2132	$11.12	$5.88	$2.22
88161	X		Cytopath smear, other source	0343	0.4457	$23.24	$12.55	$4.65
88162	X		Cytopath smear, other source	0343	0.4457	$23.24	$12.55	$4.65
88164	A		Cytopath tbs, c/v, manual					
88165	A		Cytopath tbs, c/v, redo					
88166	A		Cytopath tbs, c/v, auto redo					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
88167	A		Cytopath tbs, c/v, select					
88172	X		Cytopathology eval of fna	0343	0.4457	$23.24	$12.55	$4.65
88173	X		Cytopath eval, fna, report	0343	0.4457	$23.24	$12.55	$4.65
88174	A	NI	Cytopath, c/v auto, in fluid					
88175	A	NI	Cytopath c/v auto fluid redo					
88180	X		Cell marker study	0343	0.4457	$23.24	$12.55	$4.65
88182	X		Cell marker study	0344	0.6201	$32.34	$17.46	$6.47
88199	A		Cytopathology procedure					
88230	A		Tissue culture, lymphocyte					
88233	A		Tissue culture, skin/biopsy					
88235	A		Tissue culture, placenta					
88237	A		Tissue culture, bone marrow					
88239	A		Tissue culture, tumor					
88240	A		Cell cryopreserve/storage					
88241	A		Frozen cell preparation					
88245	A		Chromosome analysis, 20-25					
88248	A		Chromosome analysis, 50-100					
88249	A		Chromosome analysis, 100					
88261	A		Chromosome analysis, 5					
88262	A		Chromosome analysis, 15-20					
88263	A		Chromosome analysis, 45					
88264	A		Chromosome analysis, 20-25					
88267	A		Chromosome analys, placenta					
88269	A		Chromosome analys, amniotic					
88271	A		Cytogenetics, dna probe					
88272	A		Cytogenetics, 3-5					
88273	A		Cytogenetics, 10-30					
88274	A		Cytogenetics, 25-99					
88275	A		Cytogenetics, 100-300					
88280	A		Chromosome karyotype study					
88283	A		Chromosome banding study					
88285	A		Chromosome count, additional					
88289	A		Chromosome study, additional					
88291	A		Cyto/molecular report					
88299	X		Cytogenetic study	0342	0.2132	$11.12	$5.88	$2.22
88300	X		Surgical path, gross	0342	0.2132	$11.12	$5.88	$2.22
88302	X		Tissue exam by pathologist	0342	0.2132	$11.12	$5.88	$2.22
88304	X		Tissue exam by pathologist	0343	0.4457	$23.24	$12.55	$4.65
88305	X		Tissue exam by pathologist	0343	0.4457	$23.24	$12.55	$4.65
88307	X		Tissue exam by pathologist	0344	0.6201	$32.34	$17.46	$6.47
88309	X		Tissue exam by pathologist	0344	0.6201	$32.34	$17.46	$6.47
88311	X		Decalcify tissue	0342	0.2132	$11.12	$5.88	$2.22
88312	X		Special stains	0342	0.2132	$11.12	$5.88	$2.22
88313	X		Special stains	0342	0.2132	$11.12	$5.88	$2.22
88314	X		Histochemical stain	0342	0.2132	$11.12	$5.88	$2.22
88318	X		Chemical histochemistry	0342	0.2132	$11.12	$5.88	$2.22
88319	X		Enzyme histochemistry	0342	0.2132	$11.12	$5.88	$2.22
88321	X		Microslide consultation	0342	0.2132	$11.12	$5.88	$2.22
88323	X		Microslide consultation	0343	0.4457	$23.24	$12.55	$4.65
88325	X		Comprehensive review of data	0344	0.6201	$32.34	$17.46	$6.47
88329	X		Path consult introp	0342	0.2132	$11.12	$5.88	$2.22
88331	X		Path consult intraop, 1 bloc	0343	0.4457	$23.24	$12.55	$4.65
88332	X		Path consult intraop, addl	0342	0.2132	$11.12	$5.88	$2.22
88342	X		Immunocytochemistry	0344	0.6201	$32.34	$17.46	$6.47
88346	X		Immunofluorescent study	0343	0.4457	$23.24	$12.55	$4.65
88347	X		Immunofluorescent study	0344	0.6201	$32.34	$17.46	$6.47
88348	X		Electron microscopy	0661	3.5077	$182.93	$100.61	$36.59
88349	X		Scanning electron microscopy	0661	3.5077	$182.93	$100.61	$36.59
88355	X		Analysis, skeletal muscle	0344	0.6201	$32.34	$17.46	$6.47
88356	X		Analysis, nerve	0344	0.6201	$32.34	$17.46	$6.47
88358	X		Analysis, tumor	0344	0.6201	$32.34	$17.46	$6.47
88362	X		Nerve teasing preparations	0343	0.4457	$23.24	$12.55	$4.65
88365	X		Tissue hybridization	0344	0.6201	$32.34	$17.46	$6.47
88371	A		Protein, western blot tissue					
88372	A		Protein analysis w/probe					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
88380	A		Microdissection					
88399	A		Surgical pathology procedure					
88400	A		Bilirubin total transcut					
89050	A		Body fluid cell count					
89051	A		Body fluid cell count					
89055	A	NI	Leukocyte count, fecal					
89060	A		Exam,synovial fluid crystals					
89100	X		Sample intestinal contents	0360	1.6279	$84.90	$42.45	$16.98
89105	X		Sample intestinal contents	0360	1.6279	$84.90	$42.45	$16.98
89125	A		Specimen fat stain					
89130	X		Sample stomach contents	0360	1.6279	$84.90	$42.45	$16.98
89132	X		Sample stomach contents	0360	1.6279	$84.90	$42.45	$16.98
89135	X		Sample stomach contents	0360	1.6279	$84.90	$42.45	$16.98
89136	X		Sample stomach contents	0360	1.6279	$84.90	$42.45	$16.98
89140	X		Sample stomach contents	0360	1.6279	$84.90	$42.45	$16.98
89141	X		Sample stomach contents	0360	1.6279	$84.90	$42.45	$16.98
89160	A		Exam feces for meat fibers					
89190	A		Nasal smear for eosinophils					
89250	X		Fertilization of oocyte	0348	0.5523	$28.80		$5.76
89251	X		Culture oocyte w/embryos	0348	0.5523	$28.80		$5.76
89252	X		Assist oocyte fertilization	0348	0.5523	$28.80		$5.76
89253	X		Embryo hatching	0348	0.5523	$28.80		$5.76
89254	X		Oocyte identification	0348	0.5523	$28.80		$5.76
89255	X		Prepare embryo for transfer	0348	0.5523	$28.80		$5.76
89256	X		Prepare cryopreserved embryo	0348	0.5523	$28.80		$5.76
89257	X		Sperm identification	0348	0.5523	$28.80		$5.76
89258	X		Cryopreservation, embryo	0348	0.5523	$28.80		$5.76
89259	X		Cryopreservation, sperm	0348	0.5523	$28.80		$5.76
89260	X		Sperm isolation, simple	0348	0.5523	$28.80		$5.76
89261	X		Sperm isolation, complex	0348	0.5523	$28.80		$5.76
89264	X		Identify sperm tissue	0348	0.5523	$28.80		$5.76
89300	A		Semen analysis w/huhner					
89310	A		Semen analysis					
89320	A		Semen analysis, complete					
89321	A		Semen analysis & motility					
89325	A		Sperm antibody test					
89329	A		Sperm evaluation test					
89330	A		Evaluation, cervical mucus					
89350	X		Sputum specimen collection	0344	0.6201	$32.34	$17.46	$6.47
89355	A		Exam feces for starch					
89360	X		Collect sweat for test	0344	0.6201	$32.34	$17.46	$6.47
89365	A		Water load test					
89399	A		Pathology lab procedure					
90281	E		Human ig, im					
90283	E		Human ig, iv					
90287	E		Botulinum antitoxin					
90288	E		Botulism ig, iv					
90291	E		Cmv ig, iv					
90296	K		Diphtheria antitoxin	0356	0.7655	$39.92		$7.98
90371	E		Hep b ig, im					
90375	K		Rabies ig, im/sc	0356	0.7655	$39.92		$7.98
90376	K		Rabies ig, heat treated	0356	0.7655	$39.92		$7.98
90378	E		Rsv ig, im, 50mg					
90379	K		Rsv ig, iv	0356	0.7655	$39.92		$7.98
90384	E		Rh ig, full-dose, im					
90385	N		Rh ig, minidose, im					
90386	E		Rh ig, iv					
90389	N		Tetanus ig, im					
90393	N		Vaccina ig, im					
90396	N		Varicella-zoster ig, im					
90399	E		Immune globulin					
90471	N		Immunization admin					
90472	N		Immunization admin, each add					
90473	E		Immune admin oral/nasal					
90474	E		Immune admin oral/nasal addl					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90476	N		Adenovirus vaccine, type 4					
90477	N		Adenovirus vaccine, type 7					
90581	K		Anthrax vaccine, sc	0356	0.7655	$39.92		$7.98
90585	N		Bcg vaccine, percut					
90586	N		Bcg vaccine, intravesical					
90632	N		Hep a vaccine, adult im					
90633	N		Hep a vacc, ped/adol, 2 dose					
90634	N		Hep a vacc, ped/adol, 3 dose					
90636	K		Hep a/hep b vacc, adult im	0355	0.2132	$11.12		$2.22
90645	N		Hib vaccine, hboc, im					
90646	N		Hib vaccine, prp-d, im					
90647	N		Hib vaccine, prp-omp, im					
90648	N		Hib vaccine, prp-t, im					
90657	L		Flu vaccine, 6-35 mo, im					
90658	L		Flu vaccine, 3 yrs, im					
90659	L		Flu vaccine, whole, im					
90660	E		Flu vaccine, nasal					
90665	N		Lyme disease vaccine, im					
90669	E		Pneumococcal vacc, ped <5					
90675	N		Rabies vaccine, im					
90676	N		Rabies vaccine, id					
90680	N		Rotovirus vaccine, oral					
90690	N		Typhoid vaccine, oral					
90691	N		Typhoid vaccine, im					
90692	N		Typhoid vaccine, h-p, sc/id					
90693	K		Typhoid vaccine, akd, sc	0356	0.7655	$39.92		$7.98
90700	N		Dtap vaccine, im					
90701	N		Dtp vaccine, im					
90702	N		Dt vaccine < 7, im					
90703	N		Tetanus vaccine, im					
90704	N		Mumps vaccine, sc					
90705	N		Measles vaccine, sc					
90706	N		Rubella vaccine, sc					
90707	N		Mmr vaccine, sc					
90708	N		Measles-rubella vaccine, sc					
90709	K	DG	Rubella & mumps vaccine, sc	0356	0.7655	$39.92		$7.98
90710	N		Mmrv vaccine, sc					
90712	N		Oral poliovirus vaccine					
90713	N		Poliovirus, ipv, sc					
90716	N		Chicken pox vaccine, sc					
90717	N		Yellow fever vaccine, sc					
90718	N		Td vaccine > 7, im					
90719	N		Diphtheria vaccine, im					
90720	N		Dtp/hib vaccine, im					
90721	N		Dtap/hib vaccine, im					
90723	K		Dtap-hep b-ipv vaccine, im	0356	0.7655	$39.92		$7.98
90725	N		Cholera vaccine, injectable					
90727	N		Plague vaccine, im					
90732	L		Pneumococcal vaccine					
90733	N		Meningococcal vaccine, sc					
90735	N		Encephalitis vaccine, sc					
90740	E		Hepb vacc, ill pat 3 dose im					
90743	E		Hep b vacc, adol, 2 dose, im					
90744	E		Hepb vacc ped/adol 3 dose im					
90746	E		Hep b vaccine, adult, im					
90747	E		Hepb vacc, ill pat 4 dose im					
90748	E		Hep b/hib vaccine, im					
90749	N		Vaccine toxoid					
90780	E		IV infusion therapy, 1 hour					
90781	E		IV infusion, additional hour					
90782	X		Injection, sc/im	0353	0.3973	$20.72		$4.14
90783	X		Injection, ia	0359	1.1337	$59.12		$11.82
90784	X		Injection, iv	0359	1.1337	$59.12		$11.82
90788	X		Injection of antibiotic	0359	1.1337	$59.12		$11.82
90799	X		Ther/prophylactic/dx inject	0352	0.2229	$11.62		$2.32

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90801	S		Psy dx interview	0323	1.8410	$96.01	$21.26	$19.20
90802	S		Intac psy dx interview	0323	1.8410	$96.01	$21.26	$19.20
90804	S		Psytx, office, 20-30 min	0322	1.3275	$69.23	$12.40	$13.85
90805	S		Psytx, off, 20-30 min w/e&m	0322	1.3275	$69.23	$12.40	$13.85
90806	S		Psytx, off, 45-50 min	0323	1.8410	$96.01	$21.26	$19.20
90807	S		Psytx, off, 45-50 min w/e&m	0323	1.8410	$96.01	$21.26	$19.20
90808	S		Psytx, office, 75-80 min	0323	1.8410	$96.01	$21.26	$19.20
90809	S		Psytx, off, 75-80, w/e&m	0323	1.8410	$96.01	$21.26	$19.20
90810	S		Intac psytx, off, 20-30 min	0322	1.3275	$69.23	$12.40	$13.85
90811	S		Intac psytx, 20-30, w/e&m	0322	1.3275	$69.23	$12.40	$13.85
90812	S		Intac psytx, off, 45-50 min	0323	1.8410	$96.01	$21.26	$19.20
90813	S		Intac psytx, 45-50 min w/e&m	0323	1.8410	$96.01	$21.26	$19.20
90814	S		Intac psytx, off, 75-80 min	0323	1.8410	$96.01	$21.26	$19.20
90815	S		Intac psytx, 75-80 w/e&m	0323	1.8410	$96.01	$21.26	$19.20
90816	S		Psytx, hosp, 20-30 min	0322	1.3275	$69.23	$12.40	$13.85
90817	S		Psytx, hosp, 20-30 min w/e&m	0322	1.3275	$69.23	$12.40	$13.85
90818	S		Psytx, hosp, 45-50 min	0323	1.8410	$96.01	$21.26	$19.20
90819	S		Psytx, hosp, 45-50 min w/e&m	0323	1.8410	$96.01	$21.26	$19.20
90821	S		Psytx, hosp, 75-80 min	0323	1.8410	$96.01	$21.26	$19.20
90822	S		Psytx, hosp, 75-80 min w/e&m	0323	1.8410	$96.01	$21.26	$19.20
90823	S		Intac psytx, hosp, 20-30 min	0322	1.3275	$69.23	$12.40	$13.85
90824	S		Intac psytx, hsp 20-30 w/e&m	0322	1.3275	$69.23	$12.40	$13.85
90826	S		Intac psytx, hosp, 45-50 min	0323	1.8410	$96.01	$21.26	$19.20
90827	S		Intac psytx, hsp 45-50 w/e&m	0323	1.8410	$96.01	$21.26	$19.20
90828	S		Intac psytx, hosp, 75-80 min	0323	1.8410	$96.01	$21.26	$19.20
90829	S		Intac psytx, hsp 75-80 w/e&m	0323	1.8410	$96.01	$21.26	$19.20
90845	S		Psychoanalysis	0323	1.8410	$96.01	$21.26	$19.20
90846	S		Family psytx w/o patient	0324	2.4612	$128.35		$25.67
90847	S		Family psytx w/patient	0324	2.4612	$128.35		$25.67
90849	S		Multiple family group psytx	0325	1.4244	$74.28	$18.27	$14.86
90853	S		Group psychotherapy	0325	1.4244	$74.28	$18.27	$14.86
90857	S		Intac group psytx	0325	1.4244	$74.28	$18.27	$14.86
90862	X		Medication management	0374	1.1434	$59.63	$9.97	$11.93
90865	S		Narcosynthesis	0323	1.8410	$96.01	$21.26	$19.20
90870	S		Electroconvulsive therapy	0320	4.2635	$222.35	$80.06	$44.47
90871	S		Electroconvulsive therapy	0320	4.2635	$222.35	$80.06	$44.47
90875	E		Psychophysiological therapy					
90876	E		Psychophysiological therapy					
90880	S		Hypnotherapy	0323	1.8410	$96.01	$21.26	$19.20
90882	E		Environmental manipulation					
90885	N		Psy evaluation of records					
90887	N		Consultation with family					
90889	N		Preparation of report					
90899	S		Psychiatric service/therapy	0322	1.3275	$69.23	$12.40	$13.85
90901	S		Biofeedback train, any meth	0321	1.2112	$63.17	$21.78	$12.63
90911	S		Biofeedback peri/uro/rectal	0321	1.2112	$63.17	$21.78	$12.63
90918	A		ESRD related services, month					
90919	A		ESRD related services, month					
90920	A		ESRD related services, month					
90921	A		ESRD related services, month					
90922	A		ESRD related services, day					
90923	A		Esrd related services, day					
90924	A		Esrd related services, day					
90925	A		Esrd related services, day					
90935	S		Hemodialysis, one evaluation	0170	4.8352	$252.16		$50.43
90937	E		Hemodialysis, repeated eval					
90939	N		Hemodialysis study, transcut					
90940	N		Hemodialysis access study					
90945	S		Dialysis, one evaluation	0170	4.8352	$252.16		$50.43
90947	E		Dialysis, repeated eval					
90989	E		Dialysis training, complete					
90993	E		Dialysis training, incompl					
90997	E		Hemoperfusion					
90999	E		Dialysis procedure					
91000	X		Esophageal intubation	0361	3.3914	$176.86	$83.23	$35.37

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
91010	X		Esophagus motility study	0361	3.3914	$176.86	$83.23	$35.37
91011	X		Esophagus motility study	0361	3.3914	$176.86	$83.23	$35.37
91012	X		Esophagus motility study	0361	3.3914	$176.86	$83.23	$35.37
91020	X		Gastric motility	0361	3.3914	$176.86	$83.23	$35.37
91030	X		Acid perfusion of esophagus	0361	3.3914	$176.86	$83.23	$35.37
91032	X		Esophagus, acid reflux test	0361	3.3914	$176.86	$83.23	$35.37
91033	X		Prolonged acid reflux test	0361	3.3914	$176.86	$83.23	$35.37
91052	X		Gastric analysis test	0361	3.3914	$176.86	$83.23	$35.37
91055	X		Gastric intubation for smear	0360	1.6279	$84.90	$42.45	$16.98
91060	X		Gastric saline load test	0360	1.6279	$84.90	$42.45	$16.98
91065	X		Breath hydrogen test	0360	1.6279	$84.90	$42.45	$16.98
91100	X		Pass intestine bleeding tube	0360	1.6279	$84.90	$42.45	$16.98
91105	X		Gastric intubation treatment	0360	1.6279	$84.90	$42.45	$16.98
91122	T		Anal pressure record	0156	2.9747	$155.13	$46.55	$31.03
91123	N		Irrigate fecal impaction					
91132	X		Electrogastrography	0360	1.6279	$84.90	$42.45	$16.98
91133	X		Electrogastrography w/test	0360	1.6279	$84.90	$42.45	$16.98
91299	X		Gastroenterology procedure	0360	1.6279	$84.90	$42.45	$16.98
92002	V		Eye exam, new patient	0601	0.9690	$50.53		$10.11
92004	V		Eye exam, new patient	0602	1.4631	$76.30		$15.26
92012	V		Eye exam established pat	0600	0.8430	$43.96		$8.79
92014	V		Eye exam & treatment	0602	1.4631	$76.30		$15.26
92015	E		Refraction					
92018	T		New eye exam & treatment	0699	3.7596	$196.07	$88.23	$39.21
92019	S		Eye exam & treatment	0698	0.9205	$48.00	$18.72	$9.60
92020	S		Special eye evaluation	0230	0.7364	$38.40	$14.97	$7.68
92060	S		Special eye evaluation	0230	0.7364	$38.40	$14.97	$7.68
92065	S		Orthoptic/pleoptic training	0230	0.7364	$38.40	$14.97	$7.68
92070	N		Fitting of contact lens					
92081	S		Visual field examination(s)	0230	0.7364	$38.40	$14.97	$7.68
92082	S		Visual field examination(s)	0698	0.9205	$48.00	$18.72	$9.60
92083	S		Visual field examination(s)	0698	0.9205	$48.00	$18.72	$9.60
92100	N		Serial tonometry exam(s)					
92120	S		Tonography & eye evaluation	0230	0.7364	$38.40	$14.97	$7.68
92130	S		Water provocation tonography	0698	0.9205	$48.00	$18.72	$9.60
92135	S		Opthalmic dx imaging	0230	0.7364	$38.40	$14.97	$7.68
92136	S		Ophthalmic biometry	0230	0.7364	$38.40	$14.97	$7.68
92140	S		Glaucoma provocative tests	0698	0.9205	$48.00	$18.72	$9.60
92225	S		Special eye exam, initial	0698	0.9205	$48.00	$18.72	$9.60
92226	S		Special eye exam, subsequent	0698	0.9205	$48.00	$18.72	$9.60
92230	T		Eye exam with photos	0699	3.7596	$196.07	$88.23	$39.21
92235	T		Eye exam with photos	0699	3.7596	$196.07	$88.23	$39.21
92240	S		Icg angiography	0231	2.1705	$113.19	$50.94	$22.64
92250	S		Eye exam with photos	0230	0.7364	$38.40	$14.97	$7.68
92260	S		Ophthalmoscopy/dynamometry	0230	0.7364	$38.40	$14.97	$7.68
92265	S		Eye muscle evaluation	0231	2.1705	$113.19	$50.94	$22.64
92270	S		Electro-oculography	0698	0.9205	$48.00	$18.72	$9.60
92275	S		Electroretinography	0231	2.1705	$113.19	$50.94	$22.64
92283	S		Color vision examination	0230	0.7364	$38.40	$14.97	$7.68
92284	S		Dark adaptation eye exam	0698	0.9205	$48.00	$18.72	$9.60
92285	S		Eye photography	0230	0.7364	$38.40	$14.97	$7.68
92286	S		Internal eye photography	0698	0.9205	$48.00	$18.72	$9.60
92287	S		Internal eye photography	0231	2.1705	$113.19	$50.94	$22.64
92310	E		Contact lens fitting					
92311	X		Contact lens fitting	0362	2.8391	$148.06		$29.61
92312	X		Contact lens fitting	0362	2.8391	$148.06		$29.61
92313	X		Contact lens fitting	0362	2.8391	$148.06		$29.61
92314	E		Prescription of contact lens					
92315	X		Prescription of contact lens	0362	2.8391	$148.06		$29.61
92316	X		Prescription of contact lens	0362	2.8391	$148.06		$29.61
92317	X		Prescription of contact lens	0362	2.8391	$148.06		$29.61
92325	X		Modification of contact lens	0362	2.8391	$148.06		$29.61
92326	X		Replacement of contact lens	0362	2.8391	$148.06		$29.61
92330	S		Fitting of artificial eye	0230	0.7364	$38.40	$14.97	$7.68
92335	N		Fitting of artificial eye					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92340	E		Fitting of spectacles					
92341	E		Fitting of spectacles					
92342	E		Fitting of spectacles					
92352	X		Special spectacles fitting	0362	2.8391	$148.06		$29.61
92353	X		Special spectacles fitting	0362	2.8391	$148.06		$29.61
92354	X		Special spectacles fitting	0362	2.8391	$148.06		$29.61
92355	X		Special spectacles fitting	0362	2.8391	$148.06		$29.61
92358	X		Eye prosthesis service	0362	2.8391	$148.06		$29.61
92370	E		Repair & adjust spectacles					
92371	X		Repair & adjust spectacles	0362	2.8391	$148.06		$29.61
92390	E		Supply of spectacles					
92391	E		Supply of contact lenses					
92392	E		Supply of low vision aids					
92393	E		Supply of artificial eye					
92395	E		Supply of spectacles					
92396	E		Supply of contact lenses					
92499	S		Eye service or procedure	0230	0.7364	$38.40	$14.97	$7.68
92502	T		Ear and throat examination	0251	1.9089	$99.55		$19.91
92504	N		Ear microscopy examination					
92506	A		Speech/hearing evaluation					
92507	A		Speech/hearing therapy					
92508	A		Speech/hearing therapy					
92510	A		Rehab for ear implant					
92511	T		Nasopharyngoscopy	0071	0.9205	$48.00	$12.89	$9.60
92512	X		Nasal function studies	0363	1.0852	$56.59	$20.94	$11.32
92516	X		Facial nerve function test	0660	1.5891	$82.87	$30.66	$16.57
92520	X		Laryngeal function studies	0660	1.5891	$82.87	$30.66	$16.57
92525	A	DG	Oral function evaluation					
92526	A		Oral function therapy					
92531	N		Spontaneous nystagmus study					
92532	N		Positional nystagmus test					
92533	N		Caloric vestibular test					
92534	N		Optokinetic nystagmus test					
92541	X		Spontaneous nystagmus test	0363	1.0852	$56.59	$20.94	$11.32
92542	X		Positional nystagmus test	0363	1.0852	$56.59	$20.94	$11.32
92543	X		Caloric vestibular test	0660	1.5891	$82.87	$30.66	$16.57
92544	X		Optokinetic nystagmus test	0363	1.0852	$56.59	$20.94	$11.32
92545	X		Oscillating tracking test	0363	1.0852	$56.59	$20.94	$11.32
92546	X		Sinusoidal rotational test	0660	1.5891	$82.87	$30.66	$16.57
92547	X		Supplemental electrical test	0363	1.0852	$56.59	$20.94	$11.32
92548	X		Posturography	0660	1.5891	$82.87	$30.66	$16.57
92551	E		Pure tone hearing test, air					
92552	X		Pure tone audiometry, air	0364	0.4457	$23.24	$9.06	$4.65
92553	X		Audiometry, air & bone	0365	1.2112	$63.17	$18.95	$12.63
92555	X		Speech threshold audiometry	0364	0.4457	$23.24	$9.06	$4.65
92556	X		Speech audiometry, complete	0364	0.4457	$23.24	$9.06	$4.65
92557	X		Comprehensive hearing test	0365	1.2112	$63.17	$18.95	$12.63
92559	E		Group audiometric testing					
92560	E		Bekesy audiometry, screen					
92561	X		Bekesy audiometry, diagnosis	0365	1.2112	$63.17	$18.95	$12.63
92562	X		Loudness balance test	0364	0.4457	$23.24	$9.06	$4.65
92563	X		Tone decay hearing test	0364	0.4457	$23.24	$9.06	$4.65
92564	X		Sisi hearing test	0364	0.4457	$23.24	$9.06	$4.65
92565	X		Stenger test, pure tone	0364	0.4457	$23.24	$9.06	$4.65
92567	X		Tympanometry	0364	0.4457	$23.24	$9.06	$4.65
92568	X		Acoustic reflex testing	0364	0.4457	$23.24	$9.06	$4.65
92569	X		Acoustic reflex decay test	0364	0.4457	$23.24	$9.06	$4.65
92571	X		Filtered speech hearing test	0364	0.4457	$23.24	$9.06	$4.65
92572	X		Staggered spondaic word test	0364	0.4457	$23.24	$9.06	$4.65
92573	X		Lombard test	0364	0.4457	$23.24	$9.06	$4.65
92575	X		Sensorineural acuity test	0365	1.2112	$63.17	$18.95	$12.63
92576	X		Synthetic sentence test	0364	0.4457	$23.24	$9.06	$4.65
92577	X		Stenger test, speech	0365	1.2112	$63.17	$18.95	$12.63
92579	X		Visual audiometry (vra)	0365	1.2112	$63.17	$18.95	$12.63
92582	X		Conditioning play audiometry	0365	1.2112	$63.17	$18.95	$12.63

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92583	X		Select picture audiometry	0364	0.4457	$23.24	$9.06	$4.65
92584	X		Electrocochleography	0660	1.5891	$82.87	$30.66	$16.57
92585	S		Auditor evoke potent, compre	0216	2.8972	$151.09	$67.98	$30.22
92586	S		Auditor evoke potent, limit	0218	1.0077	$52.55		$10.51
92587	X		Evoked auditory test	0363	1.0852	$56.59	$20.94	$11.32
92588	X		Evoked auditory test	0660	1.5891	$82.87	$30.66	$16.57
92589	X		Auditory function test(s)	0364	0.4457	$23.24	$9.06	$4.65
92590	E		Hearing aid exam, one ear					
92591	E		Hearing aid exam, both ears					
92592	E		Hearing aid check, one ear					
92593	E		Hearing aid check, both ears					
92594	E		Electro hearng aid test, one					
92595	E		Electro hearng aid tst, both					
92596	X		Ear protector evaluation	0365	1.2112	$63.17	$18.95	$12.63
92597	E		Voice Prosthetic Evaluation					
92598	E	DG	Voice Prosthetic Modification					
92599	X	DG	ENT procedure/service	0364	0.4457	$23.24	$9.06	$4.65
92601	A	NI	Cochlear implt f/up exam < 7					
92602	A	NI	Reprogram cochlear implt < 7					
92603	A	NI	Cochlear implt f/up exam 7 >					
92604	A	NI	Reprogram cochlear implt 7 >					
92605	A	NI	Eval for nonspeech device rx					
92606	A	NI	Non-speech device service					
92607	A	NI	Ex for speech device rx, 1hr					
92608	A	NI	Ex for speech device rx addl					
92609	A	NI	Use of speech device service					
92610	A	NI	Evaluate swallowing function					
92611	A	NI	Motion fluoroscopy/swallow					
92612	A	NI	Endoscopy swallow tst (fees)					
92613	E	NI	Endoscopy swallow tst (fees)					
92614	A	NI	Laryngoscopic sensory test					
92615	E	NI	Eval laryngoscopy sense tst					
92616	A	NI	Fees w/laryngeal sense test					
92617	E	NI	Interprt fees/laryngeal test					
92700	X	NI	Ent procedure/service	0364	0.4457	$23.24	$9.06	$4.65
92950	S		Heart/lung resuscitation cpr	0094	3.8371	$200.11	$67.63	$40.02
92953	S		Temporary external pacing	0094	3.8371	$200.11	$67.63	$40.02
92960	S		Cardioversion electric, ext	0679	5.4069	$281.98	$95.30	$56.40
92961	S		Cardioversion, electric, int	0679	5.4069	$281.98	$95.30	$56.40
92970	C		Cardioassist, internal					
92971	C		Cardioassist, external					
92973	T		Percut coronary thrombectomy	0973		$250.00		$50.00
92974	T		Cath place, cardio brachytx	0981		$2,250.00		$450.00
92975	C		Dissolve clot, heart vessel					
92977	T		Dissolve clot, heart vessel	0676	4.1278	$215.27	$58.21	$43.05
92978	S		Intravasc us, heart add-on	0670	30.2416	$1,577.13	$571.17	$315.43
92979	S		Intravasc us, heart add-on	0670	30.2416	$1,577.13	$571.17	$315.43
92980	T		Insert intracoronary stent	0104	76.5486	$3,992.09		$798.42
92981	T		Insert intracoronary stent	0104	76.5486	$3,992.09		$798.42
92982	T		Coronary artery dilation	0083	51.9755	$2,710.57		$542.11
92984	T		Coronary artery dilation	0083	51.9755	$2,710.57		$542.11
92986	T		Revision of aortic valve	0083	51.9755	$2,710.57		$542.11
92987	T		Revision of mitral valve	0083	51.9755	$2,710.57		$542.11
92990	T		Revision of pulmonary valve	0083	51.9755	$2,710.57		$542.11
92992	C		Revision of heart chamber					
92993	C		Revision of heart chamber					
92995	T		Coronary atherectomy	0082	86.4321	$4,507.52	$1,293.59	$901.50
92996	T		Coronary atherectomy add-on	0082	86.4321	$4,507.52	$1,293.59	$901.50
92997	T		Pul art balloon repr, percut	0081	43.5067	$2,268.92		$453.78
92998	T		Pul art balloon repr, percut	0081	43.5067	$2,268.92		$453.78
93000	E		Electrocardiogram, complete					
93005	S		Electrocardiogram, tracing	0099	0.3682	$19.20		$3.84
93010	A		Electrocardiogram report					
93012	N		Transmission of ecg					
93014	E		Report on transmitted ecg					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93015	E	.....	Cardiovascular stress test	.....	.....	.....	.....	.....
93016	E	.....	Cardiovascular stress test	.....	.....	.....	.....	.....
93017	X	.....	Cardiovascular stress test	0100	1.6085	$83.88	$41.44	$16.78
93018	E	.....	Cardiovascular stress test	.....	.....	.....	.....	.....
93024	X	.....	Cardiac drug stress test	0100	1.6085	$83.88	$41.44	$16.78
93025	X	.....	Microvolt t-wave assess	0100	1.6085	$83.88	$41.44	$16.78
93040	E	.....	Rhythm ECG with report	.....	.....	.....	.....	.....
93041	S	.....	Rhythm ECG, tracing	0099	0.3682	$19.20	.....	$3.84
93042	E	.....	Rhythm ECG, report	.....	.....	.....	.....	.....
93224	E	.....	ECG monitor/report, 24 hrs	.....	.....	.....	.....	.....
93225	X	.....	ECG monitor/record, 24 hrs	0097	1.0077	$52.55	$23.80	$10.51
93226	X	.....	ECG monitor/report, 24 hrs	0097	1.0077	$52.55	$23.80	$10.51
93227	E	.....	ECG monitor/review, 24 hrs	.....	.....	.....	.....	.....
93230	E	.....	ECG monitor/report, 24 hrs	.....	.....	.....	.....	.....
93231	X	.....	Ecg monitor/record, 24 hrs	0097	1.0077	$52.55	$23.80	$10.51
93232	X	.....	ECG monitor/report, 24 hrs	0097	1.0077	$52.55	$23.80	$10.51
93233	E	.....	ECG monitor/review, 24 hrs	.....	.....	.....	.....	.....
93235	E	.....	ECG monitor/report, 24 hrs	.....	.....	.....	.....	.....
93236	X	.....	ECG monitor/report, 24 hrs	0097	1.0077	$52.55	$23.80	$10.51
93237	E	.....	ECG monitor/review, 24 hrs	.....	.....	.....	.....	.....
93268	E	.....	ECG record/review	.....	.....	.....	.....	.....
93270	X	.....	ECG recording	0097	1.0077	$52.55	$23.80	$10.51
93271	X	.....	Ecg/monitoring and analysis	0097	1.0077	$52.55	$23.80	$10.51
93272	E	.....	Ecg/review, interpret only	.....	.....	.....	.....	.....
93278	S	.....	ECG/signal-averaged	0099	0.3682	$19.20	.....	$3.84
93303	S	.....	Echo transthoracic	0269	3.2170	$167.77	$87.24	$33.55
93304	S	.....	Echo transthoracic	0697	1.5697	$81.86	$42.57	$16.37
93307	S	.....	Echo exam of heart	0269	3.2170	$167.77	$87.24	$33.55
93308	S	.....	Echo exam of heart	0697	1.5697	$81.86	$42.57	$16.37
93312	S	.....	Echo transesophageal	0270	5.3003	$276.42	$146.79	$55.28
93313	S	.....	Echo transesophageal	0270	5.3003	$276.42	$146.79	$55.28
93314	N	.....	Echo transesophageal	.....	.....	.....	.....	.....
93315	S	.....	Echo transesophageal	0270	5.3003	$276.42	$146.79	$55.28
93316	S	.....	Echo transesophageal	0270	5.3003	$276.42	$146.79	$55.28
93317	N	.....	Echo transesophageal	.....	.....	.....	.....	.....
93318	S	.....	Echo transesophageal intraop	0270	5.3003	$276.42	$146.79	$55.28
93320	S	.....	Doppler echo exam, heart	0671	2.3643	$123.30	$64.12	$24.66
93321	S	.....	Doppler echo exam, heart	0697	1.5697	$81.86	$42.57	$16.37
93325	S	.....	Doppler color flow add-on	0697	1.5697	$81.86	$42.57	$16.37
93350	S	.....	Echo transthoracic	0269	3.2170	$167.77	$87.24	$33.55
93501	T	.....	Right heart catheterization	0080	35.2996	$1,840.91	$838.92	$368.18
93503	T	.....	Insert/place heart catheter	0103	11.8408	$617.51	$223.63	$123.50
93505	T	.....	Biopsy of heart lining	0103	11.8408	$617.51	$223.63	$123.50
93508	T	.....	Cath placement, angiography	0080	35.2996	$1,840.91	$838.92	$368.18
93510	T	.....	Left heart catheterization	0080	35.2996	$1,840.91	$838.92	$368.18
93511	T	.....	Left heart catheterization	0080	35.2996	$1,840.91	$838.92	$368.18
93514	T	.....	Left heart catheterization	0080	35.2996	$1,840.91	$838.92	$368.18
93524	T	.....	Left heart catheterization	0080	35.2996	$1,840.91	$838.92	$368.18
93526	T	.....	Rt & Lt heart catheters	0080	35.2996	$1,840.91	$838.92	$368.18
93527	T	.....	Rt & Lt heart catheters	0080	35.2996	$1,840.91	$838.92	$368.18
93528	T	.....	Rt & Lt heart catheters	0080	35.2996	$1,840.91	$838.92	$368.18
93529	T	.....	Rt, lt heart catheterization	0080	35.2996	$1,840.91	$838.92	$368.18
93530	T	.....	Rt heart cath, congenital	0080	35.2996	$1,840.91	$838.92	$368.18
93531	T	.....	R & l heart cath, congenital	0080	35.2996	$1,840.91	$838.92	$368.18
93532	T	.....	R & l heart cath, congenital	0080	35.2996	$1,840.91	$838.92	$368.18
93533	T	.....	R & l heart cath, congenital	0080	35.2996	$1,840.91	$838.92	$368.18
93539	N	.....	Injection, cardiac cath	.....	.....	.....	.....	.....
93540	N	.....	Injection, cardiac cath	.....	.....	.....	.....	.....
93541	N	.....	Injection for lung angiogram	.....	.....	.....	.....	.....
93542	N	.....	Injection for heart x-rays	.....	.....	.....	.....	.....
93543	N	.....	Injection for heart x-rays	.....	.....	.....	.....	.....
93544	N	.....	Injection for aortography	.....	.....	.....	.....	.....
93545	N	.....	Inject for coronary x-rays	.....	.....	.....	.....	.....
93555	N	.....	Imaging, cardiac cath	.....	.....	.....	.....	.....
93556	N	.....	Imaging, cardiac cath	.....	.....	.....	.....	.....

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93561	N		Cardiac output measurement					
93562	N		Cardiac output measurement					
93571	N		Heart flow reserve measure					
93572	N		Heart flow reserve measure					
93580	T	NI	Transcath closure of asd	0981		$2,250.00		$450.00
93581	T	NI	Transcath closure of vsd	0981		$2,250.00		$450.00
93600	T		Bundle of His recording	0087	39.3983	$2,054.66		$410.93
93602	T		Intra-atrial recording	0087	39.3983	$2,054.66		$410.93
93603	T		Right ventricular recording	0087	39.3983	$2,054.66		$410.93
93609	T		Map tachycardia, add-on	0087	39.3983	$2,054.66		$410.93
93610	T		Intra-atrial pacing	0087	39.3983	$2,054.66		$410.93
93612	T		Intraventricular pacing	0087	39.3983	$2,054.66		$410.93
93613	T		Electrophys map 3d, add-on	0087	39.3983	$2,054.66		$410.93
93615	T		Esophageal recording	0087	39.3983	$2,054.66		$410.93
93616	T		Esophageal recording	0087	39.3983	$2,054.66		$410.93
93618	T		Heart rhythm pacing	0087	39.3983	$2,054.66		$410.93
93619	T		Electrophysiology evaluation	0085	41.7238	$2,175.94	$480.03	$435.19
93620	T		Electrophysiology evaluation	0085	41.7238	$2,175.94	$480.03	$435.19
93621	T		Electrophysiology evaluation	0085	41.7238	$2,175.94	$480.03	$435.19
93622	T		Electrophysiology evaluation	0085	41.7238	$2,175.94	$480.03	$435.19
93623	T		Stimulation, pacing heart	0087	39.3983	$2,054.66		$410.93
93624	S		Electrophysiologic study	0084	9.3312	$486.63		$97.33
93631	T		Heart pacing, mapping	0087	39.3983	$2,054.66		$410.93
93640	S		Evaluation heart device	0084	9.3312	$486.63		$97.33
93641	S		Electrophysiology evaluation	0084	9.3312	$486.63		$97.33
93642	S		Electrophysiology evaluation	0084	9.3312	$486.63		$97.33
93650	T		Ablate heart dysrhythm focus	0086	52.8282	$2,755.04	$936.35	$551.01
93651	T		Ablate heart dysrhythm focus	0086	52.8282	$2,755.04	$936.35	$551.01
93652	T		Ablate heart dysrhythm focus	0086	52.8282	$2,755.04	$936.35	$551.01
93660	S		Tilt table evaluation	0101	4.2247	$220.32	$105.27	$44.06
93662	S		Intracardiac ecg (ice)	0670	30.2416	$1,577.13	$571.17	$315.43
93668	E		Peripheral vascular rehab					
93701	S		Bioimpedance, thoracic	0099	0.3682	$19.20		$3.84
93720	E		Total body plethysmography					
93721	X		Plethysmography tracing	0368	1.0562	$55.08	$27.55	$11.02
93722	E		Plethysmography report					
93724	S		Analyze pacemaker system	0690	0.4263	$22.23	$10.63	$4.45
93727	S		Analyze ilr system	0690	0.4263	$22.23	$10.63	$4.45
93731	S		Analyze pacemaker system	0690	0.4263	$22.23	$10.63	$4.45
93732	S		Analyze pacemaker system	0690	0.4263	$22.23	$10.63	$4.45
93733	S		Telephone analy, pacemaker	0690	0.4263	$22.23	$10.63	$4.45
93734	S		Analyze pacemaker system	0690	0.4263	$22.23	$10.63	$4.45
93735	S		Analyze pacemaker system	0690	0.4263	$22.23	$10.63	$4.45
93736	S		Telephone analy, pacemaker	0690	0.4263	$22.23	$10.63	$4.45
93740	X		Temperature gradient studies	0367	0.5814	$30.32	$15.16	$6.06
93741	S		Analyze ht pace device sngl	0689	0.5814	$30.32		$6.06
93742	S		Analyze ht pace device sngl	0689	0.5814	$30.32		$6.06
93743	S		Analyze ht pace device dual	0689	0.5814	$30.32		$6.06
93744	S		Analyze ht pace device dual	0689	0.5814	$30.32		$6.06
93760	E		Cephalic thermogram					
93762	E		Peripheral thermogram					
93770	N		Measure venous pressure					
93784	E		Ambulatory BP monitoring					
93786	X		Ambulatory BP recording	0097	1.0077	$52.55	$23.80	$10.51
93788	E		Ambulatory BP analysis					
93790	E		Review/report BP recording					
93797	S		Cardiac rehab	0095	0.6105	$31.84	$16.73	$6.37
93798	S		Cardiac rehab/monitor	0095	0.6105	$31.84	$16.73	$6.37
93799	S		Cardiovascular procedure	0096	1.7054	$88.94	$48.15	$17.79
93875	S		Extracranial study	0096	1.7054	$88.94	$48.15	$17.79
93880	S		Extracranial study	0267	2.4418	$127.34	$65.52	$25.47
93882	S		Extracranial study	0267	2.4418	$127.34	$65.52	$25.47
93886	S		Intracranial study	0267	2.4418	$127.34	$65.52	$25.47
93888	S		Intracranial study	0266	1.5988	$83.38	$45.86	$16.68
93922	S		Extremity study	0096	1.7054	$88.94	$48.15	$17.79

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93923	S		Extremity study	0096	1.7054	$88.94	$48.15	$17.79
93924	S		Extremity study	0096	1.7054	$88.94	$48.15	$17.79
93925	S		Lower extremity study	0267	2.4418	$127.34	$65.52	$25.47
93926	S		Lower extremity study	0267	2.4418	$127.34	$65.52	$25.47
93930	S		Upper extremity study	0267	2.4418	$127.34	$65.52	$25.47
93931	S		Upper extremity study	0266	1.5988	$83.38	$45.86	$16.68
93965	S		Extremity study	0096	1.7054	$88.94	$48.15	$17.79
93970	S		Extremity study	0267	2.4418	$127.34	$65.52	$25.47
93971	S		Extremity study	0267	2.4418	$127.34	$65.52	$25.47
93975	S		Vascular study	0267	2.4418	$127.34	$65.52	$25.47
93976	S		Vascular study	0267	2.4418	$127.34	$65.52	$25.47
93978	S		Vascular study	0267	2.4418	$127.34	$65.52	$25.47
93979	S		Vascular study	0267	2.4418	$127.34	$65.52	$25.47
93980	S		Penile vascular study	0267	2.4418	$127.34	$65.52	$25.47
93981	S		Penile vascular study	0267	2.4418	$127.34	$65.52	$25.47
93990	S		Doppler flow testing	0267	2.4418	$127.34	$65.52	$25.47
94010	X		Breathing capacity test	0368	1.0562	$55.08	$27.55	$11.02
94014	X		Patient recorded spirometry	0367	0.5814	$30.32	$15.16	$6.06
94015	X		Patient recorded spirometry	0367	0.5814	$30.32	$15.16	$6.06
94016	A		Review patient spirometry					
94060	X		Evaluation of wheezing	0368	1.0562	$55.08	$27.55	$11.02
94070	X		Evaluation of wheezing	0369	2.5871	$134.92	$44.18	$26.98
94150	X		Vital capacity test	0367	0.5814	$30.32	$15.16	$6.06
94200	X		Lung function test (MBC/MVV)	0367	0.5814	$30.32	$15.16	$6.06
94240	X		Residual lung capacity	0368	1.0562	$55.08	$27.55	$11.02
94250	X		Expired gas collection	0367	0.5814	$30.32	$15.16	$6.06
94260	X		Thoracic gas volume	0368	1.0562	$55.08	$27.55	$11.02
94350	X		Lung nitrogen washout curve	0368	1.0562	$55.08	$27.55	$11.02
94360	X		Measure airflow resistance	0367	0.5814	$30.32	$15.16	$6.06
94370	X		Breath airway closing volume	0367	0.5814	$30.32	$15.16	$6.06
94375	X		Respiratory flow volume loop	0367	0.5814	$30.32	$15.16	$6.06
94400	X		CO2 breathing response curve	0367	0.5814	$30.32	$15.16	$6.06
94450	X		Hypoxia response curve	0367	0.5814	$30.32	$15.16	$6.06
94620	X		Pulmonary stress test/simple	0368	1.0562	$55.08	$27.55	$11.02
94621	X		Pulm stress test/complex	0369	2.5871	$134.92	$44.18	$26.98
94640	S		Airway inhalation treatment	0077	0.2907	$15.16	$8.34	$3.03
94642	S		Aerosol inhalation treatment	0078	0.6492	$33.86	$14.55	$6.77
94650	S	DG	Pressure breathing (IPPB)	0077	0.2907	$15.16	$8.34	$3.03
94651	S	DG	Pressure breathing (IPPB)	0077	0.2907	$15.16	$8.34	$3.03
94652	C	DG	Pressure breathing (IPPB)					
94656	S		Initial ventilator mgmt	0079	1.6376	$85.40		$17.08
94657	S		Continued ventilator mgmt	0079	1.6376	$85.40		$17.08
94660	S		Pos airway pressure, CPAP	0068	2.0736	$108.14	$59.48	$21.63
94662	S		Neg press ventilation, cnp	0079	1.6376	$85.40		$17.08
94664	S		Aerosol or vapor inhalations	0077	0.2907	$15.16	$8.34	$3.03
94665	S	DG	Aerosol or vapor inhalations	0077	0.2907	$15.16	$8.34	$3.03
94667	S		Chest wall manipulation	0077	0.2907	$15.16	$8.34	$3.03
94668	S		Chest wall manipulation	0077	0.2907	$15.16	$8.34	$3.03
94680	X		Exhaled air analysis, o2	0367	0.5814	$30.32	$15.16	$6.06
94681	X		Exhaled air analysis, o2/co2	0368	1.0562	$55.08	$27.55	$11.02
94690	X		Exhaled air analysis	0367	0.5814	$30.32	$15.16	$6.06
94720	X		Monoxide diffusing capacity	0368	1.0562	$55.08	$27.55	$11.02
94725	X		Membrane diffusion capacity	0368	1.0562	$55.08	$27.55	$11.02
94750	X		Pulmonary compliance study	0367	0.5814	$30.32	$15.16	$6.06
94760	N		Measure blood oxygen level					
94761	N		Measure blood oxygen level					
94762	N		Measure blood oxygen level					
94770	X		Exhaled carbon dioxide test	0367	0.5814	$30.32	$15.16	$6.06
94772	X		Breath recording, infant	0369	2.5871	$134.92	$44.18	$26.98
94799	X		Pulmonary service/procedure	0367	0.5814	$30.32	$15.16	$6.06
95004	X		Percut allergy skin tests	0370	0.7752	$40.43	$11.58	$8.09
95010	X		Percut allergy titrate test	0370	0.7752	$40.43	$11.58	$8.09
95015	X		Id allergy titrate-drug/bug	0370	0.7752	$40.43	$11.58	$8.09
95024	X		Id allergy test, drug/bug	0370	0.7752	$40.43	$11.58	$8.09
95027	X		Skin end point titration	0370	0.7752	$40.43	$11.58	$8.09

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95028	X	.....	Id allergy test-delayed type	0370	0.7752	$40.43	$11.58	$8.09
95044	X	.....	Allergy patch tests	0370	0.7752	$40.43	$11.58	$8.09
95052	X	.....	Photo patch test	0370	0.7752	$40.43	$11.58	$8.09
95056	X	.....	Photosensitivity tests	0370	0.7752	$40.43	$11.58	$8.09
95060	X	.....	Eye allergy tests	0370	0.7752	$40.43	$11.58	$8.09
95065	X	.....	Nose allergy test	0370	0.7752	$40.43	$11.58	$8.09
95070	X	.....	Bronchial allergy tests	0369	2.5871	$134.92	$44.18	$26.98
95071	X	.....	Bronchial allergy tests	0369	2.5871	$134.92	$44.18	$26.98
95075	X	.....	Ingestion challenge test	0361	3.3914	$176.86	$83.23	$35.37
95078	X	.....	Provocative testing	0370	0.7752	$40.43	$11.58	$8.09
95115	X	.....	Immunotherapy, one injection	0352	0.2229	$11.62	.....	$2.32
95117	X	.....	Immunotherapy injections	0353	0.3973	$20.72	.....	$4.14
95120	E	.....	Immunotherapy, one injection	.....	.....	.....	.....	.....
95125	E	.....	Immunotherapy, many antigens	.....	.....	.....	.....	.....
95130	E	.....	Immunotherapy, insect venom	.....	.....	.....	.....	.....
95131	E	.....	Immunotherapy, insect venoms	.....	.....	.....	.....	.....
95132	E	.....	Immunotherapy, insect venoms	.....	.....	.....	.....	.....
95133	E	.....	Immunotherapy, insect venoms	.....	.....	.....	.....	.....
95134	E	.....	Immunotherapy, insect venoms	.....	.....	.....	.....	.....
95144	X	.....	Antigen therapy services	0371	0.5039	$26.28	.....	$5.26
95145	X	.....	Antigen therapy services	0371	0.5039	$26.28	.....	$5.26
95146	X	.....	Antigen therapy services	0371	0.5039	$26.28	.....	$5.26
95147	X	.....	Antigen therapy services	0371	0.5039	$26.28	.....	$5.26
95148	X	.....	Antigen therapy services	0371	0.5039	$26.28	.....	$5.26
95149	X	.....	Antigen therapy services	0371	0.5039	$26.28	.....	$5.26
95165	X	.....	Antigen therapy services	0371	0.5039	$26.28	.....	$5.26
95170	X	.....	Antigen therapy services	0371	0.5039	$26.28	.....	$5.26
95180	X	.....	Rapid desensitization	0370	0.7752	$40.43	$11.58	$8.09
95199	X	.....	Allergy immunology services	0370	0.7752	$40.43	$11.58	$8.09
95250	T	.....	Glucose monitoring, cont	0972	.....	$150.00	.....	$30.00
95805	S	.....	Multiple sleep latency test	0209	11.3369	$591.23	$280.58	$118.25
95806	S	.....	Sleep study, unattended	0213	3.2557	$169.79	$70.41	$33.96
95807	S	.....	Sleep study, attended	0209	11.3369	$591.23	$280.58	$118.25
95808	S	.....	Polysomnography, 1-3	0209	11.3369	$591.23	$280.58	$118.25
95810	S	.....	Polysomnography, 4 or more	0209	11.3369	$591.23	$280.58	$118.25
95811	S	.....	Polysomnography w/cpap	0209	11.3369	$591.23	$280.58	$118.25
95812	S	.....	Electroencephalogram (EEG)	0213	3.2557	$169.79	$70.41	$33.96
95813	S	.....	Eeg, over 1 hour	0213	3.2557	$169.79	$70.41	$33.96
95816	S	.....	Electroencephalogram (EEG)	0214	2.2286	$116.22	$58.12	$23.24
95819	S	.....	Electroencephalogram (EEG)	0214	2.2286	$116.22	$58.12	$23.24
95822	S	.....	Sleep electroencephalogram	0214	2.2286	$116.22	$58.12	$23.24
95824	S	.....	Eeg, cerebral death only	0214	2.2286	$116.22	$58.12	$23.24
95827	S	.....	Night electroencephalogram	0209	11.3369	$591.23	$280.58	$118.25
95829	S	.....	Surgery electrocorticogram	0214	2.2286	$116.22	$58.12	$23.24
95830	E	.....	Insert electrodes for EEG	.....	.....	.....	.....	.....
95831	N	.....	Limb muscle testing, manual	.....	.....	.....	.....	.....
95832	N	.....	Hand muscle testing, manual	.....	.....	.....	.....	.....
95833	N	.....	Body muscle testing, manual	.....	.....	.....	.....	.....
95834	N	.....	Body muscle testing, manual	.....	.....	.....	.....	.....
95851	N	.....	Range of motion measurements	.....	.....	.....	.....	.....
95852	N	.....	Range of motion measurements	.....	.....	.....	.....	.....
95857	S	.....	Tensilon test	0218	1.0077	$52.55	.....	$10.51
95858	S	.....	Tensilon test & myogram	0218	1.0077	$52.55	.....	$10.51
95860	S	.....	Muscle test, one limb	0218	1.0077	$52.55	.....	$10.51
95861	S	.....	Muscle test, 2 limbs	0218	1.0077	$52.55	.....	$10.51
95863	S	.....	Muscle test, 3 limbs	0218	1.0077	$52.55	.....	$10.51
95864	S	.....	Muscle test, 4 limbs	0218	1.0077	$52.55	.....	$10.51
95867	S	.....	Muscle test, head or neck	0218	1.0077	$52.55	.....	$10.51
95868	S	.....	Muscle test cran nerve bilat	0218	1.0077	$52.55	.....	$10.51
95869	S	.....	Muscle test, thor paraspinal	0215	0.5814	$30.32	$15.76	$6.06
95870	S	.....	Muscle test, nonparaspinal	0218	1.0077	$52.55	.....	$10.51
95872	S	.....	Muscle test, one fiber	0218	1.0077	$52.55	.....	$10.51
95875	S	.....	Limb exercise test	0215	0.5814	$30.32	$15.76	$6.06
95900	S	.....	Motor nerve conduction test	0218	1.0077	$52.55	.....	$10.51
95903	S	.....	Motor nerve conduction test	0218	1.0077	$52.55	.....	$10.51

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95904	S		Sense nerve conduction test	0215	0.5814	$30.32	$15.76	$6.06
95920	S		Intraop nerve test add-on	0216	2.8972	$151.09	$67.98	$30.22
95921	S		Autonomic nerv function test	0218	1.0077	$52.55		$10.51
95922	S		Autonomic nerv function test	0218	1.0077	$52.55		$10.51
95923	S		Autonomic nerv function test	0215	0.5814	$30.32	$15.76	$6.06
95925	S		Somatosensory testing	0216	2.8972	$151.09	$67.98	$30.22
95926	S		Somatosensory testing	0216	2.8972	$151.09	$67.98	$30.22
95927	S		Somatosensory testing	0216	2.8972	$151.09	$67.98	$30.22
95930	S		Visual evoked potential test	0218	1.0077	$52.55		$10.51
95933	S		Blink reflex test	0215	0.5814	$30.32	$15.76	$6.06
95934	S		H-reflex test	0215	0.5814	$30.32	$15.76	$6.06
95936	S		H-reflex test	0215	0.5814	$30.32	$15.76	$6.06
95937	S		Neuromuscular junction test	0218	1.0077	$52.55		$10.51
95950	S		Ambulatory eeg monitoring	0213	3.2557	$169.79	$70.41	$33.96
95951	S		EEG monitoring/videorecord	0209	11.3369	$591.23	$280.58	$118.25
95953	S		EEG monitoring/computer	0209	11.3369	$591.23	$280.58	$118.25
95954	S		EEG monitoring/giving drugs	0214	2.2286	$116.22	$58.12	$23.24
95955	S		EEG during surgery	0214	2.2286	$116.22	$58.12	$23.24
95956	S		Eeg monitoring, cable/radio	0214	2.2286	$116.22	$58.12	$23.24
95957	S		EEG digital analysis	0214	2.2286	$116.22	$58.12	$23.24
95958	S		EEG monitoring/function test	0213	3.2557	$169.79	$70.41	$33.96
95961	S		Electrode stimulation, brain	0216	2.8972	$151.09	$67.98	$30.22
95962	S		Electrode stim, brain add-on	0216	2.8972	$151.09	$67.98	$30.22
95965	S		Meg, spontaneous	0717		$2,250.00		$450.00
95966	S		Meg, evoked, single	0714		$1,375.00		$275.00
95967	S		Meg, evoked, each addl	0712		$875.00		$175.00
95970	S		Analyze neurostim, no prog	0692	6.2595	$326.44	$179.54	$65.29
95971	S		Analyze neurostim, simple	0692	6.2595	$326.44	$179.54	$65.29
95972	S		Analyze neurostim, complex	0692	6.2595	$326.44	$179.54	$65.29
95973	S		Analyze neurostim, complex	0692	6.2595	$326.44	$179.54	$65.29
95974	S		Cranial neurostim, complex	0692	6.2595	$326.44	$179.54	$65.29
95975	S		Cranial neurostim, complex	0692	6.2595	$326.44	$179.54	$65.29
95990	T	NI	Spin/brain pump refil & main	0125	2.0639	$107.63		$21.53
95999	S		Neurological procedure	0215	0.5814	$30.32	$15.76	$6.06
96000	S		Motion analysis, video/3d	0708		$150.00		$30.00
96001	S		Motion test w/ft press meas	0708		$150.00		$30.00
96002	S		Dynamic surface emg	0708		$150.00		$30.00
96003	S		Dynamic fine wire emg	0708		$150.00		$30.00
96004	E		Phys review of motion tests					
96100	X		Psychological testing	0373	2.2577	$117.74		$23.55
96105	X		Assessment of aphasia	0373	2.2577	$117.74		$23.55
96110	X		Developmental test, lim	0373	2.2577	$117.74		$23.55
96111	X		Developmental test, extend	0373	2.2577	$117.74		$23.55
96115	X		Neurobehavior status exam	0373	2.2577	$117.74		$23.55
96117	X		Neuropsych test battery	0373	2.2577	$117.74		$23.55
96150	S		Assess lth/behave, init	0322	1.3275	$69.23	$12.40	$13.85
96151	S		Assess hlth/behave, subseq	0322	1.3275	$69.23	$12.40	$13.85
96152	S		Intervene hlth/behave, indiv	0322	1.3275	$69.23	$12.40	$13.85
96153	S		Intervene hlth/behave, group	0322	1.3275	$69.23	$12.40	$13.85
96154	S		Interv hlth/behav, fam w/pt	0322	1.3275	$69.23	$12.40	$13.85
96155	S		Interv hlth/behav fam no pt	0322	1.3275	$69.23	$12.40	$13.85
96400	E		Chemotherapy, sc/im					
96405	E		Intralesional chemo admin					
96406	E		Intralesional chemo admin					
96408	E		Chemotherapy, push technique					
96410	E		Chemotherapy,infusion method					
96412	E		Chemo, infuse method add-on					
96414	E		Chemo, infuse method add-on					
96420	E		Chemotherapy, push technique					
96422	E		Chemotherapy,infusion method					
96423	E		Chemo, infuse method add-on					
96425	E		Chemotherapy,infusion method					
96440	E		Chemotherapy, intracavitary					
96445	E		Chemotherapy, intracavitary					
96450	E		Chemotherapy, into CNS					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
96520	T		Port pump refill & main	0125	2.0639	$107.63		$21.53
96530	T		Pump refilling, maintenance	0125	2.0639	$107.63		$21.53
96542	E		Chemotherapy injection					
96545	E		Provide chemotherapy agent					
96549	E		Chemotherapy, unspecified					
96567	T		Photodynamic tx, skin	0972		$150.00		$30.00
96570	T		Photodynamic tx, 30 min	0973		$250.00		$50.00
96571	T		Photodynamic tx, addl 15 min	0973		$250.00		$50.00
96900	S		Ultraviolet light therapy	0001	0.3779	$19.71	$7.09	$3.94
96902	N		Trichogram					
96910	S		Photochemotherapy with UV-B	0001	0.3779	$19.71	$7.09	$3.94
96912	S		Photochemotherapy with UV-A	0001	0.3779	$19.71	$7.09	$3.94
96913	S		Photochemotherapy, UV-A or B	0683	1.8992	$99.05	$35.65	$19.81
96920	T	NI	Laser tx, skin < 250 sq cm	0012	0.7849	$40.93	$11.18	$8.19
96921	T	NI	Laser tx, skin 250-500 sq cm	0012	0.7849	$40.93	$11.18	$8.19
96922	T	NI	Laser tx, skin > 500 sq cm	0013	1.0756	$56.09	$14.20	$11.22
96999	T		Dermatological procedure	0010	0.6589	$34.36	$10.08	$6.87
97001	A		Pt evaluation					
97002	A		Pt re-evaluation					
97003	A		Ot evaluation					
97004	A		Ot re-evaluation					
97005	E		Athletic train eval					
97006	E		Athletic train reeval					
97010	A		Hot or cold packs therapy					
97012	A		Mechanical traction therapy					
97014	A		Electric stimulation therapy					
97016	A		Vasopneumatic device therapy					
97018	A		Paraffin bath therapy					
97020	A		Microwave therapy					
97022	A		Whirlpool therapy					
97024	A		Diathermy treatment					
97026	A		Infrared therapy					
97028	A		Ultraviolet therapy					
97032	A		Electrical stimulation					
97033	A		Electric current therapy					
97034	A		Contrast bath therapy					
97035	A		Ultrasound therapy					
97036	A		Hydrotherapy					
97039	A		Physical therapy treatment					
97110	A		Therapeutic exercises					
97112	A		Neuromuscular reeducation					
97113	A		Aquatic therapy/exercises					
97116	A		Gait training therapy					
97124	A		Massage therapy					
97139	A		Physical medicine procedure					
97140	A		Manual therapy					
97150	A		Group therapeutic procedures					
97504	A		Orthotic training					
97520	A		Prosthetic training					
97530	A		Therapeutic activities					
97532	A		Cognitive skills development					
97533	A		Sensory integration					
97535	A		Self care mngment training					
97537	A		Community/work reintegration					
97542	A		Wheelchair mngment training					
97545	A		Work hardening					
97546	A		Work hardening add-on					
97601	A		Wound(s) care, selective					
97602	N		Wound(s) care non-selective					
97703	A		Prosthetic checkout					
97750	A		Physical performance test					
97780	E		Acupuncture w/o stimul					
97781	E		Acupuncture w/stimul					
97799	A		Physical medicine procedure					
97802	A		Medical nutrition, indiv, in					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
97803	A		Med nutrition, indiv, subseq					
97804	A		Medical nutrition, group					
98925	S		Osteopathic manipulation	0060	0.3294	$17.18		$3.44
98926	S		Osteopathic manipulation	0060	0.3294	$17.18		$3.44
98927	S		Osteopathic manipulation	0060	0.3294	$17.18		$3.44
98928	S		Osteopathic manipulation	0060	0.3294	$17.18		$3.44
98929	S		Osteopathic manipulation	0060	0.3294	$17.18		$3.44
98940	S		Chiropractic manipulation	0060	0.3294	$17.18		$3.44
98941	S		Chiropractic manipulation	0060	0.3294	$17.18		$3.44
98942	S		Chiropractic manipulation	0060	0.3294	$17.18		$3.44
98943	E		Chiropractic manipulation					
99000	E		Specimen handling					
99001	E		Specimen handling					
99002	E		Device handling					
99024	E		Postop follow-up visit					
99025	E		Initial surgical evaluation					
99026	E	NI	In-hospital on call service					
99027	E	NI	Out-of-hosp on call service					
99050	E		Medical services after hrs					
99052	E		Medical services at night					
99054	E		Medical servcs, unusual hrs					
99056	E		Non-office medical services					
99058	E		Office emergency care					
99070	E		Special supplies					
99071	E		Patient education materials					
99075	E		Medical testimony					
99078	N		Group health education					
99080	E		Special reports or forms					
99082	E		Unusual physician travel					
99090	E		Computer data analysis					
99091	E		Collect/review data from pt					
99100	E		Special anesthesia service					
99116	E		Anesthesia with hypothermia					
99135	E		Special anesthesia procedure					
99140	E		Emergency anesthesia					
99141	N		Sedation, iv/im or inhalant					
99142	N		Sedation, oral/rectal/nasal					
99170	T		Anogenital exam, child	0191	0.2035	$10.61	$3.08	$2.12
99172	E		Ocular function screen					
99173	E		Visual acuity screen					
99175	N		Induction of vomiting					
99183	E		Hyperbaric oxygen therapy					
99185	N		Regional hypothermia					
99186	N		Total body hypothermia					
99190	C		Special pump services					
99191	C		Special pump services					
99192	C		Special pump services					
99195	X		Phlebotomy	0372	0.5329	$27.79	$10.09	$5.56
99199	E		Special service/proc/report					
99201	V		Office/outpatient visit, new	0600	0.8430	$43.96		$8.79
99202	V		Office/outpatient visit, new	0600	0.8430	$43.96		$8.79
99203	V		Office/outpatient visit, new	0601	0.9690	$50.53		$10.11
99204	V		Office/outpatient visit, new	0602	1.4631	$76.30		$15.26
99205	V		Office/outpatient visit, new	0602	1.4631	$76.30		$15.26
99211	V		Office/outpatient visit, est	0600	0.8430	$43.96		$8.79
99212	V		Office/outpatient visit, est	0600	0.8430	$43.96		$8.79
99213	V		Office/outpatient visit, est	0601	0.9690	$50.53		$10.11
99214	V		Office/outpatient visit, est	0602	1.4631	$76.30		$15.26
99215	V		Office/outpatient visit, est	0602	1.4631	$76.30		$15.26
99217	N		Observation care discharge					
99218	N		Observation care					
99219	N		Observation care					
99220	N		Observation care					
99221	E		Initial hospital care					
99222	E		Initial hospital care					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99223	E		Initial hospital care					
99231	E		Subsequent hospital care					
99232	E		Subsequent hospital care					
99233	E		Subsequent hospital care					
99234	N		Observ/hosp same date					
99235	N		Observ/hosp same date					
99236	N		Observ/hosp same date					
99238	E		Hospital discharge day					
99239	E		Hospital discharge day					
99241	V		Office consultation	0600	0.8430	$43.96		$8.79
99242	V		Office consultation	0600	0.8430	$43.96		$8.79
99243	V		Office consultation	0601	0.9690	$50.53		$10.11
99244	V		Office consultation	0602	1.4631	$76.30		$15.26
99245	V		Office consultation	0602	1.4631	$76.30		$15.26
99251	C		Initial inpatient consult					
99252	C		Initial inpatient consult					
99253	C		Initial inpatient consult					
99254	C		Initial inpatient consult					
99255	C		Initial inpatient consult					
99261	C		Follow-up inpatient consult					
99262	C		Follow-up inpatient consult					
99263	C		Follow-up inpatient consult					
99271	V		Confirmatory consultation	0600	0.8430	$43.96		$8.79
99272	V		Confirmatory consultation	0600	0.8430	$43.96		$8.79
99273	V		Confirmatory consultation	0601	0.9690	$50.53		$10.11
99274	V		Confirmatory consultation	0602	1.4631	$76.30		$15.26
99275	V		Confirmatory consultation	0602	1.4631	$76.30		$15.26
99281	V		Emergency dept visit	0610	1.4147	$73.78	$19.57	$14.76
99282	V		Emergency dept visit	0610	1.4147	$73.78	$19.57	$14.76
99283	V		Emergency dept visit	0611	2.5290	$131.89	$36.47	$26.38
99284	V		Emergency dept visit	0612	4.3410	$226.39	$54.14	$45.28
99285	V		Emergency dept visit	0612	4.3410	$226.39	$54.14	$45.28
99288	E		Direct advanced life support					
99289	N		Pt transport, 30-74 min					
99290	N		Pt transport, addl 30 min					
99291	S		Critical care, first hour	0620	9.9610	$519.48	$150.55	$103.90
99292	N		Critical care, addl 30 min					
99293	C	NI	Ped critical care, initial					
99294	C	NI	Ped critical care, subseq					
99295	C		Neonatal critical care					
99296	C		Neonatal critical care					
99297	C	DG	Neonatal critical care					
99298	C		Neonatal critical care					
99299	C	NI	Ic, lbw infant 1500-2500 gm					
99301	E		Nursing facility care					
99302	E		Nursing facility care					
99303	E		Nursing facility care					
99311	E		Nursing fac care, subseq					
99312	E		Nursing fac care, subseq					
99313	E		Nursing fac care, subseq					
99315	E		Nursing fac discharge day					
99316	E		Nursing fac discharge day					
99321	E		Rest home visit, new patient					
99322	E		Rest home visit, new patient					
99323	E		Rest home visit, new patient					
99331	E		Rest home visit, est pat					
99332	E		Rest home visit, est pat					
99333	E		Rest home visit, est pat					
99341	E		Home visit, new patient					
99342	E		Home visit, new patient					
99343	E		Home visit, new patient					
99344	E		Home visit, new patient					
99345	E		Home visit, new patient					
99347	E		Home visit, est patient					
99348	E		Home visit, est patient					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99349	E		Home visit, est patient					
99350	E		Home visit, est patient					
99354	N		Prolonged service, office					
99355	N		Prolonged service, office					
99356	C		Prolonged service, inpatient					
99357	C		Prolonged service, inpatient					
99358	N		Prolonged serv, w/o contact					
99359	N		Prolonged serv, w/o contact					
99360	E		Physician standby services					
99361	E		Physician/team conference					
99362	E		Physician/team conference					
99371	E		Physician phone consultation					
99372	E		Physician phone consultation					
99373	E		Physician phone consultation					
99374	E		Home health care supervision					
99377	E		Hospice care supervision					
99379	E		Nursing fac care supervision					
99380	E		Nursing fac care supervision					
99381	E		Prev visit, new, infant					
99382	E		Prev visit, new, age 1-4					
99383	E		Prev visit, new, age 5-11					
99384	E		Prev visit, new, age 12-17					
99385	E		Prev visit, new, age 18-39					
99386	E		Prev visit, new, age 40-64					
99387	E		Prev visit, new, 65 & over					
99391	E		Prev visit, est, infant					
99392	E		Prev visit, est, age 1-4					
99393	E		Prev visit, est, age 5-11					
99394	E		Prev visit, est, age 12-17					
99395	E		Prev visit, est, age 18-39					
99396	E		Prev visit, est, age 40-64					
99397	E		Prev visit, est, 65 & over					
99401	E		Preventive counseling, indiv					
99402	E		Preventive counseling, indiv					
99403	E		Preventive counseling, indiv					
99404	E		Preventive counseling, indiv					
99411	E		Preventive counseling, group					
99412	E		Preventive counseling, group					
99420	E		Health risk assessment test					
99429	E		Unlisted preventive service					
99431	V		Initial care, normal newborn	0600	0.8430	$43.96		$8.79
99432	N		Newborn care, not in hosp					
99433	C		Normal newborn care/hospital					
99435	E		Newborn discharge day hosp					
99436	N		Attendance, birth					
99440	S		Newborn resuscitation	0094	3.8371	$200.11	$67.63	$40.02
99450	E		Life/disability evaluation					
99455	E		Disability examination					
99456	E		Disability examination					
99499	E		Unlisted e&m service					
99500	E		Home visit, prenatal					
99501	E		Home visit, postnatal					
99502	E		Home visit, nb care					
99503	E		Home visit, resp therapy					
99504	E		Home visit mech ventilator					
99505	E		Home visit, stoma care					
99506	E		Home visit, im injection					
99507	E		Home visit, cath maintain					
99508	E	DG	Home visit, sleep studies					
99509	E		Home visit day life activity					
99510	E		Home visit, sing/m/fam couns					
99511	E		Home visit, fecal/enema mgmt					
99512	E		Home visit, hemodialysis					
99539	E	DG	Home visit, nos					
99551	E		Home infus, pain mgmt, iv/sc					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99552	E		Hm infus pain mgmt, epid/ith					
99553	E		Home infuse, tocolytic tx					
99554	E		Home infus, hormone/platelet					
99555	E		Home infuse, chemotheraphy					
99556	E		Home infus, antibio/fung/vir					
99557	E		Home infuse, anticoagulant					
99558	E		Home infuse, immunotherapy					
99559	E		Home infus, periton dialysis					
99560	E		Home infus, entero nutrition					
99561	E		Home infuse, hydration tx					
99562	E		Home infus, parent nutrition					
99563	E		Home admin, pentamidine					
99564	E		Hme infus, antihemophil agnt					
99565	E		Home infus, proteinase inhib					
99566	E		Home infuse, iv therapy					
99567	E		Home infuse, sympath agent					
99568	E		Home infus, misc drug, daily					
99569	E		Home infuse, each addl tx					
99600	E	NI	Home visit nos					
A0021	E		Outside state ambulance serv					
A0080	E		Noninterest escort in non er					
A0090	E		Interest escort in non er					
A0100	E		Nonemergency transport taxi					
A0110	E		Nonemergency transport bus					
A0120	E		Noner transport mini-bus					
A0130	E		Noner transport wheelch van					
A0140	E		Nonemergency transport air					
A0160	E		Noner transport case worker					
A0170	E		Noner transport parking fees					
A0180	E		Noner transport lodgng recip					
A0190	E		Noner transport meals recip					
A0200	E		Noner transport lodgng escrt					
A0210	E		Noner transport meals escort					
A0225	A		Neonatal emergency transport					
A0380	A		Basic life support mileage					
A0382	A		Basic support routine suppls					
A0384	A		Bls defibrillation supplies					
A0390	A		Advanced life support mileag					
A0392	A		Als defibrillation supplies					
A0394	A		Als IV drug therapy supplies					
A0396	A		Als esophageal intub suppls					
A0398	A		Als routine disposble suppls					
A0420	A		Ambulance waiting 1/2 hr					
A0422	A		Ambulance 02 life sustaining					
A0424	A		Extra ambulance attendant					
A0425	A		Ground mileage					
A0426	A		Als 1					
A0427	A		ALS1-emergency					
A0428	A		bls					
A0429	A		BLS-emergency					
A0430	A		Fixed wing air transport					
A0431	A		Rotary wing air transport					
A0432	A		PI volunteer ambulance co					
A0433	A		als 2					
A0434	A		Specialty care transport					
A0435	A		Fixed wing air mileage					
A0436	A		Rotary wing air mileage					
A0888	E		Noncovered ambulance mileage					
A0999	A		Unlisted ambulance service					
A4206	A		1 CC sterile syringe&needle					
A4207	A		2 CC sterile syringe&needle					
A4208	A		3 CC sterile syringe&needle					
A4209	E		5+ CC sterile syringe&needle					
A4210	E		Nonneedle injection device					
A4211	E		Supp for self-adm injections					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4212	E		Non coring needle or stylet					
A4213	E		20+ CC syringe only					
A4214	A		30 CC sterile water/saline					
A4215	E		Sterile needle					
A4220	A		Infusion pump refill kit					
A4221	A		Maint drug infus cath per wk					
A4222	A		Drug infusion pump supplies					
A4230	A		Infus insulin pump non needl					
A4231	A		Infusion insulin pump needle					
A4232	A		Syringe w/needle insulin 3cc					
A4244	E		Alcohol or peroxide per pint					
A4245	E		Alcohol wipes per box					
A4246	E		Betadine/phisohex solution					
A4247	E		Betadine/iodine swabs/wipes					
A4250	E		Urine reagent strips/tablets					
A4253	A		Blood glucose/reagent strips					
A4254	A		Battery for glucose monitor					
A4255	A		Glucose monitor platforms					
A4256	A		Calibrator solution/chips					
A4257	A		Replace Lensshield Cartridge					
A4258	A		Lancet device each					
A4259	A		Lancets per box					
A4260	E		Levonorgestrel implant					
A4261	E		Cervical cap contraceptive					
A4262	N		Temporary tear duct plug					
A4263	N		Permanent tear duct plug					
A4265	A		Paraffin					
A4266	E	NI	Diaphragm					
A4267	E	NI	Male condom					
A4268	E	NI	Female condom					
A4269	E	NI	Spermicide					
A4270	A		Disposable endoscope sheath					
A4280	A		Brst prsths adhsv attchmnt					
A4281	E	NI	Replacement breastpump tube					
A4282	E	NI	Replacement breastpump adpt					
A4283	E	NI	Replacement breastpump cap					
A4284	E	NI	Replcmnt breast pump shield					
A4285	E	NI	Replcmnt breast pump bottle					
A4286	E	NI	Replcmnt breastpump lok ring					
A4290	E		Sacral nerve stim test lead					
A4300	N		Cath impl vasc access portal					
A4301	N		Implantable access syst perc					
A4305	A		Drug delivery system >=50 ML					
A4306	A		Drug delivery system <=5 ML					
A4310	A		Insert tray w/o bag/cath					
A4311	A		Catheter w/o bag 2-way latex					
A4312	A		Cath w/o bag 2-way silicone					
A4313	A		Catheter w/bag 3-way					
A4314	A		Cath w/drainage 2-way latex					
A4315	A		Cath w/drainage 2-way silcne					
A4316	A		Cath w/drainage 3-way					
A4319	A		Sterile H2O irrigation solut					
A4320	A		Irrigation tray					
A4321	A		Cath therapeutic irrig agent					
A4322	A		Irrigation syringe					
A4323	A		Saline irrigation solution					
A4324	A		Male ext cath w/adh coating					
A4325	A		Male ext cath w/adh strip					
A4326	A		Male external catheter					
A4327	A		Fem urinary collect dev cup					
A4328	A		Fem urinary collect pouch					
A4330	A		Stool collection pouch					
A4331	A		Extension drainage tubing					
A4332	A		Lubricant for cath insertion					
A4333	A		Urinary cath anchor device					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4334	A		Urinary cath leg strap					
A4335	A		Incontinence supply					
A4338	A		Indwelling catheter latex					
A4340	A		Indwelling catheter special					
A4344	A		Cath indw foley 2 way silicn					
A4346	A		Cath indw foley 3 way					
A4347	A		Male external catheter					
A4348	A		Male ext cath extended wear					
A4351	A		Straight tip urine catheter					
A4352	A		Coude tip urinary catheter					
A4353	A		Intermittent urinary cath					
A4354	A		Cath insertion tray w/bag					
A4355	A		Bladder irrigation tubing					
A4356	A		Ext ureth clmp or compr dvc					
A4357	A		Bedside drainage bag					
A4358	A		Urinary leg or abdomen bag					
A4359	A		Urinary suspensory w/o leg b					
A4360	A	DG	Adult incontinence garment					
A4361	A		Ostomy face plate					
A4362	A		Solid skin barrier					
A4364	A		Adhesive, liquid or equal					
A4365	A		Adhesive remover wipes					
A4367	A		Ostomy belt					
A4368	A		Ostomy filter					
A4369	A		Skin barrier liquid per oz					
A4370	A	DG	Skin barrier paste per oz					
A4371	A		Skin barrier powder per oz					
A4372	A		Skin barrier solid 4x4 equiv					
A4373	A		Skin barrier with flange					
A4374	A	DG	Skin barrier extended wear					
A4375	A		Drainable plastic pch w fcpl					
A4376	A		Drainable rubber pch w fcplt					
A4377	A		Drainable plstic pch w/o fp					
A4378	A		Drainable rubber pch w/o fp					
A4379	A		Urinary plastic pouch w fcpl					
A4380	A		Urinary rubber pouch w fcplt					
A4381	A		Urinary plastic pouch w/o fp					
A4382	A		Urinary hvy plstc pch w/o fp					
A4383	A		Urinary rubber pouch w/o fp					
A4384	A		Ostomy faceplt/silicone ring					
A4385	A		Ost skn barrier sld ext wear					
A4386	A	DG	Ost skn barrier w flng ex wr					
A4387	A		Ost clsd pouch w att st barr					
A4388	A		Drainable pch w ex wear barr					
A4389	A		Drainable pch w st wear barr					
A4390	A		Drainable pch ex wear convex					
A4391	A		Urinary pouch w ex wear barr					
A4392	A		Urinary pouch w st wear barr					
A4393	A		Urine pch w ex wear bar conv					
A4394	A		Ostomy pouch liq deodorant					
A4395	A		Ostomy pouch solid deodorant					
A4396	A		Peristomal hernia supprt blt					
A4397	A		Irrigation supply sleeve					
A4398	A		Ostomy irrigation bag					
A4399	A		Ostomy irrig cone/cath w brs					
A4400	A		Ostomy irrigation set					
A4402	A		Lubricant per ounce					
A4404	A		Ostomy ring each					
A4405	A	NI	Nonpectin based ostomy paste					
A4406	A	NI	Pectin based ostomy paste					
A4407	A	NI	Ext wear ost skn barr <=4sq≧					
A4408	A	NI	Ext wear ost skn barr >4sq≧					
A4409	A	NI	Ost skn barr w flng <=4 sq≧					
A4410	A	NI	Ost skn barr w flng >4sq≧					
A4413	A	NI	2 pc drainable ost pouch					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4414	A	NI	Ostomy sknbarr w flng <=4sq≧					
A4415	A	NI	Ostomy skn barr w flng >4sq≧					
A4421	A		Ostomy supply misc					
A4422	A	NI	Ost pouch absorbent material					
A4450	A	NI	Non-waterproof tape					
A4452	A	NI	Waterproof tape					
A4454	A	DG	Tape all types all sizes					
A4455	A		Adhesive remover per ounce					
A4458	E	NI	Reusable enema bag					
A4460	A	DG	Elastic compression bandage					
A4462	A		Abdmnl drssng holder/binder					
A4464	A	DG	Joint support device/garment					
A4465	A		Non-elastic extremity binder					
A4470	A		Gravlee jet washer					
A4480	A		Vabra aspirator					
A4481	A		Tracheostoma filter					
A4483	A		Moisture exchanger					
A4490	E		Above knee surgical stocking					
A4495	E		Thigh length surg stocking					
A4500	E		Below knee surgical stocking					
A4510	E		Full length surg stocking					
A4521	E	NI	Adult size diaper sm each					
A4522	E	NI	Adult size diaper med each					
A4523	E	NI	Adult size diaper lg each					
A4524	E	NI	Adult size diaper xl each					
A4525	E	NI	Adult size brief sm each					
A4526	E	NI	Adult size brief med each					
A4527	E	NI	Adult size brief lg each					
A4528	E	NI	Adult size brief xl each					
A4529	E	NI	Child size diaper sm/med ea					
A4530	E	NI	Child size diaper lg each					
A4531	E	NI	Child size brief sm/med each					
A4532	E	NI	Child size brief lg each					
A4533	E	NI	Youth size diaper each					
A4534	E	NI	Youth size brief each					
A4535	E	NI	Disp incont liner/shield ea					
A4536	E	NI	Prot underwr wshbl any sz ea					
A4537	E	NI	Under pad reusable any sz ea					
A4538	E	NI	Diaper sv ea reusable diaper					
A4550	E		Surgical trays					
A4554	E		Disposable underpads					
A4556	A		Electrodes, pair					
A4557	A		Lead wires, pair					
A4558	A		Conductive paste or gel					
A4561	N		Pessary rubber, any type					
A4562	N		Pessary, non rubber,any type					
A4565	A		Slings					
A4570	N		Splint					
A4572	A	DG	Rib belt					
A4575	E		Hyperbaric o2 chamber disps					
A4580	N		Cast supplies (plaster)					
A4590	N		Special casting material					
A4595	A		TENS suppl 2 lead per month					
A4606	A	NI	Oxygen probe used w oximeter					
A4608	A		Transtracheal oxygen cath					
A4609	A	NI	Trach suction cath clsed sys					
A4610	A	NI	Trach sctn cath 72h clsedsys					
A4611	A		Heavy duty battery					
A4612	A		Battery cables					
A4613	A		Battery charger					
A4614	A		Hand-held PEFR meter					
A4615	A		Cannula nasal					
A4616	A		Tubing (oxygen) per foot					
A4617	A		Mouth piece					
A4618	A		Breathing circuits					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4619	A		Face tent					
A4620	A		Variable concentration mask					
A4621	A		Tracheotomy mask or collar					
A4622	A		Tracheostomy or larngectomy					
A4623	A		Tracheostomy inner cannula					
A4624	A		Tracheal suction tube					
A4625	A		Trach care kit for new trach					
A4626	A		Tracheostomy cleaning brush					
A4627	E		Spacer bag/reservoir					
A4628	A		Oropharyngeal suction cath					
A4629	A		Tracheostomy care kit					
A4630	A		Repl bat t.e.n.s. own by pt					
A4631	A		Wheelchair battery					
A4632	A	NI	Infus pump rplcemnt battery					
A4633	A	NI	Uvl replacement bulb					
A4634	A	NI	Replacement bulb th lightbox					
A4635	A		Underarm crutch pad					
A4636	A		Handgrip for cane etc					
A4637	A		Repl tip cane/crutch/walker					
A4639	A	NI	Infrared ht sys replcmnt pad					
A4640	A		Alternating pressure pad					
A4641	N		Diagnostic imaging agent					
A4642	N		Satumomab pendetide per dose					
A4643	N		High dose contrast MRI					
A4644	N		Contrast 100-199 MGs iodine					
A4645	N		Contrast 200-299 MGs iodine					
A4646	N		Contrast 300-399 MGs iodine					
A4647	N		Supp- paramagnetic contr mat					
A4649	A		Surgical supplies					
A4651	A		Calibrated microcap tube					
A4652	A		Microcapillary tube sealant					
A4653	A	NI	PD catheter anchor belt					
A4656	A		Dialysis needle					
A4657	A		Dialysis syringe w/wo needle					
A4660	A		Sphyg/bp app w cuff and stet					
A4663	A		Dialysis blood pressure cuff					
A4670	E		Automatic bp monitor, dial					
A4680	A		Activated carbon filter, ea					
A4690	A		Dialyzer, each					
A4706	A		Bicarbonate conc sol per gal					
A4707	A		Bicarbonate conc pow per pac					
A4708	A		Acetate conc sol per gallon					
A4709	A		Acid conc sol per gallon					
A4712	A		Sterile water inj per 10 ml					
A4714	A		Treated water per gallon					
A4719	A		≧Y set≧ tubing					
A4720	A		Dialysat sol fld vol > 249cc					
A4721	A		Dialysat sol fld vol > 999cc					
A4722	A		Dialys sol fld vol > 1999cc					
A4723	A		Dialys sol fld vol > 2999cc					
A4724	A		Dialys sol fld vol > 3999cc					
A4725	A		Dialys sol fld vol > 4999cc					
A4726	A		Dialys sol fld vol > 5999cc					
A4730	A		Fistula cannulation set, ea					
A4736	A		Topical anesthetic, per gram					
A4737	A		Inj anesthetic per 10 ml					
A4740	A		Shunt accessory					
A4750	A		Art or venous blood tubing					
A4755	A		Comb art/venous blood tubing					
A4760	A		Dialysate sol test kit, each					
A4765	A		Dialysate conc pow per pack					
A4766	A		Dialysate conc sol add 10 ml					
A4770	A		Blood collection tube/vacuum					
A4771	A		Serum clotting time tube					
A4772	A		Blood glucose test strips					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4773	A		Occult blood test strips					
A4774	A		Ammonia test strips					
A4801	A	DG	Heparin per 1000 units					
A4802	A		Protamine sulfate per 50 mg					
A4860	A		Disposable catheter tips					
A4870	A		Plumb/elec wk hm hemo equip					
A4890	A		Repair/maint cont hemo equip					
A4911	A		Drain bag/bottle					
A4913	A		Misc dialysis supplies noc					
A4918	A		Venous pressure clamp					
A4927	A		Non-sterile gloves					
A4928	A		Surgical mask					
A4929	A		Tourniquet for dialysis, ea					
A4930	A	NI	Sterile, gloves per pair					
A4931	A	NI	Reusable oral thermometer					
A4932	E	NI	Reusable rectal thermometer					
A5051	A		Pouch clsd w barr attached					
A5052	A		Clsd ostomy pouch w/o barr					
A5053	A		Clsd ostomy pouch faceplate					
A5054	A		Clsd ostomy pouch w/flange					
A5055	A		Stoma cap					
A5061	A		Pouch drainable w barrier at					
A5062	A		Drnble ostomy pouch w/o barr					
A5063	A		Drain ostomy pouch w/flange					
A5071	A		Urinary pouch w/barrier					
A5072	A		Urinary pouch w/o barrier					
A5073	A		Urinary pouch on barr w/flng					
A5081	A		Continent stoma plug					
A5082	A		Continent stoma catheter					
A5093	A		Ostomy accessory convex inse					
A5102	A		Bedside drain btl w/wo tube					
A5105	A		Urinary suspensory					
A5112	A		Urinary leg bag					
A5113	A		Latex leg strap					
A5114	A		Foam/fabric leg strap					
A5119	A		Skin barrier wipes box pr 50					
A5121	A		Solid skin barrier 6x6					
A5122	A		Solid skin barrier 8x8					
A5123	A	DG	Skin barrier with flange					
A5126	A		Disk/foam pad +or- adhesive					
A5131	A		Appliance cleaner					
A5200	A		Percutaneous catheter anchor					
A5500	A		Diab shoe for density insert					
A5501	A		Diabetic custom molded shoe					
A5503	A		Diabetic shoe w/roller/rockr					
A5504	A		Diabetic shoe with wedge					
A5505	A		Diab shoe w/metatarsal bar					
A5506	A		Diabetic shoe w/off set heel					
A5507	A		Modification diabetic shoe					
A5508	A		Diabetic deluxe shoe					
A5509	A		Direct heat form shoe insert					
A5510	A		Compression form shoe insert					
A5511	A		Custom fab molded shoe inser					
A6000	E		Wound warming wound cover					
A6010	A		Collagen based wound filler					
A6011	A	NI	Collagen gel/paste wound fil					
A6021	A		Collagen dressing <=16 sq in					
A6022	A		Collagen drsg>6<=48 sq in					
A6023	A		Collagen dressing >48 sq in					
A6024	A		Collagen dsg wound filler					
A6025	E		Silicone gel sheet, each					
A6154	A		Wound pouch each					
A6196	A		Alginate dressing <=16 sq in					
A6197	A		Alginate drsg >16 <=48 sq in					
A6198	A		alginate dressing > 48 sq in					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A6199	A		Alginate drsg wound filler					
A6200	A		Compos drsg <=16 no border					
A6201	A		Compos drsg >16<=48 no bdr					
A6202	A		Compos drsg >48 no border					
A6203	A		Composite drsg <= 16 sq in					
A6204	A		Composite drsg >16<=48 sq in					
A6205	A		Composite drsg > 48 sq in					
A6206	A		Contact layer <= 16 sq in					
A6207	A		Contact layer >16<= 48 sq in					
A6208	A		Contact layer > 48 sq in					
A6209	A		Foam drsg <=16 sq in w/o bdr					
A6210	A		Foam drg >16<=48 sq in w/o b					
A6211	A		Foam drg > 48 sq in w/o brdr					
A6212	A		Foam drg <=16 sq in w/border					
A6213	A		Foam drg >16<=48 sq in w/bdr					
A6214	A		Foam drg > 48 sq in w/border					
A6215	A		Foam dressing wound filler					
A6216	A		Non-sterile gauze<=16 sq in					
A6217	A		Non-sterile gauze>16<=48 sq					
A6218	A		Non-sterile gauze > 48 sq in					
A6219	A		Gauze <= 16 sq in w/border					
A6220	A		Gauze >16 <=48 sq in w/bordr					
A6221	A		Gauze > 48 sq in w/border					
A6222	A		Gauze <=16 in no w/sal w/o b					
A6223	A		Gauze >16<=48 no w/sal w/o b					
A6224	A		Gauze > 48 in no w/sal w/o b					
A6228	A		Gauze <= 16 sq in water/sal					
A6229	A		Gauze >16<=48 sq in watr/sal					
A6230	A		Gauze > 48 sq in water/salne					
A6231	A		Hydrogel dsg<=16 sq in					
A6232	A		Hydrogel dsg>16<=48 sq in					
A6233	A		Hydrogel dressing >48 sq in					
A6234	A		Hydrocolld drg <=16 w/o bdr					
A6235	A		Hydrocolld drg >16<=48 w/o b					
A6236	A		Hydrocolld drg > 48 in w/o b					
A6237	A		Hydrocolld drg <=16 in w/bdr					
A6238	A		Hydrocolld drg >16<=48 w/bdr					
A6239	A		Hydrocolld drg > 48 in w/bdr					
A6240	A		Hydrocolld drg filler paste					
A6241	A		Hydrocolloid drg filler dry					
A6242	A		Hydrogel drg <=16 in w/o bdr					
A6243	A		Hydrogel drg >16<=48 w/o bdr					
A6244	A		Hydrogel drg >48 in w/o bdr					
A6245	A		Hydrogel drg <= 16 in w/bdr					
A6246	A		Hydrogel drg >16<=48 in w/b					
A6247	A		Hydrogel drg > 48 sq in w/b					
A6248	A		Hydrogel drsg gel filler					
A6250	A		Skin seal protect moisturizr					
A6251	A		Absorpt drg <=16 sq in w/o b					
A6252	A		Absorpt drg >16 <=48 w/o bdr					
A6253	A		Absorpt drg > 48 sq in w/o b					
A6254	A		Absorpt drg <=16 sq in w/bdr					
A6255	A		Absorpt drg >16<=48 in w/bdr					
A6256	A		Absorpt drg > 48 sq in w/bdr					
A6257	A		Transparent film <= 16 sq in					
A6258	A		Transparent film >16<=48 in					
A6259	A		Transparent film > 48 sq in					
A6260	A		Wound cleanser any type/size					
A6261	A		Wound filler gel/paste /oz					
A6262	A		Wound filler dry form / gram					
A6263	A	DG	Non-sterile elastic gauze/yd					
A6264	A	DG	Non-sterile no elastic gauze					
A6265	A	DG	Tape per 18 sq inches					
A6266	A		Impreg gauze no h20/sal/yard					
A6402	A		Sterile gauze <= 16 sq in					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A6403	A		Sterile gauze>16 <= 48 sq in					
A6404	A		Sterile gauze > 48 sq in					
A6405	A	DG	Sterile elastic gauze /yd					
A6406	A	DG	Sterile non-elastic gauze/yd					
A6410	A	NI	Sterile eye pad					
A6411	A	NI	Non-sterile eye pad					
A6412	E	NI	Occlusive eye patch					
A6421	A	NI	Pad bandage >=3 <5in w /roll					
A6422	A	NI	Conf bandage ns >=3<5≧w/roll					
A6424	A	NI	Conf bandage ns >=5≧w /roll					
A6426	A	NI	Conf bandage s >=3<5≧ w/roll					
A6428	A	NI	Conf bandage s >=5≧ w /roll					
A6430	A	NI	Lt compres bdg >=3<5≧w /roll					
A6432	A	NI	Lt compres bdg >=5≧w /roll					
A6434	A	NI	Mo compres bdg >=3<5≧w /roll					
A6436	A	NI	Hi compres bdg >=3<5≧w /roll					
A6438	A	NI	Self-adher bdg >=3<5≧w /roll					
A6440	A	NI	Zinc paste bdg >=3<5≧w /roll					
A6501	A	NI	Compres burngarment bodysuit					
A6502	A	NI	Compres burngarment chinstrp					
A6503	A	NI	Compres burngarment facehood					
A6504	A	NI	Cmprsburngarment glove-wrist					
A6505	A	NI	Cmprsburngarment glove-elbow					
A6506	A	NI	Cmprsburngrmnt glove-axilla					
A6507	A	NI	Cmprs burngarment foot-knee					
A6508	A	NI	Cmprs burngarment foot-thigh					
A6509	A	NI	Compres burn garment jacket					
A6510	A	NI	Compres burn garment leotard					
A6511	A	NI	Compres burn garment panty					
A6512	A	NI	Compres burn garment, noc					
A7000	A		Disposable canister for pump					
A7001	A		Nondisposable pump canister					
A7002	A		Tubing used w suction pump					
A7003	A		Nebulizer administration set					
A7004	A		Disposable nebulizer sml vol					
A7005	A		Nondisposable nebulizer set					
A7006	A		Filtered nebulizer admin set					
A7007	A		Lg vol nebulizer disposable					
A7008	A		Disposable nebulizer prefill					
A7009	A		Nebulizer reservoir bottle					
A7010	A		Disposable corrugated tubing					
A7011	A		Nondispos corrugated tubing					
A7012	A		Nebulizer water collec devic					
A7013	A		Disposable compressor filter					
A7014	A		Compressor nondispos filter					
A7015	A		Aerosol mask used w nebulize					
A7016	A		Nebulizer dome & mouthpiece					
A7017	A		Nebulizer not used w oxygen					
A7018	A		Water distilled w/nebulizer					
A7019	A		Saline solution dispenser					
A7020	A		Sterile H2O or NSS w lgv neb					
A7025	A	NI	Replace chest compress vest					
A7026	A	NI	Replace chst cmprss sys hose					
A7030	A	NI	CPAP full face mask					
A7031	A	NI	Replacement facemask interfa					
A7032	A	NI	Replacement nasal cushion					
A7033	A	NI	Replacement nasal pillows					
A7034	A	NI	Nasal application device					
A7035	A	NI	Pos airway press headgear					
A7036	A	NI	Pos airway press chinstrap					
A7037	A	NI	Pos airway pressure tubing					
A7038	A	NI	Pos airway pressure filter					
A7039	A	NI	Filter, non disposable w pap					
A7042	A	NI	Implanted pleural catheter					
A7043	A	NI	Vacuum drainagebottle/tubing					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A7044	A	NI	PAP oral interface					
A7501	A		Tracheostoma valve w diaphra					
A7502	A		Replacement diaphragm/fplate					
A7503	A		HMES filter holder or cap					
A7504	A		Tracheostoma HMES filter					
A7505	A		HMES or trach valve housing					
A7506	A		HMES/trachvalve adhesivedisk					
A7507	A		Integrated filter & holder					
A7508	A		Housing & Integrated Adhesiv					
A7509	A		Heat & moisture exchange sys					
A9150	E		Misc/exper non-prescript dru					
A9270	E		Non-covered item or service					
A9300	E		Exercise equipment					
A9500	N		Technetium TC 99m sestamibi					
A9502	N		Technetium TC99M tetrofosmin					
A9503	N		Technetium TC 99m medronate					
A9504	N		Technetium tc 99m apcitide					
A9505	N		Thallous chloride TL 201/mci					
A9507	K		Indium/111 capromab pendetid	1604	16.4434	$857.54		$171.51
A9508	K		Iobenguane sulfate I-131	1045	1.5697	$81.86		$16.37
A9510	N		Technetium TC99m Disofenin					
A9511	K		Technetium TC 99m depreotide	1095	5.6006	$292.08		$58.42
A9512	N	NI	Technetium tc99m pertechnetate					
A9513	N	NI	Technetium tc-99m mebrofenin					
A9514	N	NI	Technetium tc99m pyrophosphate					
A9515	N	NI	Technetium tc-99m pentetate					
A9516	N	NI	I-123 sodium iodide capsule					
A9517	N	NI	I-131 sodium iodide capsule					
A9518	K	NI	I-131 sodium iodide solution	1348	0.9399	$49.02		$9.80
A9519	N	NI	Technetium tc-99m macroag albu					
A9520	N	NI	Technetium tc-99m sulfur clld					
A9521	K	NI	Technetium tc-99m exametazine	1096	4.4379	$231.44		$46.29
A9522	E	NI	Indium111ibritumomabtiuxetan					
A9523	E	NI	Yttrium90ibritumomabtiuxetan					
A9524	N	NI	Iodinated I-131 serumalbumin					
A9600	K		Strontium-89 chloride	0701	8.9920	$468.94		$93.79
A9603	N	NI	I-131sodiumiodidecap per mci					
A9605	K		Samarium sm153 lexidronamm	0702	14.6218	$762.54		$152.51
A9699	N	NI	Noc therapeutic radiopharm					
A9700	G		Echocardiography Contrast	9016		$118.75		$17.75
A9900	A		Supply/accessory/service					
A9901	A		Delivery/set up/dispensing					
B4034	A		Enter feed supkit syr by day					
B4035	A		Enteral feed supp pump per d					
B4036	A		Enteral feed sup kit grav by					
B4081	A		Enteral ng tubing w/ stylet					
B4082	A		Enteral ng tubing w/o stylet					
B4083	A		Enteral stomach tube levine					
B4086	A		Gastrostomy/jejunostomy tube					
B4100	E	NI	Food thickener oral					
B4150	A		Enteral formulae category i					
B4151	A		Enteral formulae cat1natural					
B4152	A		Enteral formulae category ii					
B4153	A		Enteral formulae categoryIII					
B4154	A		Enteral formulae category IV					
B4155	A		Enteral formulae category v					
B4156	A		Enteral formulae category vi					
B4164	A		Parenteral 50% dextrose solu					
B4168	A		Parenteral sol amino acid 3.					
B4172	A		Parenteral sol amino acid 5.					
B4176	A		Parenteral sol amino acid 7-					
B4178	A		Parenteral sol amino acid >					
B4180	A		Parenteral sol carb > 50%					
B4184	A		Parenteral sol lipids 10%					
B4186	A		Parenteral sol lipids 20%					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
B4189	A		Parenteral sol amino acid &					
B4193	A		Parenteral sol 52-73 gm prot					
B4197	A		Parenteral sol 74-100 gm pro					
B4199	A		Parenteral sol > 100gm prote					
B4216	A		Parenteral nutrition additiv					
B4220	A		Parenteral supply kit premix					
B4222	A		Parenteral supply kit homemi					
B4224	A		Parenteral administration ki					
B5000	A		Parenteral sol renal-amirosy					
B5100	A		Parenteral sol hepatic-fream					
B5200	A		Parenteral sol stres-brnch c					
B9000	A		Enter infusion pump w/o alrm					
B9002	A		Enteral infusion pump w/ ala					
B9004	A		Parenteral infus pump portab					
B9006	A		Parenteral infus pump statio					
B9998	A		Enteral supp not otherwise c					
B9999	A		Parenteral supp not othrws c					
C1010	K		Blood, L/R, CMV-NEG	1010	2.3352	$121.78		$24.36
C1011	K		Platelets, HLA-m, L/R, unit	1011	9.5831	$499.77		$99.95
C1012	K	DG	PLATELET CONC, L/R, Irrad	0954	2.2868	$119.26		$23.85
C1013	K	DG	PLATELET CONC, L/R, Unit	1013	0.9496	$49.52		$9.90
C1014	K	DG	Platelet,Aph/Pher, L/R, unit	9501	7.8390	$408.81		$81.76
C1015	K	NI	Plt, pher,L/R,CMV, irrad	1020	9.4959	$495.22		$99.04
C1016	K		BLOOD,L/R,FROZ/DEGLY/Washed	1016	5.7848	$301.68		$60.34
C1017	K		Plt, APH/PHER,L/R,CMV-NEG	1017	7.5386	$393.15		$78.63
C1018	K		Blood, L/R, IRRADIATED	1018	2.5387	$132.40		$26.48
C1020	K	NI	RBC, frz/deg/wsh, L/R, irrad	1021	6.4436	$336.04		$67.21
C1021	K	NI	RBC, L/R, CMV neg, irrad	1022	3.8565	$201.12		$40.22
C1022	K	NI	Plasma, frz within 24 hour	0955	1.8217	$95.00		$19.00
C1058	N	DG	TC 99M oxidronate, per vial					
C1064	N	DG	I-131 cap, each add mCi					
C1065	N	DG	I-131 sol, each add mCi					
C1066	N	DG	IN 111 satumomab pendetide					
C1079	N		CO 57/58 per 0.5 uCi					
C1087	N	DG	I-123 per 100 uCi					
C1088	T		LASER OPTIC TR Sys	0980		$1,875.00		$375.00
C1091	K		IN111 oxyquinoline,per0.5mCi	1091	4.7092	$245.59		$49.12
C1092	K		IN 111 pentetate per 0.5 mCi	1092	4.4379	$231.44		$46.29
C1094	N	DG	TC99Malbumin aggr,per 1.0mCi					
C1096	K	DG	TC 99M EXAMETAZIME, PER Dose	1096	4.4379	$231.44		$46.29
C1097	N	DG	TC 99M MEBROFENIN, PER Vial					
C1098	N	DG	TC 99M PENTETATE, PER Vial					
C1099	N	DG	TC 99M PYROPHOSPHATE,PER Via.					
C1122	K		Tc 99M ARCITUMOMAB PER VIAL	1122	11.4726	$598.31		$119.66
C1166	N		CYTARABINE LIPOSOMAL, 10 mg					
C1167	K		EPIRUBICIN HCL, 2 mg	1167	0.3294	$17.18		$3.44
C1178	K		BUSULFAN IV, 6 Mg	1178	0.4845	$25.27		$5.05
C1188	N	DG	I-131 cap, per 1-5 mCi					
C1200	N		TC 99M Sodium Glucoheptonat					
C1201	N		TC 99M SUCCIMER, PER Vial					
C1202	N	DG	TC 99M SULFUR COLLOID, Vial					
C1207	K	DG	OCTREOTIDE ACETATE DEPOT 1mg.	1207	1.4244	$74.28		$14.86
C1300	S		HYPERBARIC Oxygen	0659	3.2364	$168.78		$33.76
C1305	K		Apligraf	1305	13.0520	$680.67		$136.13
C1348	K	DG	I-131 sol, per 1-6 mCi	1348	0.9399	$49.02		$9.80
C1713	D	DNG	Anchor/screw bn/bn,tis/bn					
C1714	D	DNG	Cath, trans atherectomy, dir					
C1715	D	DNG	Brachytherapy needle					
C1716	K		Brachytx seed, Gold 198	1716	0.4360	$22.74		$4.55
C1717	D	DNG	Brachytx seed, HDR Ir-192					
C1718	K		Brachytx seed, Iodine 125	1718	0.6008	$31.33		$6.27
C1719	K		Brachytx seed,Non-HDR Ir-192	1719	0.5232	$27.29		$5.46
C1720	K		Brachytx seed, Palladium 103	1720	0.8430	$43.96		$8.79

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1721	D	DNG	AICD, dual chamber					
C1722	D	DNG	AICD, single chamber					
C1724	D	DNG	Cath, trans atherec,rotation					
C1725	D	DNG	Cath, translumin non-laser					
C1726	D	DNG	Cath, bal dil, non-vascular					
C1727	D	DNG	Cath, bal tis dis, non-vas					
C1728	D	DNG	Cath, brachytx seed adm					
C1729	D	DNG	Cath, drainage					
C1730	D	DNG	Cath, EP, 19 or few elect					
C1731	D	DNG	Cath, EP, 20 or more elec					
C1732	D	DNG	Cath, EP, diag/abl, 3D/vect					
C1733	D	DNG	Cath, EP, othr than cool-tip					
C1750	D	DNG	Cath, hemodialysis,long-term					
C1751	D	DNG	Cath, inf, per/cent/midline					
C1752	D	DNG	Cath,hemodialysis,short-term					
C1753	D	DNG	Cath, intravas ultrasound					
C1754	D	DNG	Catheter, intradiscal					
C1755	D	DNG	Catheter, intraspinal					
C1756	D	DNG	Cath, pacing, transesoph					
C1757	D	DNG	Cath, thrombectomy/embolect					
C1758	D	DNG	Catheter, ureteral					
C1759	D	DNG	Cath, intra echocardiography					
C1760	D	DNG	Closure dev, vasc					
C1762	D	DNG	Conn tiss, human(inc fascia)					
C1763	D	DNG	Conn tiss, non-human					
C1764	D	DNG	Event recorder, cardiac					
C1765	H		Adhesion barrier	1765				
C1766	D	DNG	Intro/sheath,strble,non-peel					
C1767	D	DNG	Generator, neurostim, imp					
C1768	D	DNG	Graft, vascular					
C1769	D	DNG	Guide wire					
C1770	D	DNG	Imaging coil, MR, insertable					
C1771	D	DNG	Rep dev, urinary, w/sling					
C1772	D	DNG	Infusion pump, programmable					
C1773	D	DNG	Ret dev, insertable					
C1774	K		Darbepoetin alfa, 1 mcg	0734	0.0454	$2.37		$.47
C1775	K		FDG, per dose (4-40 mCi/ml)	1775	7.5289	$392.64		$78.53
C1776	D	DNG	Joint device (implantable)					
C1777	D	DNG	Lead, AICD, endo single coil					
C1778	D	DNG	Lead, neurostimulator					
C1779	D	DNG	Lead, pmkr, transvenous VDD					
C1780	D	DNG	Lens, intraocular (new tech)					
C1781	D	DNG	Mesh (implantable)					
C1782	D	DNG	Morcellator					
C1783	H		Ocular imp, aqueous drain dev	1783				
C1784	D	DNG	Ocular dev, intraop, det ret					
C1785	D	DNG	Pmkr, dual, rate-resp					
C1786	D	DNG	Pmkr, single, rate-resp					
C1787	D	DNG	Patient progr, neurostim					
C1788	D	DNG	Port, indwelling, imp					
C1789	D	DNG	Prosthesis, breast, imp					
C1813	D	DNG	Prosthesis, penile, inflatab					
C1815	D	DNG	Pros, urinary sph, imp					
C1816	D	DNG	Receiver/transmitter, neuro					
C1817	D	DNG	Septal defect imp sys					
C1874	D	DNG	Stent, coated/cov w/del sys					
C1875	D	DNG	Stent, coated/cov w/o del sy					
C1876	D	DNG	Stent, non-coa/non-cov w/del					
C1877	D	DNG	Stent, non-coat/cov w/o del					
C1878	D	DNG	Matrl for vocal cord					
C1879	D	DNG	Tissue marker, implantable					
C1880	D	DNG	Vena cava filter					
C1881	D	DNG	Dialysis access system					
C1882	D	DNG	AICD, other than sing/dual					
C1883	D	DNG	Adapt/ext, pacing/neuro lead					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1885	D	DNG	Cath, translumin angio laser					
C1887	D	DNG	Catheter, guiding					
C1888	H		Endovas non-cardiac abl cath	1888				
C1891	D	DNG	Infusion pump,non-prog, perm					
C1892	D	DNG	Intro/sheath,fixed,peel-away					
C1893	D	DNG	Intro/sheath, fixed,non-peel					
C1894	D	DNG	Intro/sheath, non-laser					
C1895	D	DNG	Lead, AICD, endo dual coil					
C1896	D	DNG	Lead, AICD, non sing/dual					
C1897	D	DNG	Lead, neurostim test kit					
C1898	D	DNG	Lead, pmkr, other than trans					
C1899	D	DNG	Lead, pmkr/AICD combination					
C1900	H		Lead coronary venous	1900				
C2614	H	NI	Probe, perc lumb disc	2614				
C2615	D	DNG	Sealant, pulmonary, liquid					
C2616	K		Brachytx seed, Yttrium-90	2616	8.8370	$460.86		$92.17
C2617	D	DNG	Stent, non-cor, tem w/o del					
C2618	H		Probe, cryoablation	2618				
C2619	D	DNG	Pmkr, dual, non rate-resp					
C2620	D	DNG	Pmkr, single, non rate-resp					
C2621	D	DNG	Pmkr, other than sing/dual					
C2622	D	DNG	Prosthesis, penile, non-inf					
C2625	D	DNG	Stent, non-cor, tem w/del sy					
C2626	D	DNG	Infusion pump, non-prog,temp					
C2627	D	DNG	Cath, suprapubic/cystoscopic					
C2628	D	DNG	Catheter, occlusion					
C2629	D	DNG	Intro/sheath, laser					
C2630	D	DNG	Cath, EP, cool-tip					
C2631	D	DNG	Rep dev, urinary, w/o sling					
C2632	H	NI	Brachytx sol, I-125, per mCi	2632				
C8900	S		MRA w/cont, abd	0284	7.2382	$377.48	$201.02	$75.50
C8901	S		MRA w/o cont, abd	0336	6.5987	$344.13	$176.94	$68.83
C8902	S		MRA w/o fol w/cont, abd	0337	9.2440	$482.08	$240.77	$96.42
C8903	S		MRI w/cont, breast, uni	0284	7.2382	$377.48	$201.02	$75.50
C8904	S		MRI w/o cont, breast, uni	0336	6.5987	$344.13	$176.94	$68.83
C8905	S		MRI w/o fol w/cont, brst, un	0337	9.2440	$482.08	$240.77	$96.42
C8906	S		MRI w/cont, breast, bi	0284	7.2382	$377.48	$201.02	$75.50
C8907	S		MRI w/o cont, breast, bi	0336	6.5987	$344.13	$176.94	$68.83
C8908	S		MRI w/o fol w/cont, breast,	0337	9.2440	$482.08	$240.77	$96.42
C8909	S		MRA w/cont, chest	0284	7.2382	$377.48	$201.02	$75.50
C8910	S		MRA w/o cont, chest	0336	6.5987	$344.13	$176.94	$68.83
C8911	S		MRA w/o fol w/cont, chest	0337	9.2440	$482.08	$240.77	$96.42
C8912	S		MRA w/cont, lwr ext	0284	7.2382	$377.48	$201.02	$75.50
C8913	S		MRA w/o cont, lwr ext	0336	6.5987	$344.13	$176.94	$68.83
C8914	S		MRA w/o fol w/cont, lwr ext	0337	9.2440	$482.08	$240.77	$96.42
C9000	K		Na chromateCr51, per 0.25mCi	9000	1.8798	$98.03		$19.61
C9003	K		Palivizumab, per 50 mg	9003	8.5657	$446.71		$89.34
C9007	N		Baclofen Intrathecal kit-1am					
C9008	N		Baclofen Refill Kit-500mcg					
C9009	K		Baclofen Refill Kit-2000mcg	9009	0.7267	$37.90		$7.58
C9010	K		Baclofen Refill Kit--4000mcg	9010	0.9205	$48.00		$9.60
C9013	N		Co 57 cobaltous chloride					
C9019	G	DG	Caspofungin acetate, 5 mg	9019		$34.20		$5.11
C9020	K	DG	Sirolimussolution, 1 mg	9020	0.0581	$3.03		$.61
C9100	N	DG	Iodinated I-131 Albumin					
C9102	N		51 Na Chromate, 50mCi					
C9103	N		Na Iothalamate I-125, 10 uCi					
C9105	K		Hep B imm glob, per 1 ml	9105	1.5116	$78.83		$15.77
C9108	K	DG	Thyrotropin alfa, 1.1 mg	9108	7.5870	$395.67		$79.13
C9109	K		Tirofiban hcl, 6.25 mg	9109	2.1996	$114.71		$22.94
C9110	G	DG	Alemtuzumab, per 10mg/ml	9110		$511.22		$76.41
C9111	G		Inj, bivalirudin, 250mg vial	9111		$397.81		$56.46
C9112	G		Perflutren lipid micro, 2ml	9112		$4.94		$.74
C9113	G		Inj pantoprazole sodium, via	9113		$22.80		$3.41
C9114	G	DG	Nesiritide, per 1.5 mg vial	9114		$433.20		$64.75

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C9115	G	DG	Inj, zoledronic acid, 2 mg	9115		$406.78		$60.80
C9116	G	NI	Ertapenem sodium, per 1 gm	9116		$45.31		$6.77
C9117	E	DG	Y-90 ibritumomab tiuxetan					
C9118	E	DG	IN-111 ibritumomab tiuxetan					
C9119	G	NI	Injection, pegfilgrastim	9119		$2,802.50		$418.90
C9120	G	NI	Injection, fulvestrant	9120		$87.58		$13.09
C9121	G	NI	Injection, argatroban	9121		$14.25		$2.13
C9200	G		Orcel, per 36 cm2	9200		$1,135.25		$169.69
C9201	G		Dermagraft, per 37.5 sq cm	9201		$577.60		$86.34
C9503	K		Fresh frozen plasma, ea unit	9503	1.3372	$69.74		$13.95
C9701	T		Stretta System	0980		$1,875.00		$375.00
C9703	T		Bard Endoscopic Suturing Sys	0979		$1,625.00		$325.00
C9708	T	DG	Preview Tx Planning Software	0975		$625.00		$125.00
C9711	T		H.E.L.P. Apheresis System	0978		$1,375.00		$275.00
D0120	E		Periodic oral evaluation					
D0140	E		Limit oral eval problm focus					
D0150	S		Comprehensve oral evaluation	0330	4.7770	$249.13		$49.83
D0160	E		Extensv oral eval prob focus					
D0170	E		Re-eval,est pt,problem focus					
D0180	E	NI	Comp periodontal evaluation					
D0210	E		Intraor complete film series					
D0220	E		Intraoral periapical first f					
D0230	E		Intraoral periapical ea add					
D0240	S		Intraoral occlusal film	0330	4.7770	$249.13		$49.83
D0250	S		Extraoral first film	0330	4.7770	$249.13		$49.83
D0260	S		Extraoral ea additional film	0330	4.7770	$249.13		$49.83
D0270	S		Dental bitewing single film	0330	4.7770	$249.13		$49.83
D0272	S		Dental bitewings two films	0330	4.7770	$249.13		$49.83
D0274	S		Dental bitewings four films	0330	4.7770	$249.13		$49.83
D0277	S		Vert bitewings-sev to eight	0330	4.7770	$249.13		$49.83
D0290	E		Dental film skull/facial bon					
D0310	E		Dental saliography					
D0320	E		Dental tmj arthrogram incl i					
D0321	E		Dental other tmj films					
D0322	E		Dental tomographic survey					
D0330	E		Dental panoramic film					
D0340	E		Dental cephalometric film					
D0350	E		Oral/facial images					
D0415	E		Bacteriologic study					
D0425	E		Caries susceptibility test					
D0460	S		Pulp vitality test	0330	4.7770	$249.13		$49.83
D0470	E		Diagnostic casts					
D0472	S		Gross exam, prep & report	0330	4.7770	$249.13		$49.83
D0473	S		Micro exam, prep & report	0330	4.7770	$249.13		$49.83
D0474	S		Micro w exam of surg margins	0330	4.7770	$249.13		$49.83
D0480	S		Cytopath smear prep & report	0330	4.7770	$249.13		$49.83
D0501	S	DG	Histopathologic examinations	0330	4.7770	$249.13		$49.83
D0502	S		Other oral pathology procedu	0330	4.7770	$249.13		$49.83
D0999	S		Unspecified diagnostic proce	0330	4.7770	$249.13		$49.83
D1110	E		Dental prophylaxis adult					
D1120	E		Dental prophylaxis child					
D1201	E		Topical fluor w prophy child					
D1203	E		Topical fluor w/o prophy chi					
D1204	E		Topical fluor w/o prophy adu					
D1205	E		Topical fluoride w/ prophy a					
D1310	E		Nutri counsel-control caries					
D1320	E		Tobacco counseling					
D1330	E		Oral hygiene instruction					
D1351	E		Dental sealant per tooth					
D1510	S		Space maintainer fxd unilat	0330	4.7770	$249.13		$49.83
D1515	S		Fixed bilat space maintainer	0330	4.7770	$249.13		$49.83
D1520	S		Remove unilat space maintain	0330	4.7770	$249.13		$49.83
D1525	S		Remove bilat space maintain	0330	4.7770	$249.13		$49.83
D1550	S		Recement space maintainer	0330	4.7770	$249.13		$49.83
D2110	E	DG	Amalgam one surface primary					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D2120	E	DG	Amalgam two surfaces primary					
D2130	E	DG	Amalgam three surfaces prima					
D2131	E	DG	Amalgam four/more surf prima					
D2140	E		Amalgam one surface permanen					
D2150	E		Amalgam two surfaces permane					
D2160	E		Amalgam three surfaces perma					
D2161	E		Amalgam 4 or > surfaces perm					
D2330	E		Resin one surface-anterior					
D2331	E		Resin two surfaces-anterior					
D2332	E		Resin three surfaces-anterio					
D2335	E		Resin 4/> surf or w incis an					
D2336	E	DG	Composite resin crown					
D2337	E	DG	Compo resin crown ant-perm					
D2380	E	DG	Resin one surf poster primar					
D2381	E	DG	Resin two surf poster primar					
D2382	E	DG	Resin three/more surf post p					
D2385	E	DG	Resin one surf poster perman					
D2386	E	DG	Resin two surf poster perman					
D2387	E	DG	Resin three/more surf post p					
D2388	E	DG	Resin four/more, post perm					
D2390	E	NI	Ant resin-based cmpst crown					
D2391	E	NI	Post 1 srfc resinbased cmpst					
D2392	E	NI	Post 2 srfc resinbased cmpst					
D2393	E	NI	Post 3 srfc resinbased cmpst					
D2394	E	NI	Post >=4srfc resinbase cmpst					
D2410	E		Dental gold foil one surface					
D2420	E		Dental gold foil two surface					
D2430	E		Dental gold foil three surfa					
D2510	E		Dental inlay metalic 1 surf					
D2520	E		Dental inlay metallic 2 surf					
D2530	E		Dental inlay metl 3/more sur					
D2542	E		Dental onlay metallic 2 surf					
D2543	E		Dental onlay metallic 3 surf					
D2544	E		Dental onlay metl 4/more sur					
D2610	E		Inlay porcelain/ceramic 1 su					
D2620	E		Inlay porcelain/ceramic 2 su					
D2630	E		Dental onlay porc 3/more sur					
D2642	E		Dental onlay porcelin 2 surf					
D2643	E		Dental onlay porcelin 3 surf					
D2644	E		Dental onlay porc 4/more sur					
D2650	E		Inlay composite/resin one su					
D2651	E		Inlay composite/resin two su					
D2652	E		Dental inlay resin 3/mre sur					
D2662	E		Dental onlay resin 2 surface					
D2663	E		Dental onlay resin 3 surface					
D2664	E		Dental onlay resin 4/mre sur					
D2710	E		Crown resin laboratory					
D2720	E		Crown resin w/ high noble me					
D2721	E		Crown resin w/ base metal					
D2722	E		Crown resin w/ noble metal					
D2740	E		Crown porcelain/ceramic subs					
D2750	E		Crown porcelain w/ h noble m					
D2751	E		Crown porcelain fused base m					
D2752	E		Crown porcelain w/ noble met					
D2780	E		Crown 3/4 cast hi noble met					
D2781	E		Crown 3/4 cast base metal					
D2782	E		Crown 3/4 cast noble metal					
D2783	E		Crown 3/4 porcelain/ceramic					
D2790	E		Crown full cast high noble m					
D2791	E		Crown full cast base metal					
D2792	E		Crown full cast noble metal					
D2799	E		Provisional crown					
D2910	E		Dental recement inlay					
D2920	E		Dental recement crown					
D2930	E		Prefab stnlss steel crwn pri					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D2931	E		Prefab stnlss steel crown pe					
D2932	E		Prefabricated resin crown					
D2933	E		Prefab stainless steel crown					
D2940	E		Dental sedative filling					
D2950	E		Core build-up incl any pins					
D2951	E		Tooth pin retention					
D2952	E		Post and core cast + crown					
D2953	E		Each addtnl cast post					
D2954	E		Prefab post/core + crown					
D2955	E		Post removal					
D2957	E		Each addtnl prefab post					
D2960	E		Laminate labial veneer					
D2961	E		Lab labial veneer resin					
D2962	E		Lab labial veneer porcelain					
D2970	S		Temporary- fractured tooth	0330	4.7770	$249.13		$49.83
D2980	E		Crown repair					
D2999	S		Dental unspec restorative pr	0330	4.7770	$249.13		$49.83
D3110	E		Pulp cap direct					
D3120	E		Pulp cap indirect					
D3220	E		Therapeutic pulpotomy					
D3221	E		Gross pulpal debridement					
D3230	E		Pulpal therapy anterior prim					
D3240	E		Pulpal therapy posterior pri					
D3310	E		Anterior					
D3320	E		Root canal therapy 2 canals					
D3330	E		Root canal therapy 3 canals					
D3331	E		Non-surg tx root canal obs					
D3332	E		Incomplete endodontic tx					
D3333	E		Internal root repair					
D3346	E		Retreat root canal anterior					
D3347	E		Retreat root canal bicuspid					
D3348	E		Retreat root canal molar					
D3351	E		Apexification/recalc initial					
D3352	E		Apexification/recalc interim					
D3353	E		Apexification/recalc final					
D3410	E		Apicoect/perirad surg anter					
D3421	E		Root surgery bicuspid					
D3425	E		Root surgery molar					
D3426	E		Root surgery ea add root					
D3430	E		Retrograde filling					
D3450	E		Root amputation					
D3460	S		Endodontic endosseous implan	0330	4.7770	$249.13		$49.83
D3470	E		Intentional replantation					
D3910	E		Isolation- tooth w rubb dam					
D3920	E		Tooth splitting					
D3950	E		Canal prep/fitting of dowel					
D3999	S		Endodontic procedure	0330	4.7770	$249.13		$49.83
D4210	E		Gingivectomy/plasty per quad					
D4211	E		Gingivectomy/plasty per toot					
D4220	E	DG	Gingival curettage per quadr					
D4240	E		Gingival flap proc w/ planin					
D4241	E	NI	Gngvl flap w rootplan 1-3 th					
D4245	E		Apically positioned flap					
D4249	E		Crown lengthen hard tissue					
D4260	S		Osseous surgery per quadrant	0330	4.7770	$249.13		$49.83
D4261	E	NI	Osseous surgl-3teethperquad					
D4263	S		Bone replce graft first site	0330	4.7770	$249.13		$49.83
D4264	S		Bone replce graft each add	0330	4.7770	$249.13		$49.83
D4265	E	NI	Bio mtrls to aid soft/os reg					
D4266	E		Guided tiss regen resorble					
D4267	E		Guided tiss regen nonresorb					
D4268	S		Surgical revision procedure	0330	4.7770	$249.13		$49.83
D4270	S		Pedicle soft tissue graft pr	0330	4.7770	$249.13		$49.83
D4271	S		Free soft tissue graft proc	0330	4.7770	$249.13		$49.83
D4273	S		Subepithelial tissue graft	0330	4.7770	$249.13		$49.83

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D4274	E		Distal/proximal wedge proc					
D4275	E	NI	Soft tissue allograft					
D4276	E	NI	Con tissue w dble ped graft					
D4320	E		Provision splnt intracoronal					
D4321	E		Provisional splint extracoro					
D4341	E		Periodontal scaling & root					
D4342	E	NI	Periodontal scaling 1-3teeth					
D4355	S		Full mouth debridement	0330	4.7770	$249.13		$49.83
D4381	S		Localized chemo delivery	0330	4.7770	$249.13		$49.83
D4910	E		Periodontal maint procedures					
D4920	E		Unscheduled dressing change					
D4999	E		Unspecified periodontal proc					
D5110	E		Dentures complete maxillary					
D5120	E		Dentures complete mandible					
D5130	E		Dentures immediat maxillary					
D5140	E		Dentures immediat mandible					
D5211	E		Dentures maxill part resin					
D5212	E		Dentures mand part resin					
D5213	E		Dentures maxill part metal					
D5214	E		Dentures mandibl part metal					
D5281	E		Removable partial denture					
D5410	E		Dentures adjust cmplt maxil					
D5411	E		Dentures adjust cmplt mand					
D5421	E		Dentures adjust part maxill					
D5422	E		Dentures adjust part mandbl					
D5510	E		Dentur repr broken compl bas					
D5520	E		Replace denture teeth complt					
D5610	E		Dentures repair resin base					
D5620	E		Rep part denture cast frame					
D5630	E		Rep partial denture clasp					
D5640	E		Replace part denture teeth					
D5650	E		Add tooth to partial denture					
D5660	E		Add clasp to partial denture					
D5670	E	NI	Replc tth&acrlc on mtl frmwk					
D5671	E	NI	Replc tth&acrlc mandibular					
D5710	E		Dentures rebase cmplt maxil					
D5711	E		Dentures rebase cmplt mand					
D5720	E		Dentures rebase part maxill					
D5721	E		Dentures rebase part mandbl					
D5730	E		Denture reln cmplt maxil ch					
D5731	E		Denture reln cmplt mand chr					
D5740	E		Denture reln part maxil chr					
D5741	E		Denture reln part mand chr					
D5750	E		Denture reln cmplt max lab					
D5751	E		Denture reln cmplt mand lab					
D5760	E		Denture reln part maxil lab					
D5761	E		Denture reln part mand lab					
D5810	E		Denture interm cmplt maxill					
D5811	E		Denture interm cmplt mandbl					
D5820	E		Denture interm part maxill					
D5821	E		Denture interm part mandbl					
D5850	E		Denture tiss conditn maxill					
D5851	E		Denture tiss condtin mandbl					
D5860	E		Overdenture complete					
D5861	E		Overdenture partial					
D5862	E		Precision attachment					
D5867	E		Replacement of precision att					
D5875	E		Prosthesis modification					
D5899	E		Removable prosthodontic proc					
D5911	S		Facial moulage sectional	0330	4.7770	$249.13		$49.83
D5912	S		Facial moulage complete	0330	4.7770	$249.13		$49.83
D5913	E		Nasal prosthesis					
D5914	E		Auricular prosthesis					
D5915	E		Orbital prosthesis					
D5916	E		Ocular prosthesis					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D5919	E		Facial prosthesis					
D5922	E		Nasal septal prosthesis					
D5923	E		Ocular prosthesis interim					
D5924	E		Cranial prosthesis					
D5925	E		Facial augmentation implant					
D5926	E		Replacement nasal prosthesis					
D5927	E		Auricular replacement					
D5928	E		Orbital replacement					
D5929	E		Facial replacement					
D5931	E		Surgical obturator					
D5932	E		Postsurgical obturator					
D5933	E		Refitting of obturator					
D5934	E		Mandibular flange prosthesis					
D5935	E		Mandibular denture prosth					
D5936	E		Temp obturator prosthesis					
D5937	E		Trismus appliance					
D5951	E		Feeding aid					
D5952	E		Pediatric speech aid					
D5953	E		Adult speech aid					
D5954	E		Superimposed prosthesis					
D5955	E		Palatal lift prosthesis					
D5958	E		Intraoral con def inter plt					
D5959	E		Intraoral con def mod palat					
D5960	E		Modify speech aid prosthesis					
D5982	E		Surgical stent					
D5983	S		Radiation applicator	0330	4.7770	$249.13		$49.83
D5984	S		Radiation shield	0330	4.7770	$249.13		$49.83
D5985	S		Radiation cone locator	0330	4.7770	$249.13		$49.83
D5986	E		Fluoride applicator					
D5987	S		Commissure splint	0330	4.7770	$249.13		$49.83
D5988	E		Surgical splint					
D5999	E		Maxillofacial prosthesis					
D6010	E		Odontics endosteal implant					
D6020	E		Odontics abutment placement					
D6040	E		Odontics eposteal implant					
D6050	E		Odontics transosteal implnt					
D6053	E	NI	Implnt/abtmnt spprt remv dnt					
D6054	E	NI	Implnt/abtmnt spprt remvprtl					
D6055	E		Implant connecting bar					
D6056	E		Prefabricated abutment					
D6057	E		Custom abutment					
D6058	E		Abutment supported crown					
D6059	E		Abutment supported mtl crown					
D6060	E		Abutment supported mtl crown					
D6061	E		Abutment supported mtl crown					
D6062	E		Abutment supported mtl crown					
D6063	E		Abutment supported mtl crown					
D6064	E		Abutment supported mtl crown					
D6065	E		Implant supported crown					
D6066	E		Implant supported mtl crown					
D6067	E		Implant supported mtl crown					
D6068	E		Abutment supported retainer					
D6069	E		Abutment supported retainer					
D6070	E		Abutment supported retainer					
D6071	E		Abutment supported retainer					
D6072	E		Abutment supported retainer					
D6073	E		Abutment supported retainer					
D6074	E		Abutment supported retainer					
D6075	E		Implant supported retainer					
D6076	E		Implant supported retainer					
D6077	E		Implant supported retainer					
D6078	E		Implnt/abut suprtd fixd dent					
D6079	E		Implnt/abut suprtd fixd dent					
D6080	E		Implant maintenance					
D6090	E		Repair implant					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D6095	E		Odontics repr abutment					
D6100	E		Removal of implant					
D6199	E		Implant procedure					
D6210	E		Prosthodont high noble metal					
D6211	E		Bridge base metal cast					
D6212	E		Bridge noble metal cast					
D6240	E		Bridge porcelain high noble					
D6241	E		Bridge porcelain base metal					
D6242	E		Bridge porcelain nobel metal					
D6245	E		Bridge porcelain/ceramic					
D6250	E		Bridge resin w/high noble					
D6251	E		Bridge resin base metal					
D6252	E		Bridge resin w/noble metal					
D6253	E	NI	Provisional pontic					
D6519	E	DG	Inlay/onlay porce/ceramic					
D6520	E	DG	Dental retainer two surfaces					
D6530	E	DG	Retainer metallic 3+ surface					
D6543	E	DG	Dental retainr onlay 3 surf					
D6544	E	DG	Dental retainr onlay 4/more					
D6545	E		Dental retainr cast metl					
D6548	E		Porcelain/ceramic retainer					
D6600	E	NI	Porcelain/ceramic inlay 2srf					
D6601	E	NI	Porc/ceram inlay >= 3 surfac					
D6602	E	NI	Cst hgh nble mtl inlay 2 srf					
D6603	E	NI	Cst hgh nble mtl inlay >=3sr					
D6604	E	NI	Cst bse mtl inlay 2 surfaces					
D6605	E	NI	Cst bse mtl inlay >= 3 surfa					
D6606	E	NI	Cast noble metal inlay 2 sur					
D6607	E	NI	Cst noble mtl inlay >=3 surf					
D6608	E	NI	Onlay porc/crmc 2 surfaces					
D6609	E	NI	Onlay porc/crmc >=3 surfaces					
D6610	E	NI	Onlay cst hgh nbl mtl 2 srfc					
D6611	E	NI	Onlay cst hgh nbl mtl >=3srf					
D6612	E	NI	Onlay cst base mtl 2 surface					
D6613	E	NI	Onlay cst base mtl >=3 surfa					
D6614	E	NI	Onlay cst nbl mtl 2 surfaces					
D6615	E	NI	Onlay cst nbl mtl >=3 surfac					
D6720	E		Retain crown resin w hi nble					
D6721	E		Crown resin w/base metal					
D6722	E		Crown resin w/noble metal					
D6740	E		Crown porcelain/ceramic					
D6750	E		Crown porcelain high noble					
D6751	E		Crown porcelain base metal					
D6752	E		Crown porcelain noble metal					
D6780	E		Crown 3/4 high noble metal					
D6781	E		Crown 3/4 cast based metal					
D6782	E		Crown 3/4 cast noble metal					
D6783	E		Crown 3/4 porcelain/ceramic					
D6790	E		Crown full high noble metal					
D6791	E		Crown full base metal cast					
D6792	E		Crown full noble metal cast					
D6793	E	NI	Provisional retainer crown					
D6920	S		Dental connector bar	0330	4.7770	$249.13		$49.83
D6930	E		Dental recement bridge					
D6940	E		Stress breaker					
D6950	E		Precision attachment					
D6970	E		Post & core plus retainer					
D6971	E		Cast post bridge retainer					
D6972	E		Prefab post & core plus reta					
D6973	E		Core build up for retainer					
D6975	E		Coping metal					
D6976	E		Each addtnl cast post					
D6977	E		Each addtl prefab post					
D6980	E		Bridge repair					
D6985	E	NI	Pediatric partial denture fx					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D6999	E		Fixed prosthodontic proc					
D7110	S	DG	Oral surgery single tooth	0330	4.7770	$249.13		$49.83
D7111	S	NI	Coronal remnants deciduous t	0330	4.7770	$249.13		$49.83
D7120	S	DG	Each add tooth extraction	0330	4.7770	$249.13		$49.83
D7130	S	DG	Tooth root removal	0330	4.7770	$249.13		$49.83
D7140	S	NI	Extraction erupted tooth/exr	0330	4.7770	$249.13		$49.83
D7210	S		Rem imp tooth w mucoper flp	0330	4.7770	$249.13		$49.83
D7220	S		Impact tooth remov soft tiss	0330	4.7770	$249.13		$49.83
D7230	S		Impact tooth remov part bony	0330	4.7770	$249.13		$49.83
D7240	S		Impact tooth remov comp bony	0330	4.7770	$249.13		$49.83
D7241	S		Impact tooth rem bony w/comp	0330	4.7770	$249.13		$49.83
D7250	S		Tooth root removal	0330	4.7770	$249.13		$49.83
D7260	S		Oral antral fistula closure	0330	4.7770	$249.13		$49.83
D7261	S	NI	Primary closure sinus perf	0330	4.7770	$249.13		$49.83
D7270	E		Tooth reimplantation					
D7272	E		Tooth transplantation					
D7280	E		Exposure impact tooth orthod					
D7281	E		Exposure tooth aid eruption					
D7282	E	NI	Mobilize erupted/malpos toot					
D7285	E		Biopsy of oral tissue hard					
D7286	E		Biopsy of oral tissue soft					
D7287	E	NI	Cytology sample collection					
D7290	E		Repositioning of teeth					
D7291	S		Transseptal fiberotomy	0330	4.7770	$249.13		$49.83
D7310	E		Alveoplasty w/ extraction					
D7320	E		Alveoplasty w/o extraction					
D7340	E		Vestibuloplasty ridge extens					
D7350	E		Vestibuloplasty exten graft					
D7410	E		Rad exc lesion up to 1.25 cm					
D7411	E	NI	Excision benign lesion>1.25c					
D7412	E	NI	Excision benign lesion compl					
D7413	E	NI	Excision malig lesion<=1.25c					
D7414	E	NI	Excision malig lesion>1.25cm					
D7415	E	NI	Excision malig les complicat					
D7420	E	DG	Lesion > 1.25 cm					
D7430	E	DG	Exc benign tumor to 1.25 cm					
D7431	E	DG	Benign tumor exc > 1.25 cm					
D7440	E		Malig tumor exc to 1.25 cm					
D7441	E		Malig tumor > 1.25 cm					
D7450	E		Rem odontogen cyst to 1.25cm					
D7451	E		Rem odontogen cyst > 1.25 cm					
D7460	E		Rem nonodonto cyst to 1.25cm					
D7461	E		Rem nonodonto cyst > 1.25 cm					
D7465	E		Lesion destruction					
D7471	E		Rem exostosis any site					
D7472	E	NI	Removal of torus palatinus					
D7473	E	NI	Remove torus mandibularis					
D7480	E	DG	Partial ostectomy					
D7485	E	NI	Surg reduct osseoustuberosit					
D7490	E		Mandible resection					
D7510	E		I&d absc intraoral soft tiss					
D7520	E		I&d abscess extraoral					
D7530	E		Removal fb skin/areolar tiss					
D7540	E		Removal of fb reaction					
D7550	E		Removal of sloughed off bone					
D7560	E		Maxillary sinusotomy					
D7610	E		Maxilla open reduct simple					
D7620	E		Clsd reduct simpl maxilla fx					
D7630	E		Open red simpl mandible fx					
D7640	E		Clsd red simpl mandible fx					
D7650	E		Open red simp malar/zygom fx					
D7660	E		Clsd red simp malar/zygom fx					
D7670	E		Closd rductn splint alveolus					
D7671	E	NI	Alveolus open reduction					
D7680	E		Reduct simple facial bone fx					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D7710	E		Maxilla open reduct compound					
D7720	E		Clsd reduct compd maxilla fx					
D7730	E		Open reduct compd mandble fx					
D7740	E		Clsd reduct compd mandble fx					
D7750	E		Open red comp malar/zygma fx					
D7760	E		Clsd red comp malar/zygma fx					
D7770	E		Open reduc compd alveolus fx					
D7771	E	NI	Alveolus clsd reduc stblz te					
D7780	E		Reduct compnd facial bone fx					
D7810	E		Tmj open reduct-dislocation					
D7820	E		Closed tmp manipulation					
D7830	E		Tmj manipulation under anest					
D7840	E		Removal of tmj condyle					
D7850	E		Tmj meniscectomy					
D7852	E		Tmj repair of joint disc					
D7854	E		Tmj excisn of joint membrane					
D7856	E		Tmj cutting of a muscle					
D7858	E		Tmj reconstruction					
D7860	E		Tmj cutting into joint					
D7865	E		Tmj reshaping components					
D7870	E		Tmj aspiration joint fluid					
D7871	E		Lysis + lavage w catheters					
D7872	E		Tmj diagnostic arthroscopy					
D7873	E		Tmj arthroscopy lysis adhesn					
D7874	E		Tmj arthroscopy disc reposit					
D7875	E		Tmj arthroscopy synovectomy					
D7876	E		Tmj arthroscopy discectomy					
D7877	E		Tmj arthroscopy debridement					
D7880	E		Occlusal orthotic appliance					
D7899	E		Tmj unspecified therapy					
D7910	E		Dent sutur recent wnd to 5cm					
D7911	E		Dental suture wound to 5 cm					
D7912	E		Suture complicate wnd > 5 cm					
D7920	E		Dental skin graft					
D7940	S		Reshaping bone orthognathic	0330	4.7770	$249.13		$49.83
D7941	E		Bone cutting ramus closed					
D7943	E		Cutting ramus open w/graft					
D7944	E		Bone cutting segmented					
D7945	E		Bone cutting body mandible					
D7946	E		Reconstruction maxilla total					
D7947	E		Reconstruct maxilla segment					
D7948	E		Reconstruct midface no graft					
D7949	E		Reconstruct midface w/graft					
D7950	E		Mandible graft					
D7955	E		Repair maxillofacial defects					
D7960	E		Frenulectomy/frenulotomy					
D7970	E		Excision hyperplastic tissue					
D7971	E		Excision pericoronal gingiva					
D7972	E	NI	Surg redct fibrous tuberosit					
D7980	E		Sialolithotomy					
D7981	E		Excision of salivary gland					
D7982	E		Sialodochoplasty					
D7983	E		Closure of salivary fistula					
D7990	E		Emergency tracheotomy					
D7991	E		Dental coronoidectomy					
D7995	E		Synthetic graft facial bones					
D7996	E		Implant mandible for augment					
D7997	E		Appliance removal					
D7999	E		Oral surgery procedure					
D8010	E		Limited dental tx primary					
D8020	E		Limited dental tx transition					
D8030	E		Limited dental tx adolescent					
D8040	E		Limited dental tx adult					
D8050	E		Intercep dental tx primary					
D8060	E		Intercep dental tx transitn					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D8070	E		Compre dental tx transition					
D8080	E		Compre dental tx adolescent					
D8090	E		Compre dental tx adult					
D8210	E		Orthodontic rem appliance tx					
D8220	E		Fixed appliance therapy habt					
D8660	E		Preorthodontic tx visit					
D8670	E		Periodic orthodontc tx visit					
D8680	E		Orthodontic retention					
D8690	E		Orthodontic treatment					
D8691	E		Repair ortho appliance					
D8692	E		Replacement retainer					
D8999	E		Orthodontic procedure					
D9110	N		Tx dental pain minor proc					
D9210	E		Dent anesthesia w/o surgery					
D9211	E		Regional block anesthesia					
D9212	E		Trigeminal block anesthesia					
D9215	E		Local anesthesia					
D9220	E		General anesthesia					
D9221	E		General anesthesia ea ad 15m					
D9230	N		Analgesia					
D9241	E		Intravenous sedation					
D9242	E		IV sedation ea ad 30 m					
D9248	N		Sedation (non-iv)					
D9310	E		Dental consultation					
D9410	E		Dental house call					
D9420	E		Hospital call					
D9430	E		Office visit during hours					
D9440	E		Office visit after hours					
D9450	E	NI	Case presentation tx plan					
D9610	E		Dent therapeutic drug inject					
D9630	S		Other drugs/medicaments	0330	4.7770	$249.13		$49.83
D9910	E		Dent appl desensitizing med					
D9911	E		Appl desensitizing resin					
D9920	E		Behavior management					
D9930	S		Treatment of complications	0330	4.7770	$249.13		$49.83
D9940	S		Dental occlusal guard	0330	4.7770	$249.13		$49.83
D9941	E		Fabrication athletic guard					
D9950	S		Occlusion analysis	0330	4.7770	$249.13		$49.83
D9951	S		Limited occlusal adjustment	0330	4.7770	$249.13		$49.83
D9952	S		Complete occlusal adjustment	0330	4.7770	$249.13		$49.83
D9970	E		Enamel microabrasion					
D9971	E		Odontoplasty 1-2 teeth					
D9972	E		Extrnl bleaching per arch					
D9973	E		Extrnl bleaching per tooth					
D9974	E		Intrnl bleaching per tooth					
D9999	E		Adjunctive procedure					
E0100	A		Cane adjust/fixed with tip					
E0105	A		Cane adjust/fixed quad/3 pro					
E0110	A		Crutch forearm pair					
E0111	A		Crutch forearm each					
E0112	A		Crutch underarm pair wood					
E0113	A		Crutch underarm each wood					
E0114	A		Crutch underarm pair no wood					
E0116	A		Crutch underarm each no wood					
E0117	A	NI	Underarm springassist crutch					
E0130	A		Walker rigid adjust/fixed ht					
E0135	A		Walker folding adjust/fixed					
E0141	A		Rigid walker wheeled wo seat					
E0142	A		Walker rigid wheeled with se					
E0143	A		Walker folding wheeled w/o s					
E0144	A		Enclosed walker w rear seat					
E0145	A		Walker whled seat/crutch att					
E0146	A		Folding walker wheels w seat					
E0147	A		Walker variable wheel resist					
E0148	A		Heavyduty walker no wheels					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0149	A		Heavy duty wheeled walker					
E0153	A		Forearm crutch platform atta					
E0154	A		Walker platform attachment					
E0155	A		Walker wheel attachment,pair					
E0156	A		Walker seat attachment					
E0157	A		Walker crutch attachment					
E0158	A		Walker leg extenders set of4					
E0159	A		Brake for wheeled walker					
E0160	A		Sitz type bath or equipment					
E0161	A		Sitz bath/equipment w/faucet					
E0162	A		Sitz bath chair					
E0163	A		Commode chair stationry fxd					
E0164	A		Commode chair mobile fixed a					
E0165	A		Commode chair stationry det					
E0166	A		Commode chair mobile detach					
E0167	A		Commode chair pail or pan					
E0168	A		Heavyduty/wide commode chair					
E0169	A		Seatlift incorp commodechair					
E0175	A		Commode chair foot rest					
E0176	A		Air pressre pad/cushion nonp					
E0177	A		Water press pad/cushion nonp					
E0178	A		Gel pressre pad/cushion nonp					
E0179	A		Dry pressre pad/cushion nonp					
E0180	A		Press pad alternating w pump					
E0181	A		Press pad alternating w/ pum					
E0182	A		Pressure pad alternating pum					
E0184	A		Dry pressure mattress					
E0185	A		Gel pressure mattress pad					
E0186	A		Air pressure mattress					
E0187	A		Water pressure mattress					
E0188	E		Synthetic sheepskin pad					
E0189	E		Lambswool sheepskin pad					
E0191	A		Protector heel or elbow					
E0192	A		Pad wheelchr low press/posit					
E0193	A		Powered air flotation bed					
E0194	A		Air fluidized bed					
E0196	A		Gel pressure mattress					
E0197	A		Air pressure pad for mattres					
E0198	A		Water pressure pad for mattr					
E0199	A		Dry pressure pad for mattres					
E0200	A		Heat lamp without stand					
E0202	A		Phototherapy light w/ photom					
E0203	A	NI	Therapeutic lightbox tabletp					
E0205	A		Heat lamp with stand					
E0210	A		Electric heat pad standard					
E0215	A		Electric heat pad moist					
E0217	A		Water circ heat pad w pump					
E0218	E		Water circ cold pad w pump					
E0220	A		Hot water bottle					
E0221	A		Infrared heating pad system					
E0225	A		Hydrocollator unit					
E0230	A		Ice cap or collar					
E0231	E		Wound warming device					
E0232	E		Warming card for NWT					
E0235	A		Paraffin bath unit portable					
E0236	A		Pump for water circulating p					
E0238	A		Heat pad non-electric moist					
E0239	A		Hydrocollator unit portable					
E0241	E		Bath tub wall rail					
E0242	E		Bath tub rail floor					
E0243	E		Toilet rail					
E0244	E		Toilet seat raised					
E0245	E		Tub stool or bench					
E0246	E		Transfer tub rail attachment					
E0249	A		Pad water circulating heat u					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0250	A		Hosp bed fixed ht w/ mattres					
E0251	A		Hosp bed fixd ht w/o mattres					
E0255	A		Hospital bed var ht w/ mattr					
E0256	A		Hospital bed var ht w/o matt					
E0260	A		Hosp bed semi-electr w/ matt					
E0261	A		Hosp bed semi-electr w/o mat					
E0265	A		Hosp bed total electr w/ mat					
E0266	A		Hosp bed total elec w/o matt					
E0270	E		Hospital bed institutional t					
E0271	A		Mattress innerspring					
E0272	A		Mattress foam rubber					
E0273	E		Bed board					
E0274	E		Over-bed table					
E0275	A		Bed pan standard					
E0276	A		Bed pan fracture					
E0277	A		Powered pres-redu air mattrs					
E0280	A		Bed cradle					
E0290	A		Hosp bed fx ht w/o rails w/m					
E0291	A		Hosp bed fx ht w/o rail w/o					
E0292	A		Hosp bed var ht w/o rail w/o					
E0293	A		Hosp bed var ht w/o rail w/					
E0294	A		Hosp bed semi-elect w/ mattr					
E0295	A		Hosp bed semi-elect w/o matt					
E0296	A		Hosp bed total elect w/ matt					
E0297	A		Hosp bed total elect w/o mat					
E0305	A		Rails bed side half length					
E0310	A		Rails bed side full length					
E0315	E		Bed accessory brd/tbl/supprt					
E0316	A		Bed safety enclosure					
E0325	A		Urinal male jug-type					
E0326	A		Urinal female jug-type					
E0350	E		Control unit bowel system					
E0352	E		Disposable pack w/bowel syst					
E0370	E		Air elevator for heel					
E0371	A		Nonpower mattress overlay					
E0372	A		Powered air mattress overlay					
E0373	A		Nonpowered pressure mattress					
E0424	A		Stationary compressed gas 02					
E0425	E		Gas system stationary compre					
E0430	E		Oxygen system gas portable					
E0431	A		Portable gaseous 02					
E0434	A		Portable liquid 02					
E0435	E		Oxygen system liquid portabl					
E0439	A		Stationary liquid 02					
E0440	E		Oxygen system liquid station					
E0441	A		Oxygen contents, gaseous					
E0442	A		Oxygen contents, liquid					
E0443	A		Portable 02 contents, gas					
E0444	A		Portable 02 contents, liquid					
E0445	A	NI	Oximeter non-invasive					
E0450	A		Volume vent stationary/porta					
E0454	A	NI	Pressure ventilator					
E0455	A		Oxygen tent excl croup/ped t					
E0457	A		Chest shell					
E0459	A		Chest wrap					
E0460	A		Neg press vent portabl/statn					
E0461	A	NI	Vol vent noninvasive interfa					
E0462	A		Rocking bed w/ or w/o side r					
E0480	A		Percussor elect/pneum home m					
E0481	A		Intrpulmnry percuss vent sys					
E0482	A		Cough stimulating device					
E0483	A	NI	Chest compression gen system					
E0484	A	NI	Non-elec oscillatory pep dvc					
E0500	A		Ippb all types					
E0550	A		Humidif extens supple w ippb					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0555	A		Humidifier for use w/ regula					
E0560	A		Humidifier supplemental w/ i					
E0565	A		Compressor air power source					
E0570	A		Nebulizer with compression					
E0571	A		Aerosol compressor for svneb					
E0572	A		Aerosol compressor adjust pr					
E0574	A		Ultrasonic generator w svneb					
E0575	A		Nebulizer ultrasonic					
E0580	A		Nebulizer for use w/ regulat					
E0585	A		Nebulizer w/ compressor & he					
E0590	A		Dispensing fee dme neb drug					
E0600	A		Suction pump portab hom modl					
E0601	A		Cont airway pressure device					
E0602	E		Manual breast pump					
E0603	A		Electric breast pump					
E0604	A		Hosp grade elec breast pump					
E0605	A		Vaporizer room type					
E0606	A		Drainage board postural					
E0607	A		Blood glucose monitor home					
E0608	A	DG	Apnea monitor					
E0610	A		Pacemaker monitr audible/vis					
E0615	A		Pacemaker monitr digital/vis					
E0616	N		Cardiac event recorder					
E0617	A		Automatic ext defibrillator					
E0618	A	NI	Apnea monitor					
E0619	A	NI	Apnea monitor w recorder					
E0620	A		Cap bld skin piercing laser					
E0621	A		Patient lift sling or seat					
E0625	E		Patient lift bathroom or toi					
E0627	A		Seat lift incorp lift-chair					
E0628	A		Seat lift for pt furn-electr					
E0629	A		Seat lift for pt furn-non-el					
E0630	A		Patient lift hydraulic					
E0635	A		Patient lift electric					
E0636	A	NI	PT support & positioning sys					
E0650	A		Pneuma compresor non-segment					
E0651	A		Pneum compressor segmental					
E0652	A		Pneum compres w/cal pressure					
E0655	A		Pneumatic appliance half arm					
E0660	A		Pneumatic appliance full leg					
E0665	A		Pneumatic appliance full arm					
E0666	A		Pneumatic appliance half leg					
E0667	A		Seg pneumatic appl full leg					
E0668	A		Seg pneumatic appl full arm					
E0669	A		Seg pneumatic appli half leg					
E0671	A		Pressure pneum appl full leg					
E0672	A		Pressure pneum appl full arm					
E0673	A		Pressure pneum appl half leg					
E0690	A	DG	Ultraviolet cabinet					
E0691	A	NI	Uvl pnl 2 sq ft or less					
E0692	A	NI	Uvl sys panel 4 ft					
E0693	A	NI	Uvl sys panel 6 ft					
E0694	A	NI	Uvl md cabinet sys 6 ft					
E0700	E		Safety equipment					
E0701	A	NI	Helmet w face guard prefab					
E0710	E		Restraints any type					
E0720	A		Tens two lead					
E0730	A		Tens four lead					
E0731	A		Conductive garment for tens/					
E0740	E		Incontinence treatment systm					
E0744	A		Neuromuscular stim for scoli					
E0745	A		Neuromuscular stim for shock					
E0746	E		Electromyograph biofeedback					
E0747	A		Elec osteogen stim not spine					
E0748	A		Elec osteogen stim spinal					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0749	N		Elec osteogen stim implanted					
E0752	E		Neurostimulator electrode					
E0754	A		Pulsegenerator pt programmer					
E0755	E		Electronic salivary reflex s					
E0756	E		Implantable pulse generator					
E0757	E		Implantable RF receiver					
E0758	A		External RF transmitter					
E0759	A		Replace rdfrquncy transmittr					
E0760	E		Osteogen ultrasound stimltor					
E0761	E	NI	Nontherm electromgntc device					
E0765	E		Nerve stimulator for tx n&v					
E0776	A		Iv pole					
E0779	A		Amb infusion pump mechanical					
E0780	A		Mech amb infusion pump <8hrs					
E0781	A		External ambulatory infus pu					
E0782	E		Non-programble infusion pump					
E0783	E		Programmable infusion pump					
E0784	A		Ext amb infusn pump insulin					
E0785	E		Replacement impl pump cathet					
E0786	E		Implantable pump replacement					
E0791	A		Parenteral infusion pump sta					
E0830	N		Ambulatory traction device					
E0840	A		Tract frame attach headboard					
E0850	A		Traction stand free standing					
E0855	A		Cervical traction equipment					
E0860	A		Tract equip cervical tract					
E0870	A		Tract frame attach footboard					
E0880	A		Trac stand free stand extrem					
E0890	A		Traction frame attach pelvic					
E0900	A		Trac stand free stand pelvic					
E0910	A		Trapeze bar attached to bed					
E0920	A		Fracture frame attached to b					
E0930	A		Fracture frame free standing					
E0935	A		Exercise device passive moti					
E0940	A		Trapeze bar free standing					
E0941	A		Gravity assisted traction de					
E0942	A		Cervical head harness/halter					
E0943	A		Cervical pillow					
E0944	A		Pelvic belt/harness/boot					
E0945	A		Belt/harness extremity					
E0946	A		Fracture frame dual w cross					
E0947	A		Fracture frame attachmnts pe					
E0948	A		Fracture frame attachmnts ce					
E0950	E		Tray					
E0951	E		Loop heel					
E0952	E		Loop tie					
E0953	E		Pneumatic tire					
E0954	E		Wheelchair semi-pneumatic ca					
E0958	A		Whlchr att- conv 1 arm drive					
E0959	E		Amputee adapter					
E0961	E		Wheelchair brake extension					
E0962	A		Wheelchair 1 inch cushion					
E0963	A		Wheelchair 2 inch cushion					
E0964	A		Wheelchair 3 inch cushion					
E0965	A		Wheelchair 4 inch cushion					
E0966	E		Wheelchair head rest extensi					
E0967	E		Wheelchair hand rims					
E0968	A		Wheelchair commode seat					
E0969	E		Wheelchair narrowing device					
E0970	E		Wheelchair no. 2 footplates					
E0971	E		Wheelchair anti-tipping devi					
E0972	A		Transfer board or device					
E0973	E		Wheelchair adjustabl height					
E0974	E		Wheelchair grade-aid					
E0975	E		Wheelchair reinforced seat u					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0976	E		Wheelchair reinforced back u					
E0977	E		Wheelchair wedge cushion					
E0978	E		Wheelchair belt w/airplane b					
E0979	E		Wheelchair belt with velcro					
E0980	E		Wheelchair safety vest					
E0990	E		Whellchair elevating leg res					
E0991	E		Wheelchair upholstry seat					
E0992	E		Wheelchair solid seat insert					
E0993	E		Wheelchair back upholstery					
E0994	E		Wheelchair arm rest					
E0995	E		Wheelchair calf rest					
E0996	E		Wheelchair tire solid					
E0997	E		Wheelchair caster w/ a fork					
E0998	E		Wheelchair caster w/o a fork					
E0999	E		Wheelchr pneumatic tire w/wh					
E1000	E		Wheelchair tire pneumatic ca					
E1001	E		Wheelchair wheel					
E1011	A	NI	Ped wc modify width adjustm					
E1012	A	NI	Int seat sys planar ped w/c					
E1013	A	NI	Int seat sys contour ped w/c					
E1014	A	NI	Reclining back add ped w/c					
E1015	A	NI	Shock absorber for man w/c					
E1016	A	NI	Shock absorber for power w/c					
E1017	A	NI	HD shck absrbr for hd man wc					
E1018	A	NI	HD shck absrber for hd powwc					
E1020	A	NI	Residual limb support system					
E1025	A	NI	Pedwc lat/thor sup nocontour					
E1026	A	NI	Pedwc contoured lat/thor sup					
E1027	A	NI	Ped wc lat/ant support					
E1031	A		Rollabout chair with casters					
E1035	E		Patient transfer system					
E1037	A	NI	Transport chair, ped size					
E1038	A	NI	Transport chair, adult size					
E1050	A		Whelchr fxd full length arms					
E1060	A		Wheelchair detachable arms					
E1065	E		Wheelchair power attachment					
E1066	E		Wheelchair battery charger					
E1069	E		Wheelchair deep cycle batter					
E1070	A		Wheelchair detachable foot r					
E1083	A		Hemi-wheelchair fixed arms					
E1084	A		Hemi-wheelchair detachable a					
E1085	A		Hemi-wheelchair fixed arms					
E1086	A		Hemi-wheelchair detachable a					
E1087	A		Wheelchair lightwt fixed arm					
E1088	A		Wheelchair lightweight det a					
E1089	A		Wheelchair lightwt fixed arm					
E1090	A		Wheelchair lightweight det a					
E1091	A		Wheelchair youth					
E1092	A		Wheelchair wide w/ leg rests					
E1093	A		Wheelchair wide w/ foot rest					
E1100	A		Whchr s-recl fxd arm leg res					
E1110	A		Wheelchair semi-recl detach					
E1130	A		Whlchr stand fxd arm ft rest					
E1140	A		Wheelchair standard detach a					
E1150	A		Wheelchair standard w/ leg r					
E1160	A		Wheelchair fixed arms					
E1161	A	NI	Manual adult wc w tiltinspac					
E1170	A		Whlchr ampu fxd arm leg rest					
E1171	A		Wheelchair amputee w/o leg r					
E1172	A		Wheelchair amputee detach ar					
E1180	A		Wheelchair amputee w/ foot r					
E1190	A		Wheelchair amputee w/ leg re					
E1195	A		Wheelchair amputee heavy dut					
E1200	A		Wheelchair amputee fixed arm					
E1210	A		Whlchr moto ful arm leg rest					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E1211	A		Wheelchair motorized w/ det					
E1212	A		Wheelchair motorized w full					
E1213	A		Wheelchair motorized w/ det					
E1220	A		Whlchr special size/constrc					
E1221	A		Wheelchair spec size w foot					
E1222	A		Wheelchair spec size w/ leg					
E1223	A		Wheelchair spec size w foot					
E1224	A		Wheelchair spec size w/ leg					
E1225	A		Wheelchair spec sz semi-recl					
E1226	E		Wheelchair spec sz full-recl					
E1227	E		Wheelchair spec sz spec ht a					
E1228	A		Wheelchair spec sz spec ht b					
E1230	A		Power operated vehicle					
E1231	A	NI	Rigid ped w/c tilt-in-space					
E1232	A	NI	Folding ped wc tilt-in-space					
E1233	A	NI	Rig ped wc tltnspc w/o seat					
E1234	A	NI	Fld ped wc tltnspc w/o seat					
E1235	A	NI	Rigid ped wc adjustable					
E1236	A	NI	Folding ped wc adjustable					
E1237	A	NI	Rgd ped wc adjstabl w/o seat					
E1238	A	NI	Fld ped wc adjstabl w/o seat					
E1240	A		Whchr litwt det arm leg rest					
E1250	A		Wheelchair lightwt fixed arm					
E1260	A		Wheelchair lightwt foot rest					
E1270	A		Wheelchair lightweight leg r					
E1280	A		Whchr h-duty det arm leg res					
E1285	A		Wheelchair heavy duty fixed					
E1290	A		Wheelchair hvy duty detach a					
E1295	A		Wheelchair heavy duty fixed					
E1296	A		Wheelchair special seat heig					
E1297	A		Wheelchair special seat dept					
E1298	A		Wheelchair spec seat depth/w					
E1300	E		Whirlpool portable					
E1310	A		Whirlpool non-portable					
E1340	A		Repair for DME, per 15 min					
E1353	A		Oxygen supplies regulator					
E1355	A		Oxygen supplies stand/rack					
E1372	A		Oxy suppl heater for nebuliz					
E1390	A		Oxygen concentrator					
E1399	A		Durable medical equipment mi					
E1405	A		O2/water vapor enrich w/heat					
E1406	A		O2/water vapor enrich w/o he					
E1500	A		Centrifuge					
E1510	A		Kidney dialysate delivry sys					
E1520	A		Heparin infusion pump					
E1530	A		Replacement air bubble detec					
E1540	A		Replacement pressure alarm					
E1550	A		Bath conductivity meter					
E1560	A		Replace blood leak detector					
E1570	A		Adjustable chair for esrd pt					
E1575	A		Transducer protect/fld bar					
E1580	A		Unipuncture control system					
E1590	A		Hemodialysis machine					
E1592	A		Auto interm peritoneal dialy					
E1594	A		Cycler dialysis machine					
E1600	A		Deli/install chrg hemo equip					
E1610	A		Reverse osmosis h2o puri sys					
E1615	A		Deionizer H2O puri system					
E1620	A		Replacement blood pump					
E1625	A		Water softening system					
E1630	A		Reciprocating peritoneal dia					
E1632	A		Wearable artificial kidney					
E1635	A		Compact travel hemodialyzer					
E1636	A		Sorbent cartridges per 10					
E1637	A		Hemostats for dialysis, each					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E1638	A	DG	Peri dialysis heating pad					
E1639	A		Dialysis scale					
E1699	A		Dialysis equipment noc					
E1700	A		Jaw motion rehab system					
E1701	A		Repl cushions for jaw motion					
E1702	A		Repl measr scales jaw motion					
E1800	A		Adjust elbow ext/flex device					
E1801	A		SPS elbow device					
E1802	A	NI	Adjst forearm pro/sup device					
E1805	A		Adjust wrist ext/flex device					
E1806	A		SPS wrist device					
E1810	A		Adjust knee ext/flex device					
E1811	A		SPS knee device					
E1815	A		Adjust ankle ext/flex device					
E1816	A		SPS ankle device					
E1818	A		SPS forearm device					
E1820	A		Soft interface material					
E1821	A		Replacement interface SPSD					
E1825	A		Adjust finger ext/flex devc					
E1830	A		Adjust toe ext/flex device					
E1840	A		Adj shoulder ext/flex device					
E1902	A		AAC non-electronic board					
E2000	A		Gastric suction pump hme mdl					
E2100	A		Bld glucose monitor w voice					
E2101	A		Bld glucose monitor w lance					
G0001	A		Drawing blood for specimen					
G0002	X	DG	Temporary urinary catheter	0340	0.6492	$33.86		$6.77
G0004	E	DG	ECG transm phys review & int					
G0005	X	DG	ECG 24 hour recording	0097	1.0077	$52.55	$23.80	$10.51
G0006	X	DG	ECG transmission & analysis	0097	1.0077	$52.55	$23.80	$10.51
G0007	N	DG	ECG phy review & interpret					
G0008	L		Admin influenza virus vac					
G0009	L		Admin pneumococcal vaccine					
G0010	K		Admin hepatitis b vaccine	0355	0.2132	$11.12		$2.22
G0015	X	DG	Post symptom ECG tracing	0097	1.0077	$52.55	$23.80	$10.51
G0025	N		Collagen skin test kit					
G0026	A	DG	Fecal leukocyte examination					
G0027	A	DG	Semen analysis					
G0030	S		PET imaging prev PET single	0285	18.1294	$945.47	$409.56	$189.09
G0031	S		PET imaging prev PET multple	0285	18.1294	$945.47	$409.56	$189.09
G0032	S		PET follow SPECT 78464 singl	0285	18.1294	$945.47	$409.56	$189.09
G0033	S		PET follow SPECT 78464 mult	0285	18.1294	$945.47	$409.56	$189.09
G0034	S		PET follow SPECT 76865 singl	0285	18.1294	$945.47	$409.56	$189.09
G0035	S		PET follow SPECT 78465 mult	0285	18.1294	$945.47	$409.56	$189.09
G0036	S		PET follow cornry angio sing	0285	18.1294	$945.47	$409.56	$189.09
G0037	S		PET follow cornry angio mult	0285	18.1294	$945.47	$409.56	$189.09
G0038	S		PET follow myocard perf sing	0285	18.1294	$945.47	$409.56	$189.09
G0039	S		PET follow myocard perf mult	0285	18.1294	$945.47	$409.56	$189.09
G0040	S		PET follow stress echo singl	0285	18.1294	$945.47	$409.56	$189.09
G0041	S		PET follow stress echo mult	0285	18.1294	$945.47	$409.56	$189.09
G0042	S		PET follow ventriculogm sing	0285	18.1294	$945.47	$409.56	$189.09
G0043	S		PET follow ventriculogm mult	0285	18.1294	$945.47	$409.56	$189.09
G0044	S		PET following rest ECG singl	0285	18.1294	$945.47	$409.56	$189.09
G0045	S		PET following rest ECG mult	0285	18.1294	$945.47	$409.56	$189.09
G0046	S		PET follow stress ECG singl	0285	18.1294	$945.47	$409.56	$189.09
G0047	S		PET follow stress ECG mult	0285	18.1294	$945.47	$409.56	$189.09
G0050	S	DG	Residual urine by ultrasound	0265	0.9787	$51.04	$28.07	$10.21
G0101	V		CA screen;pelvic/breast exam	0600	0.8430	$43.96		$8.79
G0102	N		Prostate ca screening; dre					
G0103	A		Psa, total screening					
G0104	S		CA screen;flexi sigmoidscope	0159	2.3255	$121.28		$30.32
G0105	T		Colorectal scrn; hi risk ind	0158	7.0638	$368.38		$92.10
G0106	S		Colon CA screen;barium enema	0157	2.5387	$132.40		$26.48
G0107	A		CA screen; fecal blood test					
G0108	A		Diab manage trn per indiv					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0109	A		Diab manage trn ind/group					
G0110	A		Nett pulm-rehab educ; ind					
G0111	A		Nett pulm-rehab educ; group					
G0112	A		Nett;nutrition guid, initial					
G0113	A		Nett;nutrition guid,subseqnt					
G0114	A		Nett; psychosocial consult					
G0115	A		Nett; psychological testing					
G0116	A		Nett; psychosocial counsel					
G0117	S		Glaucoma scrn hgh risk direc	0230	0.7364	$38.40	$14.97	$7.68
G0118	S		Glaucoma scrn hgh risk direc	0230	0.7364	$38.40	$14.97	$7.68
G0120	S		Colon ca scrn; barium enema	0157	2.5387	$132.40		$26.48
G0121	T		Colon ca scrn not hi rsk ind	0158	7.0638	$368.38		$92.10
G0122	E		Colon ca scrn; barium enema					
G0123	A		Screen cerv/vag thin layer					
G0124	A		Screen c/v thin layer by MD					
G0125	S		PET img WhBD sgl pulm ring	0714		$1,375.00		$275.00
G0127	T		Trim nail(s)	0009	0.6298	$32.84	$8.34	$6.57
G0128	E		CORF skilled nursing service					
G0129	P		Partial hosp prog service	0033	4.6026	$240.03	$48.17	$48.01
G0130	X		Single energy x-ray study	0260	0.7655	$39.92	$21.95	$7.98
G0131	S	DG	CT scan, bone density study	0288	1.2984	$67.71		$13.54
G0132	S	DG	CT scan, bone density study	0665	0.8236	$42.95		$8.59
G0141	E		Scr c/v cyto,autosys and md					
G0143	A		Scr c/v cyto,thinlayer,rescr					
G0144	A		Scr c/v cyto,thinlayer,rescr					
G0145	A		Scr c/v cyto,thinlayer,rescr					
G0147	A		Scr c/v cyto, automated sys					
G0148	A		Scr c/v cyto, autosys, rescr					
G0151	E		HHCP-serv of pt,ea 15 min					
G0152	E		HHCP-serv of ot,ea 15 min					
G0153	E		HHCP-svs of s/l path,ea 15mn					
G0154	E		HHCP-svs of rn,ea 15 min					
G0155	E		HHCP-svs of csw,ea 15 min					
G0156	E		HHCP-svs of aide,ea 15 min					
G0166	T		Extrnl counterpulse, per tx	0678	2.2189	$115.72		$23.14
G0167	E		Hyperbaric oz tx;no md reqrd					
G0168	X		Wound closure by adhesive	0340	0.6492	$33.86		$6.77
G0173	S		Stereo radoisurgery,complete	0721		$5,500.00		$1,100.00
G0175	V		OPPS Service,sched team conf	0602	1.4631	$76.30		$15.26
G0176	P		OPPS/PHP;activity therapy	0033	4.6026	$240.03	$48.17	$48.01
G0177	P		OPPS/PHP; train & educ serv	0033	4.6026	$240.03	$48.17	$48.01
G0179	E		MD recertification HHA PT					
G0180	E		MD certification HHA patient					
G0181	E		Home health care supervision					
G0182	E		Hospice care supervision					
G0185	T	DG	Transpuppillary thermotx	0235	5.0871	$265.30	$73.44	$53.06
G0186	T		Dstry eye lesn,fdr vssl tech	0235	5.0871	$265.30	$73.44	$53.06
G0187	T	DG	Dstry mclr drusen,photocoag	0235	5.0871	$265.30	$73.44	$53.06
G0192	N	DG	Immunization oral/intranasal					
G0193	A	DG	Endoscopicstudyswallowfunctn					
G0194	A	DG	Sensorytestingendoscopicstud					
G0195	A	DG	Clinicalevalswallowingfunct					
G0196	A	DG	Evalofswallowingwithradioopa					
G0197	A	DG	Evalofptforprescipspeechdevi					
G0198	A	DG	Patientadapation&trainforspe					
G0199	A	DG	Reevaluationofpatientusespec					
G0200	A	DG	Evalofpatientprescipofvoicep					
G0201	A	DG	Modifortraininginusevoicepro					
G0202	A		Screeningmammographydigital					
G0204	S		Diagnosticmammographydigital	0669	0.8915	$46.49		$9.30
G0206	S		Diagnosticmammographydigital	0669	0.8915	$46.49		$9.30
G0210	S		PET img whbd ring dxlung ca	0714		$1,375.00		$275.00
G0211	S		PET img whbd ring init lung	0714		$1,375.00		$275.00
G0212	S		PET img whbd ring restag lun	0714		$1,375.00		$275.00
G0213	S		PET img whbd ring dx colorec	0714		$1,375.00		$275.00

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0214	S		PET img whbd ring init colre	0714		$1,375.00		$275.00
G0215	S		PET img whbd restag col	0714		$1,375.00		$275.00
G0216	S		PET img whbd ring dx melanom	0714		$1,375.00		$275.00
G0217	S		PET img whbd ring init melan	0714		$1,375.00		$275.00
G0218	S		PET img whbd ring restag mel	0714		$1,375.00		$275.00
G0219	E		PET img whbd ring noncov ind					
G0220	S		PET img whbd ring dx lymphom	0714		$1,375.00		$275.00
G0221	S		PET img whbd ring init lymph	0714		$1,375.00		$275.00
G0222	S		PET img whbd ring resta lymp	0714		$1,375.00		$275.00
G0223	S		PET img whbd reg ring dx hea	0714		$1,375.00		$275.00
G0224	S		PETimg whbd reg ring ini hea	0714		$1,375.00		$275.00
G0225	S		PET img whbd ring restag hea	0714		$1,375.00		$275.00
G0226	S		PET img whbd dx esophag	0714		$1,375.00		$275.00
G0227	S		PET img whbd ring ini esopha	0714		$1,375.00		$275.00
G0228	S		PET img whbd ring restg esop	0714		$1,375.00		$275.00
G0229	S		PET img metabolic brain ring	0714		$1,375.00		$275.00
G0230	S		PET myocard viability ring	0714		$1,375.00		$275.00
G0231	S		PET WhBD colorec; gamma cam	0714		$1,375.00		$275.00
G0232	S		PET whbd lymphoma; gamma cam	0714		$1,375.00		$275.00
G0233	S		PET whbd melanoma; gamma cam	0714		$1,375.00		$275.00
G0234	S		PET WhBD pulm nod; gamma cam	0714		$1,375.00		$275.00
G0236	S		Digital film convert diag ma	0706		$25.00		$5.00
G0237	T		Therapeutic procd strg endur	0970		$25.00		$5.00
G0238	T		Oth resp proc, indiv	0970		$25.00		$5.00
G0239	T		Oth resp proc, group	0970		$25.00		$5.00
G0240	A	DG	Critic care by MD transport					
G0241	A	DG	Each additional 30 minutes					
G0242	S		Multisource photon ster plan	0714		$1,375.00		$275.00
G0243	S		Multisour photon stero treat	0721		$5,500.00		$1,100.00
G0244	S		Observ care by facility topt	0339	7.2188	$376.47		$75.29
G0245	V		Initial Foot Exam PTLOPS	0600	0.8430	$43.96		$8.79
G0246	V		Follow-up Eval of Foot PTLOPS	0600	0.8430	$43.96		$8.79
G0247	T		Routine footcare w LOPS	0009	0.6298	$32.84	$8.34	$6.57
G0248	S		Demonstrate use home INR mon	0708		$150.00		$30.00
G0249	S		Provide test material,equipm	0708		$150.00		$30.00
G0250	E		MD review interpret of test					
G0251	S	NI	Linear acc based stero radio	0713		$1,125.00		$225.00
G0252	S	NI	PET imaging initial dx	0714		$1,375.00		$275.00
G0253	S	NI	PET image brst dection recur	0714		$1,375.00		$275.00
G0254	S	NI	PET image brst eval to tx	0714		$1,375.00		$275.00
G0255	E	NI	Current percep threshold tst					
G0256	T	NF	Prostate brachy w palladium	0649	115.0167	$5,998.24		$1,199.65
G0257	S	NF	Unsched dialysis ESRD pt hos	0170	4.8352	$252.16		$50.43
G0258	X	DG	IV infusion during obs stay	0340	0.6492	$33.86		$6.77
G0259	N	NF	Inject for sacroiliac joint					
G0260	T	NF	Inj for sacroiliac jt anesth	0204	2.0251	$105.61	$40.13	$21.12
G0261	T	NF	Prostate brachy w iodine see	0684	98.8349	$5,154.34		$1,030.87
G0262	S	NI	Sm intestinal image capsule	0711		$625.00		$125.00
G0263	N	NF	Adm with CHF, CP, asthma					
G0264	V	NF	Assmt otr CHF, CP, asthma	0600	0.8430	$43.96		$8.79
G0265	A	NI	Cryopresevation Freeze+stora					
G0266	A	NI	Thawing + expansion froz cel					
G0267	A	NI	Bone marrow or psc harvest					
G0268	X	NI	Removal of impacted wax md	0340	0.6492	$33.86		$6.77
G0269	N	NI	Occlusive device in vein art					
G0270	A	NI	MNT subs tx for change dx					
G0271	A	NI	Group MNT 2 or more 30 mins					
G0272	X	NI	Naso/oro gastric tube pl MD	0272	1.3372	$69.74	$38.36	$13.95
G0273	S	NI	Pretx planning, non-Hodgkins	0718		$2,750.00		$550.00
G0274	S	NI	Radiopharm tx, non-Hodgkins	0725		$20,000.00		$4,000.00
G0275	N	NI	Renal angio, cardiac cath					
G0278	N	NI	Iliac art angio,cardiac cath					
G0279	A	NI	Excorp shock tx, elbow epi					
G0280	A	NI	Excorp shock tx other than					
G0281	A	NI	Elec stim unattend for press					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0282	A	NI	Elect stim wound care not pd					
G0283	A	NI	Elec stim other than wound					
G0288	T	NI	Recon, CTA for surg plan	0975		$625.00		$125.00
G0289	N	NI	Arthro, loose body + chondro					
G0290	E	NF	Drug-eluting stents, single					
G0291	E	NF	Drug-eluting stents,each add					
G0292	S	NI	Adm exp drugs,clinical trial	0708		$150.00		$30.00
G0293	S	NI	Non-cov surg proc,clin trial	0710		$400.00		$80.00
G0294	S	NI	Non-cov proc, clinical trial	0707		$75.00		$15.00
G0295	E	NI	Electromagnetic therapy onc					
G9001	E		MCCD, initial rate					
G9002	E		MCCD,maintenance rate					
G9003	E		MCCD, risk adj hi, initial					
G9004	E		MCCD, risk adj lo, initial					
G9005	E		MCCD, risk adj, maintenance					
G9006	E		MCCD, Home monitoring					
G9007	E		MCCD, sch team conf					
G9008	E		Mccd,phys coor-care ovrsght					
G9009	E		MCCD, risk adj, level 3					
G9010	E		MCCD, risk adj, level 4					
G9011	E		MCCD, risk adj, level 5					
G9012	E		Other Specified Case Mgmt					
G9016	A		Demo-smoking cessation coun					
H0001	E		Alcohol and/or drug assess					
H0002	E		Alcohol and/or drug screenin					
H0003	E		Alcohol and/or drug screenin					
H0004	E		Alcohol and/or drug services					
H0005	E		Alcohol and/or drug services					
H0006	E		Alcohol and/or drug services					
H0007	E		Alcohol and/or drug services					
H0008	E		Alcohol and/or drug services					
H0009	E		Alcohol and/or drug services					
H0010	E		Alcohol and/or drug services					
H0011	E		Alcohol and/or drug services					
H0012	E		Alcohol and/or drug services					
H0013	E		Alcohol and/or drug services					
H0014	E		Alcohol and/or drug services					
H0015	E		Alcohol and/or drug services					
H0016	E		Alcohol and/or drug services					
H0017	E		Alcohol and/or drug services					
H0018	E		Alcohol and/or drug services					
H0019	E		Alcohol and/or drug services					
H0020	E		Alcohol and/or drug services					
H0021	E		Alcohol and/or drug training					
H0022	E		Alcohol and/or drug interven					
H0023	E		Alcohol and/or drug outreach					
H0024	E		Alcohol and/or drug preventi					
H0025	E		Alcohol and/or drug preventi					
H0026	E		Alcohol and/or drug preventi					
H0027	E		Alcohol and/or drug preventi					
H0028	E		Alcohol and/or drug preventi					
H0029	E		Alcohol and/or drug preventi					
H0030	E		Alcohol and/or drug hotline					
H0031	E	NI	MH health assess by non-md					
H0032	E	NI	MH svc plan dev by non-md					
H0033	E	NI	Oral med adm direct observe					
H0034	E	NI	Med trng & support per 15min					
H0035	E	NI	MH partial hosp tx under 24h					
H0036	E	NI	Comm psy face-face per 15min					
H0037	E	NI	Comm psy sup tx pgm per diem					
H0038	E	NI	Self-help/peer svc per 15min					
H0039	E	NI	Asser com tx face-face/15min					
H0040	E	NI	Assert comm tx pgm per diem					
H0041	E	NI	Fos c chld non-ther per diem					
H0042	E	NI	Fos c chld non-ther per mon					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
H0043	E	NI	Supported housing, per diem					
H0044	E	NI	Supported housing, per month					
H0045	E	NI	Respite not-in-home per diem					
H0046	E	NI	Mental health service, nos					
H0047	E	NI	Alcohol/drug abuse svc nos					
H0048	E	NI	Spec coll non-blood:a/d test					
H1000	A		Prenatal care atrisk assessm					
H1001	A		Antepartum management					
H1002	A		Carecoordination prenatal					
H1003	A		Prenatal at risk education					
H1004	A		Follow up home visit/prental					
H1005	A		Prenatalcare enhanced srv pk					
H1010	E	NI	Nonmed family planning ed					
H1011	E	NI	Family assessment					
H2000	E	NI	Comp multidisipln evaluation					
H2001	E	NI	Rehabilitation program 1/2 d					
J0120	N		Tetracyclin injection					
J0130	K		Abciximab injection	1605	5.8526	$305.22		$61.04
J0150	N		Injection adenosine 6 MG					
J0151	K		Adenosine injection	0917	3.1986	$166.81		$33.36
J0170	N		Adrenalin epinephrin inject					
J0190	N		Inj biperiden lactate/5 mg					
J0200	N		Alatrofloxacin mesylate					
J0205	F		Alglucerase injection					
J0207	K		Amifostine	7000	4.5057	$234.98		$47.00
J0210	N		Methyldopate hcl injection					
J0256	F		Alpha 1 proteinase inhibitor					
J0270	E		Alprostadil for injection					
J0275	E		Alprostadil urethral suppos					
J0280	N		Aminophyllin 250 MG inj					
J0282	N		Amiodarone HCl					
J0285	N		Amphotericin B					
J0286	K	DG	Amphotericin B lipid complex	7001	2.3449	$122.29		$24.46
J0287	K	NI	Amphotericin b lipid complex	9024	0.4167	$21.73		$4.35
J0288	N	NI	Ampho b cholesteryl sulfate					
J0289	N	NI	Amphotericin b liposome inj					
J0290	N		Ampicillin 500 MG inj					
J0295	N		Ampicillin sodium per 1.5 gm					
J0300	N		Amobarbital 125 MG inj					
J0330	N		Succinycholine chloride inj					
J0350	N		Injection anistreplase 30 u					
J0360	N		Hydralazine hcl injection					
J0380	N		Inj metaraminol bitartrate					
J0390	N		Chloroquine injection					
J0395	N		Arbutamine HCl injection					
J0456	N		Azithromycin					
J0460	N		Atropine sulfate injection					
J0470	N		Dimecaprol injection					
J0475	N		Baclofen 10 MG injection					
J0476	E		Baclofen intrathecal trial					
J0500	N		Dicyclomine injection					
J0515	N		Inj benztropine mesylate					
J0520	N		Bethanechol chloride inject					
J0530	N		Penicillin g benzathine inj					
J0540	N		Penicillin g benzathine inj					
J0550	N		Penicillin g benzathine inj					
J0560	N		Penicillin g benzathine inj					
J0570	N		Penicillin g benzathine inj					
J0580	N		Penicillin g benzathine inj					
J0585	K		Botulinum toxin a per unit	0902	0.0484	$2.52		$.50
J0587	G		Botulinum toxin type B	9018		$8.79		$1.31
J0592	N	NI	Buprenorphine hydrochloride					
J0600	N		Edetate calcium disodium inj					
J0610	N		Calcium gluconate injection					
J0620	N		Calcium glycer & lact/10 ML					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J0630	N		Calcitonin salmon injection					
J0635	N	DG	Calcitriol injection					
J0636	N	NI	Inj calcitriol per 0.1 mcg					
J0637	G	NI	Caspofungin acetate	9019		$34.20		$5.11
J0640	N		Leucovorin calcium injection					
J0670	N		Inj mepivacaine HCL/10 ml					
J0690	N		Cefazolin sodium injection					
J0692	N		Cefepime HCl for injection					
J0694	N		Cefoxitin sodium injection					
J0696	N		Ceftriaxone sodium injection					
J0697	N		Sterile cefuroxime injection					
J0698	N		Cefotaxime sodium injection					
J0702	N		Betamethasone acet&sod phosp					
J0704	N		Betamethasone sod phosp/4 MG					
J0706	N		Caffeine citrate injection					
J0710	N		Cephapirin sodium injection					
J0713	N		Inj ceftazidime per 500 mg					
J0715	N		Ceftizoxime sodium / 500 MG					
J0720	N		Chloramphenicol sodium injec					
J0725	N		Chorionic gonadotropin/1000u					
J0735	N		Clonidine hydrochloride					
J0740	N		Cidofovir injection					
J0743	N		Cilastatin sodium injection					
J0744	N		Ciprofloxacin iv					
J0745	N		Inj codeine phosphate /30 MG					
J0760	N		Colchicine injection					
J0770	N		Colistimethate sodium inj					
J0780	N		Prochlorperazine injection					
J0800	N		Corticotropin injection					
J0835	N		Inj cosyntropin per 0.25 MG					
J0850	K		Cytomegalovirus imm IV /vial	0903	4.7383	$247.11		$49.42
J0880	E	NI	Darbepoetin alfa injection					
J0895	N		Deferoxamine mesylate inj					
J0900	N		Testosterone enanthate inj					
J0945	N		Brompheniramine maleate inj					
J0970	N		Estradiol valerate injection					
J1000	N		Depo-estradiol cypionate inj					
J1020	N		Methylprednisolone 20 MG inj					
J1030	N		Methylprednisolone 40 MG inj					
J1040	N		Methylprednisolone 80 MG inj					
J1050	N	DG	Medroxyprogesterone inj					
J1051	N	NI	Medroxyprogesterone inj					
J1055	E		Medrxyprogester acetate inj					
J1056	E		MA/EC contraceptiveinjection					
J1060	N		Testosterone cypionate 1 ML					
J1070	N		Testosterone cypionat 100 MG					
J1080	N		Testosterone cypionat 200 MG					
J1094	N	NI	Inj dexamethasone acetate					
J1095	N	DG	Inj dexamethasone acetate					
J1100	N		Dexamethasone sodium phos					
J1110	N		Inj dihydroergotamine mesylt					
J1120	N		Acetazolamid sodium injectio					
J1160	N		Digoxin injection					
J1165	N		Phenytoin sodium injection					
J1170	N		Hydromorphone injection					
J1180	N		Dyphylline injection					
J1190	K		Dexrazoxane HCl injection	0726	2.2577	$117.74		$23.55
J1200	N		Diphenhydramine hcl injectio					
J1205	N		Chlorothiazide sodium inj					
J1212	N		Dimethyl sulfoxide 50% 50 ML					
J1230	N		Methadone injection					
J1240	N		Dimenhydrinate injection					
J1245	N		Dipyridamole injection					
J1250	N		Inj dobutamine HCL/250 mg					
J1260	N		Dolasetron mesylate					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1270	N		Injection, doxercalciferol					
J1320	N		Amitriptyline injection					
J1325	N		Epoprostenol injection					
J1327	N		Eptifibatide injection					
J1330	N		Ergonovine maleate injection					
J1364	N		Erythro lactobionate /500 MG					
J1380	N		Estradiol valerate 10 MG inj					
J1390	N		Estradiol valerate 20 MG inj					
J1410	N		Inj estrogen conjugate 25 MG					
J1435	N		Injection estrone per 1 MG					
J1436	N		Etidronate disodium inj					
J1438	N		Etanercept injection					
J1440	K		Filgrastim 300 mcg injection	0728	2.1027	$109.66		$21.93
J1441	K		Filgrastim 480 mcg injection	7049	3.2267	$168.28		$33.66
J1450	N		Fluconazole					
J1452	N		Intraocular Fomivirsen na					
J1455	N		Foscarnet sodium injection					
J1460	N		Gamma globulin 1 CC inj					
J1470	E		Gamma globulin 2 CC inj					
J1480	E		Gamma globulin 3 CC inj					
J1490	E		Gamma globulin 4 CC inj					
J1500	E		Gamma globulin 5 CC inj					
J1510	E		Gamma globulin 6 CC inj					
J1520	E		Gamma globulin 7 CC inj					
J1530	E		Gamma globulin 8 CC inj					
J1540	E		Gamma globulin 9 CC inj					
J1550	E		Gamma globulin 10 CC inj					
J1560	E		Gamma globulin > 10 CC inj					
J1561	K	DG	Immune globulin 500 mg	0905	0.8333	$43.46		$8.69
J1563	E		IV immune globulin					
J1564	K	NI	Immune globulin 10 mg	9021	0.0097	$.51		$.10
J1565	K		RSV-ivig	0906	0.5911	$30.83		$6.17
J1570	N		Ganciclovir sodium injection					
J1580	N		Garamycin gentamicin inj					
J1590	N		Gatifloxacin injection					
J1600	N		Gold sodium thiomaleate inj					
J1610	N		Glucagon hydrochloride/1 MG					
J1620	N		Gonadorelin hydroch/ 100 mcg					
J1626	N		Granisetron HCl injection					
J1630	N		Haloperidol injection					
J1631	N		Haloperidol decanoate inj					
J1642	N		Inj heparin sodium per 10 u					
J1644	N		Inj heparin sodium per 1000u					
J1645	N		Dalteparin sodium					
J1650	N		Inj enoxaparin sodium					
J1652	N	NI	Fondaparinux sodium					
J1655	N		Tinzaparin sodium injection					
J1670	N		Tetanus immune globulin inj					
J1700	N		Hydrocortisone acetate inj					
J1710	N		Hydrocortisone sodium ph inj					
J1720	N		Hydrocortisone sodium succ i					
J1730	N		Diazoxide injection					
J1742	N		Ibutilide fumarate injection					
J1745	K		Infliximab injection	7043	0.7364	$38.40		$7.68
J1750	N		Iron dextran					
J1755	N	DG	Iron sucrose injection					
J1756	N	NI	Iron sucrose injection					
J1785	K		Injection imiglucerase /unit	0916	0.0484	$2.52		$.50
J1790	N		Droperidol injection					
J1800	N		Propranolol injection					
J1810	E		Droperidol/fentanyl inj					
J1815	N	NI	Insulin injection					
J1817	N	NI	Insulin for insulin pump use					
J1820	N	DG	Insulin injection					
J1825	K		Interferon beta-1a	0909	2.7906	$145.53		$29.11

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1830	K		Interferon beta-1b / .25 MG	0910	1.9864	$103.59		$20.72
J1835	N		Itraconazole injection					
J1840	N		Kanamycin sulfate 500 MG inj					
J1850	N		Kanamycin sulfate 75 MG inj					
J1885	N		Ketorolac tromethamine inj					
J1890	N		Cephalothin sodium injection					
J1910	N		Kutapressin injection					
J1940	N		Furosemide injection					
J1950	K		Leuprolide acetate /3.75 MG	0800	3.7984	$198.09		$39.62
J1955	E		Inj levocarnitine per 1 gm					
J1956	N		Levofloxacin injection					
J1960	N		Levorphanol tartrate inj					
J1980	N		Hyoscyamine sulfate inj					
J1990	N		Chlordiazepoxide injection					
J2000	N		Lidocaine injection					
J2010	N		Lincomycin injection					
J2020	N		Linezolid injection					
J2060	N		Lorazepam injection					
J2150	N		Mannitol injection					
J2175	N		Meperidine hydrochl /100 MG					
J2180	N		Meperidine/promethazine inj					
J2210	N		Methylergonovin maleate inj					
J2250	N		Inj midazolam hydrochloride					
J2260	N		Inj milrinone lactate / 5 ML					
J2270	N		Morphine sulfate injection					
J2271	N		Morphine so4 injection 100mg					
J2275	N		Morphine sulfate injection					
J2300	N		Inj nalbuphine hydrochloride					
J2310	N		Inj naloxone hydrochloride					
J2320	N		Nandrolone decanoate 50 MG					
J2321	N		Nandrolone decanoate 100 MG					
J2322	N		Nandrolone decanoate 200 MG					
J2324	G	NI	Nesiritide	9114		$433.20		$64.75
J2352	K		Octreotide acetate injection	7031	1.2694	$66.20		$13.24
J2355	K		Oprelvekin injection	7011	2.7325	$142.50		$28.50
J2360	N		Orphenadrine injection					
J2370	N		Phenylephrine hcl injection					
J2400	N		Chloroprocaine hcl injection					
J2405	N		Ondansetron hcl injection					
J2410	N		Oxymorphone hcl injection					
J2430	K		Pamidronate disodium /30 MG	0730	3.2654	$170.29		$34.06
J2440	N		Papaverin hcl injection					
J2460	N		Oxytetracycline injection					
J2500	N	DG	Paricalcitol					
J2501	N	NI	Paricalcitol					
J2510	N		Penicillin g procaine inj					
J2515	N		Pentobarbital sodium inj					
J2540	N		Penicillin g potassium inj					
J2543	N		Piperacillin/tazobactam					
J2545	A		Pentamidine isethionte/300mg					
J2550	N		Promethazine hcl injection					
J2560	N		Phenobarbital sodium inj					
J2590	N		Oxytocin injection					
J2597	N		Inj desmopressin acetate					
J2650	N		Prednisolone acetate inj					
J2670	N		Totazoline hcl injection					
J2675	N		Inj progesterone per 50 MG					
J2680	N		Fluphenazine decanoate 25 MG					
J2690	N		Procainamide hcl injection					
J2700	N		Oxacillin sodium injeciton					
J2710	N		Neostigmine methylslfte inj					
J2720	N		Inj protamine sulfate/10 MG					
J2725	N		Inj protirelin per 250 mcg					
J2730	N		Pralidoxime chloride inj					
J2760	N		Phentolaine mesylate inj					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2765	N		Metoclopramide hcl injection					
J2770	N		Quinupristin/dalfopristin					
J2780	N		Ranitidine hydrochloride inj					
J2788	K	NI	Rho d immune globulin 50 mcg	9023	0.0484	$2.52		$.50
J2790	N		Rho d immune globulin inj					
J2792	K		Rho(D) immune globulin h, sd	1609	0.2229	$11.62		$2.32
J2795	N		Ropivacaine HCl injection					
J2800	N		Methocarbamol injection					
J2810	N		Inj theophylline per 40 MG					
J2820	N		Sargramostim injection					
J2910	N		Aurothioglucose injeciton					
J2912	N		Sodium chloride injection					
J2915	N	DG	NA Ferric Gluconate Complex					
J2916	N	NI	Na ferric gluconate complex					
J2920	N		Methylprednisolone injection					
J2930	N		Methylprednisolone injection					
J2940	N		Somatrem injection					
J2941	K		Somatropin injection	7034	0.7170	$37.39		$7.48
J2950	N		Promazine hcl injection					
J2993	K		Reteplase injection	9005	12.6547	$659.96		$131.99
J2995	N		Inj streptokinase /250000 IU					
J2997	N		Alteplase recombinant					
J3000	N		Streptomycin injection					
J3010	N		Fentanyl citrate injeciton					
J3030	N		Sumatriptan succinate / 6 MG					
J3070	N		Pentazocine hcl injection					
J3100	K		Tenecteplase injection	9002	27.5963	$1,439.17		$287.83
J3105	N		Terbutaline sulfate inj					
J3120	N		Testosterone enanthate inj					
J3130	N		Testosterone enanthate inj					
J3140	N		Testosterone suspension inj					
J3150	N		Testosteron propionate inj					
J3230	N		Chlorpromazine hcl injection					
J3240	K		Thyrotropin injection	9108	7.5870	$395.67		$79.13
J3245	K		Tirofiban hydrochloride	7041	4.9417	$257.71		$51.54
J3250	N		Trimethobenzamide hcl inj					
J3260	N		Tobramycin sulfate injection					
J3265	N		Injection torsemide 10 mg/ml					
J3280	N		Thiethylperazine maleate inj					
J3301	N		Triamcinolone acetonide inj					
J3302	N		Triamcinolone diacetate inj					
J3303	N		Triamcinolone hexacetonl inj					
J3305	K		Inj trimetrexate glucoronate	7045	1.3081	$68.22		$13.64
J3310	N		Perphenazine injeciton					
J3315	E	NI	Triptorelin pamoate					
J3320	N		Spectinomycn di-hcl inj					
J3350	N		Urea injection					
J3360	N		Diazepam injection					
J3364	N		Urokinase 5000 IU injection					
J3365	N		Urokinase 250,000 IU inj					
J3370	N		Vancomycin hcl injection					
J3395	K		Verteporfin injection	1203	16.5209	$861.58		$172.32
J3400	N		Triflupromazine hcl inj					
J3410	N		Hydroxyzine hcl injection					
J3420	N		Vitamin b12 injection					
J3430	N		Vitamin k phytonadione inj					
J3470	N		Hyaluronidase injection					
J3475	N		Inj magnesium sulfate					
J3480	N		Inj potassium chloride					
J3485	N		Zidovudine					
J3487	G	NI	Zoledronic acid	9115		$406.78		$60.80
J3490	N		Drugs unclassified injection					
J3520			Edetate disodium per 150 mg					
J3530	N		Nasal vaccine inhalation					
J3535	E		Metered dose inhaler drug					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J3570	E		Laetrile amygdalin vit B17					
J3590	N	NI	Unclassified biologics					
J7030	N		Normal saline solution infus					
J7040	N		Normal saline solution infus					
J7042	N		5% dextrose/normal saline					
J7050	N		Normal saline solution infus					
J7051	N		Sterile saline/water					
J7060	N		5% dextrose/water					
J7070	N		D5w infusion					
J7100	N		Dextran 40 infusion					
J7110	N		Dextran 75 infusion					
J7120	N		Ringers lactate infusion					
J7130	N		Hypertonic saline solution					
J7190	K		Factor viii	0925	0.0097	$.51		$.10
J7191	K		Factor VIII (porcine)	0926	0.0291	$1.52		$.30
J7192	K		Factor viii recombinant	0927	0.0194	$1.01		$.20
J7193	K		Factor IX non-recombinant	0931	0.0097	$.51		$.10
J7194	K		Factor ix complex	0928	0.0097	$.51		$.10
J7195	K		Factor IX recombinant	0932	0.0194	$1.01		$.20
J7197	K		Antithrombin iii injection	0930	0.0194	$1.01		$.20
J7198	K		Anti-inhibitor	0929	0.0194	$1.01		$.20
J7199	E		Hemophilia clot factor noc					
J7300	E		Intraut copper contraceptive					
J7302	E		Levonorgestrel iu contracept					
J7308	N		Aminolevulinic acid hcl top					
J7310	N		Ganciclovir long act implant					
J7316	N	DG	Sodium hyaluronate injection					
J7317	N	NI	Sodium hyaluronate injection					
J7320	K		Hylan G-F 20 injection	1611	2.3643	$123.30		$24.66
J7330	K		Cultured chondrocytes implnt	1059	114.2706	$5,959.33		$1,191.87
J7340	E		Metabolic active D/E tissue					
J7342	N	NI	Metabolically active tissue					
J7350	N	NI	Injectable human tissue					
J7500	N		Azathioprine oral 50mg					
J7501	N		Azathioprine parenteral					
J7502	K		Cyclosporine oral 100 mg	0888	0.0484	$2.52		$.50
J7504	K		Lymphocyte immune globulin	0890	3.3429	$174.34		$34.87
J7505	K		Monoclonal antibodies	7038	6.9572	$362.82		$72.56
J7506	N		Prednisone oral					
J7507	K		Tacrolimus oral per 1 MG	0891	0.0291	$1.52		$.30
J7508	E		Tacrolimus oral per 5 MG					
J7509	N		Methylprednisolone oral					
J7510	N		Prednisolone oral per 5 mg					
J7511	K		Antithymocyte globuln rabbit	9104	2.6356	$137.45		$27.49
J7513	K		Daclizumab, parenteral	1612	4.3991	$229.42		$45.88
J7515	N		Cyclosporine oral 25 mg					
J7516	N		Cyclosporin parenteral 250mg					
J7517	K		Mycophenolate mofetil oral	9015	0.0291	$1.52		$.30
J7520	K		Sirolimus, oral	9020	0.0581	$3.03		$.61
J7525	N		Tacrolimus injection					
J7599	E		Immunosuppressive drug noc					
J7608	A		Acetylcysteine inh sol u d					
J7618	A		Albuterol inh sol con					
J7619	A		Albuterol inh sol u d					
J7622	A		Beclomethasone inhalatn sol					
J7624	A		Betamethasone inhalation sol					
J7626	A		Budesonide inhalation sol					
J7628	A		Bitolterol mes inhal sol con					
J7629	A		Bitolterol mes inh sol u d					
J7631	A		Cromolyn sodium inh sol u d					
J7633	N	NI	Budesonide concentrated sol					
J7635	A		Atropine inhal sol con					
J7636	A		Atropine inhal sol unit dose					
J7637	A		Dexamethasone inhal sol con					
J7638	A		Dexamethasone inhal sol u d					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J7639	A		Dornase alpha inhal sol u d					
J7641	A		Flunisolide, inhalation sol					
J7642	A		Glycopyrrolate inhal sol con					
J7643	A		Glycopyrrolate inhal sol u d					
J7644	A		Ipratropium brom inh sol u d					
J7648	A		Isoetharine hcl inh sol con					
J7649	A		Isoetharine hcl inh sol u d					
J7658	A		Isoproterenolhcl inh sol con					
J7659	A		Isoproterenol hcl inh sol ud					
J7668	A		Metaproterenol inh sol con					
J7669	A		Metaproterenol inh sol u d					
J7680	A		Terbutaline so4 inh sol con					
J7681	A		Terbutaline so4 inh sol u d					
J7682	A		Tobramycin inhalation sol					
J7683	A		Triamcinolone inh sol con					
J7684	A		Triamcinolone inh sol u d					
J7699	A		Inhalation solution for DME					
J7799	A		Non-inhalation drug for DME					
J8499	E		Oral prescrip drug non chemo					
J8510	N		Oral busulfan					
J8520	K		Capecitabine, oral, 150 mg	7042	0.0291	$1.52		$.30
J8521	E		Capecitabine, oral, 500 mg					
J8530	N		Cyclophosphamide oral 25 MG					
J8560	K		Etoposide oral 50 MG	0802	0.5523	$28.80		$5.76
J8600	N		Melphalan oral 2 MG					
J8610	N		Methotrexate oral 2.5 MG					
J8700	K		Temozolmide	1086	0.0581	$3.03		$.61
J8999	E		Oral prescription drug chemo					
J9000	N		Doxorubic hcl 10 MG vl chemo					
J9001	K		Doxorubicin hcl liposome inj	7046	4.3894	$228.91		$45.78
J9010	G	NI	Alemtuzumab injection	9110		$511.22		$76.41
J9015	K		Aldesleukin/single use vial	0807	7.2867	$380.01		$76.00
J9017	G		Arsenic trioxide	9012		$31.35		$4.69
J9020	N		Asparaginase injection					
J9031	N		Bcg live intravesical vac					
J9040	K		Bleomycin sulfate injection	0857	3.1879	$166.25		$33.25
J9045	K		Carboplatin injection	0811	1.4922	$77.82		$15.56
J9050	K		Carmus bischl nitro inj	0812	1.5310	$79.84		$15.97
J9060	K		Cisplatin 10 MG injection	0813	0.4263	$22.23		$4.45
J9062	E		Cisplatin 50 MG injection					
J9065	K		Inj cladribine per 1 MG	0858	0.7946	$41.44		$8.29
J9070	N		Cyclophosphamide 100 MG inj					
J9080	E		Cyclophosphamide 200 MG inj					
J9090	E		Cyclophosphamide 500 MG inj					
J9091	E		Cyclophosphamide 1.0 grm inj					
J9092	E		Cyclophosphamide 2.0 grm inj					
J9093	N		Cyclophosphamide lyophilized					
J9094	E		Cyclophosphamide lyophilized					
J9095	E		Cyclophosphamide lyophilized					
J9096	E		Cyclophosphamide lyophilized					
J9097	E		Cyclophosphamide lyophilized					
J9100	N		Cytarabine hcl 100 MG inj					
J9110	E		Cytarabine hcl 500 MG inj					
J9120	N		Dactinomycin actinomycin d					
J9130	N		Dacarbazine 10 MG inj					
J9140	E		Dacarbazine 200 MG inj					
J9150	K		Daunorubicin	0820	1.9379	$101.06		$20.21
J9151	K		Daunorubicin citrate liposom	0821	2.9069	$151.60		$30.32
J9160	K		Denileukin diftitox, 300 mcg	1084	12.1315	$632.67		$126.53
J9165	K		Diethylstilbestrol injection	0822	2.0251	$105.61		$21.12
J9170	K		Docetaxel	0823	3.8953	$203.14		$40.63
J9180	E		Epirubicin HCl injection					
J9181	N		Etoposide 10 MG inj					
J9182	E		Etoposide 100 MG inj					
J9185	K		Fludarabine phosphate inj	0842	3.2848	$171.31		$34.26

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J9190	N		Fluorouracil injection					
J9200	K		Floxuridine injection	0827	2.2189	$115.72		$23.14
J9201	K		Gemcitabine HCl	0828	1.2984	$67.71		$13.54
J9202	K		Goserelin acetate implant	0810	5.5619	$290.06		$58.01
J9206	K		Irinotecan injection	0830	1.7538	$91.46		$18.29
J9208	K		Ifosfomide injection	0831	1.9186	$100.06		$20.01
J9209	K		Mesna injection	0732	0.5039	$26.28		$5.26
J9211	K		Idarubicin hcl injection	0832	4.8642	$253.67		$50.73
J9212	N		Interferon alfacon-1					
J9213	N		Interferon alfa-2a inj					
J9214	N		Interferon alfa-2b inj					
J9215	N		Interferon alfa-n3 inj					
J9216	K		Interferon gamma 1-b inj	0838	3.0426	$158.67		$31.73
J9217	K		Leuprolide acetate suspnsion	9217	6.5696	$342.61		$68.52
J9218	K		Leuprolide acetate injeciton	0861	0.7752	$40.43		$8.09
J9219	G		Leuprolide acetate implant	7051		$5,399.80		$807.13
J9230	N		Mechlorethamine hcl inj					
J9245	K		Inj melphalan hydrochl 50 MG	0840	4.5348	$236.49		$47.30
J9250	N		Methotrexate sodium inj					
J9260	E		Methotrexate sodium inj					
J9265	K		Paclitaxel injection	0863	2.3158	$120.77		$24.15
J9266	K		Pegaspargase/singl dose vial	0843	8.8079	$459.34		$91.87
J9268	K		Pentostatin injection	0844	19.8833	$1,036.93		$207.39
J9270	N		Plicamycin (mithramycin) inj					
J9280	K		Mitomycin 5 MG inj	0862	1.1337	$59.12		$11.82
J9290	E		Mitomycin 20 MG inj					
J9291	E		Mitomycin 40 MG inj					
J9293	K		Mitoxantrone hydrochl / 5 MG	0864	2.9263	$152.61		$30.52
J9300	F		Gemtuzumab ozogamicin					
J9310	K		Rituximab cancer treatment	0849	5.4941	$286.52		$57.30
J9320	N		Streptozocin injection					
J9340	N		Thiotepa injection					
J9350	K		Topotecan	0852	7.7130	$402.24		$80.45
J9355	K		Trastuzumab	1613	0.6298	$32.84		$6.57
J9357	K		Valrubicin, 200 mg	1614	3.5658	$185.96		$37.19
J9360	N		Vinblastine sulfate inj					
J9370	N		Vincristine sulfate 1 MG inj					
J9375	E		Vincristine sulfate 2 MG inj					
J9380	E		Vincristine sulfate 5 MG inj					
J9390	K		Vinorelbine tartrate/10 mg	0855	1.0756	$56.09		$11.22
J9600	K		Porfimer sodium	0856	29.6117	$1,544.28		$308.86
J9999	E		Chemotherapy drug					
K0001	A		Standard wheelchair					
K0002	A		Stnd hemi (low seat) whlchr					
K0003	A		Lightweight wheelchair					
K0004	A		High strength ltwt whlchr					
K0005	A		Ultralightweight wheelchair					
K0006	A		Heavy duty wheelchair					
K0007	A		Extra heavy duty wheelchair					
K0009	A		Other manual wheelchair/base					
K0010	A		Stnd wt frame power whlchr					
K0011	A		Stnd wt pwr whlchr w control					
K0012	A		Ltwt portbl power whlchr					
K0014	A		Other power whlchr base					
K0015	A		Detach non-adjus hght armrst					
K0016	A		Detach adjust armrst cmplete					
K0017	A		Detach adjust armrest base					
K0018	A		Detach adjust armrst upper					
K0019	A		Arm pad each					
K0020	A		Fixed adjust armrest pair					
K0021	A	DG	Anti-tipping device each					
K0022	A		Reinforced back upholstery					
K0023	A		Planr back insrt foam w/strp					
K0024	A		Plnr back insrt foam w/hrdwr					
K0025	A		Hook-on headrest extension					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0026	A		Back upholst lgtwt whlchr					
K0027	A		Back upholst other whlchr					
K0028	A		Manual fully reclining back					
K0029	A		Reinforced seat upholstery					
K0030	A		Solid plnr seat sngl dnsfoam					
K0031	A		Safety belt/pelvic strap					
K0032	A		Seat uphols lgtwt whlchr					
K0033	A		Seat upholstery other whlchr					
K0034	A	DG	Heel loop each					
K0035	A		Heel loop with ankle strap					
K0036	A		Toe loop each					
K0037	A		High mount flip-up footrest					
K0038	A		Leg strap each					
K0039	A		Leg strap h style each					
K0040	A		Adjustable angle footplate					
K0041	A		Large size footplate each					
K0042	A		Standard size footplate each					
K0043	A		Ftrst lower extension tube					
K0044	A		Ftrst upper hanger bracket					
K0045	A		Footrest complete assembly					
K0046	A		Elevat legrst low extension					
K0047	A		Elevat legrst up hangr brack					
K0048	A		Elevate legrest complete					
K0049	A		Calf pad each					
K0050	A		Ratchet assembly					
K0051	A		Cam relese assem ftrst/lgrst					
K0052	A		Swingaway detach footrest					
K0053	A		Elevate footrest articulate					
K0054	A		Seat wdth 10-12/15/17/20 wc					
K0055	A		Seat dpth 15/17/18 ltwt wc					
K0056	A		Seat ht <17 or >=21 ltwt wc					
K0057	A		Seat wdth 19/20 hvy dty wc					
K0058	A		Seat dpth 17/18 power wc					
K0059	A		Plastic coated handrim each					
K0060	A		Steel handrim each					
K0061	A		Aluminum handrim each					
K0062	A		Handrim 8-10 vert/obliq proj					
K0063	A		Hndrm 12-16 vert/obliq proj					
K0064	A		Zero pressure tube flat free					
K0065	A		Spoke protectors					
K0066	A		Solid tire any size each					
K0067	A		Pneumatic tire any size each					
K0068	A		Pneumatic tire tube each					
K0069	A		Rear whl complete solid tire					
K0070	A		Rear whl compl pneum tire					
K0071	A		Front castr compl pneum tire					
K0072	A		Frnt cstr cmpl sem-pneum tir					
K0073	A		Caster pin lock each					
K0074	A		Pneumatic caster tire each					
K0075	A		Semi-pneumatic caster tire					
K0076	A		Solid caster tire each					
K0077	A		Front caster assem complete					
K0078	A		Pneumatic caster tire tube					
K0079	A		Wheel lock extension pair					
K0080	A		Anti-rollback device pair					
K0081	A		Wheel lock assembly complete					
K0082	A		22 nf deep cycl acid battery					
K0083	A		22 nf gel cell battery each					
K0084	A		Grp 24 deep cycl acid battry					
K0085	A		Group 24 gel cell battery					
K0086	A		U-1 lead acid battery each					
K0087	A		U-1 gel cell battery each					
K0088	A		Battry chrgr acid/gel cell					
K0089	A		Battery charger dual mode					
K0090	A		Rear tire power wheelchair					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0091	A		Rear tire tube power whlchr					
K0092	A		Rear assem cmplt powr whlchr					
K0093	A		Rear zero pressure tire tube					
K0094	A		Wheel tire for power base					
K0095	A		Wheel tire tube each base					
K0096	A		Wheel assem powr base complt					
K0097	A		Wheel zero presure tire tube					
K0098	A		Drive belt power wheelchair					
K0099	A		Pwr wheelchair front caster					
K0100	A		Amputee adapter pair					
K0101	A	DG	One-arm drive attachment					
K0102	A		Crutch and cane holder					
K0103	A		Transfer board < 25≧					
K0104	A		Cylinder tank carrier					
K0105	A		Iv hanger					
K0106	A		Arm trough each					
K0107	A		Wheelchair tray					
K0108	A		W/c component-accessory NOS					
K0112	A		Trunk vest supprt innr frame					
K0113	A		Trunk vest suprt w/o inr frm					
K0114	A		Whlchr back suprt inr frame					
K0115	A		Back module orthotic system					
K0116	A		Back & seat modul orthot sys					
K0183	A	DG	Nasal application device					
K0184	A	DG	Nasal pillow or face seal					
K0185	A	DG	Pos airway pressure headgear					
K0186	A	DG	Pos airway prssure chinstrap					
K0187	A	DG	Pos airway pressure tubing					
K0188	A	DG	Pos airway pressure filter					
K0189	A	DG	Filter nondisposable w PAP					
K0195	A		Elevating whlchair leg rests					
K0268	A		Humidifier nonheated w PAP					
K0415	E		RX antiemetic drg, oral NOS					
K0416	E		Rx antiemetic drg,rectal NOS					
K0452	A		Wheelchair bearings					
K0455	A		Pump uninterrupted infusion					
K0460	A		WC power add-on joystick					
K0461	A		WC power add-on tiller cntrl					
K0462	A		Temporary replacement eqpmnt					
K0531	A		Heated humidifier used w pap					
K0532	A		Noninvasive assist wo backup					
K0533	A		Noninvasive assist w backup					
K0534	A		Invasive assist w backup					
K0538	A		Neg pressure wnd thrpy pump					
K0539	A		Neg pres wnd thrpy dsg set					
K0540	A		Neg pres wnd thrp canister					
K0541	A		SGD prerecorded msg <= 8 min					
K0542	A		SGD prerecorded msg > 8 min					
K0543	A		SGD msg formed by spelling					
K0544	A		SGD w multi methods msg/accs					
K0545	A		SGD sftwre prgrm for PC/PDA					
K0546	A		SGD accessory,mounting systm					
K0547	A		SGD accessory NOC					
K0548	A		Insulin lispro					
K0549	A		Hosp bed hvy dty xtra wide					
K0550	A		Hosp bed xtra hvy dty x wide					
K0551	A	DG	Residual limb support system					
K0556	A	NI	Socket insert w lock mech					
K0557	A	NI	Socket insert w/o lock mech					
K0558	A	NI	Intl custm cong/atyp insert					
K0559	A	NI	Initial custom socket insert					
K0581	A	NI	Ost pch clsd w barrier/filtr					
K0582	A	NI	Ost pch w bar/bltinconv/fltr					
K0583	A	NI	Ost pch clsd w/o bar w filtr					
K0584	A	NI	Ost pch for bar w flange/flt					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0585	A	NI	Ost pch clsd for bar w lk fl					
K0586	A	NI	Ost pch for bar w lk fl/fltr					
K0587	A	NI	Ost pch drain w bar & filter					
K0588	A	NI	Ost pch drain for barrier fl					
K0589	A	NI	Ost pch drain 2 piece system					
K0590	A	NI	Ost pch drain/barr lk flng/f					
K0591	A	NI	Urine ost pouch w faucet/tap					
K0592	A	NI	Urine ost pouch w bltinconv					
K0593	A	NI	Ost urine pch w b/bltin conv					
K0594	A	NI	Ost pch urine w barrier/tapv					
K0595	A	NI	Os pch urine w bar/fange/tap					
K0596	A	NI	Urine ost pch bar w lock fln					
K0597	A	NI	Ost pch urine w lock flng/ft					
L0100	A		Cranial orthosis/helmet mold					
L0110	A		Cranial orthosis/helmet nonm					
L0120	A		Cerv flexible non-adjustable					
L0130	A		Flex thermoplastic collar mo					
L0140	A		Cervical semi-rigid adjustab					
L0150	A		Cerv semi-rig adj molded chn					
L0160	A		Cerv semi-rig wire occ/mand					
L0170	A		Cervical collar molded to pt					
L0172	A		Cerv col thermplas foam 2 pi					
L0174	A		Cerv col foam 2 piece w thor					
L0180	A		Cer post col occ/man sup adj					
L0190	A		Cerv collar supp adj cerv ba					
L0200	A		Cerv col supp adj bar & thor					
L0210	A		Thoracic rib belt					
L0220	A		Thor rib belt custom fabrica					
L0300	A	DG	TLSO flex surgical support					
L0310	A	DG	Tlso flexible custom fabrica					
L0315	A	DG	Tlso flex elas rigid post pa					
L0317	A	DG	Tlso flex hypext elas post p					
L0320	A	DG	Tlso a-p contrl w apron frnt					
L0321	A	DG	Tlso anti-post-cntrl prefab					
L0330	A	DG	Tlso ant-pos-lateral control					
L0331	A	DG	Tlso ant-post-lat cntrl prfb					
L0340	A	DG	Tlso a-p-l-rotary with apron					
L0350	A	DG	Tlso flex compress jacket cu					
L0360	A	DG	Tlso flex compress jacket mo					
L0370	A	DG	Tlso a-p-l-rotary hyperexten					
L0380	A	DG	Tlso a-p-l-rot w/ pos extens					
L0390	A	DG	Tlso a-p-l control molded					
L0391	A	DG	Tlso ant-post-lat-rot cntrl					
L0400	A	DG	Tlso a-p-l w interface mater					
L0410	A	DG	Tlso a-p-l two piece constr					
L0420	A	DG	Tlso a-p-l 2 piece w interfa					
L0430	A	DG	Tlso a-p-l w interface custm					
L0440	A	DG	Tlso a-p-l overlap frnt cust					
L0450	A	NI	TLSO flex prefab thoracic					
L0452	A	NI	tlso flex custom fab thoraci					
L0454	A	NI	TLSO flex prefab sacrococ-T9					
L0456	A	NI	TLSO flex prefab					
L0458	A	NI	TLSO 2Mod symphis-xipho pre					
L0460	A	NI	TLSO2Mod symphysis-stern pre					
L0462	A	NI	TLSO 3Mod sacro-scap pre					
L0464	A	NI	TLSO 4Mod sacro-scap pre					
L0466	A	NI	TLSO rigid frame pre soft ap					
L0468	A	NI	TLSO rigid frame prefab pelv					
L0470	A	NI	TLSO rigid frame pre subclav					
L0472	A	NI	TLSO rigid frame hyperex pre					
L0474	A	NI	TLSO rigid frame pre pelvic					
L0476	A	NI	TLSO flexion compres jac pre					
L0478	A	NI	TLSO flexion compres jac cus					
L0480	A	NI	TLSO rigid plastic custom fa					
L0482	A	NI	TLSO rigid lined custom fab					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L0484	A	NI	TLSO rigid plastic cust fab					
L0486	A	NI	TLSO rigidlined cust fab two					
L0488	A	NI	TLSO rigid lined pre one pie					
L0490	A	NI	TLSO rigid plastic pre one					
L0500	A		Lso flex surgical support					
L0510	A		Lso flexible custom fabricat					
L0515	A		Lso flex elas w/ rig post pa					
L0520	A		Lso a-p-l control with apron					
L0530	A		Lso ant-pos control w apron					
L0540	A		Lso lumbar flexion a-p-l					
L0550	A		Lso a-p-l control molded					
L0560	A		Lso a-p-l w interface					
L0561	A		Prefab lso					
L0565	A		Lso a-p-l control custom					
L0600	A		Sacroiliac flex surg support					
L0610	A		Sacroiliac flexible custm fa					
L0620	A		Sacroiliac semi-rig w apron					
L0700	A		Ctlso a-p-l control molded					
L0710	A		Ctlso a-p-l control w/ inter					
L0810	A		Halo cervical into jckt vest					
L0820	A		Halo cervical into body jack					
L0830	A		Halo cerv into milwaukee typ					
L0860	A		Magnetic resonanc image comp					
L0900	A	DG	Torso/ptosis support					
L0910	A	DG	Torso & ptosis supp custm fa					
L0920	A	DG	Torso/pendulous abd support					
L0930	A	DG	Pendulous abdomen supp custm					
L0940	A	DG	Torso/postsurgical support					
L0950	A	DG	Post surg support custom fab					
L0960	A		Post surgical support pads					
L0970	A		Tlso corset front					
L0972	A		Lso corset front					
L0974	A		Tlso full corset					
L0976	A		Lso full corset					
L0978	A		Axillary crutch extension					
L0980	A		Peroneal straps pair					
L0982	A		Stocking supp grips set of f					
L0984	A		Protective body sock each					
L0986	A	DG	Spinal orth abdm pnl prefab					
L0999	A		Add to spinal orthosis NOS					
L1000	A		Ctlso milwauke initial model					
L1005	A		Tension based scoliosis orth					
L1010	A		Ctlso axilla sling					
L1020	A		Kyphosis pad					
L1025	A		Kyphosis pad floating					
L1030	A		Lumbar bolster pad					
L1040	A		Lumbar or lumbar rib pad					
L1050	A		Sternal pad					
L1060	A		Thoracic pad					
L1070	A		Trapezius sling					
L1080	A		Outrigger					
L1085	A		Outrigger bil w/ vert extens					
L1090	A		Lumbar sling					
L1100	A		Ring flange plastic/leather					
L1110	A		Ring flange plas/leather mol					
L1120	A		Covers for upright each					
L1200	A		Furnsh initial orthosis only					
L1210	A		Lateral thoracic extension					
L1220	A		Anterior thoracic extension					
L1230	A		Milwaukee type superstructur					
L1240	A		Lumbar derotation pad					
L1250	A		Anterior asis pad					
L1260	A		Anterior thoracic derotation					
L1270	A		Abdominal pad					
L1280	A		Rib gusset (elastic) each					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L1290	A		Lateral trochanteric pad					
L1300	A		Body jacket mold to patient					
L1310	A		Post-operative body jacket					
L1499	A		Spinal orthosis NOS					
L1500	A		Thkao mobility frame					
L1510	A		Thkao standing frame					
L1520	A		Thkao swivel walker					
L1600	A		Abduct hip flex frejka w cvr					
L1610	A		Abduct hip flex frejka covr					
L1620	A		Abduct hip flex pavlik harne					
L1630	A		Abduct control hip semi-flex					
L1640	A		Pelv band/spread bar thigh c					
L1650	A		HO abduction hip adjustable					
L1652	A	NI	HO bi thighcuffs w sprdr bar					
L1660	A		HO abduction static plastic					
L1680	A		Pelvic & hip control thigh c					
L1685	A		Post-op hip abduct custom fa					
L1686	A		HO post-op hip abduction					
L1690	A		Combination bilateral HO					
L1700	A		Leg perthes orth toronto typ					
L1710	A		Legg perthes orth newington					
L1720	A		Legg perthes orthosis trilat					
L1730	A		Legg perthes orth scottish r					
L1750	A		Legg perthes sling					
L1755	A		Legg perthes patten bottom t					
L1800	A		Knee orthoses elas w stays					
L1810	A		Ko elastic with joints					
L1815	A		Elastic with condylar pads					
L1820	A		Ko elas w/ condyle pads & jo					
L1825	A		Ko elastic knee cap					
L1830	A		Ko immobilizer canvas longit					
L1832	A		KO adj jnt pos rigid support					
L1834	A		Ko w/0 joint rigid molded to					
L1836	A	NI	Rigid KO wo joints					
L1840	A		Ko derot ant cruciate custom					
L1843	A		KO single upright custom fit					
L1844	A		Ko w/adj jt rot cntrl molded					
L1845	A		Ko w/ adj flex/ext rotat cus					
L1846	A		Ko w adj flex/ext rotat mold					
L1847	A		KO adjustable w air chambers					
L1850	A		Ko swedish type					
L1855	A		Ko plas doub upright jnt mol					
L1858	A		Ko polycentric pneumatic pad					
L1860	A		Ko supracondylar socket mold					
L1870	A		Ko doub upright lacers molde					
L1880	A		Ko doub upright cuffs/lacers					
L1885	A		Knee upright w/resistance					
L1900	A		Afo sprng wir drsflx calf bd					
L1901	A	NI	Prefab ankle orthosis					
L1902	A		Afo ankle gauntlet					
L1904	A		Afo molded ankle gauntlet					
L1906	A		Afo multiligamentus ankle su					
L1910	A		Afo sing bar clasp attach sh					
L1920	A		Afo sing upright w/ adjust s					
L1930	A		Afo plastic					
L1940	A		Afo molded to patient plasti					
L1945	A		Afo molded plas rig ant tib					
L1950	A		Afo spiral molded to pt plas					
L1960	A		Afo pos solid ank plastic mo					
L1970	A		Afo plastic molded w/ankle j					
L1980	A		Afo sing solid stirrup calf					
L1990	A		Afo doub solid stirrup calf					
L2000	A		Kafo sing fre stirr thi/calf					
L2010	A		Kafo sng solid stirrup w/o j					
L2020	A		Kafo dbl solid stirrup band/					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L2030	A		Kafo dbl solid stirrup w/o j					
L2035	A		KAFO plastic pediatric size					
L2036	A		Kafo plas doub free knee mol					
L2037	A		Kafo plas sing free knee mol					
L2038	A		Kafo w/o joint multi-axis an					
L2039	A		KAFO,plstic,medlat rotat con					
L2040	A		Hkafo torsion bil rot straps					
L2050	A		Hkafo torsion cable hip pelv					
L2060	A		Hkafo torsion ball bearing j					
L2070	A		Hkafo torsion unilat rot str					
L2080	A		Hkafo unilat torsion cable					
L2090	A		Hkafo unilat torsion ball br					
L2102	E		Afo tibial fx cast plstr mol					
L2104	E		Afo tib fx cast synthetic mo					
L2106	A		Afo tib fx cast plaster mold					
L2108	A		Afo tib fx cast molded to pt					
L2112	A		Afo tibial fracture soft					
L2114	A		Afo tib fx semi-rigid					
L2116	A		Afo tibial fracture rigid					
L2122	E		Kafo fem fx cast plaster mol					
L2124	E		Kafo fem fx cast synthet mol					
L2126	A		Kafo fem fx cast thermoplas					
L2128	A		Kafo fem fx cast molded to p					
L2132	A		Kafo femoral fx cast soft					
L2134	A		Kafo fem fx cast semi-rigid					
L2136	A		Kafo femoral fx cast rigid					
L2180	A		Plas shoe insert w ank joint					
L2182	A		Drop lock knee					
L2184	A		Limited motion knee joint					
L2186	A		Adj motion knee jnt lerman t					
L2188	A		Quadrilateral brim					
L2190	A		Waist belt					
L2192	A		Pelvic band & belt thigh fla					
L2200	A		Limited ankle motion ea jnt					
L2210	A		Dorsiflexion assist each joi					
L2220	A		Dorsi & plantar flex ass/res					
L2230	A		Split flat caliper stirr & p					
L2240	A		Round caliper and plate atta					
L2250	A		Foot plate molded stirrup at					
L2260	A		Reinforced solid stirrup					
L2265	A		Long tongue stirrup					
L2270	A		Varus/valgus strap padded/li					
L2275	A		Plastic mod low ext pad/line					
L2280	A		Molded inner boot					
L2300	A		Abduction bar jointed adjust					
L2310	A		Abduction bar-straight					
L2320	A		Non-molded lacer					
L2330	A		Lacer molded to patient mode					
L2335	A		Anterior swing band					
L2340	A		Pre-tibial shell molded to p					
L2350	A		Prosthetic type socket molde					
L2360	A		Extended steel shank					
L2370	A		Patten bottom					
L2375	A		Torsion ank & half solid sti					
L2380	A		Torsion straight knee joint					
L2385	A		Straight knee joint heavy du					
L2390	A		Offset knee joint each					
L2395	A		Offset knee joint heavy duty					
L2397	A		Suspension sleeve lower ext					
L2405	A		Knee joint drop lock ea jnt					
L2415	A		Knee joint cam lock each joi					
L2425	A		Knee disc/dial lock/adj flex					
L2430	A		Knee jnt ratchet lock ea jnt					
L2435	A		Knee joint polycentric joint					
L2492	A		Knee lift loop drop lock rin					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L2500	A		Thi/glut/ischia wgt bearing					
L2510	A		Th/wght bear quad-lat brim m					
L2520	A		Th/wght bear quad-lat brim c					
L2525	A		Th/wght bear nar m-l brim mo					
L2526	A		Th/wght bear nar m-l brim cu					
L2530	A		Thigh/wght bear lacer non-mo					
L2540	A		Thigh/wght bear lacer molded					
L2550	A		Thigh/wght bear high roll cu					
L2570	A		Hip clevis type 2 posit jnt					
L2580	A		Pelvic control pelvic sling					
L2600	A		Hip clevis/thrust bearing fr					
L2610	A		Hip clevis/thrust bearing lo					
L2620	A		Pelvic control hip heavy dut					
L2622	A		Hip joint adjustable flexion					
L2624	A		Hip adj flex ext abduct cont					
L2627	A		Plastic mold recipro hip & c					
L2628	A		Metal frame recipro hip & ca					
L2630	A		Pelvic control band & belt u					
L2640	A		Pelvic control band & belt b					
L2650	A		Pelv & thor control gluteal					
L2660	A		Thoracic control thoracic ba					
L2670	A		Thorac cont paraspinal uprig					
L2680	A		Thorac cont lat support upri					
L2750	A		Plating chrome/nickel pr bar					
L2755	A		Carbon graphite lamination					
L2760	A		Extension per extension per					
L2768	A		Ortho sidebar disconnect					
L2770	A		Low ext orthosis per bar/jnt					
L2780	A		Non-corrosive finish					
L2785	A		Drop lock retainer each					
L2795	A		Knee control full kneecap					
L2800	A		Knee cap medial or lateral p					
L2810	A		Knee control condylar pad					
L2820	A		Soft interface below knee se					
L2830	A		Soft interface above knee se					
L2840	A		Tibial length sock fx or equ					
L2850	A		Femoral lgth sock fx or equa					
L2860	A		Torsion mechanism knee/ankle					
L2999	A		Lower extremity orthosis NOS					
L3000	E		Ft insert ucb berkeley shell					
L3001	E		Foot insert remov molded spe					
L3002	E		Foot insert plastazote or eq					
L3003	E		Foot insert silicone gel eac					
L3010	E		Foot longitudinal arch suppo					
L3020	E		Foot longitud/metatarsal sup					
L3030	E		Foot arch support remov prem					
L3040	E		Ft arch suprt premold longit					
L3050	E		Foot arch supp premold metat					
L3060	E		Foot arch supp longitud/meta					
L3070	E		Arch suprt att to sho longit					
L3080	E		Arch supp att to shoe metata					
L3090	E		Arch supp att to shoe long/m					
L3100	E		Hallus-valgus nght dynamic s					
L3140	E		Abduction rotation bar shoe					
L3150	E		Abduct rotation bar w/o shoe					
L3160	E		Shoe styled positioning dev					
L3170	E		Foot plastic heel stabilizer					
L3201	E		Oxford w supinat/pronat inf					
L3202	E		Oxford w/ supinat/pronator c					
L3203	E		Oxford w/ supinator/pronator					
L3204	E		Hightop w/ supp/pronator inf					
L3206	E		Hightop w/ supp/pronator chi					
L3207	E		Hightop w/ supp/pronator jun					
L3208	E		Surgical boot each infant					
L3209	E		Surgical boot each child					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3211	E		Surgical boot each junior					
L3212	E		Benesch boot pair infant					
L3213	E		Benesch boot pair child					
L3214	E		Benesch boot pair junior					
L3215	E		Orthopedic ftwear ladies oxf					
L3216	E		Orthoped ladies shoes dpth i					
L3217	E		Ladies shoes hightop depth i					
L3218	E	DG	Ladies surgical boot each					
L3219	E		Orthopedic mens shoes oxford					
L3221	E		Orthopedic mens shoes dpth i					
L3222	E		Mens shoes hightop depth inl					
L3223	E	DG	Mens surgical boot each					
L3224	A		Woman's shoe oxford brace					
L3225	A		Man's shoe oxford brace					
L3230			Custom shoes depth inlay					
L3250	E		Custom mold shoe remov prost					
L3251	E		Shoe molded to pt silicone s					
L3252	E		Shoe molded plastazote cust					
L3253	E		Shoe molded plastazote cust					
L3254	E		Orth foot non-stndard size/w					
L3255	E		Orth foot non-standard size/					
L3257	E		Orth foot add charge split s					
L3260	E		Ambulatory surgical boot eac					
L3265	E		Plastazote sandal each					
L3300	E		Sho lift taper to metatarsal					
L3310	E		Shoe lift elev heel/sole neo					
L3320	E		Shoe lift elev heel/sole cor					
L3330	E		Lifts elevation metal extens					
L3332	E		Shoe lifts tapered to one-ha					
L3334	E		Shoe lifts elevation heel /i					
L3340	E		Shoe wedge sach					
L3350	E		Shoe heel wedge					
L3360	E		Shoe sole wedge outside sole					
L3370	E		Shoe sole wedge between sole					
L3380	E		Shoe clubfoot wedge					
L3390	E		Shoe outflare wedge					
L3400	E		Shoe metatarsal bar wedge ro					
L3410	E		Shoe metatarsal bar between					
L3420	E		Full sole/heel wedge btween					
L3430	E		Sho heel count plast reinfor					
L3440	E		Heel leather reinforced					
L3450	E		Shoe heel sach cushion type					
L3455	E		Shoe heel new leather standa					
L3460	E		Shoe heel new rubber standar					
L3465	E		Shoe heel thomas with wedge					
L3470	E		Shoe heel thomas extend to b					
L3480	E		Shoe heel pad & depress for					
L3485	E		Shoe heel pad removable for					
L3500	E		Ortho shoe add leather insol					
L3510	E		Orthopedic shoe add rub insl					
L3520	E		O shoe add felt w leath insl					
L3530	E		Ortho shoe add half sole					
L3540	E		Ortho shoe add full sole					
L3550	E		O shoe add standard toe tap					
L3560	E		O shoe add horseshoe toe tap					
L3570	E		O shoe add instep extension					
L3580	E		O shoe add instep velcro clo					
L3590	E		O shoe convert to sof counte					
L3595	E		Ortho shoe add march bar					
L3600	E		Trans shoe calip plate exist					
L3610	E		Trans shoe caliper plate new					
L3620	E		Trans shoe solid stirrup exi					
L3630	E		Trans shoe solid stirrup new					
L3640	E		Shoe dennis browne splint bo					
L3649	E		Orthopedic shoe modifica NOS					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3650	A		Shlder fig 8 abduct restrain					
L3651	A	NI	Prefab shoulder orthosis					
L3652	A	NI	Prefab dbl shoulder orthosis					
L3660	A		Abduct restrainer canvas&web					
L3670	A		Acromio/clavicular canvas&we					
L3675	A		Canvas vest SO					
L3677	A		SO hard plastic stabilizer					
L3700	A		Elbow orthoses elas w stays					
L3701	A	NI	Prefab elbow orthosis					
L3710	A		Elbow elastic with metal joi					
L3720	A		Forearm/arm cuffs free motio					
L3730	A		Forearm/arm cuffs ext/flex a					
L3740	A		Cuffs adj lock w/ active con					
L3760	A		EO withjoint, Prefabricated					
L3762	A	NI	Rigid EO wo joints					
L3800	A		Whfo short opponen no attach					
L3805	A		Whfo long opponens no attach					
L3807	A		WHFO,no joint, prefabricated					
L3810	A		Whfo thumb abduction bar					
L3815	A		Whfo second m.p. abduction a					
L3820	A		Whfo ip ext asst w/ mp ext s					
L3825	A		Whfo m.p. extension stop					
L3830	A		Whfo m.p. extension assist					
L3835	A		Whfo m.p. spring extension a					
L3840	A		Whfo spring swivel thumb					
L3845	A		Whfo thumb ip ext ass w/ mp					
L3850	A		Action wrist w/ dorsiflex as					
L3855	A		Whfo adj m.p. flexion contro					
L3860	A		Whfo adj m.p. flex ctrl & i.					
L3890	E		Torsion mechanism wrist/elbo					
L3900	A		Hinge extension/flex wrist/f					
L3901	A		Hinge ext/flex wrist finger					
L3902	A		Whfo ext power compress gas					
L3904	A		Whfo electric custom fitted					
L3906	A		Wrist gauntlet molded to pt					
L3907	A		Whfo wrst gauntlt thmb spica					
L3908	A		Wrist cock-up non-molded					
L3909	A	NI	Prefab wrist orthosis					
L3910	A		Whfo swanson design					
L3911	A	NI	Prefab hand finger orthosis					
L3912	A		Flex glove w/elastic finger					
L3914	A		WHO wrist extension cock-up					
L3916	A		Whfo wrist extens w/ outrigg					
L3918	A		HFO knuckle bender					
L3920	A		Knuckle bender with outrigge					
L3922	A		Knuckle bend 2 seg to flex j					
L3923	A		HFO, no joint, prefabricated					
L3924	A		Oppenheimer					
L3926	A		Thomas suspension					
L3928	A		Finger extension w/ clock sp					
L3930	A		Finger extension with wrist					
L3932	A		Safety pin spring wire					
L3934	A		Safety pin modified					
L3936	A		Palmer					
L3938	A		Dorsal wrist					
L3940	A		Dorsal wrist w/ outrigger at					
L3942	A		Reverse knuckle bender					
L3944	A		Reverse knuckle bend w/ outr					
L3946	A		HFO composite elastic					
L3948	A		Finger knuckle bender					
L3950	A		Oppenheimer w/ knuckle bend					
L3952	A		Oppenheimer w/ rev knuckle 2					
L3954	A		Spreading hand					
L3956	A		Add joint upper ext orthosis					
L3960	A		Sewho airplan desig abdu pos					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3962	A		Sewho erbs palsey design abd					
L3963	A		Molded w/ articulating elbow					
L3964	A		Seo mobile arm sup att to wc					
L3965	A		Arm supp att to wc rancho ty					
L3966	A		Mobile arm supports reclinin					
L3968	A		Friction dampening arm supp					
L3969	A		Monosuspension arm/hand supp					
L3970	A		Elevat proximal arm support					
L3972	A		Offset/lat rocker arm w/ ela					
L3974	A		Mobile arm support supinator					
L3980	A		Upp ext fx orthosis humeral					
L3982	A		Upper ext fx orthosis rad/ul					
L3984	A		Upper ext fx orthosis wrist					
L3985	A		Forearm hand fx orth w/ wr h					
L3986	A		Humeral rad/ulna wrist fx or					
L3995	A		Sock fracture or equal each					
L3999	A		Upper limb orthosis NOS					
L4000	A		Repl girdle milwaukee orth					
L4010	A		Replace trilateral socket br					
L4020	A		Replace quadlat socket brim					
L4030	A		Replace socket brim cust fit					
L4040	A		Replace molded thigh lacer					
L4045	A		Replace non-molded thigh lac					
L4050	A		Replace molded calf lacer					
L4055	A		Replace non-molded calf lace					
L4060	A		Replace high roll cuff					
L4070	A		Replace prox & dist upright					
L4080	A		Repl met band kafo-afo prox					
L4090	A		Repl met band kafo-afo calf/					
L4100	A		Repl leath cuff kafo prox th					
L4110	A		Repl leath cuff kafo-afo cal					
L4130	A		Replace pretibial shell					
L4205	A		Ortho dvc repair per 15 min					
L4210	A		Orth dev repair/repl minor p					
L4350	A		Pneumatic ankle cntrl splint					
L4360	A		Pneumatic walking splint					
L4370	A		Pneumatic full leg splint					
L4380	A		Pneumatic knee splint					
L4386	A	NI	Non-pneumatic walking splint					
L4392	A		Replace AFO soft interface					
L4394	A		Replace foot drop spint					
L4396	A		Static AFO					
L4398	A		Foot drop splint recumbent					
L5000	A		Sho insert w arch toe filler					
L5010	A		Mold socket ank hgt w/ toe f					
L5020	A		Tibial tubercle hgt w/ toe f					
L5050	A		Ank symes mold sckt sach ft					
L5060	A		Symes met fr leath socket ar					
L5100	A		Molded socket shin sach foot					
L5105	A		Plast socket jts/thgh lacer					
L5150	A		Mold sckt ext knee shin sach					
L5160	A		Mold socket bent knee shin s					
L5200	A		Kne sing axis fric shin sach					
L5210	A		No knee/ankle joints w/ ft b					
L5220	A		No knee joint with artic ali					
L5230	A		Fem focal defic constant fri					
L5250	A		Hip canad sing axi cons fric					
L5270	A		Tilt table locking hip sing					
L5280	A		Hemipelvect canad sing axis					
L5301	A		BK mold socket SACH ft endo					
L5311	A		Knee disart, SACH ft, endo					
L5321	A		AK open end SACH					
L5331	A		Hip disart canadian SACH ft					
L5341	A		Hemipelvectomy canadian SACH					
L5400	A		Postop dress & 1 cast chg bk					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5410	A		Postop dsg bk ea add cast ch					
L5420	A		Postop dsg & 1 cast chg ak/d					
L5430	A		Postop dsg ak ea add cast ch					
L5450	A		Postop app non-wgt bear dsg					
L5460	A		Postop app non-wgt bear dsg					
L5500	A		Init bk ptb plaster direct					
L5505	A		Init ak ischal plstr direct					
L5510	A		Prep BK ptb plaster molded					
L5520	A		Perp BK ptb thermopls direct					
L5530	A		Prep BK ptb thermopls molded					
L5535	A		Prep BK ptb open end socket					
L5540	A		Prep BK ptb laminated socket					
L5560	A		Prep AK ischial plast molded					
L5570	A		Prep AK ischial direct form					
L5580	A		Prep AK ischial thermo mold					
L5585	A		Prep AK ischial open end					
L5590	A		Prep AK ischial laminated					
L5595	A		Hip disartic sach thermopls					
L5600	A		Hip disart sach laminat mold					
L5610	A		Above knee hydracadence					
L5611	A		Ak 4 bar link w/fric swing					
L5613	A		Ak 4 bar ling w/hydraul swig					
L5614	A		4-bar link above knee w/swng					
L5616	A		Ak univ multiplex sys frict					
L5617	A		AK/BK self-aligning unit ea					
L5618	A		Test socket symes					
L5620	A		Test socket below knee					
L5622	A		Test socket knee disarticula					
L5624	A		Test socket above knee					
L5626	A		Test socket hip disarticulat					
L5628	A		Test socket hemipelvectomy					
L5629	A		Below knee acrylic socket					
L5630	A		Syme typ expandabl wall sckt					
L5631	A		Ak/knee disartic acrylic soc					
L5632	A		Symes type ptb brim design s					
L5634	A		Symes type poster opening so					
L5636	A		Symes type medial opening so					
L5637	A		Below knee total contact					
L5638	A		Below knee leather socket					
L5639	A		Below knee wood socket					
L5640	A		Knee disarticulat leather so					
L5642	A		Above knee leather socket					
L5643	A		Hip flex inner socket ext fr					
L5644	A		Above knee wood socket					
L5645	A		Bk flex inner socket ext fra					
L5646	A		Below knee air cushion socke					
L5647	A		Below knee suction socket					
L5648	A		Above knee air cushion socke					
L5649	A		Isch containmt/narrow m-l so					
L5650	A		Tot contact ak/knee disart s					
L5651	A		Ak flex inner socket ext fra					
L5652	A		Suction susp ak/knee disart					
L5653	A		Knee disart expand wall sock					
L5654	A		Socket insert symes					
L5655	A		Socket insert below knee					
L5656	A		Socket insert knee articulat					
L5658	A		Socket insert above knee					
L5660	A	DG	Sock insrt syme silicone gel					
L5661	A		Multi-durometer symes					
L5662	A	DG	Socket insert bk silicone ge					
L5663	A	DG	Sock knee disartic silicone					
L5664	A	DG	Socket insert ak silicone ge					
L5665	A		Multi-durometer below knee					
L5666	A		Below knee cuff suspension					
L5668	A		Socket insert w/o lock lower					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5670	A		Bk molded supracondylar susp					
L5671	A		BK/AK locking mechanism					
L5672	A		Bk removable medial brim sus					
L5674	A		Bk suspension sleeve					
L5675	A		Bk heavy duty susp sleeve					
L5676	A		Bk knee joints single axis p					
L5677	A		Bk knee joints polycentric p					
L5678	A		Bk joint covers pair					
L5680	A		Bk thigh lacer non-molded					
L5682	A		Bk thigh lacer glut/ischia m					
L5684	A		Bk fork strap					
L5686	A		Bk back check					
L5688	A		Bk waist belt webbing					
L5690	A		Bk waist belt padded and lin					
L5692	A		Ak pelvic control belt light					
L5694	A		Ak pelvic control belt pad/l					
L5695	A		Ak sleeve susp neoprene/equa					
L5696	A		Ak/knee disartic pelvic join					
L5697	A		Ak/knee disartic pelvic band					
L5698	A		Ak/knee disartic silesian ba					
L5699	A		Shoulder harness					
L5700	A		Replace socket below knee					
L5701	A		Replace socket above knee					
L5702	A		Replace socket hip					
L5704	A		Custom shape cover BK					
L5705	A		Custom shape cover AK					
L5706	A		Custom shape cvr knee disart					
L5707	A		Custom shape cvr hip disart					
L5710	A		Kne-shin exo sng axi mnl loc					
L5711	A		Knee-shin exo mnl lock ultra					
L5712	A		Knee-shin exo frict swg & st					
L5714	A		Knee-shin exo variable frict					
L5716	A		Knee-shin exo mech stance ph					
L5718	A		Knee-shin exo frct swg & sta					
L5722	A		Knee-shin pneum swg frct exo					
L5724	A		Knee-shin exo fluid swing ph					
L5726	A		Knee-shin ext jnts fld swg e					
L5728	A		Knee-shin fluid swg & stance					
L5780	A		Knee-shin pneum/hydra pneum					
L5781	A	NI	Lower limb pros vacuum pump					
L5782	A	NI	HD low limb pros vacuum pump					
L5785	A		Exoskeletal bk ultralt mater					
L5790	A		Exoskeletal ak ultra-light m					
L5795	A		Exoskel hip ultra-light mate					
L5810	A		Endoskel knee-shin mnl lock					
L5811	A		Endo knee-shin mnl lck ultra					
L5812	A		Endo knee-shin frct swg & st					
L5814	A		Endo knee-shin hydral swg ph					
L5816	A		Endo knee-shin polyc mch sta					
L5818	A		Endo knee-shin frct swg & st					
L5822	A		Endo knee-shin pneum swg frc					
L5824	A		Endo knee-shin fluid swing p					
L5826	A		Miniature knee joint					
L5828	A		Endo knee-shin fluid swg/sta					
L5830	A		Endo knee-shin pneum/swg pha					
L5840	A		Multi-axial knee/shin system					
L5845	A		Knee-shin sys stance flexion					
L5846	A		Knee-shin sys microprocessor					
L5847	A		Microprocessor cntrl feature					
L5848	A	NI	Knee-shin sys hydraul stance					
L5850	A		Endo ak/hip knee extens assi					
L5855	A		Mech hip extension assist					
L5910	A		Endo below knee alignable sy					
L5920	A		Endo ak/hip alignable system					
L5925	A		Above knee manual lock					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5930	A		High activity knee frame					
L5940	A		Endo bk ultra-light material					
L5950	A		Endo ak ultra-light material					
L5960	A		Endo hip ultra-light materia					
L5962	A		Below knee flex cover system					
L5964	A		Above knee flex cover system					
L5966	A		Hip flexible cover system					
L5968	A		Multiaxial ankle w dorsiflex					
L5970	A		Foot external keel sach foot					
L5972	A		Flexible keel foot					
L5974	A		Foot single axis ankle/foot					
L5975	A		Combo ankle/foot prosthesis					
L5976	A		Energy storing foot					
L5978	A		Ft prosth multiaxial ankl/ft					
L5979	A		Multi-axial ankle/ft prosth					
L5980	A		Flex foot system					
L5981	A		Flex-walk sys low ext prosth					
L5982	A		Exoskeletal axial rotation u					
L5984	A		Endoskeletal axial rotation					
L5985	A		Lwr ext dynamic prosth pylon					
L5986	A		Multi-axial rotation unit					
L5987	A		Shank ft w vert load pylon					
L5988	A		Vertical shock reducing pylo					
L5989	A		Pylon w elctrnc force sensor					
L5990	A		User adjustable heel height					
L5995	A	NI	Lower ext pros heavyduty fea					
L5999	A		Lowr extremity prosthes NOS					
L6000	A		Par hand robin-aids thum rem					
L6010	A		Hand robin-aids little/ring					
L6020	A		Part hand robin-aids no fing					
L6025	A	NI	Part hand disart myoelectric					
L6050	A		Wrst MLd sck flx hng tri pad					
L6055	A		Wrst mold sock w/exp interfa					
L6100	A		Elb mold sock flex hinge pad					
L6110	A		Elbow mold sock suspension t					
L6120	A		Elbow mold doub splt soc ste					
L6130	A		Elbow stump activated lock h					
L6200	A		Elbow mold outsid lock hinge					
L6205	A		Elbow molded w/ expand inter					
L6250	A		Elbow inter loc elbow forarm					
L6300	A		Shlder disart int lock elbow					
L6310	A		Shoulder passive restor comp					
L6320	A		Shoulder passive restor cap					
L6350	A		Thoracic intern lock elbow					
L6360	A		Thoracic passive restor comp					
L6370	A		Thoracic passive restor cap					
L6380	A		Postop dsg cast chg wrst/elb					
L6382	A		Postop dsg cast chg elb dis/					
L6384	A		Postop dsg cast chg shlder/t					
L6386	A		Postop ea cast chg & realign					
L6388	A		Postop applicat rigid dsg on					
L6400	A		Below elbow prosth tiss shap					
L6450	A		Elb disart prosth tiss shap					
L6500	A		Above elbow prosth tiss shap					
L6550	A		Shldr disar prosth tiss shap					
L6570	A		Scap thorac prosth tiss shap					
L6580	A		Wrist/elbow bowden cable mol					
L6582	A		Wrist/elbow bowden cbl dir f					
L6584	A		Elbow fair lead cable molded					
L6586	A		Elbow fair lead cable dir fo					
L6588	A		Shdr fair lead cable molded					
L6590	A		Shdr fair lead cable direct					
L6600	A		Polycentric hinge pair					
L6605	A		Single pivot hinge pair					
L6610	A		Flexible metal hinge pair					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L6615	A		Disconnect locking wrist uni					
L6616	A		Disconnect insert locking wr					
L6620	A		Flexion-friction wrist unit					
L6623	A		Spring-ass rot wrst w/ latch					
L6625	A		Rotation wrst w/ cable lock					
L6628	A		Quick disconn hook adapter o					
L6629	A		Lamination collar w/ couplin					
L6630	A		Stainless steel any wrist					
L6632	A		Latex suspension sleeve each					
L6635	A		Lift assist for elbow					
L6637	A		Nudge control elbow lock					
L6638	A	NI	Elec lock on manual pw elbow					
L6640	A		Shoulder abduction joint pai					
L6641	A		Excursion amplifier pulley t					
L6642	A		Excursion amplifier lever ty					
L6645	A		Shoulder flexion-abduction j					
L6646	A	NI	Multipo locking shoulder jnt					
L6647	A	NI	Shoulder lock actuator					
L6648	A	NI	Ext pwrd shlder lock/unlock					
L6650	A		Shoulder universal joint					
L6655	A		Standard control cable extra					
L6660	A		Heavy duty control cable					
L6665	A		Teflon or equal cable lining					
L6670	A		Hook to hand cable adapter					
L6672	A		Harness chest/shlder saddle					
L6675	A		Harness figure of 8 sing con					
L6676	A		Harness figure of 8 dual con					
L6680	A		Test sock wrist disart/bel e					
L6682	A		Test sock elbw disart/above					
L6684	A		Test socket shldr disart/tho					
L6686	A		Suction socket					
L6687	A		Frame typ socket bel elbow/w					
L6688	A		Frame typ sock above elb/dis					
L6689	A		Frame typ socket shoulder di					
L6690	A		Frame typ sock interscap-tho					
L6691	A		Removable insert each					
L6692	A		Silicone gel insert or equal					
L6693	A		Lockingelbow forearm cntrbal					
L6700	A		Terminal device model #3					
L6705	A		Terminal device model #5					
L6710	A		Terminal device model #5x					
L6715	A		Terminal device model #5xa					
L6720	A		Terminal device model #6					
L6725	A		Terminal device model #7					
L6730	A		Terminal device model #7lo					
L6735	A		Terminal device model #8					
L6740	A		Terminal device model #8x					
L6745	A		Terminal device model #88x					
L6750	A		Terminal device model #10p					
L6755	A		Terminal device model #10x					
L6765	A		Terminal device model #12p					
L6770	A		Terminal device model #99x					
L6775	A		Terminal device model#555					
L6780	A		Terminal device model #ss555					
L6790	A		Hooks-accu hook or equal					
L6795	A		Hooks-2 load or equal					
L6800	A		Hooks-aprl vc or equal					
L6805	A		Modifier wrist flexion unit					
L6806	A		Trs grip vc or equal					
L6807	A		Term device grip1/2 or equal					
L6808	A		Term device infant or child					
L6809	A		Trs super sport passive					
L6810	A		Pincher tool otto bock or eq					
L6825	A		Hands dorrance vo					
L6830	A		Hand aprl vc					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L6835	A		Hand sierra vo					
L6840	A		Hand becker imperial					
L6845	A		Hand becker lock grip					
L6850	A		Term dvc-hand becker plylite					
L6855	A		Hand robin-aids vo					
L6860	A		Hand robin-aids vo soft					
L6865	A		Hand passive hand					
L6867	A		Hand detroit infant hand					
L6868	A		Passive inf hand steeper/hos					
L6870	A		Hand child mitt					
L6872	A		Hand nyu child hand					
L6873	A		Hand mech inf steeper or equ					
L6875	A		Hand bock vc					
L6880	A		Hand bock vo					
L6881	A		Autograsp feature ul term dv					
L6882	A		Microprocessor control uplmb					
L6890	A		Production glove					
L6895	A		Custom glove					
L6900	A		Hand restorat thumb/1 finger					
L6905	A		Hand restoration multiple fi					
L6910	A		Hand restoration no fingers					
L6915	A		Hand restoration replacmnt g					
L6920	A		Wrist disarticul switch ctrl					
L6925	A		Wrist disart myoelectronic c					
L6930	A		Below elbow switch control					
L6935	A		Below elbow myoelectronic ct					
L6940	A		Elbow disarticulation switch					
L6945	A		Elbow disart myoelectronic c					
L6950	A		Above elbow switch control					
L6955	A		Above elbow myoelectronic ct					
L6960	A		Shldr disartic switch contro					
L6965	A		Shldr disartic myoelectronic					
L6970	A		Interscapular-thor switch ct					
L6975	A		Interscap-thor myoelectronic					
L7010	A		Hand otto back steeper/eq sw					
L7015	A		Hand sys teknik village swit					
L7020	A		Electronic greifer switch ct					
L7025	A		Electron hand myoelectronic					
L7030	A		Hand sys teknik vill myoelec					
L7035	A		Electron greifer myoelectro					
L7040	A		Prehensile actuator hosmer s					
L7045	A		Electron hook child michigan					
L7170	A		Electronic elbow hosmer swit					
L7180	A		Electronic elbow utah myoele					
L7185	A		Electron elbow adolescent sw					
L7186	A		Electron elbow child switch					
L7190	A		Elbow adolescent myoelectron					
L7191	A		Elbow child myoelectronic ct					
L7260	A		Electron wrist rotator otto					
L7261	A		Electron wrist rotator utah					
L7266	A		Servo control steeper or equ					
L7272	A		Analogue control unb or equa					
L7274	A		Proportional ctl 12 volt uta					
L7360	A		Six volt bat otto bock/eq ea					
L7362	A		Battery chrgr six volt otto					
L7364	A		Twelve volt battery utah/equ					
L7366	A		Battery chrgr 12 volt utah/e					
L7367	A	NI	Replacemnt lithium ionbatter					
L7368	A	NI	Lithium ion battery charger					
L7499	A		Upper extremity prosthes NOS					
L7500	A		Prosthetic dvc repair hourly					
L7510	A		Prosthetic device repair rep					
L7520	A		Repair prosthesis per 15 min					
L7900	A		Vacuum erection system					
L8000	A		Mastectomy bra					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L8001	A		Breast prosthesis bra & form					
L8002	A		Brst prsth bra & bilat form					
L8010	A		Mastectomy sleeve					
L8015	A		Ext breastprosthesis garment					
L8020	A		Mastectomy form					
L8030	A		Breast prosthesis silicone/e					
L8035	A		Custom breast prosthesis					
L8039	A		Breast prosthesis NOS					
L8040	A		Nasal prosthesis					
L8041	A		Midfacial prosthesis					
L8042	A		Orbital prosthesis					
L8043	A		Upper facial prosthesis					
L8044	A		Hemi-facial prosthesis					
L8045	A		Auricular prosthesis					
L8046	A		Partial facial prosthesis					
L8047	A		Nasal septal prosthesis					
L8048	A		Unspec maxillofacial prosth					
L8049	A		Repair maxillofacial prosth					
L8100	E		Compression stocking BK18-30					
L8110	E		Compression stocking BK30-40					
L8120	E		Compression stocking BK40-50					
L8130	E		Gc stocking thighlngth 18-30					
L8140	E		Gc stocking thighlngth 30-40					
L8150	E		Gc stocking thighlngth 40-50					
L8160	E		Gc stocking full lngth 18-30					
L8170	E		Gc stocking full lngth 30-40					
L8180	E		Gc stocking full lngth 40-50					
L8190	E		Gc stocking waistlngth 18-30					
L8195	E		Gc stocking waistlngth 30-40					
L8200	E		Gc stocking waistlngth 40-50					
L8210	E		Gc stocking custom made					
L8220	E		Gc stocking lymphedema					
L8230	E		Gc stocking garter belt					
L8239	E		G compression stocking NOS					
L8300	A		Truss single w/ standard pad					
L8310	A		Truss double w/ standard pad					
L8320	A		Truss addition to std pad wa					
L8330	A		Truss add to std pad scrotal					
L8400	A		Sheath below knee					
L8410	A		Sheath above knee					
L8415	A		Sheath upper limb					
L8417	A		Pros sheath/sock w gel cushn					
L8420	A		Prosthetic sock multi ply BK					
L8430	A		Prosthetic sock multi ply AK					
L8435	A		Pros sock multi ply upper lm					
L8440	A		Shrinker below knee					
L8460	A		Shrinker above knee					
L8465	A		Shrinker upper limb					
L8470	A		Pros sock single ply BK					
L8480	A		Pros sock single ply AK					
L8485	A		Pros sock single ply upper l					
L8490	A		Air seal suction reten systm					
L8499	A		Unlisted misc prosthetic ser					
L8500	A		Artificial larynx					
L8501	A		Tracheostomy speaking valve					
L8505	A		Artificial larynx, accessory					
L8507	A		Trach-esoph voice pros pt in					
L8509	A		Trach-esoph voice pros md in					
L8510	A		Voice amplifier					
L8600	N		Implant breast silicone/eq					
L8603	N		Collagen imp urinary 2.5 ml					
L8606	A		Synthetic implnt urinary 1ml					
L8610	N		Ocular implant					
L8612	N		Aqueous shunt prosthesis					
L8613	N		Ossicular implant					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L8614	E		Cochlear device/system					
L8619	A		Replace cochlear processor					
L8630	N		Metacarpophalangeal implant					
L8641	N		Metatarsal joint implant					
L8642	N		Hallux implant					
L8658	N		Interphalangeal joint implnt					
L8670	N		Vascular graft, synthetic					
L8699	N		Prosthetic implant NOS					
L9900	A		O&P supply/accessory/service					
M0064	X		Visit for drug monitoring	0374	1.1434	$59.63	$9.97	$11.93
M0075	E		Cellular therapy					
M0076	E		Prolotherapy					
M0100	E		Intragastric hypothermia					
M0300	E		IV chelationtherapy					
M0301	E		Fabric wrapping of aneurysm					
P2028	A		Cephalin floculation test					
P2029	A		Congo red blood test					
P2031	E		Hair analysis					
P2033	A		Blood thymol turbidity					
P2038	A		Blood mucoprotein					
P3000	A		Screen pap by tech w md supv					
P3001	E		Screening pap smear by phys					
P7001	E		Culture bacterial urine					
P9010	K		Whole blood for transfusion	0950	1.6860	$87.93		$17.59
P9011	E		Blood split unit					
P9012	K		Cryoprecipitate each unit	0952	0.5620	$29.31		$5.86
P9016	K		RBC leukocytes reduced	0954	2.2868	$119.26		$23.85
P9017	K		One donor fresh frozn plasma	0955	1.8217	$95.00		$19.00
P9019	K		Platelets, each unit	0957	0.7946	$41.44		$8.29
P9020	K		Plaelet rich plasma unit	0958	1.0271	$53.56		$10.71
P9021	K		Red blood cells unit	0959	1.6569	$86.41		$17.28
P9022	K		Washed red blood cells unit	0960	3.0813	$160.69		$32.14
P9023	K		Frozen plasma, pooled, sd	0949	2.3837	$124.31		$24.86
P9031	K		Platelets leukocytes reduced	1013	0.9496	$49.52		$9.90
P9032	K		Platelets, irradiated	9500	1.4341	$74.79		$14.96
P9033	K		Platelets leukoreduced irrad	0954	2.2868	$119.26		$23.85
P9034	K		Platelets, pheresis	9501	7.8390	$408.81		$81.76
P9035	K		Platelet pheres leukoreduced	9501	7.8390	$408.81		$81.76
P9036	K		Platelet pheresis irradiated	9502	8.5076	$443.68		$88.74
P9037	K		Plate pheres leukoredu irrad	1019	7.7905	$406.28		$81.26
P9038	K		RBC irradiated	9505	2.0833	$108.65		$21.73
P9039	K		RBC deglycerolized	9504	3.5174	$183.44		$36.69
P9040	K		RBC leukoreduced irradiated	9504	3.5174	$183.44		$36.69
P9041	K		Albumin (human),5%, 50ml	0961	0.9980	$52.05		$10.41
P9043	K		Plasma protein fract,5%,50ml	0956	1.7829	$92.98		$18.60
P9044	K		Cryoprecipitatereducedplasma	1009	0.7170	$37.39		$7.48
P9045	K		Albumin (human), 5%, 250 ml	0963	4.9708	$259.23		$51.85
P9046	K		Albumin (human), 25%, 20 ml	0964	1.0756	$56.09		$11.22
P9047	K		Albumin (human), 25%, 50ml	0965	2.6840	$139.97		$27.99
P9048	K		Plasmaprotein fract,5%,250ml	0966	8.9145	$464.90		$92.98
P9050	K		Granulocytes, pheresis unit	9506	23.9432	$1,248.66		$249.73
P9603	A		One-way allow prorated miles					
P9604	A		One-way allow prorated trip					
P9612	N		Catheterize for urine spec					
P9615	N		Urine specimen collect mult					
Q0035	X		Cardiokymography	0100	1.6085	$83.88	$41.44	$16.78
Q0081	T		Infusion ther other than che	0120	2.1802	$113.70	$30.75	$22.74
Q0083	S		Chemo by other than infusion	0116	0.7752	$40.43		$8.09
Q0084	S		Chemotherapy by infusion	0117	3.6046	$187.98	$48.28	$37.60
Q0085	S		Chemo by both infusion and o	0118	5.4844	$286.02	$72.03	$57.20
Q0086	A		Physical therapy evaluation/					
Q0091	T		Obtaining screen pap smear	0191	0.2035	$10.61	$3.08	$2.12
Q0092	N		Set up port xray equipment					
Q0111	A		Wet mounts/ w preparations					
Q0112	A		Potassium hydroxide preps					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q0113	A		Pinworm examinations					
Q0114	A		Fern test					
Q0115	A		Post-coital mucous exam					
Q0136	K		Non esrd epoetin alpha inj	0733	0.1744	$9.10		$1.82
Q0144	E		Azithromycin dihydrate, oral					
Q0163	N		Diphenhydramine HCl 50mg					
Q0164	N		Prochlorperazine maleate 5mg					
Q0165	E		Prochlorperazine maleate10mg					
Q0166	N		Granisetron HCl 1 mg oral					
Q0167	N		Dronabinol 2.5mg oral					
Q0168	E		Dronabinol 5mg oral					
Q0169	N		Promethazine HCl 12.5mg oral					
Q0170	E		Promethazine HCl 25 mg oral					
Q0171	N		Chlorpromazine HCl 10mg oral					
Q0172	E		Chlorpromazine HCl 25mg oral					
Q0173	N		Trimethobenzamide HCl 250mg					
Q0174	N		Thiethylperazine maleate10mg					
Q0175	N		Perphenazine 4mg oral					
Q0176	E		Perphenazine 8mg oral					
Q0177	N		Hydroxyzine pamoate 25mg					
Q0178	E		Hydroxyzine pamoate 50mg					
Q0179	N		Ondansetron HCl 8mg oral					
Q0180	N		Dolasetron mesylate oral					
Q0181	E		Unspecified oral anti-emetic					
Q0183	N		Nonmetabolic active tissue					
Q0184	N		Metabolically active tissue					
Q0187	K		Factor viia recombinant	1409	20.7844	$1,083.93		$216.79
Q1001	E		Ntiol category 1					
Q1002	E		Ntiol category 2					
Q1003	E		Ntiol category 3					
Q1004	E		Ntiol category 4					
Q1005	E		Ntiol category 5					
Q2001	N		Oral cabergoline 0.5 mg					
Q2002	N		Elliotts b solution per ml					
Q2003	N		Aprotinin, 10,000 kiu					
Q2004	N		Bladder calculi irrig sol					
Q2005	K		Corticorelin ovine triflutat	7024	2.2965	$119.76		$23.95
Q2006	K		Digoxin immune fab (ovine)	7025	4.9805	$259.74		$51.95
Q2007	N		Ethanolamine oleate 100 mg					
Q2008	N		Fomepizole, 15 mg					
Q2009	N		Fosphenytoin, 50 mg					
Q2010	N		Glatiramer acetate, per dose					
Q2011	K		Hemin, per 1 mg	7030	0.0097	$.51		$.10
Q2012	N		Pegademase bovine, 25 iu					
Q2013	N		Pentastarch 10% solution					
Q2014	N		Sermorelin acetate, 0.5 mg					
Q2017	K		Teniposide, 50 mg	7035	1.9573	$102.08		$20.42
Q2018	N		Urofollitropin, 75 iu					
Q2019	K		Basiliximab	1615	13.3621	$696.85		$139.37
Q2020	E		Histrelin acetate					
Q2021	N		Lepirudin					
Q2022	K		VonWillebrandFactrCmplxperIU	1618	0.0194	$1.01		$.20
Q3001	N		Brachytherapy Radioelements					
Q3002	N		Gallium ga 67					
Q3003	K		Technetium tc99m bicisate	1620	3.8759	$202.13		$40.43
Q3004	N		Xenon xe 133					
Q3005	N		Technetium tc99m mertiatide					
Q3006	N		Technetium tc99m glucepatate					
Q3007	N		Sodium phosphate p32					
Q3008	K		Indium 111-in pentetreotide	1625	8.2169	$428.52		$85.70
Q3009	N		Technetium tc99m oxidronate					
Q3010	N		Technetium tc99mlabeledrbcs					
Q3011	K		Chromic phosphate p32	1628	1.5891	$82.87		$16.57
Q3012	N		Cyanocobalamin cobalt co57					
Q3014	A		Telehealth facility fee					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q3017	E	DG	ALS assessment					
Q3019	A		ALS emer trans no ALS serv					
Q3020	A		ALS nonemer trans no ALS se					
Q3021	K	NI	Ped hepatitis b vaccine inj	0355	0.2132	$11.12		$2.22
Q3022	K	NI	Hepatitis b vaccine adult ds	0356	0.7655	$39.92		$7.98
Q3023	K	NI	Injection hepatitis Bvaccine	0356	0.7655	$39.92		$7.98
Q3025	K	NI	IM inj interferon beta 1-a	9022	0.9302	$48.51		$9.70
Q3026	N	NI	Subc inj interferon beta-1a					
Q4001	A		Cast sup body cast plaster					
Q4002	A		Cast sup body cast fiberglas					
Q4003	A		Cast sup shoulder cast plstr					
Q4004	A		Cast sup shoulder cast fbrgl					
Q4005	A		Cast sup long arm adult plst					
Q4006	A		Cast sup long arm adult fbrg					
Q4007	A		Cast sup long arm ped plster					
Q4008	A		Cast sup long arm ped fbrgls					
Q4009	A		Cast sup sht arm adult plstr					
Q4010	A		Cast sup sht arm adult fbrgl					
Q4011	A		Cast sup sht arm ped plaster					
Q4012	A		Cast sup sht arm ped fbrglas					
Q4013	A		Cast sup gauntlet plaster					
Q4014	A		Cast sup gauntlet fiberglass					
Q4015	A		Cast sup gauntlet ped plster					
Q4016	A		Cast sup gauntlet ped fbrgls					
Q4017	A		Cast sup lng arm splint plst					
Q4018	A		Cast sup lng arm splint fbrg					
Q4019	A		Cast sup lng arm splnt ped p					
Q4020	A		Cast sup lng arm splnt ped f					
Q4021	A		Cast sup sht arm splint plst					
Q4022	A		Cast sup sht arm splint fbrg					
Q4023	A		Cast sup sht arm splnt ped p					
Q4024	A		Cast sup sht arm splnt ped f					
Q4025	A		Cast sup hip spica plaster					
Q4026	A		Cast sup hip spica fiberglas					
Q4027	A		Cast sup hip spica ped plstr					
Q4028	A		Cast sup hip spica ped fbrgl					
Q4029	A		Cast sup long leg plaster					
Q4030	A		Cast sup long leg fiberglass					
Q4031	A		Cast sup lng leg ped plaster					
Q4032	A		Cast sup lng leg ped fbrgls					
Q4033	A		Cast sup lng leg cylinder pl					
Q4034	A		Cast sup lng leg cylinder fb					
Q4035	A		Cast sup lngleg cylndr ped p					
Q4036	A		Cast sup lngleg cylndr ped f					
Q4037	A		Cast sup shrt leg plaster					
Q4038	A		Cast sup shrt leg fiberglass					
Q4039	A		Cast sup shrt leg ped plster					
Q4040	A		Cast sup shrt leg ped fbrgls					
Q4041	A		Cast sup lng leg splnt plstr					
Q4042	A		Cast sup lng leg splnt fbrgl					
Q4043	A		Cast sup lng leg splnt ped p					
Q4044	A		Cast sup lng leg splnt ped f					
Q4045	A		Cast sup sht leg splnt plstr					
Q4046	A		Cast sup sht leg splnt fbrgl					
Q4047	A		Cast sup sht leg splnt ped p					
Q4048	A		Cast sup sht leg splnt ped f					
Q4049	A		Finger splint, static					
Q4050	A		Cast supplies unlisted					
Q4051	A		Splint supplies misc					
Q9920	A		Epoetin with hct <= 20					
Q9921	A		Epoetin with hct = 21					
Q9922	A		Epoetin with hct = 22					
Q9923	A		Epoetin with hct = 23					
Q9924	A		Epoetin with hct = 24					
Q9925	A		Epoetin with hct = 25					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q9926	A		Epoetin with hct = 26					
Q9927	A		Epoetin with hct = 27					
Q9928	A		Epoetin with hct = 28					
Q9929	A		Epoetin with hct = 29					
Q9930	A		Epoetin with hct = 30					
Q9931	A		Epoetin with hct = 31					
Q9932	A		Epoetin with hct = 32					
Q9933	A		Epoetin with hct = 33					
Q9934	A		Epoetin with hct = 34					
Q9935	A		Epoetin with hct = 35					
Q9936	A		Epoetin with hct = 36					
Q9937	A		Epoetin with hct = 37					
Q9938	A		Epoetin with hct = 38					
Q9939	A		Epoetin with hct = 39					
Q9940	A		Epoetin with hct >= 40					
R0070	N		Transport portable x-ray					
R0075	N		Transport port x-ray multipl					
R0076	N		Transport portable EKG					
T1015	E		Clinic service					
T1016	E	NI	Case management					
T1017	E	NI	Targeted case management					
T1018	E	NI	School-based IEP ser bundled					
T1019	E	NI	Personal care ser per 15 min					
T1020	E	NI	Personal care ser per diem					
T1021	E	NI	HH Aide or cn aide per visit					
T1022	E	NI	Contracted services per day					
T1023	E	NI	Program intake assessment					
T1024	E	NI	Team evaluation & management					
T1025	E	NI	Ped compr care pkg, per diem					
T1026	E	NI	Ped compr care pkg, per hour					
T1027	E	NI	Family training & counseling					
T1028	E	NI	Home environment assessment					
T1029	E	NI	Dwelling lead investigation					
T1030	E	NI	RN home care per diem					
T1031	E	NI	LPN home care per diem					
T1500	E	NI	Reusable diaper/pant					
T1502	E	NI	Medication admin visit					
T1999	E	NI	NOC retail items andsupplies					
T2001	E	NI	N-et; patient attend/escort					
T2002	E	NI	N-et; per diem					
T2003	E	NI	N-et; encounter/trip					
T2004	E	NI	N-et; commerc carrier pass					
T2005	E	NI	N-et; stretcher van					
T2006	E	NI	Amb response & trt, no trans					
T2007	E	NI	Non-emer transport wait time					
V2020	A		Vision svcs frames purchases					
V2025	E		Eyeglasses delux frames					
V2100	A		Lens spher single plano 4.00					
V2101	A		Single visn sphere 4.12-7.00					
V2102	A		Singl visn sphere 7.12-20.00					
V2103	A		Spherocylindr 4.00d/12-2.00d					
V2104	A		Spherocylindr 4.00d/2.12-4d					
V2105	A		Spherocylinder 4.00d/4.25-6d					
V2106	A		Spherocylinder 4.00d/>6.00d					
V2107	A		Spherocylinder 4.25d/12-2d					
V2108	A		Spherocylinder 4.25d/2.12-4d					
V2109	A		Spherocylinder 4.25d/4.25-6d					
V2110	A		Spherocylinder 4.25d/over 6d					
V2111	A		Spherocylindr 7.25d/.25-2.25					
V2112	A		Spherocylindr 7.25d/2.25-4d					
V2113	A		Spherocylindr 7.25d/4.25-6d					
V2114	A		Spherocylinder over 12.00d					
V2115	A		Lens lenticular bifocal					
V2116	A		Nonaspheric lens bifocal					
V2117	A		Aspheric lens bifocal					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V2118	A		Lens aniseikonic single					
V2199	A		Lens single vision not oth c					
V2200	A		Lens spher bifoc plano 4.00d					
V2201	A		Lens sphere bifocal 4.12-7.0					
V2202	A		Lens sphere bifocal 7.12-20.					
V2203	A		Lens sphcyl bifocal 4.00d/.1					
V2204	A		Lens sphcy bifocal 4.00d/2.1					
V2205	A		Lens sphcy bifocal 4.00d/4.2					
V2206	A		Lens sphcy bifocal 4.00d/ove					
V2207	A		Lens sphcy bifocal 4.25-7d/.					
V2208	A		Lens sphcy bifocal 4.25-7/2.					
V2209	A		Lens sphcy bifocal 4.25-7/4.					
V2210	A		Lens sphcy bifocal 4.25-7/ov					
V2211	A		Lens sphcy bifo 7.25-12/.25-					
V2212	A		Lens sphcyl bifo 7.25-12/2.2					
V2213	A		Lens sphcyl bifo 7.25-12/4.2					
V2214	A		Lens sphcyl bifocal over 12.					
V2215	A		Lens lenticular bifocal					
V2216	A		Lens lenticular nonaspheric					
V2217	A		Lens lenticular aspheric bif					
V2218	A		Lens aniseikonic bifocal					
V2219	A		Lens bifocal seg width over					
V2220	A		Lens bifocal add over 3.25d					
V2299	A		Lens bifocal speciality					
V2300	A		Lens sphere trifocal 4.00d					
V2301	A		Lens sphere trifocal 4.12-7.					
V2302	A		Lens sphere trifocal 7.12-20					
V2303	A		Lens sphcy trifocal 4.0/.12-					
V2304	A		Lens sphcy trifocal 4.0/2.25					
V2305	A		Lens sphcy trifocal 4.0/4.25					
V2306	A		Lens sphcyl trifocal 4.00/>6					
V2307	A		Lens sphcy trifocal 4.25-7/.					
V2308	A		Lens sphc trifocal 4.25-7/2.					
V2309	A		Lens sphc trifocal 4.25-7/4.					
V2310	A		Lens sphc trifocal 4.25-7/>6					
V2311	A		Lens sphc trifo 7.25-12/.25-					
V2312	A		Lens sphc trifo 7.25-12/2.25					
V2313	A		Lens sphc trifo 7.25-12/4.25					
V2314	A		Lens sphcyl trifocal over 12					
V2315	A		Lens lenticular trifocal					
V2316	A		Lens lenticular nonaspheric					
V2317	A		Lens lenticular aspheric tri					
V2318	A		Lens aniseikonic trifocal					
V2319	A		Lens trifocal seg width > 28					
V2320	A		Lens trifocal add over 3.25d					
V2399	A		Lens trifocal speciality					
V2410	A		Lens variab asphericity sing					
V2430	A		Lens variable asphericity bi					
V2499	A		Variable asphericity lens					
V2500	A		Contact lens pmma spherical					
V2501	A		Cntct lens pmma-toric/prism					
V2502	A		Contact lens pmma bifocal					
V2503	A		Cntct lens pmma color vision					
V2510	A		Cntct gas permeable sphericl					
V2511	A		Cntct toric prism ballast					
V2512	A		Cntct lens gas permbl bifocl					
V2513	A		Contact lens extended wear					
V2520	A		Contact lens hydrophilic					
V2521	A		Cntct lens hydrophilic toric					
V2522	A		Cntct lens hydrophil bifocl					
V2523	A		Cntct lens hydrophil extend					
V2530	A		Contact lens gas impermeable					
V2531	A		Contact lens gas permeable					
V2599	A		Contact lens/es other type					
V2600	A		Hand held low vision aids					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V2610	A		Single lens spectacle mount					
V2615	A		Telescop/othr compound lens					
V2623	A		Plastic eye prosth custom					
V2624	A		Polishing artifical eye					
V2625	A		Enlargemnt of eye prosthesis					
V2626	A		Reduction of eye prosthesis					
V2627	A		Scleral cover shell					
V2628	A		Fabrication & fitting					
V2629	A		Prosthetic eye other type					
V2630	N		Anter chamber intraocul lens					
V2631	N		Iris support intraoclr lens					
V2632	N		Post chmbr intraocular lens					
V2700	A		Balance lens					
V2710	A		Glass/plastic slab off prism					
V2715	A		Prism lens/es					
V2718	A		Fresnell prism press-on lens					
V2730	A		Special base curve					
V2740	A		Rose tint plastic					
V2741	A		Non-rose tint plastic					
V2742	A		Rose tint glass					
V2743	A		Non-rose tint glass					
V2744	A		Tint photochromatic lens/es					
V2750	A		Anti-reflective coating					
V2755	A		UV lens/es					
V2760	A		Scratch resistant coating					
V2770	A		Occluder lens/es					
V2780	A		Oversize lens/es					
V2781	E		Progressive lens per lens					
V2785	F		Corneal tissue processing					
V2790	N		Amniotic membrane					
V2799	A		Miscellaneous vision service					
V5008	E		Hearing screening					
V5010	E		Assessment for hearing aid					
V5011	E		Hearing aid fitting/checking					
V5014	E		Hearing aid repair/modifying					
V5020	E		Conformity evaluation					
V5030	E		Body-worn hearing aid air					
V5040	E		Body-worn hearing aid bone					
V5050	E		Hearing aid monaural in ear					
V5060	E		Behind ear hearing aid					
V5070	E		Glasses air conduction					
V5080	E		Glasses bone conduction					
V5090	E		Hearing aid dispensing fee					
V5095	E	NI	Implant mid ear hearing pros					
V5100	E		Body-worn bilat hearing aid					
V5110	E		Hearing aid dispensing fee					
V5120	E		Body-worn binaur hearing aid					
V5130	E		In ear binaural hearing aid					
V5140	E		Behind ear binaur hearing ai					
V5150	E		Glasses binaural hearing aid					
V5160	E		Dispensing fee binaural					
V5170	E		Within ear cros hearing aid					
V5180	E		Behind ear cros hearing aid					
V5190	E		Glasses cros hearing aid					
V5200	E		Cros hearing aid dispens fee					
V5210	E		In ear bicros hearing aid					
V5220	E		Behind ear bicros hearing ai					
V5230	E		Glasses bicros hearing aid					
V5240	E		Dispensing fee bicros					
V5241	E		Dispensing fee, monaural					
V5242	E		Hearing aid, monaural, cic					
V5243	E		Hearing aid, monaural, itc					
V5244	E		Hearing aid, prog, mon, cic					
V5245	E		Hearing aid, prog, mon, itc					
V5246	E		Hearing aid, prog, mon, ite					

*Code is new in 2002.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

[Calendar Year 2003]

CPT/ HCPCS	Status indicator	Condition	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V5247	E		Hearing aid, prog, mon, bte					
V5248	E		Hearing aid, binaural, cic					
V5249	E		Hearing aid, binaural, itc					
V5250	E		Hearing aid, prog, bin, cic					
V5251	E		Hearing aid, prog, bin, itc					
V5252	E		Hearing aid, prog, bin, ite					
V5253	E		Hearing aid, prog, bin, bte					
V5254	E		Hearing id, digit, mon, cic					
V5255	E		Hearing aid, digit, mon, itc					
V5256	E		Hearing aid, digit, mon, ite					
V5257	E		Hearing aid, digit, mon, bte					
V5258	E		Hearing aid, digit, bin, cic					
V5259	E		Hearing aid, digit, bin, itc					
V5260	E		Hearing aid, digit, bin, ite					
V5261	E		Hearing aid, digit, bin, bte					
V5262	E		Hearing aid, disp, monaural					
V5263	E		Hearing aid, disp, binaural					
V5264	E		Ear mold/insert					
V5265	E		Ear mold/insert, disp					
V5266	E		Battery for hearing device					
V5267	E		Hearing aid supply/accessory					
V5268	E		ALD Telephone Amplifier					
V5269	E		Alerting device, any type					
V5270	E		ALD, TV amplifier, any type					
V5271	E		ALD, TV caption decoder					
V5272	E		Tdd					
V5273	E		ALD for cochlear implant					
V5274	E		ALD unspecified					
V5275	E		Ear impression					
V5298	E	NI	Hearing aid noc					
V5299	E		Hearing service					
V5336	E		Repair communication device					
V5362	A		Speech screening					
V5363	A		Language screening					
V5364	A		Dysphagia screening					

*Code is new in 2002.

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

Indicator	Service	Status
A	Ambulance	Ambulance Fee Schedule.
A	Clinical Diagnostic Laboratory Services	Laboratory Fee Schedule.
A	Durable Medical Equipment, Prosthetics and Orthotics (excluding implanted DME and prosthetics).	DMEPOS Fee Schedule.
A	EPO for ESRD Patients	National Rate.
A	Physical, Occupational and Speech Therapy	Physician Fee Schedule.
A	Physician Services for ESRD Patients	Physician Fee Schedule.
A	Screening Mammography	Physician Fee Schedule.
C	Inpatient Procedures	Not Payable under OPPS; Admit Patient; Bill as Inpatient.
D	Deleted Code	Deleted Effective Beginning of Calendar Year.
E	Non-Covered Items and Services, Codes not Reportable in Hospital Outpatient Settings.	Not Paid Under Medicare or When Performed in a Hospital Outpatient Setting.
F	Corneal tissue acquisition; orphan drugs	Paid at Reasonable Cost.
G	Drug/Biological Pass-Through	Paid Under OPPS; Separate APC Payment Includes Pass Through Amount.
H	Device Category Pass-Through	Paid Under OPPS; Separate Cost Based Pass Through Payment.
K	Non Pass-Through Drug/Biological, Radiopharmaceutical Agents, Certain Brachytherapy seeds.	Paid Under OPPS; Separate APC.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Paid reasonable cost; not subject to deductible or coinsurance.
N	Items and Services Packaged into APC Rate	Paid under OPPS; Payment Is Packaged Into Payment for Other Services.

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

Indicator	Service	Status
P	Partial Hospitalization	Paid under OPPS; Per Diem APC.
S	Significant Procedure, Not Discounted When Multiple	Paid Under OPPS; Separate APC.
T	Significant Procedure, Multiple Procedure Reduction Applies	Paid Under OPPS; Separate APC.
V	Visit to Clinic or Emergency Department	Paid Under OPPS; Separate APC .
X	Ancillary Service	Paid Under OPPS; Separate APC.

ADDENDUM D1.—CODE CONDITIONS

Code condition	Descriptor
DG	Deleted code with a grace period; payment will be made under the deleted code in accord with the status indicator during the standard grace period.
DNG	Deleted code with no grace period; payment will not be made under the deleted code after January 1, 2003.
NF	New code final APC assignment; comments were accepted on a proposed APC assignment in the NPRM; APC assignment is no longer open to comment.
NI	New code interim APC assignment; comments will be accepted on the interim APC assignment for the new code.

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
00846	C	Anesth, hysterectomy
00848	C	Anesth, pelvic organ surg
00864	C	Anesth, removal of bladder
00865	C	Anesth, removal of prostate
00866	C	Anesth, removal of adrenal
00868	C	Anesth, kidney transplant
00882	C	Anesth, major vein ligation
00904	C	Anesth, perineal surgery
00908	C	Anesth, removal of prostate
00928	C	Anesth, removal of testis
00932	C	Anesth, amputation of penis
00934	C	Anesth, penis, nodes removal
00936	C	Anesth, penis, nodes removal
00944	C	Anesth, vaginal hysterectomy
01140	C	Anesth, amputation at pelvis
01150	C	Anesth, pelvic tumor surgery
01190	C	Anesth, pelvis nerve removal
01212	C	Anesth, hip disarticulation
01214	C	Anesth, hip arthroplasty
01232	C	Anesth, amputation of femur
01234	C	Anesth, radical femur surg
01272	C	Anesth, femoral artery surg
01274	C	Anesth, femoral embolectomy
01402	C	Anesth, knee arthroplasty
01404	C	Anesth, amputation at knee
01442	C	Anesth, knee artery surg
01444	C	Anesth, knee artery repair
01486	C	Anesth, ankle replacement
01502	C	Anesth, lwr leg embolectomy
01632	C	Anesth, surgery of shoulder
01634	C	Anesth, shoulder joint amput
01636	C	Anesth, forequarter amput
01638	C	Anesth, shoulder replacement
01652	C	Anesth, shoulder vessel surg
01654	C	Anesth, shoulder vessel surg
01656	C	Anesth, arm-leg vessel surg
01756	C	Anesth, radical humerus surg
01990	C	Support for organ donor
15756	C	Free muscle flap, microvasc

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
15757	C	Free skin flap, microvasc
15758	C	Free fascial flap, microvasc
16035	C	Incision of burn scab, initi
16036	C	Incise burn scab, addl incis
19200	C	Removal of breast
19220	C	Removal of breast
19271	C	Revision of chest wall
19272	C	Extensive chest wall surgery
19361	C	Breast reconstruction
19364	C	Breast reconstruction
19367	C	Breast reconstruction
19368	C	Breast reconstruction
19369	C	Breast reconstruction
20660	C	Apply,remove fixation device
20661	C	Application of head brace
20662	C	Application of pelvis brace
20663	C	Application of thigh brace
20664	C	Halo brace application
20802	C	Replantation, arm, complete
20805	C	Replant, forearm, complete
20808	C	Replantation hand, complete
20816	C	Replantation digit, complete
20822	C	Replantation digit, complete
20824	C	Replantation thumb, complete
20827	C	Replantation thumb, complete
20838	C	Replantation foot, complete
20930	C	Spinal bone allograft
20931	C	Spinal bone allograft
20936	C	Spinal bone autograft
20937	C	Spinal bone autograft
20938	C	Spinal bone autograft
20955	C	Fibula bone graft, microvasc
20956	C	Iliac bone graft, microvasc
20957	C	Mt bone graft, microvasc
20962	C	Other bone graft, microvasc
20969	C	Bone/skin graft, microvasc
20970	C	Bone/skin graft, iliac crest
20972	C	Bone/skin graft, metatarsal
20973	C	Bone/skin graft, great toe
21045	C	Extensive jaw surgery
21141	C	Reconstruct midface, lefort
21142	C	Reconstruct midface, lefort
21143	C	Reconstruct midface, lefort
21145	C	Reconstruct midface, lefort
21146	C	Reconstruct midface, lefort
21147	C	Reconstruct midface, lefort
21150	C	Reconstruct midface, lefort
21151	C	Reconstruct midface, lefort
21154	C	Reconstruct midface, lefort
21155	C	Reconstruct midface, lefort
21159	C	Reconstruct midface, lefort
21160	C	Reconstruct midface, lefort
21172	C	Reconstruct orbit/forehead
21175	C	Reconstruct orbit/forehead
21179	C	Reconstruct entire forehead
21180	C	Reconstruct entire forehead
21182	C	Reconstruct cranial bone
21183	C	Reconstruct cranial bone
21184	C	Reconstruct cranial bone
21188	C	Reconstruction of midface
21193	C	Reconst lwr jaw w/o graft
21194	C	Reconst lwr jaw w/graft
21195	C	Reconst lwr jaw w/o fixation
21196	C	Reconst lwr jaw w/fixation
21247	C	Reconstruct lower jaw bone

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
21255	C	Reconstruct lower jaw bone
21256	C	Reconstruction of orbit
21268	C	Revise eye sockets
21343	C	Treatment of sinus fracture
21344	C	Treatment of sinus fracture
21346	C	Treat nose/jaw fracture
21347	C	Treat nose/jaw fracture
21348	C	Treat nose/jaw fracture
21356	C	Treat cheek bone fracture
21360	C	Treat cheek bone fracture
21365	C	Treat cheek bone fracture
21366	C	Treat cheek bone fracture
21385	C	Treat eye socket fracture
21386	C	Treat eye socket fracture
21387	C	Treat eye socket fracture
21395	C	Treat eye socket fracture
21408	C	Treat eye socket fracture
21422	C	Treat mouth roof fracture
21423	C	Treat mouth roof fracture
21431	C	Treat craniofacial fracture
21432	C	Treat craniofacial fracture
21433	C	Treat craniofacial fracture
21435	C	Treat craniofacial fracture
21436	C	Treat craniofacial fracture
21495	C	Treat hyoid bone fracture
21510	C	Drainage of bone lesion
21557	C	Remove tumor, neck/chest
21615	C	Removal of rib
21616	C	Removal of rib and nerves
21620	C	Partial removal of sternum
21627	C	Sternal debridement
21630	C	Extensive sternum surgery
21632	C	Extensive sternum surgery
21705	C	Revision of neck muscle/rib
21740	C	Reconstruction of sternum
21750	C	Repair of sternum separation
21810	C	Treatment of rib fracture(s)
21825	C	Treat sternum fracture
22110	C	Remove part of neck vertebra
22112	C	Remove part, thorax vertebra
22114	C	Remove part, lumbar vertebra
22116	C	Remove extra spine segment
22210	C	Revision of neck spine
22212	C	Revision of thorax spine
22214	C	Revision of lumbar spine
22216	C	Revise, extra spine segment
22220	C	Revision of neck spine
22222	C	Revision of thorax spine
22224	C	Revision of lumbar spine
22226	C	Revise, extra spine segment
22318	C	Treat odontoid fx w/o graft
22319	C	Treat odontoid fx w/graft
22325	C	Treat spine fracture
22326	C	Treat neck spine fracture
22327	C	Treat thorax spine fracture
22328	C	Treat each add spine fx
22548	C	Neck spine fusion
22554	C	Neck spine fusion
22556	C	Thorax spine fusion
22558	C	Lumbar spine fusion
22585	C	Additional spinal fusion
22590	C	Spine & skull spinal fusion
22595	C	Neck spinal fusion
22600	C	Neck spine fusion
22610	C	Thorax spine fusion

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
22630	C	Lumbar spine fusion
22632	C	Spine fusion, extra segment
22800	C	Fusion of spine
22802	C	Fusion of spine
22804	C	Fusion of spine
22808	C	Fusion of spine
22810	C	Fusion of spine
22812	C	Fusion of spine
22818	C	Kyphectomy, 1-2 segments
22819	C	Kyphectomy, 3 or more
22830	C	Exploration of spinal fusion
22840	C	Insert spine fixation device
22841	C	Insert spine fixation device
22842	C	Insert spine fixation device
22843	C	Insert spine fixation device
22844	C	Insert spine fixation device
22845	C	Insert spine fixation device
22846	C	Insert spine fixation device
22847	C	Insert spine fixation device
22848	C	Insert pelv fixation device
22849	C	Reinsert spinal fixation
22850	C	Remove spine fixation device
22851	C	Apply spine prosth device
22852	C	Remove spine fixation device
22855	C	Remove spine fixation device
23200	C	Removal of collar bone
23210	C	Removal of shoulder blade
23220	C	Partial removal of humerus
23221	C	Partial removal of humerus
23222	C	Partial removal of humerus
23332	C	Remove shoulder foreign body
23472	C	Reconstruct shoulder joint
23900	C	Amputation of arm & girdle
23920	C	Amputation at shoulder joint
24149	C	Radical resection of elbow
24900	C	Amputation of upper arm
24920	C	Amputation of upper arm
24930	C	Amputation follow-up surgery
24931	C	Amputate upper arm & implant
24940	C	Revision of upper arm
25900	C	Amputation of forearm
25905	C	Amputation of forearm
25909	C	Amputation follow-up surgery
25915	C	Amputation of forearm
25920	C	Amputate hand at wrist
25924	C	Amputation follow-up surgery
25927	C	Amputation of hand
25931	C	Amputation follow-up surgery
26551	C	Great toe-hand transfer
26553	C	Single transfer, toe-hand
26554	C	Double transfer, toe-hand
26556	C	Toe joint transfer
26992	C	Drainage of bone lesion
27005	C	Incision of hip tendon
27006	C	Incision of hip tendons
27025	C	Incision of hip/thigh fascia
27030	C	Drainage of hip joint
27036	C	Excision of hip joint/muscle
27054	C	Removal of hip joint lining
27070	C	Partial removal of hip bone
27071	C	Partial removal of hip bone
27075	C	Extensive hip surgery
27076	C	Extensive hip surgery
27077	C	Extensive hip surgery
27078	C	Extensive hip surgery

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
27079	C	Extensive hip surgery
27090	C	Removal of hip prosthesis
27091	C	Removal of hip prosthesis
27120	C	Reconstruction of hip socket
27122	C	Reconstruction of hip socket
27125	C	Partial hip replacement
27130	C	Total hip arthroplasty
27132	C	Total hip arthroplasty
27134	C	Revise hip joint replacement
27137	C	Revise hip joint replacement
27138	C	Revise hip joint replacement
27140	C	Transplant femur ridge
27146	C	Incision of hip bone
27147	C	Revision of hip bone
27151	C	Incision of hip bones
27156	C	Revision of hip bones
27158	C	Revision of pelvis
27161	C	Incision of neck of femur
27165	C	Incision/fixation of femur
27170	C	Repair/graft femur head/neck
27175	C	Treat slipped epiphysis
27176	C	Treat slipped epiphysis
27177	C	Treat slipped epiphysis
27178	C	Treat slipped epiphysis
27179	C	Revise head/neck of femur
27181	C	Treat slipped epiphysis
27185	C	Revision of femur epiphysis
27187	C	Reinforce hip bones
27215	C	Treat pelvic fracture(s)
27217	C	Treat pelvic ring fracture
27218	C	Treat pelvic ring fracture
27222	C	Treat hip socket fracture
27226	C	Treat hip wall fracture
27227	C	Treat hip fracture(s)
27228	C	Treat hip fracture(s)
27232	C	Treat thigh fracture
27236	C	Treat thigh fracture
27240	C	Treat thigh fracture
27244	C	Treat thigh fracture
27245	C	Treat thigh fracture
27248	C	Treat thigh fracture
27253	C	Treat hip dislocation
27254	C	Treat hip dislocation
27258	C	Treat hip dislocation
27259	C	Treat hip dislocation
27280	C	Fusion of sacroiliac joint
27282	C	Fusion of pubic bones
27284	C	Fusion of hip joint
27286	C	Fusion of hip joint
27290	C	Amputation of leg at hip
27295	C	Amputation of leg at hip
27303	C	Drainage of bone lesion
27365	C	Extensive leg surgery
27445	C	Revision of knee joint
27447	C	Total knee arthroplasty
27448	C	Incision of thigh
27450	C	Incision of thigh
27454	C	Realignment of thigh bone
27455	C	Realignment of knee
27457	C	Realignment of knee
27465	C	Shortening of thigh bone
27466	C	Lengthening of thigh bone
27468	C	Shorten/lengthen thighs
27470	C	Repair of thigh
27472	C	Repair/graft of thigh

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
27475	C	Surgery to stop leg growth
27477	C	Surgery to stop leg growth
27479	C	Surgery to stop leg growth
27485	C	Surgery to stop leg growth
27486	C	Revise/replace knee joint
27487	C	Revise/replace knee joint
27488	C	Removal of knee prosthesis
27495	C	Reinforce thigh
27506	C	Treatment of thigh fracture
27507	C	Treatment of thigh fracture
27511	C	Treatment of thigh fracture
27513	C	Treatment of thigh fracture
27514	C	Treatment of thigh fracture
27519	C	Treat thigh fx growth plate
27535	C	Treat knee fracture
27536	C	Treat knee fracture
27540	C	Treat knee fracture
27556	C	Treat knee dislocation
27557	C	Treat knee dislocation
27558	C	Treat knee dislocation
27580	C	Fusion of knee
27590	C	Amputate leg at thigh
27591	C	Amputate leg at thigh
27592	C	Amputate leg at thigh
27596	C	Amputation follow-up surgery
27598	C	Amputate lower leg at knee
27645	C	Extensive lower leg surgery
27646	C	Extensive lower leg surgery
27702	C	Reconstruct ankle joint
27703	C	Reconstruction, ankle joint
27712	C	Realignment of lower leg
27715	C	Revision of lower leg
27720	C	Repair of tibia
27722	C	Repair/graft of tibia
27724	C	Repair/graft of tibia
27725	C	Repair of lower leg
27727	C	Repair of lower leg
27880	C	Amputation of lower leg
27881	C	Amputation of lower leg
27882	C	Amputation of lower leg
27886	C	Amputation follow-up surgery
27888	C	Amputation of foot at ankle
28800	C	Amputation of midfoot
28805	C	Amputation thru metatarsal
31225	C	Removal of upper jaw
31230	C	Removal of upper jaw
31290	C	Nasal/sinus endoscopy, surg
31291	C	Nasal/sinus endoscopy, surg
31292	C	Nasal/sinus endoscopy, surg
31293	C	Nasal/sinus endoscopy, surg
31294	C	Nasal/sinus endoscopy, surg
31360	C	Removal of larynx
31365	C	Removal of larynx
31367	C	Partial removal of larynx
31368	C	Partial removal of larynx
31370	C	Partial removal of larynx
31375	C	Partial removal of larynx
31380	C	Partial removal of larynx
31382	C	Partial removal of larynx
31390	C	Removal of larynx & pharynx
31395	C	Reconstruct larynx & pharynx
31584	C	Treat larynx fracture
31587	C	Revision of larynx
31725	C	Clearance of airways
31760	C	Repair of windpipe

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
31766	C	Reconstruction of windpipe
31770	C	Repair/graft of bronchus
31775	C	Reconstruct bronchus
31780	C	Reconstruct windpipe
31781	C	Reconstruct windpipe
31786	C	Remove windpipe lesion
31800	C	Repair of windpipe injury
31805	C	Repair of windpipe injury
32035	C	Exploration of chest
32036	C	Exploration of chest
32095	C	Biopsy through chest wall
32100	C	Exploration/biopsy of chest
32110	C	Explore/repair chest
32120	C	Re-exploration of chest
32124	C	Explore chest free adhesions
32140	C	Removal of lung lesion(s)
32141	C	Remove/treat lung lesions
32150	C	Removal of lung lesion(s)
32151	C	Remove lung foreign body
32160	C	Open chest heart massage
32200	C	Drain, open, lung lesion
32215	C	Treat chest lining
32220	C	Release of lung
32225	C	Partial release of lung
32310	C	Removal of chest lining
32320	C	Free/remove chest lining
32402	C	Open biopsy chest lining
32440	C	Removal of lung
32442	C	Sleeve pneumonectomy
32445	C	Removal of lung
32480	C	Partial removal of lung
32482	C	Bilobectomy
32484	C	Segmentectomy
32486	C	Sleeve lobectomy
32488	C	Completion pneumonectomy
32491	C	Lung volume reduction
32500	C	Partial removal of lung
32501	C	Repair bronchus add-on
32520	C	Remove lung & revise chest
32522	C	Remove lung & revise chest
32525	C	Remove lung & revise chest
32540	C	Removal of lung lesion
32650	C	Thoracoscopy, surgical
32651	C	Thoracoscopy, surgical
32652	C	Thoracoscopy, surgical
32653	C	Thoracoscopy, surgical
32654	C	Thoracoscopy, surgical
32655	C	Thoracoscopy, surgical
32656	C	Thoracoscopy, surgical
32657	C	Thoracoscopy, surgical
32658	C	Thoracoscopy, surgical
32659	C	Thoracoscopy, surgical
32660	C	Thoracoscopy, surgical
32661	C	Thoracoscopy, surgical
32662	C	Thoracoscopy, surgical
32663	C	Thoracoscopy, surgical
32664	C	Thoracoscopy, surgical
32665	C	Thoracoscopy, surgical
32800	C	Repair lung hernia
32810	C	Close chest after drainage
32815	C	Close bronchial fistula
32820	C	Reconstruct injured chest
32850	C	Donor pneumonectomy
32851	C	Lung transplant, single
32852	C	Lung transplant with bypass

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
32853	C	Lung transplant, double
32854	C	Lung transplant with bypass
32900	C	Removal of rib(s)
32905	C	Revise & repair chest wall
32906	C	Revise & repair chest wall
32940	C	Revision of lung
32997	C	Total lung lavage
33015	C	Incision of heart sac
33020	C	Incision of heart sac
33025	C	Incision of heart sac
33030	C	Partial removal of heart sac
33031	C	Partial removal of heart sac
33050	C	Removal of heart sac lesion
33120	C	Removal of heart lesion
33130	C	Removal of heart lesion
33140	C	Heart revascularize (tmr)
33141	C	Heart tmr w/other procedure
33200	C	Insertion of heart pacemaker
33201	C	Insertion of heart pacemaker
33236	C	Remove electrode/thoracotomy
33237	C	Remove electrode/thoracotomy
33238	C	Remove electrode/thoracotomy
33243	C	Remove eltrd/thoracotomy
33245	C	Insert epic eltrd pace-defib
33246	C	Insert epic eltrd/generator
33250	C	Ablate heart dysrhythm focus
33251	C	Ablate heart dysrhythm focus
33253	C	Reconstruct atria
33261	C	Ablate heart dysrhythm focus
33300	C	Repair of heart wound
33305	C	Repair of heart wound
33310	C	Exploratory heart surgery
33315	C	Exploratory heart surgery
33320	C	Repair major blood vessel(s)
33321	C	Repair major vessel
33322	C	Repair major blood vessel(s)
33330	C	Insert major vessel graft
33332	C	Insert major vessel graft
33335	C	Insert major vessel graft
33400	C	Repair of aortic valve
33401	C	Valvuloplasty, open
33403	C	Valvuloplasty, w/cp bypass
33404	C	Prepare heart-aorta conduit
33405	C	Replacement of aortic valve
33406	C	Replacement of aortic valve
33410	C	Replacement of aortic valve
33411	C	Replacement of aortic valve
33412	C	Replacement of aortic valve
33413	C	Replacement of aortic valve
33414	C	Repair of aortic valve
33415	C	Revision, subvalvular tissue
33416	C	Revise ventricle muscle
33417	C	Repair of aortic valve
33420	C	Revision of mitral valve
33422	C	Revision of mitral valve
33425	C	Repair of mitral valve
33426	C	Repair of mitral valve
33427	C	Repair of mitral valve
33430	C	Replacement of mitral valve
33460	C	Revision of tricuspid valve
33463	C	Valvuloplasty, tricuspid
33464	C	Valvuloplasty, tricuspid
33465	C	Replace tricuspid valve
33468	C	Revision of tricuspid valve
33470	C	Revision of pulmonary valve

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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CPT/HCPCS	Status indicator	Description
33471	C	Valvotomy, pulmonary valve
33472	C	Revision of pulmonary valve
33474	C	Revision of pulmonary valve
33475	C	Replacement, pulmonary valve
33476	C	Revision of heart chamber
33478	C	Revision of heart chamber
33496	C	Repair, prosth valve clot
33500	C	Repair heart vessel fistula
33501	C	Repair heart vessel fistula
33502	C	Coronary artery correction
33503	C	Coronary artery graft
33504	C	Coronary artery graft
33505	C	Repair artery w/tunnel
33506	C	Repair artery, translocation
33510	C	CABG, vein, single
33511	C	CABG, vein, two
33512	C	CABG, vein, three
33513	C	CABG, vein, four
33514	C	CABG, vein, five
33516	C	Cabg, vein, six or more
33517	C	CABG, artery-vein, single
33518	C	CABG, artery-vein, two
33519	C	CABG, artery-vein, three
33521	C	CABG, artery-vein, four
33522	C	CABG, artery-vein, five
33523	C	Cabg, art-vein, six or more
33530	C	Coronary artery, bypass/reop
33533	C	CABG, arterial, single
33534	C	CABG, arterial, two
33535	C	CABG, arterial, three
33536	C	Cabg, arterial, four or more
33542	C	Removal of heart lesion
33545	C	Repair of heart damage
33572	C	Open coronary endarterectomy
33600	C	Closure of valve
33602	C	Closure of valve
33606	C	Anastomosis/artery-aorta
33608	C	Repair anomaly w/conduit
33610	C	Repair by enlargement
33611	C	Repair double ventricle
33612	C	Repair double ventricle
33615	C	Repair, modified fontan
33617	C	Repair single ventricle
33619	C	Repair single ventricle
33641	C	Repair heart septum defect
33645	C	Revision of heart veins
33647	C	Repair heart septum defects
33660	C	Repair of heart defects
33665	C	Repair of heart defects
33670	C	Repair of heart chambers
33681	C	Repair heart septum defect
33684	C	Repair heart septum defect
33688	C	Repair heart septum defect
33690	C	Reinforce pulmonary artery
33692	C	Repair of heart defects
33694	C	Repair of heart defects
33697	C	Repair of heart defects
33702	C	Repair of heart defects
33710	C	Repair of heart defects
33720	C	Repair of heart defect
33722	C	Repair of heart defect
33730	C	Repair heart-vein defect(s)
33732	C	Repair heart-vein defect
33735	C	Revision of heart chamber
33736	C	Revision of heart chamber

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
33737	C	Revision of heart chamber
33750	C	Major vessel shunt
33755	C	Major vessel shunt
33762	C	Major vessel shunt
33764	C	Major vessel shunt & graft
33766	C	Major vessel shunt
33767	C	Major vessel shunt
33770	C	Repair great vessels defect
33771	C	Repair great vessels defect
33774	C	Repair great vessels defect
33775	C	Repair great vessels defect
33776	C	Repair great vessels defect
33777	C	Repair great vessels defect
33778	C	Repair great vessels defect
33779	C	Repair great vessels defect
33780	C	Repair great vessels defect
33781	C	Repair great vessels defect
33786	C	Repair arterial trunk
33788	C	Revision of pulmonary artery
33800	C	Aortic suspension
33802	C	Repair vessel defect
33803	C	Repair vessel defect
33813	C	Repair septal defect
33814	C	Repair septal defect
33820	C	Revise major vessel
33822	C	Revise major vessel
33824	C	Revise major vessel
33840	C	Remove aorta constriction
33845	C	Remove aorta constriction
33851	C	Remove aorta constriction
33852	C	Repair septal defect
33853	C	Repair septal defect
33860	C	Ascending aortic graft
33861	C	Ascending aortic graft
33863	C	Ascending aortic graft
33870	C	Transverse aortic arch graft
33875	C	Thoracic aortic graft
33877	C	Thoracoabdominal graft
33910	C	Remove lung artery emboli
33915	C	Remove lung artery emboli
33916	C	Surgery of great vessel
33917	C	Repair pulmonary artery
33918	C	Repair pulmonary atresia
33919	C	Repair pulmonary atresia
33920	C	Repair pulmonary atresia
33922	C	Transect pulmonary artery
33924	C	Remove pulmonary shunt
33930	C	Removal of donor heart/lung
33935	C	Transplantation, heart/lung
33940	C	Removal of donor heart
33945	C	Transplantation of heart
33960	C	External circulation assist
33961	C	External circulation assist
33967	C	Insert ia percut device
33968	C	Remove aortic assist device
33970	C	Aortic circulation assist
33971	C	Aortic circulation assist
33973	C	Insert balloon device
33974	C	Remove intra-aortic balloon
33975	C	Implant ventricular device
33976	C	Implant ventricular device
33977	C	Remove ventricular device
33978	C	Remove ventricular device
33979	C	Insert intracorporeal device
33980	C	Remove intracorporeal device

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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CPT/HCPCS	Status indicator	Description
34001	C	Removal of artery clot
34051	C	Removal of artery clot
34151	C	Removal of artery clot
34401	C	Removal of vein clot
34451	C	Removal of vein clot
34502	C	Reconstruct vena cava
34800	C	Endovasc abdo repair w/tube
34802	C	Endovasc abdo repr w/device
34804	C	Endovasc abdo repr w/device
34808	C	Endovasc abdo occlud device
34812	C	Xpose for endoprosth, aortic
34813	C	Xpose for endoprosth, femorl
34820	C	Xpose for endoprosth, iliac
34825	C	Endovasc extend prosth, init
34826	C	Endovasc exten prosth, addl
34830	C	Open aortic tube prosth repr
34831	C	Open aortoiliac prosth repr
34832	C	Open aortofemor prosth repr
34833	C	Xpose for endoprosth, iliac
34834	C	Xpose, endoprosth, brachial
34900	C	Endovasc iliac repr w/graft
35001	C	Repair defect of artery
35002	C	Repair artery rupture, neck
35005	C	Repair defect of artery
35013	C	Repair artery rupture, arm
35021	C	Repair defect of artery
35022	C	Repair artery rupture, chest
35045	C	Repair defect of arm artery
35081	C	Repair defect of artery
35082	C	Repair artery rupture, aorta
35091	C	Repair defect of artery
35092	C	Repair artery rupture, aorta
35102	C	Repair defect of artery
35103	C	Repair artery rupture, groin
35111	C	Repair defect of artery
35112	C	Repair artery rupture,spleen
35121	C	Repair defect of artery
35122	C	Repair artery rupture, belly
35131	C	Repair defect of artery
35132	C	Repair artery rupture, groin
35141	C	Repair defect of artery
35142	C	Repair artery rupture, thigh
35151	C	Repair defect of artery
35152	C	Repair artery rupture, knee
35161	C	Repair defect of artery
35162	C	Repair artery rupture
35182	C	Repair blood vessel lesion
35189	C	Repair blood vessel lesion
35211	C	Repair blood vessel lesion
35216	C	Repair blood vessel lesion
35221	C	Repair blood vessel lesion
35241	C	Repair blood vessel lesion
35246	C	Repair blood vessel lesion
35251	C	Repair blood vessel lesion
35271	C	Repair blood vessel lesion
35276	C	Repair blood vessel lesion
35281	C	Repair blood vessel lesion
35301	C	Rechanneling of artery
35311	C	Rechanneling of artery
35331	C	Rechanneling of artery
35341	C	Rechanneling of artery
35351	C	Rechanneling of artery
35355	C	Rechanneling of artery
35361	C	Rechanneling of artery
35363	C	Rechanneling of artery

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
35371	C	Rechanneling of artery
35372	C	Rechanneling of artery
35381	C	Rechanneling of artery
35390	C	Reoperation, carotid add-on
35400	C	Angioscopy
35450	C	Repair arterial blockage
35452	C	Repair arterial blockage
35454	C	Repair arterial blockage
35456	C	Repair arterial blockage
35480	C	Atherectomy, open
35481	C	Atherectomy, open
35482	C	Atherectomy, open
35483	C	Atherectomy, open
35501	C	Artery bypass graft
35506	C	Artery bypass graft
35507	C	Artery bypass graft
35508	C	Artery bypass graft
35509	C	Artery bypass graft
35511	C	Artery bypass graft
35515	C	Artery bypass graft
35516	C	Artery bypass graft
35518	C	Artery bypass graft
35521	C	Artery bypass graft
35526	C	Artery bypass graft
35531	C	Artery bypass graft
35533	C	Artery bypass graft
35536	C	Artery bypass graft
35541	C	Artery bypass graft
35546	C	Artery bypass graft
35548	C	Artery bypass graft
35549	C	Artery bypass graft
35551	C	Artery bypass graft
35556	C	Artery bypass graft
35558	C	Artery bypass graft
35560	C	Artery bypass graft
35563	C	Artery bypass graft
35565	C	Artery bypass graft
35566	C	Artery bypass graft
35571	C	Artery bypass graft
35582	C	Vein bypass graft
35583	C	Vein bypass graft
35585	C	Vein bypass graft
35587	C	Vein bypass graft
35600	C	Harvest artery for cabg
35601	C	Artery bypass graft
35606	C	Artery bypass graft
35612	C	Artery bypass graft
35616	C	Artery bypass graft
35621	C	Artery bypass graft
35623	C	Bypass graft, not vein
35626	C	Artery bypass graft
35631	C	Artery bypass graft
35636	C	Artery bypass graft
35641	C	Artery bypass graft
35642	C	Artery bypass graft
35645	C	Artery bypass graft
35646	C	Artery bypass graft
35647	C	Artery bypass graft
35650	C	Artery bypass graft
35651	C	Artery bypass graft
35654	C	Artery bypass graft
35656	C	Artery bypass graft
35661	C	Artery bypass graft
35663	C	Artery bypass graft
35665	C	Artery bypass graft

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
35666	C	Artery bypass graft
35671	C	Artery bypass graft
35681	C	Composite bypass graft
35682	C	Composite bypass graft
35683	C	Composite bypass graft
35691	C	Arterial transposition
35693	C	Arterial transposition
35694	C	Arterial transposition
35695	C	Arterial transposition
35700	C	Reoperation, bypass graft
35701	C	Exploration, carotid artery
35721	C	Exploration, femoral artery
35741	C	Exploration popliteal artery
35800	C	Explore neck vessels
35820	C	Explore chest vessels
35840	C	Explore abdominal vessels
35870	C	Repair vessel graft defect
35901	C	Excision, graft, neck
35905	C	Excision, graft, thorax
35907	C	Excision, graft, abdomen
36510	C	Insertion of catheter, vein
36660	C	Insertion catheter, artery
36822	C	Insertion of cannula(s)
36823	C	Insertion of cannula(s)
37140	C	Revision of circulation
37145	C	Revision of circulation
37160	C	Revision of circulation
37180	C	Revision of circulation
37181	C	Splice spleen/kidney veins
37182	C	Insert hepatic shunt (tips)
37183	C	Remove hepatic shunt (tips)
37195	C	Thrombolytic therapy, stroke
37616	C	Ligation of chest artery
37617	C	Ligation of abdomen artery
37618	C	Ligation of extremity artery
37660	C	Revision of major vein
37788	C	Revascularization, penis
38100	C	Removal of spleen, total
38101	C	Removal of spleen, partial
38102	C	Removal of spleen, total
38115	C	Repair of ruptured spleen
38380	C	Thoracic duct procedure
38381	C	Thoracic duct procedure
38382	C	Thoracic duct procedure
38562	C	Removal, pelvic lymph nodes
38564	C	Removal, abdomen lymph nodes
38724	C	Removal of lymph nodes, neck
38746	C	Remove thoracic lymph nodes
38747	C	Remove abdominal lymph nodes
38765	C	Remove groin lymph nodes
38770	C	Remove pelvis lymph nodes
38780	C	Remove abdomen lymph nodes
39000	C	Exploration of chest
39010	C	Exploration of chest
39200	C	Removal chest lesion
39220	C	Removal chest lesion
39499	C	Chest procedure
39501	C	Repair diaphragm laceration
39502	C	Repair paraesophageal hernia
39503	C	Repair of diaphragm hernia
39520	C	Repair of diaphragm hernia
39530	C	Repair of diaphragm hernia
39531	C	Repair of diaphragm hernia
39540	C	Repair of diaphragm hernia
39541	C	Repair of diaphragm hernia

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
39545	C	Revision of diaphragm
39560	C	Resect diaphragm, simple
39561	C	Resect diaphragm, complex
39599	C	Diaphragm surgery procedure
41130	C	Partial removal of tongue
41135	C	Tongue and neck surgery
41140	C	Removal of tongue
41145	C	Tongue removal, neck surgery
41150	C	Tongue, mouth, jaw surgery
41153	C	Tongue, mouth, neck surgery
41155	C	Tongue, jaw, & neck surgery
42426	C	Excise parotid gland/lesion
42845	C	Extensive surgery of throat
42894	C	Revision of pharyngeal walls
42953	C	Repair throat, esophagus
42961	C	Control throat bleeding
42971	C	Control nose/throat bleeding
43045	C	Incision of esophagus
43100	C	Excision of esophagus lesion
43101	C	Excision of esophagus lesion
43107	C	Removal of esophagus
43108	C	Removal of esophagus
43112	C	Removal of esophagus
43113	C	Removal of esophagus
43116	C	Partial removal of esophagus
43117	C	Partial removal of esophagus
43118	C	Partial removal of esophagus
43121	C	Partial removal of esophagus
43122	C	Parital removal of esophagus
43123	C	Partial removal of esophagus
43124	C	Removal of esophagus
43135	C	Removal of esophagus pouch
43300	C	Repair of esophagus
43305	C	Repair esophagus and fistula
43310	C	Repair of esophagus
43312	C	Repair esophagus and fistula
43313	C	Esophagoplasty congential
43314	C	Tracheo-esophagoplasty cong
43320	C	Fuse esophagus & stomach
43324	C	Revise esophagus & stomach
43325	C	Revise esophagus & stomach
43326	C	Revise esophagus & stomach
43330	C	Repair of esophagus
43331	C	Repair of esophagus
43340	C	Fuse esophagus & intestine
43341	C	Fuse esophagus & intestine
43350	C	Surgical opening, esophagus
43351	C	Surgical opening, esophagus
43352	C	Surgical opening, esophagus
43360	C	Gastrointestinal repair
43361	C	Gastrointestinal repair
43400	C	Ligate esophagus veins
43401	C	Esophagus surgery for veins
43405	C	Ligate/staple esophagus
43410	C	Repair esophagus wound
43415	C	Repair esophagus wound
43420	C	Repair esophagus opening
43425	C	Repair esophagus opening
43460	C	Pressure treatment esophagus
43496	C	Free jejunum flap, microvasc
43500	C	Surgical opening of stomach
43501	C	Surgical repair of stomach
43502	C	Surgical repair of stomach
43510	C	Surgical opening of stomach
43520	C	Incision of pyloric muscle

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
43605	C	Biopsy of stomach
43610	C	Excision of stomach lesion
43611	C	Excision of stomach lesion
43620	C	Removal of stomach
43621	C	Removal of stomach
43622	C	Removal of stomach
43631	C	Removal of stomach, partial
43632	C	Removal of stomach, partial
43633	C	Removal of stomach, partial
43634	C	Removal of stomach, partial
43635	C	Removal of stomach, partial
43638	C	Removal of stomach, partial
43639	C	Removal of stomach, partial
43640	C	Vagotomy & pylorus repair
43641	C	Vagotomy & pylorus repair
43800	C	Reconstruction of pylorus
43810	C	Fusion of stomach and bowel
43820	C	Fusion of stomach and bowel
43825	C	Fusion of stomach and bowel
43832	C	Place gastrostomy tube
43840	C	Repair of stomach lesion
43842	C	Gastroplasty for obesity
43843	C	Gastroplasty for obesity
43846	C	Gastric bypass for obesity
43847	C	Gastric bypass for obesity
43848	C	Revision gastroplasty
43850	C	Revise stomach-bowel fusion
43855	C	Revise stomach-bowel fusion
43860	C	Revise stomach-bowel fusion
43865	C	Revise stomach-bowel fusion
43880	C	Repair stomach-bowel fistula
44005	C	Freeing of bowel adhesion
44010	C	Incision of small bowel
44015	C	Insert needle cath bowel
44020	C	Explore small intestine
44021	C	Decompress small bowel
44025	C	Incision of large bowel
44050	C	Reduce bowel obstruction
44055	C	Correct malrotation of bowel
44110	C	Excise intestine lesion(s)
44111	C	Excision of bowel lesion(s)
44120	C	Removal of small intestine
44121	C	Removal of small intestine
44125	C	Removal of small intestine
44126	C	Enterectomy w/taper, cong
44127	C	Enterectomy w/o taper, cong
44128	C	Enterectomy cong, add-on
44130	C	Bowel to bowel fusion
44132	C	Enterectomy, cadaver donor
44133	C	Enterectomy, live donor
44135	C	Intestine transplnt, cadaver
44136	C	Intestine transplant, live
44139	C	Mobilization of colon
44140	C	Partial removal of colon
44141	C	Partial removal of colon
44143	C	Partial removal of colon
44144	C	Partial removal of colon
44145	C	Partial removal of colon
44146	C	Partial removal of colon
44147	C	Partial removal of colon
44150	C	Removal of colon
44151	C	Removal of colon/ileostomy
44152	C	Removal of colon/ileostomy
44153	C	Removal of colon/ileostomy
44155	C	Removal of colon/ileostomy

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
44156	C	Removal of colon/ileostomy
44160	C	Removal of colon
44202	C	Lap resect s/intestine singl
44203	C	Lap resect s/intestine, addl
44204	C	Laparo partial colectomy
44205	C	Lap colectomy part w/ileum
44210	C	Laparo total proctocolectomy
44211	C	Laparo total proctocolectomy
44212	C	Laparo total proctocolectomy
44300	C	Open bowel to skin
44310	C	Ileostomy/jejunostomy
44314	C	Revision of ileostomy
44316	C	Devise bowel pouch
44320	C	Colostomy
44322	C	Colostomy with biopsies
44345	C	Revision of colostomy
44346	C	Revision of colostomy
44602	C	Suture, small intestine
44603	C	Suture, small intestine
44604	C	Suture, large intestine
44605	C	Repair of bowel lesion
44615	C	Intestinal stricturoplasty
44620	C	Repair bowel opening
44625	C	Repair bowel opening
44626	C	Repair bowel opening
44640	C	Repair bowel-skin fistula
44650	C	Repair bowel fistula
44660	C	Repair bowel-bladder fistula
44661	C	Repair bowel-bladder fistula
44680	C	Surgical revision, intestine
44700	C	Suspend bowel w/prosthesis
44800	C	Excision of bowel pouch
44820	C	Excision of mesentery lesion
44850	C	Repair of mesentery
44899	C	Bowel surgery procedure
44900	C	Drain app abscess, open
44901	C	Drain app abscess, percut
44950	C	Appendectomy
44955	C	Appendectomy add-on
44960	C	Appendectomy
45110	C	Removal of rectum
45111	C	Partial removal of rectum
45112	C	Removal of rectum
45113	C	Partial proctectomy
45114	C	Partial removal of rectum
45116	C	Partial removal of rectum
45119	C	Remove rectum w/reservoir
45120	C	Removal of rectum
45121	C	Removal of rectum and colon
45123	C	Partial proctectomy
45126	C	Pelvic exenteration
45130	C	Excision of rectal prolapse
45135	C	Excision of rectal prolapse
45136	C	Excise ileoanal reservoir
45540	C	Correct rectal prolapse
45541	C	Correct rectal prolapse
45550	C	Repair rectum/remove sigmoid
45562	C	Exploration/repair of rectum
45563	C	Exploration/repair of rectum
45800	C	Repair rect/bladder fistula
45805	C	Repair fistula w/colostomy
45820	C	Repair rectourethral fistula
45825	C	Repair fistula w/colostomy
46705	C	Repair of anal stricture
46715	C	Repair of anovaginal fistula

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
46716	C	Repair of anovaginal fistula
46730	C	Construction of absent anus
46735	C	Construction of absent anus
46740	C	Construction of absent anus
46742	C	Repair of imperforated anus
46744	C	Repair of cloacal anomaly
46746	C	Repair of cloacal anomaly
46748	C	Repair of cloacal anomaly
46751	C	Repair of anal sphincter
47010	C	Open drainage, liver lesion
47015	C	Inject/aspirate liver cyst
47100	C	Wedge biopsy of liver
47120	C	Partial removal of liver
47122	C	Extensive removal of liver
47125	C	Partial removal of liver
47130	C	Partial removal of liver
47133	C	Removal of donor liver
47134	C	Partial removal, donor liver
47135	C	Transplantation of liver
47136	C	Transplantation of liver
47300	C	Surgery for liver lesion
47350	C	Repair liver wound
47360	C	Repair liver wound
47361	C	Repair liver wound
47362	C	Repair liver wound
47380	C	Open ablate liver tumor rf
47381	C	Open ablate liver tumor cryo
47400	C	Incision of liver duct
47420	C	Incision of bile duct
47425	C	Incision of bile duct
47460	C	Incise bile duct sphincter
47480	C	Incision of gallbladder
47550	C	Bile duct endoscopy add-on
47570	C	Laparo cholecystoenterostomy
47600	C	Removal of gallbladder
47605	C	Removal of gallbladder
47610	C	Removal of gallbladder
47612	C	Removal of gallbladder
47620	C	Removal of gallbladder
47700	C	Exploration of bile ducts
47701	C	Bile duct revision
47711	C	Excision of bile duct tumor
47712	C	Excision of bile duct tumor
47715	C	Excision of bile duct cyst
47716	C	Fusion of bile duct cyst
47720	C	Fuse gallbladder & bowel
47721	C	Fuse upper gi structures
47740	C	Fuse gallbladder & bowel
47741	C	Fuse gallbladder & bowel
47760	C	Fuse bile ducts and bowel
47765	C	Fuse liver ducts & bowel
47780	C	Fuse bile ducts and bowel
47785	C	Fuse bile ducts and bowel
47800	C	Reconstruction of bile ducts
47801	C	Placement, bile duct support
47802	C	Fuse liver duct & intestine
47900	C	Suture bile duct injury
48000	C	Drainage of abdomen
48001	C	Placement of drain, pancreas
48005	C	Resect/debride pancreas
48020	C	Removal of pancreatic stone
48100	C	Biopsy of pancreas, open
48120	C	Removal of pancreas lesion
48140	C	Partial removal of pancreas
48145	C	Partial removal of pancreas

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
48146	C	Pancreatectomy
48148	C	Removal of pancreatic duct
48150	C	Partial removal of pancreas
48152	C	Pancreatectomy
48153	C	Pancreatectomy
48154	C	Pancreatectomy
48155	C	Removal of pancreas
48180	C	Fuse pancreas and bowel
48400	C	Injection, intraop add-on
48500	C	Surgery of pancreatic cyst
48510	C	Drain pancreatic pseudocyst
48520	C	Fuse pancreas cyst and bowel
48540	C	Fuse pancreas cyst and bowel
48545	C	Pancreatorrhaphy
48547	C	Duodenal exclusion
48556	C	Removal, allograft pancreas
49000	C	Exploration of abdomen
49002	C	Reopening of abdomen
49010	C	Exploration behind abdomen
49020	C	Drain abdominal abscess
49021	C	Drain abdominal abscess
49040	C	Drain, open, abdom abscess
49041	C	Drain, percut, abdom abscess
49060	C	Drain, open, retrop abscess
49061	C	Drain, percut, retroper absc
49062	C	Drain to peritoneal cavity
49201	C	Removal of abdominal lesion
49215	C	Excise sacral spine tumor
49220	C	Multiple surgery, abdomen
49255	C	Removal of omentum
49425	C	Insert abdomen-venous drain
49428	C	Ligation of shunt
49605	C	Repair umbilical lesion
49606	C	Repair umbilical lesion
49610	C	Repair umbilical lesion
49611	C	Repair umbilical lesion
49900	C	Repair of abdominal wall
49904	C	Omental flap, extra-abdom
49905	C	Omental flap
49906	C	Free omental flap, microvasc
50010	C	Exploration of kidney
50020	C	Renal abscess, open drain
50040	C	Drainage of kidney
50045	C	Exploration of kidney
50060	C	Removal of kidney stone
50065	C	Incision of kidney
50070	C	Incision of kidney
50075	C	Removal of kidney stone
50100	C	Revise kidney blood vessels
50120	C	Exploration of kidney
50125	C	Explore and drain kidney
50130	C	Removal of kidney stone
50135	C	Exploration of kidney
50205	C	Biopsy of kidney
50220	C	Remove kidney, open
50225	C	Removal kidney open, complex
50230	C	Removal kidney open, radical
50234	C	Removal of kidney & ureter
50236	C	Removal of kidney & ureter
50240	C	Partial removal of kidney
50280	C	Removal of kidney lesion
50290	C	Removal of kidney lesion
50300	C	Removal of donor kidney
50320	C	Removal of donor kidney
50340	C	Removal of kidney

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

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CPT/HCPCS	Status indicator	Description
50360	C	Transplantation of kidney
50365	C	Transplantation of kidney
50370	C	Remove transplanted kidney
50380	C	Reimplantation of kidney
50400	C	Revision of kidney/ureter
50405	C	Revision of kidney/ureter
50500	C	Repair of kidney wound
50520	C	Close kidney-skin fistula
50525	C	Repair renal-abdomen fistula
50526	C	Repair renal-abdomen fistula
50540	C	Revision of horseshoe kidney
50545	C	Laparo radical nephrectomy
50546	C	Laparoscopic nephrectomy
50547	C	Laparo removal donor kidney
50548	C	Laparo remove k/ureter
50570	C	Kidney endoscopy
50572	C	Kidney endoscopy
50574	C	Kidney endoscopy & biopsy
50575	C	Kidney endoscopy
50576	C	Kidney endoscopy & treatment
50578	C	Renal endoscopy/radiotracer
50580	C	Kidney endoscopy & treatment
50600	C	Exploration of ureter
50605	C	Insert ureteral support
50610	C	Removal of ureter stone
50620	C	Removal of ureter stone
50630	C	Removal of ureter stone
50650	C	Removal of ureter
50660	C	Removal of ureter
50700	C	Revision of ureter
50715	C	Release of ureter
50722	C	Release of ureter
50725	C	Release/revise ureter
50727	C	Revise ureter
50728	C	Revise ureter
50740	C	Fusion of ureter & kidney
50750	C	Fusion of ureter & kidney
50760	C	Fusion of ureters
50770	C	Splicing of ureters
50780	C	Reimplant ureter in bladder
50782	C	Reimplant ureter in bladder
50783	C	Reimplant ureter in bladder
50785	C	Reimplant ureter in bladder
50800	C	Implant ureter in bowel
50810	C	Fusion of ureter & bowel
50815	C	Urine shunt to intestine
50820	C	Construct bowel bladder
50825	C	Construct bowel bladder
50830	C	Revise urine flow
50840	C	Replace ureter by bowel
50845	C	Appendico-vesicostomy
50860	C	Transplant ureter to skin
50900	C	Repair of ureter
50920	C	Closure ureter/skin fistula
50930	C	Closure ureter/bowel fistula
50940	C	Release of ureter
51060	C	Removal of ureter stone
51525	C	Removal of bladder lesion
51530	C	Removal of bladder lesion
51535	C	Repair of ureter lesion
51550	C	Partial removal of bladder
51555	C	Partial removal of bladder
51565	C	Revise bladder & ureter(s)
51570	C	Removal of bladder
51575	C	Removal of bladder & nodes

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
51580	C	Remove bladder/revise tract
51585	C	Removal of bladder & nodes
51590	C	Remove bladder/revise tract
51595	C	Remove bladder/revise tract
51596	C	Remove bladder/create pouch
51597	C	Removal of pelvic structures
51800	C	Revision of bladder/urethra
51820	C	Revision of urinary tract
51840	C	Attach bladder/urethra
51841	C	Attach bladder/urethra
51845	C	Repair bladder neck
51860	C	Repair of bladder wound
51865	C	Repair of bladder wound
51900	C	Repair bladder/vagina lesion
51920	C	Close bladder-uterus fistula
51925	C	Hysterectomy/bladder repair
51940	C	Correction of bladder defect
51960	C	Revision of bladder & bowel
51980	C	Construct bladder opening
53085	C	Drainage of urinary leakage
53415	C	Reconstruction of urethra
53448	C	Remov/replc ur sphinctr comp
54125	C	Removal of penis
54130	C	Remove penis & nodes
54135	C	Remove penis & nodes
54332	C	Revise penis/urethra
54336	C	Revise penis/urethra
54390	C	Repair penis and bladder
54411	C	Remv/replc penis pros, comp
54417	C	Remv/replc penis pros, compl
54430	C	Revision of penis
54535	C	Extensive testis surgery
54560	C	Exploration for testis
54650	C	Orchiopexy (Fowler-Stephens)
55600	C	Incise sperm duct pouch
55605	C	Incise sperm duct pouch
55650	C	Remove sperm duct pouch
55801	C	Removal of prostate
55810	C	Extensive prostate surgery
55812	C	Extensive prostate surgery
55815	C	Extensive prostate surgery
55821	C	Removal of prostate
55831	C	Removal of prostate
55840	C	Extensive prostate surgery
55842	C	Extensive prostate surgery
55845	C	Extensive prostate surgery
55862	C	Extensive prostate surgery
55865	C	Extensive prostate surgery
55866	C	Laparo radical prostatectomy
56630	C	Extensive vulva surgery
56631	C	Extensive vulva surgery
56632	C	Extensive vulva surgery
56633	C	Extensive vulva surgery
56634	C	Extensive vulva surgery
56637	C	Extensive vulva surgery
56640	C	Extensive vulva surgery
57110	C	Remove vagina wall, complete
57111	C	Remove vagina tissue, compl
57112	C	Vaginectomy w/nodes, compl
57270	C	Repair of bowel pouch
57280	C	Suspension of vagina
57282	C	Repair of vaginal prolapse
57292	C	Construct vagina with graft
57305	C	Repair rectum-vagina fistula
57307	C	Fistula repair & colostomy

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
57308	C	Fistula repair, transperine
57311	C	Repair urethrovaginal lesion
57335	C	Repair vagina
57531	C	Removal of cervix, radical
57540	C	Removal of residual cervix
57545	C	Remove cervix/repair pelvis
58140	C	Removal of uterus lesion
58146	C	Myomectomy abdom complex
58150	C	Total hysterectomy
58152	C	Total hysterectomy
58180	C	Partial hysterectomy
58200	C	Extensive hysterectomy
58210	C	Extensive hysterectomy
58240	C	Removal of pelvis contents
58260	C	Vaginal hysterectomy
58262	C	Vaginal hysterectomy
58263	C	Vaginal hysterectomy
58267	C	Hysterectomy & vagina repair
58270	C	Hysterectomy & vagina repair
58275	C	Hysterectomy/revise vagina
58280	C	Hysterectomy/revise vagina
58285	C	Extensive hysterectomy
58290	C	Vag hyst complex
58291	C	Vag hyst incl t/o, complex
58292	C	Vag hyst t/o & repair, compl
58293	C	Vag hyst w/uro repair, compl
58294	C	Vag hyst w/enterocele, compl
58400	C	Suspension of uterus
58410	C	Suspension of uterus
58520	C	Repair of ruptured uterus
58540	C	Revision of uterus
58605	C	Division of fallopian tube
58611	C	Ligate oviduct(s) add-on
58700	C	Removal of fallopian tube
58720	C	Removal of ovary/tube(s)
58740	C	Revise fallopian tube(s)
58750	C	Repair oviduct
58752	C	Revise ovarian tube(s)
58760	C	Remove tubal obstruction
58770	C	Create new tubal opening
58805	C	Drainage of ovarian cyst(s)
58822	C	Drain ovary abscess, percut
58825	C	Transposition, ovary(s)
58940	C	Removal of ovary(s)
58943	C	Removal of ovary(s)
58950	C	Resect ovarian malignancy
58951	C	Resect ovarian malignancy
58952	C	Resect ovarian malignancy
58953	C	Tah, rad dissect for debulk
58954	C	Tah rad debulk/lymph remove
58960	C	Exploration of abdomen
59100	C	Remove uterus lesion
59120	C	Treat ectopic pregnancy
59121	C	Treat ectopic pregnancy
59130	C	Treat ectopic pregnancy
59135	C	Treat ectopic pregnancy
59136	C	Treat ectopic pregnancy
59140	C	Treat ectopic pregnancy
59325	C	Revision of cervix
59350	C	Repair of uterus
59514	C	Cesarean delivery only
59525	C	Remove uterus after cesarean
59620	C	Attempted vbac delivery only
59830	C	Treat uterus infection
59850	C	Abortion

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
59851	C	Abortion
59852	C	Abortion
59855	C	Abortion
59856	C	Abortion
59857	C	Abortion
60254	C	Extensive thyroid surgery
60270	C	Removal of thyroid
60271	C	Removal of thyroid
60502	C	Re-explore parathyroids
60505	C	Explore parathyroid glands
60520	C	Removal of thymus gland
60521	C	Removal of thymus gland
60522	C	Removal of thymus gland
60540	C	Explore adrenal gland
60545	C	Explore adrenal gland
60600	C	Remove carotid body lesion
60605	C	Remove carotid body lesion
60650	C	Laparoscopy adrenalectomy
61105	C	Twist drill hole
61107	C	Drill skull for implantation
61108	C	Drill skull for drainage
61120	C	Burr hole for puncture
61140	C	Pierce skull for biopsy
61150	C	Pierce skull for drainage
61151	C	Pierce skull for drainage
61154	C	Pierce skull & remove clot
61156	C	Pierce skull for drainage
61210	C	Pierce skull, implant device
61250	C	Pierce skull & explore
61253	C	Pierce skull & explore
61304	C	Open skull for exploration
61305	C	Open skull for exploration
61312	C	Open skull for drainage
61313	C	Open skull for drainage
61314	C	Open skull for drainage
61315	C	Open skull for drainage
61320	C	Open skull for drainage
61321	C	Open skull for drainage
61322	C	Decompressive craniotomy
61323	C	Decompressive lobectomy
61332	C	Explore/biopsy eye socket
61333	C	Explore orbit/remove lesion
61334	C	Explore orbit/remove object
61340	C	Relieve cranial pressure
61343	C	Incise skull (press relief)
61345	C	Relieve cranial pressure
61440	C	Incise skull for surgery
61450	C	Incise skull for surgery
61458	C	Incise skull for brain wound
61460	C	Incise skull for surgery
61470	C	Incise skull for surgery
61480	C	Incise skull for surgery
61490	C	Incise skull for surgery
61500	C	Removal of skull lesion
61501	C	Remove infected skull bone
61510	C	Removal of brain lesion
61512	C	Remove brain lining lesion
61514	C	Removal of brain abscess
61516	C	Removal of brain lesion
61518	C	Removal of brain lesion
61519	C	Remove brain lining lesion
61520	C	Removal of brain lesion
61521	C	Removal of brain lesion
61522	C	Removal of brain abscess
61524	C	Removal of brain lesion

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
61526	C	Removal of brain lesion
61530	C	Removal of brain lesion
61531	C	Implant brain electrodes
61533	C	Implant brain electrodes
61534	C	Removal of brain lesion
61535	C	Remove brain electrodes
61536	C	Removal of brain lesion
61538	C	Removal of brain tissue
61539	C	Removal of brain tissue
61541	C	Incision of brain tissue
61542	C	Removal of brain tissue
61543	C	Removal of brain tissue
61544	C	Remove & treat brain lesion
61545	C	Excision of brain tumor
61546	C	Removal of pituitary gland
61548	C	Removal of pituitary gland
61550	C	Release of skull seams
61552	C	Release of skull seams
61556	C	Incise skull/sutures
61557	C	Incise skull/sutures
61558	C	Excision of skull/sutures
61559	C	Excision of skull/sutures
61563	C	Excision of skull tumor
61564	C	Excision of skull tumor
61570	C	Remove foreign body, brain
61571	C	Incise skull for brain wound
61575	C	Skull base/brainstem surgery
61576	C	Skull base/brainstem surgery
61580	C	Craniofacial approach, skull
61581	C	Craniofacial approach, skull
61582	C	Craniofacial approach, skull
61583	C	Craniofacial approach, skull
61584	C	Orbitocranial approach/skull
61585	C	Orbitocranial approach/skull
61586	C	Resect nasopharynx, skull
61590	C	Infratemporal approach/skull
61591	C	Infratemporal approach/skull
61592	C	Orbitocranial approach/skull
61595	C	Transtemporal approach/skull
61596	C	Transcochlear approach/skull
61597	C	Transcondylar approach/skull
61598	C	Transpetrosal approach/skull
61600	C	Resect/excise cranial lesion
61601	C	Resect/excise cranial lesion
61605	C	Resect/excise cranial lesion
61606	C	Resect/excise cranial lesion
61607	C	Resect/excise cranial lesion
61608	C	Resect/excise cranial lesion
61609	C	Transect artery, sinus
61610	C	Transect artery, sinus
61611	C	Transect artery, sinus
61612	C	Transect artery, sinus
61613	C	Remove aneurysm, sinus
61615	C	Resect/excise lesion, skull
61616	C	Resect/excise lesion, skull
61618	C	Repair dura
61619	C	Repair dura
61624	C	Occlusion/embolization cath
61680	C	Intracranial vessel surgery
61682	C	Intracranial vessel surgery
61684	C	Intracranial vessel surgery
61686	C	Intracranial vessel surgery
61690	C	Intracranial vessel surgery
61692	C	Intracranial vessel surgery
61697	C	Brain aneurysm repr, complx

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
61698	C	Brain aneurysm repr, complx
61700	C	Brain aneurysm repr , simple
61702	C	Inner skull vessel surgery
61703	C	Clamp neck artery
61705	C	Revise circulation to head
61708	C	Revise circulation to head
61710	C	Revise circulation to head
61711	C	Fusion of skull arteries
61720	C	Incise skull/brain surgery
61735	C	Incise skull/brain surgery
61750	C	Incise skull/brain biopsy
61751	C	Brain biopsy w/ ct/mr guide
61760	C	Implant brain electrodes
61770	C	Incise skull for treatment
61850	C	Implant neuroelectrodes
61860	C	Implant neuroelectrodes
61862	C	Implant neurostimul, subcort
61870	C	Implant neuroelectrodes
61875	C	Implant neuroelectrodes
62000	C	Treat skull fracture
62005	C	Treat skull fracture
62010	C	Treatment of head injury
62100	C	Repair brain fluid leakage
62115	C	Reduction of skull defect
62116	C	Reduction of skull defect
62117	C	Reduction of skull defect
62120	C	Repair skull cavity lesion
62121	C	Incise skull repair
62140	C	Repair of skull defect
62141	C	Repair of skull defect
62142	C	Remove skull plate/flap
62143	C	Replace skull plate/flap
62145	C	Repair of skull & brain
62146	C	Repair of skull with graft
62147	C	Repair of skull with graft
62161	C	Dissect brain w/scope
62162	C	Remove colloid cyst w/scope
62163	C	Neuroendoscopy w/fb removal
62164	C	Remove brain tumor w/scope
62165	C	Remove pituit tumor w/scope
62180	C	Establish brain cavity shunt
62190	C	Establish brain cavity shunt
62192	C	Establish brain cavity shunt
62200	C	Establish brain cavity shunt
62201	C	Establish brain cavity shunt
62220	C	Establish brain cavity shunt
62223	C	Establish brain cavity shunt
62256	C	Remove brain cavity shunt
62258	C	Replace brain cavity shunt
63043	C	Laminotomy, addl cervical
63044	C	Laminotomy, addl lumbar
63075	C	Neck spine disk surgery
63076	C	Neck spine disk surgery
63077	C	Spine disk surgery, thorax
63078	C	Spine disk surgery, thorax
63081	C	Removal of vertebral body
63082	C	Remove vertebral body add-on
63085	C	Removal of vertebral body
63086	C	Remove vertebral body add-on
63087	C	Removal of vertebral body
63088	C	Remove vertebral body add-on
63090	C	Removal of vertebral body
63091	C	Remove vertebral body add-on
63170	C	Incise spinal cord tract(s)
63172	C	Drainage of spinal cyst

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
63173	C	Drainage of spinal cyst
63180	C	Revise spinal cord ligaments
63182	C	Revise spinal cord ligaments
63185	C	Incise spinal column/nerves
63190	C	Incise spinal column/nerves
63191	C	Incise spinal column/nerves
63194	C	Incise spinal column & cord
63195	C	Incise spinal column & cord
63196	C	Incise spinal column & cord
63197	C	Incise spinal column & cord
63198	C	Incise spinal column & cord
63199	C	Incise spinal column & cord
63200	C	Release of spinal cord
63250	C	Revise spinal cord vessels
63251	C	Revise spinal cord vessels
63252	C	Revise spinal cord vessels
63265	C	Excise intraspinal lesion
63266	C	Excise intraspinal lesion
63267	C	Excise intraspinal lesion
63268	C	Excise intraspinal lesion
63270	C	Excise intraspinal lesion
63271	C	Excise intraspinal lesion
63272	C	Excise intraspinal lesion
63273	C	Excise intraspinal lesion
63275	C	Biopsy/excise spinal tumor
63276	C	Biopsy/excise spinal tumor
63277	C	Biopsy/excise spinal tumor
63278	C	Biopsy/excise spinal tumor
63280	C	Biopsy/excise spinal tumor
63281	C	Biopsy/excise spinal tumor
63282	C	Biopsy/excise spinal tumor
63283	C	Biopsy/excise spinal tumor
63285	C	Biopsy/excise spinal tumor
63286	C	Biopsy/excise spinal tumor
63287	C	Biopsy/excise spinal tumor
63290	C	Biopsy/excise spinal tumor
63300	C	Removal of vertebral body
63301	C	Removal of vertebral body
63302	C	Removal of vertebral body
63303	C	Removal of vertebral body
63304	C	Removal of vertebral body
63305	C	Removal of vertebral body
63306	C	Removal of vertebral body
63307	C	Removal of vertebral body
63308	C	Remove vertebral body add-on
63700	C	Repair of spinal herniation
63702	C	Repair of spinal herniation
63704	C	Repair of spinal herniation
63706	C	Repair of spinal herniation
63707	C	Repair spinal fluid leakage
63709	C	Repair spinal fluid leakage
63710	C	Graft repair of spine defect
63740	C	Install spinal shunt
64752	C	Incision of vagus nerve
64755	C	Incision of stomach nerves
64760	C	Incision of vagus nerve
64763	C	Incise hip/thigh nerve
64766	C	Incise hip/thigh nerve
64804	C	Remove sympathetic nerves
64809	C	Remove sympathetic nerves
64818	C	Remove sympathetic nerves
64866	C	Fusion of facial/other nerve
64868	C	Fusion of facial/other nerve
65273	C	Repair of eye wound
69155	C	Extensive ear/neck surgery

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
69535	C	Remove part of temporal bone
69554	C	Remove ear lesion
69950	C	Incise inner ear nerve
69970	C	Remove inner ear lesion
75900	C	Arterial catheter exchange
75952	C	Endovasc repair abdom aorta
75953	C	Abdom aneurysm endovas rpr
75954	C	Iliac aneurysm endovas rpr
92970	C	Cardioassist, internal
92971	C	Cardioassist, external
92975	C	Dissolve clot, heart vessel
92992	C	Revision of heart chamber
92993	C	Revision of heart chamber
94652	C	Pressure breathing (IPPB)
99190	C	Special pump services
99191	C	Special pump services
99192	C	Special pump services
99251	C	Initial inpatient consult
99252	C	Initial inpatient consult
99253	C	Initial inpatient consult
99254	C	Initial inpatient consult
99255	C	Initial inpatient consult
99261	C	Follow-up inpatient consult
99262	C	Follow-up inpatient consult
99263	C	Follow-up inpatient consult
99293	C	Ped critical care, initial
99294	C	Ped critical care, subseq
99295	C	Neonatal critical care
99296	C	Neonatal critical care
99297	C	Neonatal critical care
99298	C	Neonatal critical care
99299	C	Ic, lbw infant 1500-2500 gm
99356	C	Prolonged service, inpatient
99357	C	Prolonged service, inpatient
99433	C	Normal newborn care/hospital
0001T	C	Endovas repr abdo ao aneurys
0002T	C	Endovas repr abdo ao aneurys
0005T	C	Perc cath stent/brain cv art
0006T	C	Perc cath stent/brain cv art
0007T	C	Perc cath stent/brain cv art
00174	C	Anesth, pharyngeal surgery
00176	C	Anesth, pharyngeal surgery
00192	C	Anesth, facial bone surgery
00214	C	Anesth, skull drainage
00215	C	Anesth, skull repair/fract
0021T	C	Fetal oximetry, trnsvag/cerv
0024T	C	Transcath cardiac reduction
0033T	C	Endovasc taa repr incl subcl
0034T	C	Endovasc taa repr w/o subcl
0035T	C	Insert endovasc prosth, taa
0036T	C	Endovasc prosth, taa, add-on
0037T	C	Artery transpose/endovas taa
0038T	C	Rad endovasc taa rpr w/cover
0039T	C	Rad s/i, endovasc taa repair
00404	C	Anesth, surgery of breast
00406	C	Anesth, surgery of breast
0040T	C	Rad s/i, endovasc taa prosth
00452	C	Anesth, surgery of shoulder
00474	C	Anesth, surgery of rib(s)
00524	C	Anesth, chest drainage
00540	C	Anesth, chest surgery
00542	C	Anesth, release of lung
00544	C	Anesth, chest lining removal
00546	C	Anesth, lung,chest wall surg
00560	C	Anesth, open heart surgery

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

[Calendar Year 2003]

CPT/HCPCS	Status indicator	Description
00562	C	Anesth, open heart surgery
00580	C	Anesth heart/lung transplant
00604	C	Anesth, sitting procedure
00622	C	Anesth, removal of nerves
00632	C	Anesth, removal of nerves
00634	C	Anesth for chemonucleolysis
00670	C	Anesth, spine, cord surgery
00792	C	Anesth, hemorr/excise liver
00794	C	Anesth, pancreas removal
00796	C	Anesth, for liver transplant
00802	C	Anesth, fat layer removal
00844	C	Anesth, pelvis surgery

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties)	Wage index
0040 Abilene, TX [2]	0.7827
Taylor, TX	
0060 Aguadilla, PR	0.4587
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9600
Portage, OH	
Summit, OH	
0120 Albany, GA	1.0594
Dougherty, GA	
Lee, GA	
0160 Albany-Schenectady-Troy, NY [2]	0.8542
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9390
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.7883
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	0.9735
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.9225
Blair, PA	
0320 Amarillo, TX	0.9034
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.2490
Anchorage, AK	
0440 Ann Arbor, MI	1.1103
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8044
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI [2]	0.9162
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR [2]	0.4356
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9876
Buncombe, NC	
Madison, NC	
0500 Athens, GA	1.0211
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 Atlanta, GA [1]	0.9991
Barrow, GA	
Bartow, GA	
Carroll, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
DeKalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Pickens, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
0560 Atlantic-Cape May, NJ	1.1017
Atlantic, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.8325
Lee, AL	
0600 Augusta-Aiken, GA-SC	1.0264
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 Austin-San Marcos, TX [1]	0.9637
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 Bakersfield, CA	0.9899
Kern, CA	
0720 Baltimore, MD [1]	0.9929
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne's, MD	
0733 Bangor, ME	0.9664
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	1.3202
Barnstable, MA	
0760 Baton Rouge, LA	0.8294
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8324
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.2282
Whatcom, WA	
0870 Benton Harbor, MI	0.9106
Berrien, MI	
0875 Bergen-Passaic, NJ [1]	1.2207
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.9022
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.8757
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 Binghamton, NY [2]	0.8542
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.9222
Blount, AL	
Jefferson, AL	
St. Clair, AL	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Shelby, AL	
1010 Bismarck, ND	0.7972
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.8907
Monroe, IN	
1040 Bloomington-Normal, IL	0.9109
McLean, IL	
1080 Boise City, ID	0.9310
Ada, ID	
Canyon, ID	
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (MA Hospitals) [1 2]	1.1288
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (NH Hospitals) [1]	1.1235
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1125 Boulder-Longmont, CO	0.9689
Boulder, CO	
1145 Brazoria, TX	0.8535
Brazoria, TX	
1150 Bremerton, WA	1.0944
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	0.8880
Cameron, TX	
1260 Bryan-College Station, TX	0.8821
Brazos, TX	
1280 Buffalo-Niagara Falls, NY [1]	0.9365
Erie, NY	
Niagara, NY	
1303 Burlington, VT	1.0052
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4408
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.8932
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9690
Natrona, WY	
1360 Cedar Rapids, IA	0.9056
Linn, IA	
1400 Champaign-Urbana, IL	1.0635
Champaign, IL	
1440 Charleston-North Charleston, SC	0.9235
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.8898
Kanawha, WV	
Putnam, WV	
1520 Charlotte-Gastonia-Rock Hill, NC-SC [1]	0.9850
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	1.0438
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN-GA	0.8976
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 Cheyenne, WY [2]	0.9007
Laramie, WY	
1600 Chicago, IL [1]	1.1044
Cook, IL	
DeKalb, IL	
DuPage, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA [2]	0.9840
Butte, CA	
1640 Cincinnati, OH-KY-IN [1]	0.9389
Dearborn, IN	
Ohio, IN	
Boone, KY	
Campbell, KY	
Gallatin, KY	
Grant, KY	
Kenton, KY	
Pendleton, KY	
Brown, OH	
Clermont, OH	
Hamilton, OH	
Warren, OH	
1660 Clarksville-Hopkinsville, TN-KY	0.8419
Christian, KY	
Montgomery, TN	
1680 Cleveland-Lorain-Elyria, OH [1]	0.9670
Ashtabula, OH	
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9916
El Paso, CO	
1740 Columbia, MO	0.8515
Boone, MO	
1760 Columbia, SC	0.9307
Lexington, SC	
Richland, SC	
1800 Columbus, GA-AL	0.8374
Russell, AL	
Chattahoochee, GA	
Harris, GA	
Muscogee, GA	
1840 Columbus, OH [1]	0.9751
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8729
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1453
Benton, OR	
1900 Cumberland, MD-WV (MD Hospitals) [2]	0.8946
Allegany, MD	
Mineral, WV	
1900 Cumberland, MD-WV (WV Hospitals) [2]	0.7975
Allegany, MD	
Mineral, WV	
1920 Dallas, TX [1]	0.9998
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.8859
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA-IL	0.8835
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9282
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.9062
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8973
Lawrence, AL	
Morgan, AL	
2040 Decatur, IL [2]	0.8204
Macon, IL	
2080 Denver, CO [1]	1.0601
Adams, CO	
Arapahoe, CO	
Broomfield, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.8827

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Dallas, IA	
Polk, IA	
Warren, IA	
2160 Detroit, MI [1]	1.0448
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.8158
Dale, AL	
Houston, AL	
2190 Dover, DE	0.9356
Kent, DE	
2200 Dubuque, IA	0.8795
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0368
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0684
Dutchess, NY	
2290 Eau Claire, WI [2]	0.9162
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.9265
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9722
Elkhart, IN	
2335 Elmira, NY [2]	0.8542
Chemung, NY	
2340 Enid, OK	0.8376
Garfield, OK	
2360 Erie, PA	0.8925
Erie, PA	
2400 Eugene-Springfield, OR	1.0944
Lane, OR	
2440 Evansville-Henderson, IN-KY (IN Hospitals) [2]	0.8755
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2440 Evansville-Henderson, IN-KY (KY Hospitals)	0.8177
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND-MN	0.9684
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8992
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8100
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	1.0682
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.1135
Genesee, MI	
2650 Florence, AL	0.7819
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8780
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0066
Larimer, CO	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
2680 Ft. Lauderdale, FL [1]	1.0704
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9680
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	0.9931
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.7895
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.9693
Okaloosa, FL	
2760 Fort Wayne, IN	0.9457
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 Forth Worth-Arlington, TX [1]	0.9446
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0216
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8599
Etowah, AL	
2900 Gainesville, FL	0.9871
Alachua, FL	
2920 Galveston-Texas City, TX	0.9465
Galveston, TX	
2960 Gary, IN	0.9584
Lake, IN	
Porter, IN	
2975 Glens Falls, NY [2]	0.8542
Warren, NY	
Washington, NY	
2980 Goldsboro, NC Wayne, NC	0.8892
2985 Grand Forks, ND-MN	0.9243
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9679
Mesa, CO	
3000 Grand Rapids-Muskegon-Holland, MI [1]	0.9548
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.8966
Cascade, MT	
3060 Greeley, CO	0.9336
Weld, CO	
3080 Green Bay, WI	0.9668
Brown, WI	
3120 Greensboro-Winston-Salem-High Point, NC [1]	0.9282
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9174

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9122
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.9268
Washington, MD	
3200 Hamilton-Middletown, OH	0.9418
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9223
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 Hartford, CT [1 2]	1.2394
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 Hattiesburg, MS [2]	0.7680
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.9028
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1457
Honolulu, HI	
3350 Houma, LA	0.8385
Lafourche, LA	
Terrebonne, LA	
3360 Houston, TX [1]	0.9892
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV-KY-OH	0.9636
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.8903
Limestone, AL	
Madison, AL	
3480 Indianapolis, IN [1]	0.9717
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9587
Johnson, IA	
3520 Jackson, MI	0.9532
Jackson, MI	
3560 Jackson, MS	0.8607

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.9275
Madison, TN	
Chester, TN	
3600 Jacksonville, FL [1]	0.9381
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 Jacksonville, NC [2]	0.8666
Onslow, NC	
3610 Jamestown, NY [2]	0.8542
Chautauqua, NY	
3620 Janesville-Beloit, WI	0.9849
Rock, WI	
3640 Jersey City, NJ	1.1190
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA (TN Hospitals)	0.8337
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3660 Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals) [2]	0.8504
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA [2]	0.8462
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.7843
Craighead, AR	
3710 Joplin, MO	0.8613
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.0595
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL [2]	0.8204
Kankakee, IL	
3760 Kansas City, KS-MO [1]	0.9736
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Clinton, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
3800 Kenosha, WI	0.9686
Kenosha, WI	
3810 Killeen-Temple, TX	0.9570
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.8970
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.9038
Howard, IN	
Tipton, IN	
3870 La Crosse, WI-MN	0.9400
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8475
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.9278
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7965
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.9357
Polk, FL	
4000 Lancaster, PA	0.9078
Lancaster, PA	
4040 Lansing-East Lansing, MI	0.9726
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.8472
Webb, TX	
4100 Las Cruces, NM [2]	0.8872
Dona Ana, NM	
4120 Las Vegas, NV-AZ [1]	1.1521
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.7923
Douglas, KS	
4200 Lawton, OK	0.8315
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9179
Androscoggin, ME	
4280 Lexington, KY	0.8581
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.9483
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	0.9892
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.9097
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.8629
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 Los Angeles-Long Beach, CA [1]	1.2011
Los Angeles, CA	
4520 Louisville, KY-IN [1]	0.9276
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.9646
Lubbock, TX	
4640 Lynchburg, VA	0.9219
Amherst, VA	
Bedford, VA	
Bedford City, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.9250
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0467
Dane, WI	
4800 Mansfield, OH	0.8900
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4914
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8428
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0498
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	1.0253
Brevard, Fl	
4920 Memphis, TN-AR-MS [1]	0.8920
Crittenden, AR	
DeSoto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA [2]	0.9840
Merced, CA	
5000 Miami, FL [1]	0.9815
Dade, FL	
5015 Middlesex-Somerset-Hunterdon, NJ [1]	1.1213
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 Milwaukee-Waukesha, WI [1]	0.9893
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 Minneapolis-St. Paul, MN-WI [1]	1.0903
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Isanti, MN	
Ramsey, MN	
Scott, MN	
Sherburne, MN	
Washington, MN	
Wright, MN	
Pierce, WI	
St. Croix, WI	
5140 Missoula, MT	0.9157
Missoula, MT	
5160 Mobile, AL	0.8110
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.0498
Stanislaus, CA	
5190 Monmouth-Ocean, NJ [1]	1.0814
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.8137
Ouachita, LA	
5240 Montgomery, AL	0.7734
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	0.9284
Delaware, IN	
5330 Myrtle Beach, SC	0.8976
Horry, SC	
5345 Naples, FL	0.9754
Collier, FL	
5360 Nashville, TN [1]	0.9578
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 Nassau-Suffolk, NY [1]	1.3357
Nassau, NY	
Suffolk, NY	
5483 New Haven-Bridgeport-Stamford-Waterbury- Danbury, CT [1]	1.2459
Fairfield, CT	
New Haven, CT	
5523 New London-Norwich, CT [2]	1.2394
New London, CT	
5560 New Orleans, LA [1]	0.9046
Jefferson, LA	
Orleans, LA	
Plaquemines, LA	
St. Bernard, LA	
St. Charles, LA	
St. James, LA	
St. John The Baptist, LA	
St. Tammany, LA	
5600 New York, NY [1]	1.4414
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 Newark, NJ [1]	1.1406
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY-PA	1.1387
Orange, NY	
Pike, PA	
5720 Norfolk-Virginia Beach-Newport News, VA-NC [1]	0.8574
Currituck, NC	
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
Isle of Wight, VA	
James City, VA	
Mathews, VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson City, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City VA	
Williamsburg City, VA	
York, VA	
5775 Oakland, CA [1]	1.5185
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9402
Marion, FL	
5800 Odessa-Midland, TX	0.9397
Ector, TX	
Midland, TX	
5880 Oklahoma City, OK [1]	0.8900
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.0960
Thurston, WA	
5920 Omaha, NE-IA	0.9978
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 Orange County, CA [1]	1.1594
Orange, CA	
5960 Orlando, FL [1]	0.9640
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.8344
Daviess, KY	
6015 Panama City, FL	0.8865
Bay, FL	
6020 Parkersburg-Marietta, WV-OH (WV Hospitals)	0.8127
Washington, OH	
Wood, WV	
6020 Parkersburg-Marietta, WV-OH (OH Hospitals) [2]	0.8613
Washington, OH	
Wood, WV	
6080 Pensacola, FL [2]	0.8814
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8739
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 Philadelphia, PA-NJ [1]	1.0713
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 Phoenix-Mesa, AZ [1]	0.9820
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7962
Jefferson, AR	
6280 Pittsburgh, PA [1]	0.9365
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 Pittsfield, MA [2]	1.1288
Berkshire, MA	
6340 Pocatello, ID	0.9674
Bannock, ID	
6360 Ponce, PR	0.5169
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9794
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 Portland-Vancouver, OR-WA [1]	1.0684
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 Providence-Warwick-Pawtucket, RI [1]	1.0854
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	0.9984
Utah, UT	
6560 Pueblo, CO [2]	0.9015
Pueblo, CO	
6580 Punta Gorda, FL	0.9218
Charlotte, FL	
6600 Racine, WI	0.9334
Racine, WI	
6640 Raleigh-Durham-Chapel Hill, NC [1]	0.9990
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
6660 Rapid City, SD	0.8846
Pennington, SD	
6680 Reading, PA	0.9295
Berks, PA	
6690 Redding, CA	1.1135
Shasta, CA	
6720 Reno, NV	1.0648
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.1491
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9477
Charles City County, VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
6780 Riverside-San Bernardino, CA [1]	1.1365
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8614
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.2139
Olmsted, MN	
6840 Rochester, NY [1]	0.9194
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9625
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9228
Edgecombe, NC	
Nash, NC	
6920 Sacramento, CA [1]	1.1513
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9650
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St. Cloud, MN	0.9785
Benton, MN	
Stearns, MN	
7000 St. Joseph, MO [2]	0.8026
Andrew, MO	
Buchanan, MO	
7040 St. Louis, MO-IL [1]	0.8855
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
Lincoln, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Warren, MO	
7080 Salem, OR	1.0367
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4623
Monterey, CA	
7160 Salt Lake City-Ogden, UT [1]	0.9945
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.8374
Tom Green, TX	
7240 San Antonio, TX [1]	0.8753
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 San Diego, CA [1]	1.1135
San Diego, CA	
7360 San Francisco, CA [1]	1.4142
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 San Jose, CA [1]	1.4145
Santa Clara, CA	
7440 San Juan-Bayamon, PR [1]	0.4741
Aguas Buenas, PR	
Barceloneta, PR	
Bayamon, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Ceiba, PR	
Comerio, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Morovis, PR	
Naguabo, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trujillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Yabucoa, PR	
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.1271
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0481
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.3646
Santa Cruz, CA	
7490 Santa Fe, NM	1.0712
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.3046
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9449
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9376
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton--Wilkes-Barre--Hazleton, PA	0.8599
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 Seattle-Bellevue-Everett, WA [1]	1.1474
Island, WA	
King, WA	
Snohomish, WA	
7610 Sharon, PA [2]	0.8462
Mercer, PA	
7620 Sheboygan, WI [2]	0.9162
Sheboygan, WI	
7640 Sherman-Denison, TX	0.9255
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.8987
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.9046
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.9257
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9802
St. Joseph, IN	
7840 Spokane, WA	1.0852
Spokane, WA	
7880 Springfield, IL	0.8659
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8424
Christian, MO	
Greene, MO	
Webster, MO	
8003 Springfield, MA [2]	1.1288
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.8941
Centre, PA	
8080 Steubenville-Weirton, OH-WV	0.8804
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.0650
San Joaquin, CA	
8140 Sumter, SC [2]	0.8607
Sumter, SC	
8160 Syracuse, NY	0.9714
Cayuga, NY	
Madison, NY	
Onondaga, NY	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Oswego, NY	
8200 Tacoma, WA	1.0940
Pierce, WA	
8240 Tallahassee, FL [2]	0.8814
Gadsden, FL	
Leon, FL	
8280 Tampa-St. Petersburg-Clearwater, FL [1]	0.9171
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 Terre Haute, IN [2]	0.8755
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana,AR-Texarkana, TX	0.8126
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9810
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.9199
Shawnee, KS	
8480 Trenton, NJ	1.0432
Mercer, NJ	
8520 Tucson, AZ	0.8911
Pima, AZ	
8560 Tulsa, OK	0.8332
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8203
Tuscaloosa, AL	
8640 Tyler, TX	0.9521
Smith, TX	
8680 Utica-Rome, NY [2]	0.8542
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3421
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.1096
Ventura, CA	
8750 Victoria, TX	0.8756
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0031
Cumberland, NJ	
8780 Visalia-Tulare-Porterville, CA [2]	0.9840
Tulare, CA	
8800 Waco, TX	0.8088
McLennan, TX	
8840 Washington, DC-MD-VA-WV [1]	1.0851
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Clarke, VA	
Culpeper, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Fauquier, VA	
Fredericksburg City, VA	
King George, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Spotsylvania, VA	
Stafford, VA	
Warren, VA	
Berkeley, WV	
Jefferson, WV	
8920 Waterloo-Cedar Falls, IA	0.8902
Black Hawk, IA	
8940 Wausau, WI	0.9782
Marathon, WI	
8960 West Palm Beach-Boca Raton, FL [1]	0.9939
Palm Beach, FL	
9000 Wheeling, WV-OH (WV Hospitals) [2]	0.7975
Belmont, OH	
Marshall, WV	
Ohio, WV	
9000 Wheeling, WV-OH (OH Hospitals) [2]	0.8613
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9520
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.8498
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8544
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	1.1173
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9640
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	1.0569
Yakima, WA	
9270 Yolo, CA [2]	0.9840
Yolo, CA	
9280 York, PA	0.9026
York, PA	
9320 Youngstown-Warren, OH	0.9358
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0276
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	0.8589
Yuma, AZ	

[1] Large Urban Area.

[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2003.

ADDENDUM I.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.7727
Alaska	1.2293
Arizona	0.8493
Arkansas	0.7666
California	0.9840
Colorado	0.9015
Connecticut	1.2394
Delaware	0.9128
Florida	0.8814
Georgia	0.8230
Hawaii	1.0255
Idaho	0.8747
Illinois	0.8204
Indiana	0.8755
Iowa	0.8315
Kansas	0.7923
Kentucky	0.8079
Louisiana	0.7647
Maine	0.8874
Maryland	0.8946
Massachusetts	1.1288
Michigan	0.9013
Minnesota	0.9151
Mississippi	0.7680
Missouri	0.8026
Montana	0.8481
Nebraska	0.8204
Nevada	0.9577
New Hampshire	0.9796
New Jersey [1]	.....
New Mexico	0.8872
New York	0.8542
North Carolina	0.8666
North Dakota	0.7788
Ohio	0.8613
Oklahoma	0.7590
Oregon	1.0303
Pennsylvania	0.8462
Puerto Rico	0.4356
Rhode Island [1]	.....
South Carolina	0.8607
South Dakota	0.7815
Tennessee	0.7877
Texas	0.7827
Utah	0.9312
Vermont	0.9345
Virginia	0.8504
Washington	1.0179
West Virginia	0.7975
Wisconsin	0.9162
Wyoming	0.9007

[1] All counties within the State are classified as urban.

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED

Area	Wage index
Abilene, TX	0.7827
Akron, OH	0.9600
Albany, GA	1.0427
Albuquerque, NM	0.9390
Alexandria, LA	0.7883
Allentown-Bethlehem-Easton, PA	0.9735
Altoona, PA	0.9225
Amarillo, TX	0.8884
Anchorage, AK	1.2490
Ann Arbor, MI	1.1103
Anniston, AL	0.7910
Asheville, NC	0.9575
Athens, GA	1.0066
Atlanta, GA	0.9889
Augusta-Aiken, GA-SC	0.9887
Austin-San Marcos, TX	0.9637
Barnstable-Yarmouth, MA	1.2943
Baton Rouge, LA	0.8190
Bellingham, WA	1.1642
Benton Harbor, MI	0.9106
Bergen-Passaic, NJ	1.2207
Billings, MT	0.9022
Biloxi-Gulfport-Pascagoula, MS	0.8368
Binghamton, NY	0.8462
Birmingham, AL	0.9222
Bismarck, ND	0.7972
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1235
Burlington, VT	0.9572
Caguas, PR	0.4408
Casper, WY	0.9586
Champaign-Urbana, IL	0.9772
Charleston-North Charleston, SC	0.9235
Charleston, WV	0.8649
Charlotte-Gastonia-Rock Hill, NC-SC	0.9743
Charlottesville, VA	1.0120
Chattanooga, TN-GA	0.8843
Chicago, IL	1.0905
Cincinnati, OH-KY-IN	0.9389
Clarksville-Hopkinsville, TN-KY	0.8419
Cleveland-Lorain-Elyria, OH	0.9670
Columbia, MO	0.8515
Columbia, SC	0.9194
Columbus, GA-AL (GA Hospitals)	0.8230
Columbus, GA-AL (AL Hospitals)	0.7985
Columbus, OH	0.9549
Corpus Christi, TX	0.8729
Dallas, TX	0.9998
Davenport-Moline-Rock Island, IA-IL	0.8835
Dayton-Springfield, OH	0.9282
Denver, CO	1.0484
Des Moines, IA	0.8827
Detroit, MI	1.0448
Dothan, AL	0.8158
Dover, DE	0.9254
Duluth-Superior, MN-WI	1.0368
Eau Claire, WI	0.9162
Elkhart-Goshen, IN	0.9516
Erie, PA	0.8761
Eugene-Springfield, OR	1.0944
Fargo-Moorhead, ND-MN	0.9468
Fayetteville, NC	0.8992
Flagstaff, AZ-UT	1.0131
Flint, MI	1.0963
Florence, AL	0.7819
Florence, SC	0.8780
Fort Collins-Loveland, CO	1.0066
Ft. Lauderdale, FL	1.0704

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Fort Pierce-Port St. Lucie, FL	0.9931
Fort Smith, AR-OK	0.7738
Fort Walton Beach, FL	0.9430
Forth Worth-Arlington, TX	0.9446
Gadsden, AL	0.8599
Gainesville, FL	0.9871
Grand Forks, ND-MN	0.9243
Grand Junction, CO	0.9679
Grand Rapids-Muskegon-Holland, MI	0.9548
Great Falls, MT	0.8966
Greeley, CO	0.9336
Green Bay, WI	0.9668
Greensboro-Winston-Salem-High Point, NC	0.9129
Greenville, NC	0.9174
Harrisburg-Lebanon-Carlisle, PA	0.9223
Hartford, CT	1.1549
Hattiesburg, MS	0.7680
Hickory-Morganton-Lenoir, NC	0.8926
Houston, TX	0.9792
Huntington-Ashland, WV-KY-OH	0.9167
Huntsville, AL	0.8771
Indianapolis, IN	0.9717
Iowa City, IA	0.9442
Jackson, MS	0.8607
Jackson, TN	0.9002
Jacksonville, FL	0.9237
Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals)	0.8504
Johnson City-Kingsport-Bristol, TN-VA (KY Hospitals)	0.8337
Jonesboro, AR (AR Hospitals)	0.7843
Jonesboro, AR (MO Hospitals)	0.8026
Joplin, MO	0.8613
Kalamazoo-Battlecreek, MI	1.0400
Kansas City, KS-MO	0.9736
Knoxville, TN	0.8970
Kokomo, IN	0.9038
Lafayette, LA	0.8316
Lakeland-Winter Haven, FL	0.9357
Las Vegas, NV-AZ	1.1521
Lawton, OK	0.8077
Lexington, KY	0.8581
Lima, OH	0.9483
Lincoln, NE	0.9711
Little Rock-North Little Rock, AR	0.8951
Longview-Marshall, TX	0.8629
Los Angeles-Long Beach, CA	1.2011
Louisville, KY-IN	0.9163
Lubbock, TX	0.9646
Lynchburg, VA	0.8909
Macon, GA	0.9250
Madison, WI	1.0467
Medford-Ashland, OR	1.0303
Memphis, TN-AR-MS	0.8712
Miami, FL	0.9815
Milwaukee-Waukesha, WI	0.9893
Minneapolis-St. Paul, MN-WI	1.0903
Missoula, MT	0.9047
Mobile, AL	0.8110
Modesto, CA	1.0498
Monmouth-Ocean, NJ	1.0814
Monroe, LA	0.8137
Montgomery, AL	0.7734
Nashville, TN	0.9375
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2459
New London-Norwich, CT	1.1626

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
New Orleans, LA	0.9046
New York, NY	1.4220
Newark, NJ	1.1406
Newburgh, NY-PA	1.0747
Norfolk-Virginia Beach-Newport News, VA-NC	0.8666
Oakland, CA	1.5185
Odessa-Midland, TX	0.9180
Oklahoma City, OK	0.8900
Omaha, NE-IA	0.9978
Orange County, CA	1.1594
Orlando, FL	0.9640
Peoria-Pekin, IL	0.8739
Philadelphia, PA-NJ	1.0713
Phoenix-Mesa, AZ	0.9820
Pine Bluff, AR	0.7798
Pittsburgh, PA	0.9224
Pittsfield, MA	0.9863
Pocatello, ID	0.9674
Portland, ME	0.9620
Portland-Vancouver, OR-WA	1.0684
Provo-Orem, UT	0.9984
Raleigh-Durham-Chapel Hill, NC	0.9990
Rapid City, SD	0.8846
Reading, PA	0.9108
Redding, CA	1.1135
Reno, NV	1.0466
Richland-Kennewick-Pasco, WA	1.0800
Richmond-Petersburg, VA	0.9477
Roanoke, VA	0.8614
Rochester, MN	1.2139
Rockford, IL	0.9399
Sacramento, CA	1.1513
Saginaw-Bay City-Midland, MI	0.9543
St. Cloud, MN	0.9785
St. Joseph, MO	0.8240
St. Louis, MO-IL	0.8855
Salinas, CA	1.4623
Salt Lake City-Ogden, UT	0.9945
San Antonio, TX	0.8753
San Diego, CA	1.1135
Santa Fe, NM	0.9891
Santa Rosa, CA	1.2761
Sarasota-Bradenton, FL	0.9449
Savannah, GA	0.9376
Seattle-Bellevue-Everett, WA	1.1474
Sherman-Denison, TX	0.9008
Shreveport-Bossier City, LA	0.8987
Sioux City, IA-NE	0.8647
Sioux Falls, SD	0.9059
South Bend, IN	0.9802
Spokane, WA	1.0663
Springfield, IL	0.8659
Springfield, MO	0.8153
Stockton-Lodi, CA	1.0650
Syracuse, NY	0.9612
Tampa-St. Petersburg-Clearwater, FL	0.9171
Texarkana,AR-Texarkana, TX	0.8126
Toledo, OH	0.9810
Topeka, KS	0.9031
Tucson, AZ	0.8911
Tulsa, OK	0.8332
Tuscaloosa, AL	0.8203
Tyler, TX	0.9195
Vallejo-Fairfield-Napa, CA	1.3421
Victoria, TX	0.8756
Waco, TX	0.8088
Washington, DC-MD-VA-WV	1.0851

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Waterloo-Cedar Falls, IA	0.8902
Wausau, WI	0.9782
West Palm Beach-Boca Raton, FL	0.9939
Wichita, KS	0.9179
Wichita Falls, TX	0.8498
Wilmington-Newark, DE-MD	1.0862
Wilmington, NC	0.9425
York, PA	0.9026
Youngstown-Warren, OH	0.9358

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Rural Alabama	0.7727
Rural Florida	0.8814
Rural Illinois (IA Hospitals)	0.8315
Rural Illinois (MO Hospitals)	0.8204
Rural Kentucky	0.8079
Rural Louisiana	0.7647
Rural Michigan	0.9013
Rural Minnesota	0.9151
Rural Missouri	0.8026

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Rural Montana	0.8481
Rural Nebraska	0.8204
Rural Nevada	0.9117
Rural Texas	0.7827
Rural Washington	1.0179
Rural Wyoming	0.9007

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